National Institute for Clinical Excellence

Obesity scope - Stakeholder Consultation Table

These comments will be published on the web at publication

27 January – 24 February 2004

Stakeholder	**No.**	**Comment on which section**	**Section number**	**Comments** Please insert each new comment in a new row.	**Developer's Response** Please respond to each comment

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Abbott Laboratories Ltd.	1	General	General remit: H.D.A. scope NICE scope	The terms & reference of the scope are commendable in their breadth and inclusion, but we would question whether they are realistic. The objectives for the Guideline would be better served by separating the identification and clinical management of obesity from the prevention strategies.	Noted. The revised scope addresses the latter issue. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
Abbott Laboratories Ltd.	2	General	General	**Funding:** The scope should confirm that the present recommendations and mandatory funding arrangements for the technology appraisals of sibutramine and orlistat stand until the date of publication of the obesity clinical guideline (anticipated 2006). In addition the funding conditions post-updated review should be clarified. Currently, Clinical guidelines are advisory and do not have mandatory funding instructions to support their implementation.	The scope does not make reference to funding. The current TA will stand until the guideline is published.
Abbott Laboratories Ltd.	3	4.3.1(a)(1)	4.3.1 a)1	**Hierarchy of evidence:** Comparing the relative merits of primary vs. secondary interventions may prove difficult in terms of the quality of the evidence. Results from studies on primary interventions may not have benefited from the robust, unbiased design methodology applied to clinical studies on pharmaceutical and surgical interventions.	Noted.
Abbott Laboratories Ltd.	4	General	General & 4.3.1 a)2	**Economic analysis:** The scope is unclear about the place that health economic analysis will play in the development of this clinical guideline, although NICE has confirmed the complete integration of obesity technology appraisals. It would be appreciated if the scope could give an indication of the process and evidence requirements required. Are these similar to those for full standalone technology appraisals/reviews (i.e. cost-effectiveness, budget impact models)? Should the guideline development group (CDG) develop their own health economic models in a similar fashion to the NICE technology appraisal	This information is provided in the NICE guidelines Technical Manual 'Guideline Development Methods', available from the NICE website www.nice.org.uk.

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				review teams for technology appraisals, it is essential that stakeholders be in a position to provide data and comment on the models at various stages of the modelling process.	

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Abbott Laboratories Ltd.	5	General	General	**Outcomes:** The scope should clarify the preferred outcome in which to measure obesity (e.g. BMI) and it's improvement (e.g. weight loss, percentage loss, or BMI).	Noted. The guidance, not the scope, will make recommendations in this area.
Abbott Laboratories Ltd.	6	2	Background 2b	**Updating NSFs:** How will the guideline recommendations update the associated NSFs? Will the guidance review the standards & targets for the NSFs for CHD, Diabetes and the National Cancer Plan with a view to recommending more specific obesity management goals & objectives.	The guideline provides up to date clinical recommendations based on the best available evidence.
Abbott Laboratories Ltd.	7	4.2	4.3	**Healthcare settings:** The scope identifies the variability of service provision within the NHS to date. In addressing the standards of care provided by practioners in primary & secondary care, the guidance needs to address a framework for optimal service configuration as well as the ideal 'management pathways' of patients. **Partnership;** The scope for the H.D.A development arm of the guideline identifies the potential role of other organisations outside the NHS in the prevention and management of obesity. We would hope that the reference to the 'private sector' takes into account the valuable contribution that the pharmaceutical industry can make as quoted in the Chief Medical Officer's 2002 report on Obesity.	Noted.
Abbott Laboratories Ltd.	8	4.3.1 (a)(2)	4.3.1 a 2)	**Clinical Management: Health technology appraisal manufacturer's submissions** In the context of consolidating the health technology appraisals into the clinical guideline, an early combined simultaneous review with Orlistat is not possible (Orlistat is due for review in March 2004). Abbott Laboratories has been working to the original technology appraisal review deadline of Q4 2004 and would not be in a position to make a dossier submission detailing the updated clinical and cost-effectiveness evidence until then. Further, clarification is required on the stages of the technology appraisal process within the clinical guideline. Will these follow those for standalone technology appraisals/reviews? A key difference between a clinical guideline and technology appraisal is the	Stakeholders were consulted regarding the incorporation of the update of the technology appraisal within the guideline. This information is provided in the NICE guidelines Technical Manual 'Guideline Development Methods', available from

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				submission of published evidence for the former. Since selected content in a technology appraisal is likely to be unpublished, will this data be accepted for consideration by the clinical guideline development group? Although it is likely that much of the unpublished material within the dossier at the time of submission will be in the public domain in abstract or manuscript form by the clinical guideline publication date, how will the remaining commercial-in confidential material, if any, be treated?	the NICE website www.nice.org.uk.

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Abbott Laboratories Ltd.	9	4.3.1	4.3.2 4.3.2 a)	**Areas that will be covered**: A potential paradox exists between identifying, assessing and managing Patients (adults & children) at risk of becoming overweight and obese and excluding population-based screening methods	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2). The guidance will exclude population-based screening *programmes*.
Abbott Laboratories Ltd.	10	General	Guideline Development Group	**Clinical Group Membership:** The scope identifies professionals in primary care play an important role in the identification and management of Obesity. We would recommend the inclusion of the following professionals to reflect this: ❑ Community pharmacist (LPS & extended professional services) ❑ 2 physicians ❑ 2 GPs ❑ PCT/LHB Commissioner (service & funding considerations in Local Strategic Partnerships) **H.D.A. Group Membership**: We would also advocate that PCT/LHB commissioners and/or Chief Executives are included in the H.D.A development arm in their key role within Local Strategic Partnerships	Noted. The Health Development Agency (HDA) and National Collaborating Centre for Primary Care (NCC-PC) will decide on Guideline Development Group (GDG) membership, in consultation with NICE.
Association for the Study of Obesity	1	General	General	NICE, together with the NCC-PC and the HDA are to be commended on attempting to put together comprehensive guidance for the prevention and treatment of obesity in adults and children in the United Kingdom. However, we do have some concerns about the breadth of the guideline and feel that there should be clear separation between issues that are related to public health and general community settings from those that are much more likely to be relevant in a clinical setting such as the treatment of obesity. The title is somewhat long and clumsy and a shorter title such as 'The prevention and management of obesity and overweight in adults and children' would actually	Noted. The title has been amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).

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				cover the intended scope adequately.	

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Association for the Study of Obesity	2	4.1.1	Paragraph 4.1.1	The guideline is limiting its scope to children aged 5 years or older and adults. Inherited severe genetic forms of obesity in children may well be apparent before this age. Such children need early identification, accurate clinical and genetic diagnosis and may well respond to specific treatments. Thus the scope should be broadened to include younger children especially those with particularly severe early onset obesity.	Noted and amended. We have lowered the age range for children to 2 and over.
Association for the Study of Obesity	3	4.1.1(b)	4.1.1b	Including children and adults who are 'at increased risk of becoming overweight and/or obese' includes virtually every adult and child in the United Kingdom. Likewise, all overweight and obese people are at increased risk of developing obesity-related co-morbidities though the level of risk may vary from individual to individual. It would probably be better to use separate categories for those adults who are already obese and require treatment and for those in whom prevention is the highest priority. It would also be sensible to include a separate section on maintenance of body weight loss in adults and children who have achieved clinically meaningful weight loss (5-10%) in order to help them maintain that weight loss.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
Association for the Study of Obesity	4	4.1.2	4.1.2	Although it is understood that this guidance cannot cover the management of all obesity-related co-morbidities it is important that the scope does include comment on how obesity and its treatment may impact on the management of these conditions.	The scope highlights the relevant important issues. It is inappropriate for it to offer a detailed discussion of these issues.
Association for the Study of Obesity	5	4.2(a)	4.2a	Again, looking at all individuals who are overweight or obese encompasses virtually the whole population and likewise the majority of these individuals are at greater risk of developing obesity-related conditions. It would be worth considering those with more severe 'morbid' obesity (BMI>40) as a separate group, as this group has a very high prevalence of co-morbidity, and are more likely to require secondary or tertiary care interventions, including surgery. The NHS recently issued guidance under the provision of specialist services for this group of individuals, and it might be useful for NICE to refer to and build on this document (http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SpecialisedServicesDefinition/SpecialisedServicesDefinitionArticle/fs/en?CONTENT_ID=4001826&chk=a017Ao)	Noted and agreed. Morbid obesity will be dealt with separately. See 4.3.1d. Thank you for this reference. We have used it in the revised scope.

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Association for the Study of Obesity	6	4.2(c)	4.2c	It would again be important here to make a clear distinction between those individuals who require clinical management of obesity and/or obesity-related conditions from those whom prevention strategies and other approaches are more appropriate.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
Association for the Study of Obesity	7	4.3.1	4.3.1	This section covers the management of obesity but also includes a comment on identification. Later on under 4.32a population-based screening for overweight and obesity is specifically excluded, and yet here identification of patients with obesity is included. These two statements are clearly at odds with one another, and NICE needs to be clear as to whether it is going to consider the issue of how often children and adults should be weighed and have their BMI recorded, so that obesity can be identified and treated appropriately. The use of other measures of risk of obesity-related co-morbidities, in particular waist circumference should also be considered under this section.	Noted and amended. The guidance will consider the evidence for how often children and adults should be weighed and have their BMI recorded in an appropriate setting. The guidance will, however, exclude population-based screening *programmes*.
Association for the Study of Obesity	8	4.3.1(a)	4.3.1a	1. It is unclear whether economic analysis will be applied to non-pharmacological interventions in the same way as it has to pharmacological interventions. The ASO would recommend that it is. 2. NICE may well be aware that there are a number of new drugs that are currently in development. One suggestion would be to make the guidance sufficiently generic that it could be applied in general terms to new drugs as and when they appear, furthermore some preliminary appraisal might be made of those drugs most likely to be available when the guidance is published, to ensure that it is as up to date as possible, and does not require a major new assessment shortly after launch.	Relevant cost-effectiveness evidence will be reviewed for both pharmacological and non-pharmacological interventions. Noted, thank you.

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Association for the Study of Obesity	9	4.3.1(2)	4.3.1(2)	Would NICE be able to make a statement as to whether the current guidance for orlistat and sibutramine will have their expiry dates extended to be consistent with the date for the new appraisals being available. Otherwise, we will be in the position of having only out of date guidance available for a number of years.	The guidance will be current until the guideline is published.
Association for the Study of Obesity	10	4.3.2(a)	4.3.2a 4.3.2b	Population-based screening for overweight and obesity is essential for identification of individuals who are obese or overweight and it is difficult to see how the guidance can be implemented unless there is some recommendations about regular height and weight measurements in primary care. NICE needs to be very clear about what it means by complementary therapy – some diets may fall into this category, and other complementary therapies may claim to have an evidence base.	Noted and amended. The guidance will consider the evidence for how often children and adults should be weighed and have their BMI recorded in an appropriate setting. The guidance will, however, exclude population-based screening *programmes*. Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm)
Association of Clinical Biochemists (ACB) Scientific committee	1	3	3	Perhaps address need for lower BMI cut-offs in certain ethnic groups – for example, South Asians have significantly greater fat mass and insulin resistance compared to BMI matched Caucasians	We will consider the issue of BMI cut-offs generally in the guidance .
Association of Clinical Biochemists (ACB) Scientific committee	2	3	3	Perhaps interventions to **prevent weight gain** should receive as much prominence as those aimed at getting individuals to lose weight since the primary 'pathology' here is weight gain.	Noted and agreed.
Association of Clinical Biochemists (ACB) Scientific	3	4	4	Why not address children less than 5 – recent paper from a Glasgow group published in Lancet demonstrating kids as young as three have very sedentary lifestyles.	Noted and amended. We have lowered the age range for children to 2 and over.

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committee					
Association of Clinical Biochemists (ACB) Scientific committee	4	4.3.1	4.3.1	ACB can assist in determining which biochemical tests, or group of tests, help identify overweight or obese individuals at most risk of developing chronic diseases such as diabetes, CHD etc.	Noted. This is an area the Guidance Development Group may wish to consider when developing the guidance.
Association of Clinical Biochemists (ACB) Scientific committee	5	4.3.1		ACB can assist in the role of biochemical tests to exclude secondary causes of obesity	Noted. This is an area the Guidance Development Group may wish to consider when developing the guidance.
Association of Clinical Biochemists (ACB) Scientific committee	6	4.3.1		ACB can assist in examining if biochemical tests have a role, if any, in determining which individuals are at greatest risk of becoming overweight or obese	Noted. This is an area the Guidance Development Group may wish to consider when developing the guidance.
Atkins Nutritionals (UK) Ltd with Atkins Nutritionals Inc	1	General	General	The root cause of obesity is considered in the document to be the energy balance hypothesis-calories in must equal calories out in order for weight to be neutral. But the cause of weight loss or maintenance may not be calories: it may instead be metabolic hormone signals (carbohydrates trigger insulin release and blood glucose excursions which result in carbohydrate cravings and fat storage). The scope should at least include the possibility of changes in the paradigm of weight gain and weight maintenance.	The scope highlights the relevant important issues. It is inappropriate for it to offer a detailed discussion of these issues. We will review the evidence for generic types of diet.
Atkins Nutritionals (UK) Ltd with Atkins Nutritionals Inc	2	General	General	All relevant peer-reviewed papers relating to the controlled carbohydrate approach should be considered in developing the guidelines in order accurately to reflect emerging science in this area. Atkins Health & Medical Information Services will be happy to provide references.	Noted.

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Atkins Nutritionals (UK) Ltd with Atkins Nutritionals Inc	3	General	General	The scope of the NICE report should clearly include the opportunity for pilot programs and work with partners in devising simple effective plans for teaching and implementing carbohydrate restriction in the primary practice setting. These plans/information packets should be simple, use as little practitioner time as possible but include algorithms for the practitioners in terms of medication management decisions needed in the controlled carbohydrate plan.	Noted.
Atkins Nutritionals (UK) Ltd with Atkins Nutritionals Inc	4	4.1.1	4.1.1	The scope of the NICE report should be broadened to include children of age 2 and older.	Noted and amended. We have lowered the age range for children to 2 and over.
British Association for Counselling and Psychotherapy	1	General	General	We would suggest that the intention to include both adult and child obesity in one guideline will result in a potentially unwieldy and confusing guideline. In the experience of those working in the field of obesity, the needs and management approaches are very different for adults than those of children. We would recommend that there are two separate documents. Many of the 'methods' for treating obesity in adults, do not apply to children and young people, such as surgical interventions and medication (oralstat and sibutrimine are not yet licensed in the UK for under 18's). In adults, consideration of established co-morbidities such as heart disease, hypertension, cancer, osteoporosis would have to be made whereas in children, asthma and hip problems are more prevalent, along with the social impact of being overweight. Children of all ages are more susceptible to suffer socially from obesity. At a time when body image and self-esteem are developing, growing up obese can have huge negative effects on a young person's life and can give rise to bullying and self-harm.	Noted. We have been tasked to develop guidance to cover both management of overweight and obesity and prevention in children and adults.
British Association for Counselling and Psychotherapy	2	1	1. Guidance title	A more succinct title should be considered.	Noted and amended.

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British Association for Counselling and Psychotherapy	3	2	2. Background	The Scope states that the guidelines will be based on the best available evidence. There is little scientific evidence on strategies to tackle obesity at present, especially in the UK, although there is more literature available in the USA and European countries. There is a need to consider cultural differences if these are used to make recommendations for practice in the UK.	Noted. Black and minority ethic group issues will be considered (see 4.1.1).
British Association for Counselling and Psychotherapy	4	4.1.1	4.1.1 Groups to be considered	See the 'General' comment above on adult and childhood obesity.	Noted.
British Association for Counselling and Psychotherapy	5	4.1.1	4.1.1 Groups that will not be considered	The under 5's should not be excluded from this guideline. There is evidence that breast fed babies are less likely to become overweight than powder fed babies and long thin babies are felt to be more prone to obesity that short fat babies. These are important indicators for early identification and prompt assessment and treatment as a preventative measure. This stage is considered crucial in offering dietary education and establishing early healthy eating patterns. According to recent research data the persistence of obesity into adulthood depends on several factors, including the age at which the child becomes obese, the severity of the disease and the presence of obesity in at least one parent. Overweight in a child under 3 years of age does not predict future obesity, unless at least one parent is also obese. After age 3, however, the likelihood that obesity will persist into adulthood increases with the advancing age of the child and is higher in children with severe obesity in all age groups. After an obese child reaches 6 years of age, the probability that obesity will persist exceeds 50% and 70-80%t of obese adolescents will remain so as adults. The presence of obesity in at least one parent increases the risk of persistence in children at every age.	Noted and amended. We have lowered the age range for children to 2 and over.
British Association for Counselling and Psychotherapy	6	4.3	4.3 Clinical Management	This does not address emotional or psychological issues other than behavioural approaches. It is known that eating behaviour is determined to a significant extent by psychological issues. This has been demonstrated for obese people.	The scope highlights the relevant important issues. It is inappropriate for it to offer a detailed discussion of these issues.

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				The NICE guidelines on eating disorders made very limited reference to Binge Eating Disorder (BED) but noted that cognitive behavioural responses had not been shown to produce weight loss. It is likely that the prevalence of BED is higher than has so far been identified. Psychological responses to those who are obese as a result of BED need to be adopted. The implication of these factors is that a psychological element in the treatment of obesity ought to be investigated. Please see following argument and supporting references.	
British Association for Counselling and Psychotherapy	7	General		1. Eating behaviour is not simply a response to physiological need but is also determined by cultural and emotional factors. These factors probably affect a majority of people (Lupton 1996; Ogden 2003). It has been known for some time that emotional eating is 'positively correlated with Body Mass Index' (BMI) (Van Strien, Frijter, Roosen, Knuiman-Hijl and Defares, 1985; Wardle, 1987) and that it interferes with attempts to lose weight (Leon and Chamberlain,1973; Sjoberg and Persson 1979; Blair, Lewis and Booth 1990). It is also known that maintenance of weight loss is extremely problematic and that maintenance strategies need to be developed further (NHS Centre for Reviews and Dissemination 1997; Wing and Klem 2002). The most successful maintenance strategies seem to depend on continuing psychological/social support (Perri 2002). It is also clear from a great deal of literature that psychological issues such as self-esteem, body-esteem and empowerment are relevant to the life-style change that is implied in treatment for obesity. this is demonstrated in the recent literature relating to group treatments for obesity (Lewis et al 1992; Polivy and Herman 1992; Carrier et al 1994; Omichinski and Harrison 1995; Robinson and Bacon 1996; Mellin et al 1997; Goodrick et al 1998; Allen and Craighead 1999). This data suggests that excluding psychological (as opposed to behavioural) issues from the SCOPE is inadvisable. 2. BED has generally been assigned to the realm of eating disorders rather than that of obesity in recent years. The NICE guidelines on Eating Disorders gave some minimal attention to BED and recommended that CBT be offered to patients. However the guidelines also indicated that no psychological treatments for BED can reliably be shown to produce weight loss (National Collaborating Centre for Mental Health 2004). Yet, for obvious reasons many of those suffering from BED are likely to be obese. In the interests of the management of obesity in	Noted. It is outside the scope of the guidance to address Binge-Eating Disorder. See 4.4. Reference will be made to the NICE Eating Disorders guideline as appropriate.

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				these cases further psychological treatments need to be developed. 3. The prevalence of BED has been estimated to be 3% of the adult population and 8% of the obese population. This amounts to approximately one million people in the UK - a far from negligible patient group. Among obese people seeking treatment, rates of BED of 20-40% have been reported (Grilo, 2002). By definition sufferers from BED are eating without reference to physiological need and require a psychological response. The older feminist literature which reported clinical experience (e.g. Orbach 1978; Roth 1982, 1984; Chernin1985; Lawrence and Dana 1990; Burgard and Lyons 1994; Ball and Norman 1996) and identified women who ate compulsively argued that eating behaviour of this kind has meaning and function and is susceptible to psychotherapeutic approaches. A number of recent commentators have suggested that this hypothesis needs to be formally tested. The author of this response has begun a research programme for this purpose. Further research effort in this direction is clearly necessary. REFERENCES: Allen, H.N. and Craighead, L.W. (1999) Appetite monitoring in the treatment of binge eating disorder. *Behavior Therapy.* **30.** 253-272. Ball, J. and Norman, A. (1996) 'Without the group I'd still be eating half the co-op' An example of groupwork with women who use food. *Groupwork*. **9.** (1): 48-61. Blair, A. J., Lewis, V.J. and Booth, D.A. (1989) Does emotional eating interfere with success in attempts at weight control? *Appetite* **15**, 151-157. Burgard, Deborah and Lyons, Pat (1994) Alternatives in Obesity Treatment: Focusing on Health for Fat Women in Fallon, Patricia, Katzman, Melanie A. and Wooley, Susan C. (eds) *Feminist Perspectives on Eating Disorders.* New York, NY. The Guilford Press. Carrier, K.M., Steinhardt, M.A. and Bowman, S. (1994). Rethinking traditional weight management programs: A 3-year follow-up evaluation of a new approach. *The*	

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				Journal of Psychology. **128.** 517-535. Chernin, Kim (1985) *The Hungry Self: Women, Eating and Identity.* London, UK. Virago. Goodrick, G.K., Poston, W.S.C. II, Kimball, K.T., Reeves, R.S. and Foreyt, J.P. (1998) Nondieting versus dieting treatment for overweight binge-eating women. *Journal of Consulting and Clinical Psychology.* **66.** 363-368. Grilo, Carlos M. (2002) Binge Eating Disorder in Brownell, Kelly D. and Fairburn, Christopher G (eds) *Eating Disorders and Obesity.* New York, NY. The Guilford Press. Lawrence, Marilyn and Dana, Mira (1990) *Fighting Food: Coping with Eating Disorders.* London, UK. Penguin Books Ltd. Leon, G. R. and Chamberlain, K. (1973). Emotional arousal, eating patterns and body image as differential factors associated with varying success in maintaining a weight loss. *Journal of Consulting and Clinical Psychology* **40,** 474-480. Lewis, V.J., Blair, A.J. and Booth, D.A. (1992) Outcome of group therapy for body-image emotionality and weight-control self-efficacy. *Behavioural Psychotherapy,* **20.** 155-165. Lupton, Deborah (1996) *Food, the Boy and the Self.* London, UK. Sage Publications. Mellin, L., Croughan-Minihane, M. and Dickey, L. (1997) the solution method: 2-year trends in weight, blood pressure, exercise, depression and functioning of adults trained in development skills. *Journal of the American Dietetic Association.* **97.** 1133-1138. National Collaborating Centre for Mental Health. (2004) Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. Clinical Guideline 9. London, UK. National Institute for	

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				Clinical Excellence. NHS Centre for Reviews and Dissemination. (1997) The prevention and treatment of obesity. *Effective Health Care* **3** (2). Ogden, Jane (2003) *The Psychology of Eating.* Oxford. UK. Blackwell Publishers Ltd. Omichinski, L. and Harrison, K.R. (1995). Reduction of dieting attitudes and practices after participation in a non-diet lifestyle program. *Journal of the Canadian Diabetic Association.* **56.** 81-85. Orbach, Susie (1978) *Fat is a Feminist Issue.* London, UK. Arrow. Perri, Michael G. (2002) Improving Maintenance in Behavioral Treatment in Brownell, Kelly D. and Fairburn, Christopher G (eds) *Eating Disorders and Obesity.* New York, NY. The Guilford Press. Polivy, J. and Herman, C.P. (1992) Undieting: A program to help people stop dieting. *International Journal of Eating Disorders.* **11.** 261-268. Robinson, B.E. and Bacon, J.G. (1996) The "If Only I Were Thin…" treatment program: Decreasing the stigmatizing effects of fatness. *Professional Psychology Research and Practice.* **27** (2). 175-183. Roth, Geneen (1982) *Feeding the Hungry Heart: The Experience of Compulsive Eating.* New York, NY. Signet. Roth, Geneen (1984) *Breaking Free from Compulsive Eating.* New York, NY. Plume. Sjoberg, L. and Persson, L.-O. (1979). A study of attempts by obese patients to regulate eating. *Addictive Behaviours* **4,** 349-359. Van Strien, T., Frijters, J. E. R., Roosen, R. G. F. M., Knuiman-Hijl, W. J. and Defares, P. B. (1985). Eating behaviour, personality traits and body mass in women.	

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				Addictive Behaviors. **10,** 333-343. Wardle, J. (1987). Eating style: a validation study of the Dutch eating behaviour questionnaire in normal subjects and women with eating disorders. *Journal of Psychosomatic Research* **31,** 161-169. Wing, Rena R. and Klem, MaryLou. (2002) Characteristics of Successful Weight Maintainers in Brownell, Kelly D. and Fairburn, Christopher G (eds) *Eating Disorders and Obesity.* New York, NY. The Guilford Press.	
British Association of Behavioural and Cognitive Psychotherapy				Research question – What effect does cognitive behaviour therapy have on the treatment of obesity & role of binge eating disorder in relation to obesity.	Noted.
British Association of Behavioural and Cognitive Psychotherapy	1	General	General	- 50% of morbid obese people suffer from clinical depression. - High proportion experience low self esteem, body image problems, psychological trauma. - Children experience teasing/bullying. - Discrimination in employment for adults. - Addressing social attitudes.	Noted.
British Association of Behavioural and Cognitive Psychotherapy	2	4.3	Specific 4.3	All should be cognitive behavioural interventions and behavioural interventions.	Noted and amended. The term 'psychological' rather than 'behavioural 'is used to reflect broader range of therapies.
British Association of Behavioural and Cognitive Psychotherapy	3	General	General	Not enough emphasis on psychological treatments – cognitive behaviour. Establishing different protocols for 1.Psychological 2. Medical 3. Surgical and combination of these treatments.	Noted and amended. The term 'psychological' rather than 'behavioural 'is used to reflect broader range of therapies.

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				Local and regional specialist clinics. Research question – What effect does cognitive behaviour therapy have on the treatment of obesity & role of binge eating disorder in relation to obesity.	
British Dietetic Association	1	General	General	The plans to develop guidance that addresses the prevention as well as the management of overweight and obesity are timely and welcomed. This two-tiered approach is critical if the epidemic of obesity is to be comprehensively addressed.	Noted. Thank you.
British Dietetic Association	2	General	General	There are serious concerns about the feasibility of undertaking such a broad scope within the suggested framework and timelines.	Noted. We have been tasked to develop guidance to cover both management of overweight and obesity and prevention in children and adults. We will be working to a clear timeplan agreed with NICE.
British Dietetic Association	3	General	General	This is an extremely ambitious project given the complexity of the problem and its multi-agency nature.	Noted. We have been tasked to develop guidance to cover both management of overweight and obesity and prevention in children and adults. The work will be supported by the expertise of the GDGs whose members will be drawn from a broad constituency.
British Dietetic Association	4	General	General	The proposed representation in the guidance development groups from the dietetic profession is welcomed. However there are some critical specialities missing that would seem integral to the clinical management of obesity. We suggest there needs to be representation from an endocrinologist with specialist experience in the management of morbid obesity and a bariatric surgeon. These two areas would seem particularly important given the valued and evidence based role of pharmacotherapy and surgery in the management of morbid obesity.	Noted. The HDA and NCC-PC will decide on the GDG membership in consultation with NICE. We will seek appropriate professional advice from those with expertise in the field of morbid obesity.
British Dietetic Association	5	General	General	Prevention is an extensive topic with a huge public health aspect which is very different from clinical; There is concern over how prevention will be covered and therefore it may be advisable to produce it as separate guidance (although there would be some reference to prevention as part of	Noted. We have been tasked to develop guidance to cover both management of overweight and obesity and prevention in children and adults. The guidance will

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				clinical treatment).	cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
British Dietetic Association	6	General	General	Some of the published NICE guidance for large subject areas e.g. Diabetes and Cancers have broken down their different aspects into manageable separate topics, each with their own guidance. We commend this approach for the guideline on Obesity.	Noted. We have been tasked to develop guidance to cover both management of overweight and obesity and prevention in children and adults.
British Dietetic Association	7	General	General	To ensure the final reports are user-friendly and accessible it would seem important to produce three separate documents, two clinical and one public health that could be targeted at the appropriate organisations and professions. This would be comparable to the format used in the clinical guidelines published by the National Health and Medical research Council, Australia in 2003.	We have been tasked to develop guidance to cover both management of overweight and obesity and prevention in children and adults. We will consider this point during the development of the guidance.
British Dietetic Association	8	General	General	Identification and assessment are included in the title of the guidance document and yet very little emphasis has been given to this in subsequent sections. Assessment of overweight and obesity in adults and children is a critical and often neglected aspect of management. Its importance should be reflected in the body of the scoping document and not just in the title. Only with a clear and comprehensive understanding of the factors contributing to overweight and obesity and the accompanying level of risk to health can treatment strategies be tailored to the needs of the individual.	Noted and amended. The revised scope covers in more detail identification and assessment (4.3.1a).
British Dietetic Association	9	General	General	It seems unlikely that two guidance development groups consisting of approximately 10 people per group will be able to develop such extensive documents within the suggested time-frame. It may be more feasible if the clinical group was subdivided into adult and paediatric specialties (to include the under-fives) with the development of two separate clinical guidance documents.	Noted. We plan to use adult and child clinical subgroups. The NCC-PC has experience of this approach with the NICE Epilepsies guideline.

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British Dietetic Association	10	General	General	It is critical that the guidance documents and recommendations produced are seen to be realistic to implement in practice. This will require substantial consideration to the process of service provision as well as the treatment/prevention pathway and may be facilitated by the inclusion of a representative from a strategic health authority.	Noted.
British Dietetic Association	11	General	General	It will clearly be important to establish an equivalent protocol for the grading of evidence for the public health group as already exists via NICE.	Noted and agreed.
British Dietetic Association	12	General	General	There is a concern over how well the vast workload involved in this process is matched to the dedicated capacity of those charged with the responsibility of completing the work, given the timescale.	Noted. We be working to a clear timeplan agreed with NICE.
British Dietetic Association	13	General	General	We would urge the utilisation of existing work (i.e. good systematic reviews) and simply update these, rather than start from scratch, even if the inclusion/exclusion for these reviews is slightly different. Where it is felt that existing reviews should be updated, those groups who conducted the original review should be commissioned to carry out the update.	Noted. We would plan to use existing reviews where possible. We are not funded to commission other groups to undertake further systematic reviews.
British Dietetic Association	14	General	General	We have concerns about the difficulties that may arise from the desire to develop guidance on lifestyle, drug and surgical interventions based on the same evidence base (e.g. RCT's only, minimum of one year follow-up).	Noted.
British Dietetic Association	15	General	General	We believe that the HDA should start from the basic premise of including all individuals in the review, and specify those groups that will be specifically excluded (e.g. those in prison, the armed forces)	Noted. Specific exclusions are noted in 4.4. The groups highlighted will be considered if the evidence is available.
British Dietetic Association	16	General	General	At the start of this process it is essential that the remit of all agencies and groups involved (NICE, HDA, HDA Reference Group, HDA E&G Collaborating Centre for Obesity, Guideline Development Group) should be made explicit. It should also be made clear at the start how the communication and reporting roles of these agencies and groups will operate.	Noted. Para 2a) of the scope outlines what has been agreed.
British Dietetic Association	17	General	General	Make it explicit that the needs of those with a BMI of over 40 are covered within the guidance and ensure that this includes the non-surgical management (exercise, diet and CBT/ of this group of patients for whom standard advice is not appropriate. This includes areas such as increasing	Noted and amended. The guidance will address morbid obesity (4.3.1d).

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				the amount of exercise very obese counselling/motivational strategies) people undertake which may need specialist Physiotherapist input.	
British Dietetic Association	18	2(a)	2 a	The last sentence in the paragraph states that the guidance will provide recommendations for good practice etc. Will this mean that the recommendations can be ignored because of resource issues etc?	The guideline recommendations represent considered best practice by the Guideline Development Group, and should be implemented to a locally agreed plan.
British Dietetic Association	19	2(a)	2 a	What steps will be put in place to ensure that the guidance will be implemented?	The guidance will identify key priorities for implementation and broad audit criteria for the NHS. It is outside the remit of NICE to focus on implementation.
British Dietetic Association	20	3	3	The case for the 'clinical' need for the guidance document has been made well but little argument has been presented highlighting the need for the prevention/public health aspect of the guidance	Section 3 does highlight the prevention/public health aspects of the guidance.
British Dietetic Association	21	3(a)	3 a	The definition of BMI is stated, however it is widely recognised that the definition of obesity should be adapted for ethnicity. For instance, Asians are classed as obese at a lower BMI and therefore may be under-reported. Should there be a sentence regarding this?	The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues. They will be considered in the guidance (see 4.1.1 & 4.3.1).
British Dietetic Association	22	4.1.1	4.1.1	The difficulties in giving the age cut-offs are acknowledged but it is felt that it may be better in the long-term to include all age groups. In some areas it may be best to use a family approach. Hopefully, it will be possible to cross-reference to the NSF for children. There needs to be clarity that this includes diversity e.g. ethnicity, disability.	Noted and amended. We have lowered the age range for children to 2 and over.
British Dietetic Association	23	4.1.2	Section 4.1.2	There is an escalating body of evidence that suggests the under 5 age category is a critical period in establishing eating and activity behaviours and implementing prevention strategies. There is also recognised variability in the measurement and assessment of overweight and obesity in infants and young children. This would seem an ideal opportunity to develop guidance for practitioners working with this age group. Clearly the infant/young child needs to be considered as part of the family unit with recommendations taking this into consideration.	Noted and amended. We have lowered the age range for children to 2 and over.

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British Dietetic Association	24	4.2	4.2	Omit 'healthcare' from the title. This is not an appropriate description for those settings to be considered by the public health/prevention guidance development group. It should include non healthcare settings and partnerships with the leisure and food industries, workplaces and transport.	We would prefer NICE to use the term 'Settings'.
British Dietetic Association	25	4.3.2	Section 4.3.2	It is unclear which approaches would be included in the 'complementary' category and therefore excluded from the guidance document. It would be important to clarify whether controversial dietary approaches will be considered in the main document or excluded.	Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm). The guidance will consider generic dietary approaches.
British Dietetic Association	26	4.4	Section 4.4	It may be appropriate to consider incorporating audit measures within revised criteria for the General practice GMS and PMS contracts	Noted, thank you. This will be considered before the publication of the guidance.

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British Geriatrics Society – Gastroenterology & Clinical Nutrition Group	1	General	General	I strongly believe that there should be completely separate Guidelines for Prevention of Obesity rather than combining Prevention and Management of Obesity in the same guidelines. Prevention would need to be opened out to industry (*food industry*), environment (*town planning*), government (*guidelines on food marketing, food labelling and food advertising*) – Childhood obesity is not helped by shortcomings in these areas. Perhaps the Prevention side will be too big a scope to deal with – will need to go outside the NHS.	We have been tasked to develop guidance to cover both management of overweight and obesity and prevention in children and adults. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2). The guidance will not make specific recommendations for National policies such as fiscal policy, or food labelling policy. Such policies will be addressed in broader ongoing work, for e.g. the forthcoming Food and Health Action Plan (see 4.4).
British Geriatrics Society – Gastroenterology & Clinical Nutrition Group	2	General	General	We have noted during the presentation that it was intended to include a paediatrician and a physician in the Development Group, but not a geriatrician. The society feels that the presence of a Specialist Elderly Care Physician with an interest in the nutrition and obesity in the elderly for the Development Group is paramount. The management of obese but young and relatively fit persons is completely different from that of an obese elderly person with multiple medical problems; and poor mobility.	Noted. The NCC-PC and the HDA, in consultation with NICE, will decide on the composition of the Guideline Development Group.
British Geriatrics Society – Gastroenterology & Clinical Nutrition Group	3	General	General	The assessment of nutritional status should be universal in all age group and, because assessment of overweight is relying primarily on weight and height, we feel that **MUST** should be the tool used universally for these purposes.	Noted. This is an area the Guidance Development Group may wish to consider when developing the guidance.
British Geriatrics Society – Gastroenterology &	4	General	General	We felt that the Royal College Of Surgeons should have been included as a Stakeholder. There is strong evidence that the most effective management of morbid obesity is surgery. Surgery has also been mentioned in the	The Royal College of Surgeons was invited to register as a stakeholder.

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Clinical Nutrition Group				Scope as one way of treating overweight people. However, no plans have been made for surgeons to be included in the Guideline Development Group. Equally, the lack of pharmacy representatives, both in the Stakeholder group as well as in the Guideline Development Group is evident and the advice is to have a pharmacist on the membership, as drug therapy is one of the methods used in the management of obesity, in addition to the dietitian, psychotherapist and exercise trainer.	The NCC-PC and the HDA, in consultation with NICE, will decide on the composition of the Guideline Development Group. We will seek to ensure appropriate representation from surgeons. We will seek to ensure appropriate representation from pharmacy representatives.
British Geriatrics Society – Gastroenterology & Clinical Nutrition Group	5	4.1	4.1 (Population)	Is there a reason why under 5's are not being addressed? When defining obesity I think there should be an emphasis that you ensure simple obesity and endocrine causes for obesity are excluded, as well as conditions that are genetically related, such as Prader-Willi Syndrome, etc.	Noted and amended. We have lowered the age range for children to 2 and over. The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues. Section 4.4e highlights that the guidance will not cover diagnosis and management of childhood syndromes such as Prader-Willi or childhood diseases (e.g. hypothyroidism) that lead to obesity.
British Geriatrics Society – Gastroenterology & Clinical Nutrition Group	6	4.1.1(b)	4.1.1 (b) (Groups that will be covered)	When addressing Prevention and targeting people who are at increased risk of becoming overweight or obese, I think families, rather than individuals, should be targeted and prevention should be initiated at schools. Emphasis would also have to be put on group therapy. This is essential because the aim is to change and modify the lifestyle of the individual within their own surroundings; ie: home, school, etc. Therefore, many organisations need to be involved, such as teaching unions, supermarkets, fast food agencies, etc.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
British Geriatrics	7	4.3.2(b	4.3.2	What is complimentary therapy? Does this include non-medical based	Noted and amended. The guidance will

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Society – Gastroenterology & Clinical Nutrition Group		)	(b) (Areas that will not be covered)	therapy such as Aromatherapy, Hypnotherapy, Reflexology, etc.	consider the evidence for how often children and adults should be weighed and have their BMI recorded in an appropriate setting. The guidance will, however, exclude population-based screening *programmes*. Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm).
British Heart Foundation	1	2	2 Background A	This paragraph contains a confusing statement and might imply to some that one wishes to maintain weight in people who are already obese or overweight. The phraseology is much better set out in the Appendix (page 11) "To prepare clinical guidance for the NHS in England and Wales for the prevention of obesity and the identification, evaluation, and management of overweight and obese **people** including the maintenance of weight loss".	Noted and amended.
British Obesity Surgery Society	1	4.3.1(3)	4.3.1.3	The NICE guidance as published on July 2002 is due for review on June 2005. The British Obesity Surgery Society would like to be involved in this review.	Thank you. The review of the guidance is to be incorporated into the guideline, This information is provided in the NICE guidelines Technical Manual 'Guideline Development Methods: Information for National Collaborating Centres and Giudeline Developers', available from the NICE website www.nice.org.uk.
British Psychological Society – Faculty of Clinical Health Psychology	1	General	General Comment	We welcome this development and fully support guidance construction that considers prevention and treatment options for obesity together.	Noted. Thank you.

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British Psychological Society – Faculty of Clinical Health Psychology	2	3(a)	Section 3a, page 3: 'Aetiology'	We wondered whether further consideration should be made to developing the aetiological framework based on the interaction of biological, psychological and social factors.	The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues.
British Psychological Society – Faculty of Clinical Health Psychology	3	3(a)	Section 3a, page 3: 'Aetiology'	Whilst we support the acknowledgement of the psychological consequences of obesity to both adults and children, we wondered whether specific demarcation of these (including but not exclusively negative affective state impacts) would be of benefit to understanding the breadth of psychological features relevant.	The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues.
British Psychological Society – Faculty of Clinical Health Psychology	4	3(b)	Section 3b, page 4: 'Behaviour Change'	We support the NAO view of joint agency working in terms of preventing obesity and implementing 'psychological' (rather than behavioural) change. As such, this leads to the conclusion that this guideline could benefit from being structured from a biopsychosocial frame of reference.	The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues.
British Psychological Society – Faculty of Clinical Health Psychology	5	4.2(c	Section 4.2c, page 6/7: 'Joint NICE and HAD'	As above regarding the guideline structure. (see comment on section 3(b) of the scope)	Noted.
British Psychological Society – Faculty of Clinical Health Psychology	6	4	Section 4: General Comment 1	We considered that a review of the literature on the relationship between psychological functioning (including affective state difficulties) and obesity would be of benefit to the guideline.	It is inappropriate for the scope to offer a detailed discussion of these issues. This issue will be considered by the Guidance Development Group.
British Psychological Society – Faculty of	7	4	Section 4:	We wondered whether there might also be benefit in linking the guidance to the NICE Eating Disorder guideline (in terms of the benefits of psychological	The guidance will make reference to the NICE Eating Disorder guideline as

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Clinical Health Psychology			General Comment 2	assessment and psychological treatment but also the relationship between these eating disorders and obesity).	appropriate.
British Psychological Society – Faculty of Clinical Health Psychology	8	4.3.1(a)	Section 4.3.1.a. 1, page 7: 'Non-pharmacological'	As mentioned above, psychological approaches to prevention and managing obesity are more complicated than the use of the term 'behavioural' would imply. We considered that replacement of the term 'behavioural approaches' with 'psychological approaches' would be a more comprehensive position statement for the guideline to follow, thus facilitating the use of other evidence-based psychological treatments.	Noted and amended. The term 'psychological' rather than 'behavioural' is used to reflect broader range of therapies.
British Psychological Society – Faculty of Clinical Health Psychology	9	4.3.1(a)	Section 4.3.1.a. 3, page 8: 'Surgical treatment'	As in the previous NICE guidance for surgical treatment of morbid obesity, we would support the requirement for psychological assessment and psychological support to be carried out in parallel. A further role for the proposed guidance on obesity would be to develop this objective.	Noted. This is an area the Development Group may wish to consider when developing the guidance.
British Psychological Society – Faculty of Clinical Health Psychology	10	4.3.1(a)	Section 4.3.1.a. 4, page 8: 'Maintenance'	We considered that there was a significant role for understanding psychological processes (and therefore implementing psychological treatments) in terms of both weight maintenance but also in relapse prevention.	Noted and amended. The term 'psychological' rather than 'behavioural' is used to reflect broader range of therapies.
British Psychological Society – Faculty of Clinical Health Psychology	11	4.3.1(d)	Section 4.3.1.d, page 8: 'Prevention'	We also considered a significant role for understanding psychological processes in primary prevention.	Noted.

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Cambridge Manufacturing Co Ltd	1	General	General	As both clinical and non-clinical interventions are to be evaluated under this Guidance, the term 'treatment' should be replaced throughout by 'management'	Noted. We have used the term management when appropriate.
Cambridge Manufacturing Co Ltd	2	General	General and 4.3.1.(a)	The Scope should include provision for recommendations about the role that formula slimming products can play both in clinical and in non-clinical settings in achieving and maintaining weight loss. As PARNUTS products, these are the only category of diet programme whose formulation and claims are already regulated and as such they must be included under 'Diet' as a non-pharmacological intervention.	Noted. When there is good quality evidence of effectiveness, the guidance will consider generic dietary approaches.
Cambridge Manufacturing Co Ltd	3	4.1.2(a)	4.1.2 (a)	The management of medical conditions associated with overweight or obesity is inextricably linked with interventions (for example through reduced medication) and should be taken into account when assessing effectiveness and cost effectiveness.	The guidance will advise on weight management in these groups, but not on the management of the condition *per se.*
Cambridge Manufacturing Co Ltd	4	General	General	The scope of this Guidance is exceptionally wide, taking in as it does almost the whole population as being either currently overweight/obese, or at risk of becoming so, or in weight maintenance phase, as well as evaluating both clinical and non-clinical evidence from all available – and very varied – sources. Whilst prevention is an extremely important long term strategy, the **management** of those who are currently overweight/obese through all available intervention options (both clinical and non-clinical) should be a priority if projected costs over the next 5 years are to be reversed.	We have been tasked to develop guidance to cover both management of overweight and obesity and prevention in children and adults. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
Cambridge Neurotechnology	1	4.3.1 (a)	4.3.1 a) 1)	After 'diet, physical activity and behavioural approaches . ' insert Guidance will be given on objective and reliable methods of measuring physical activity levels.	Noted. This is an area the Guideline Development Group may wish to consider when developing the guidance.

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Cancer Research UK	1	1	Title	We have slight concerns with the title of the guideline and whether or not it could be misleading. We suggest it could be changed to: "Healthy Weight Maintenance: The prevention, identification, assessment and treatment of obesity and overweight in adults." This is to avoid using the phrase: "weight maintenance of obesity", which is also used in section 2 (a).	Noted and amended.
Cancer Research UK	2	4.1.1	4.1.1/4.2	We would like the scope to clarify how specific areas of the population covered are to be identified. In section 4.1.1 (b) we would like clarification of how those who are not currently obese will be identified as being "at risk" and how their risk will be measured. In the case of children will this mean including children of a healthy weight whose parents are obese? In the case of adults deemed "at risk" will this be done by looking at socio-economic factors or other indicators? This is also relevant in section 4.2 (a) where "those who are at increased risk of becoming overweight or obese" are referred to again.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
Cancer Research UK	3	4.3.1	4.3.1	In section 4.3.1 we would like clarification of whether or not the effectiveness of psychological support for those undergoing 'treatment' will be included (i.e. for those morbidly obese who have become that way for psychological reasons).	Noted. This is an area the Guideline Development Group may wish to consider when developing the guidance. The scope highlights the relevant important issues. It is inappropriate for it to offer a detailed discussion of these issues.
Central Council of Physical Recreation (CCPR) (also supporting Move4Health's comments)	1	2(b)	2 (b)	Explore the possibility of an NSF for Obesity	This is outside the scope of the obesity guidance.
Central Council of Physical Recreation (CCPR) (also	2	4.1.1	4.1.1 (a), (b) & (c)	Whilst we understand the need to limit the scope of the guidelines for the purposes of practicality, we feel that not looking at the under fives is a missed opportunity. The CCPR as the representative body for 270 national	Noted and amended. We have lowered the age range for children to 2 and over.

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supporting Move4Health's comments)				sporting organisations encourages an active and healthy lifestyle from an early age. Tackling obesity and the causes of obesity requires a holistic approach- and learning about the benefits of activity and diet for good health is a process that should begin at an early age and be incorporated into family and school life from the offset. Thus, drawing an arbitrary line at five seems illogical in attempts to address the systemic causes of the problem.	
Central Council of Physical Recreation (CCPR) (also supporting Move4Health's comments)	3	4.3.1	4.3.1 (c), 4.3.1 (a)	Though the key focus of the guidelines is NHS staff, we urge that the strategy ultimately be disseminated far wider. We recommend that the guidelines reach NHS partners in order that effective action is taken in an early delivery setting to tackle/prevent the problem.	Noted.
Child Growth Foundation	1	General		**"The prevention, identification, assessment, treatment and weight management obesity and overweight in adults and children"** SCOPE consultation response *children younger than 5 yrs [4.2.1]* The Foundation has an overriding concern that children younger than 5yrs must **not** be excluded from the scope. Even if recent peer review papers had not placed in the public domain the fact that a significant number of children may be identified as a risk from later overweight/obesity from the 1st yr of life, the DH citation that 9% of children are obese between age 2- 4yrs should be enough to convince you to include preschool children in the scope [DH Press Release 16Feb04] If the Foundation has further involvement with the participation in the Guidance, it will emphasis that initiatives to "prevent" of obesity – which must *always* be better than its "cure" – needs to precede birth if prevention is to have any lasting effect. The crisis management measure of sending bad parents back to school [as reported in today's OBSERVER] might not be necessary if parenthood and the care of children were addressed in school and/the 9 pregnancy period. In recognition that good nutrition in pregnancy	Noted and amended. We have lowered the age range for children to 2 and over.

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				is a factor in the need for the newborn to start life at a sensible weight the DH has announced than teenage pregnant girls and poor families will get free fruit and vegetables will [DH Press Release 13Feb04]. At a recent symposium at Loughborough University sponsored by the Foundation, pregnancy, the 1st yr of life and the years surrounding the adiposity rebound [3½yrs in girls, 4½yrs in boys] were all cited as being the best periods to identify/intervene re obesity.	
Child Growth Foundation	2	4.3.2		*Population-based screening for overweight or obesity [4.3.2]* The Foundation is equally concerned that data collection is not being advocated. Simply, it is essential that ongoing "research" is written into the scope: research which will cost the NHS a penny if the National Screening Committee [NSC] recommendations on growth were implemented. It is clearly stated in *Health For All Children, ed 4,* that a 100% screen of UK at school entry should be carried out and that the data retained for calculation of BMI. The NSC is not alone in this recommendation since both the RCP/RCPCH in England and Wales and SIGN in Scotland advocate across-the-board BMI assessment. [1] [MORE] The Foundation is the opinion that the school age screen is the minimum that should be being delivered by the health services in view of the fact that the "early signs of obesity should be identified and interventions offered at an early stage " [CMO July 2003] and can be identified preschool. We are appalled that the NSC has turned its back on any kind of screening/monitoring preschool and blame the cult of "evidence based medicine" for it. Evidence based medicine certainly has its place in tertiary and secondary levels of medicine where well-controlled RCTs may come up with effective/non-effective treatments and protocols but without huge and hugely	Noted and amended. The guidance will consider the evidence for how often children and adults should be weighed and have their BMI recorded in an appropriate setting. The guidance will, however, exclude population-based screening *programmes*.

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				expensive RCTs in primary care should be discounted. In its place, expert opinion must carry the day. To ignore expert opinion without recourse to a credible primary care RCT is to throw the baby out with the bathwater. It must be stated that the NSC, champion of EBM, has no evidence whatsoever to support its decision to screen growth at 4-5yrs; it recommends it only as a way of trapping growth-related conditions <0.4th centile [which, of course, don't encompass obesity]	
Child Growth Foundation	3	3(a)		*Definition of childhood overweight/obesity* [3a] The Foundation hopes that NICE will rule on the definitions. It is absurd that UK sources vary between 3 definitions: the UK 91st%/98th%, the IOTF cut-offs and the US definitions respectively. The confusion that this engenders must weaken any argument about the levels of real obesity in this a country let alone the confusion at an individual levels. A significant number of British 17yr olds, identified as being obese at school, can quite simple become only overweight on their 18th birthday when becoming subject to WHO criteria.	The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues. They will be considered in the guidance (see 4.3.1).
City Hospitals Sunderland NHS Trust	1	General	General	The guidance will be welcomed, as a Gold Standard needs to be set with respect to obesity management. There are a wide range of views of how obesity is identified and managed. The general population are confused with the mixed messages and diets that are currently being used. If guidelines are set Health Professionals will give consistent advice and have the evidence to support it. I suspect that the guidelines will have resource implications for services now and in the future as the incidence of obesity is increasing at an alarming rate. When looking at prevention, some partnership working with the food industry would be prudent but may be outside the remit of this guideline.	Noted. Working with the food industry is outside the remit of this guidance (see 4.4). The commercial sector cannot form part of the Guideline Development Group, but we will consider evidence of effective interventions which may include partnership working between commercial and other sectors.
College of Occupational Therapists	1	4.1.1	4.1.1	Children under 5 should be covered in the Scope as failing to do so loses a valuable opportunity for health visitors and other health professionals to target this group in a preventative capacity. If mothers are given advice about weaning their children on to a healthy diet this should impact on all the family and set down a good eating pattern for the future. Failure to	Noted and amended. We have lowered the age range for children to 2 and over.

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				acknowledge this important group in the Scope gives the wrong message to health professionals about the value of their role in preventing obesity at an early stage.	
College of Occupational Therapists	2	4.3.1(a)	4.3.1(a)	Clinical management of obesity needs to address the wider public health agenda in that it needs to address advertising and provision of foods in areas such as schools. Currently there are various schemes operating to entice children and parents to buy high calorie food and drinks in order that they may avail of a reward scheme for the provision of much needed equipment for schools. This is a form of emotional blackmail and should be banned. Similarly tuck shops and drink and confectionary dispensers in schools provide a form of revenue for schools to purchase equipment that should really be resourced by the Department of Education.	Noted.
College of Occupational Therapists	3	4.3.1(b)	4.3.1 (b)	Measurement tools for obesity should be standardised both in schools and clinical settings. Guidance should be issued on when is the most appropriate times for school children to be measured and on appropriate intervention pathways following diagnosis of at risk, overweight or obesity in children or adults.	Noted.
College of Occupational Therapists	4	General	General	The guidance should highlight the importance of prevention and specify the professionals who should have a major role in the area of prevention through health promotion and advice in the early years e.g. health visitors, school nurse, nursery nurses, Surestart employees and teachers.	Noted.
Community Practitioners' and Health Visitors' Association's	1	4.1.1	4.1.1	Children under 5 should be covered in the Scope as failing to do so loses a valuable opportunity for health visitors and other health professionals to target this group in a preventative capacity. If mothers are given advice about weaning their children on to a healthy diet this should impact on all the family and set down a good eating pattern for the future. Failure to acknowledge this important group in the Scope gives the wrong message to health professionals about the value of their role in preventing obesity at an early stage.	Noted and amended. We have lowered the age range for children to 2 and over.
Community Practitioners' and Health Visitors' Association's	2	4.3.1(a)	4.3.1(a)	Clinical management of obesity needs to address the wider public health agenda in that it needs to address advertising and provision of foods in areas such as schools. Currently there are various schemes operating to entice children and parents to buy high calorie food and drinks in order that	Noted.

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				they may avail of a reward scheme for the provision of much needed equipment for schools. This is a form of emotional blackmail and should be banned. Similarly tuck shops and drink and confectionary dispensers in schools provide a form of revenue for schools to purchase equipment that should really be resourced by the Department of Education.	
Community Practitioners' and Health Visitors' Association's	3	4.3.1(b)	4.3.1 (b)	Measurement tools for obesity should be standardised both in schools and clinical settings. Guidance should be issued on when is the most appropriate times for school children to be measured and on appropriate intervention pathways following diagnosis of at risk, overweight or obesity in children or adults.	Noted.
Community Practitioners' and Health Visitors' Association's	4	General	General	The guidance should highlight the importance of prevention and specify the professionals who should have a major role in the area of prevention through health promotion and advice in the early years e.g. health visitors, school nurse, nursery nurses, Surestart employees and teachers	Noted.
Diabetes UK	1	4.1.2	4.1.2 Population groups that will not be covered	Adults and children who are overweight are included within the scope, yet the prevention and management of medical conditions associated with overweight and obesity are not. We wanted clarification and reassurance that some guidance on the management of obesity in those that already have medical conditions associated with obesity would be included. Many people who are overweight or obese have associated medical conditions. While we appreciate that there is limited space within this guidance, there should be some provision made for the management of people who have mobility problems for example, and therefore need tailored advice on physical activity. People with diabetes who are overweight will need to manage their diabetes whilst they lose weight. Current NICE guidelines for Type 2 diabetes do not include weight management for people with diabetes. There would need to be some reference made to monitoring diabetes control and reviewing diabetes management within this guidance. This reflects one reason for the need guidance being wide variation in care.	The guidance will advise on weight management in these groups, but not on the management of the condition *per se*. See 4.1.1.
Diabetes UK	2	4.1.1	4.1.1 groups that will be	The guidance is aimed at the NHS. Though some prevention messages are appropriate to the NHS through health promotion to employees and the health promotion role of staff to patients, the NHS is mainly concerned with acute and chronic disease management. We believe it's a great opportunity	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a

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			covered	to produce guidance for the prevention of obesity, which would involve other organisations in partnership with the NHS. Perhaps the guidance could be separated into prevention and management, which would make the size more manageable without losing the focus on either prevention or management?	healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
Diabetes UK	3	General	General	It is unclear from the draft scope whether the commercial sector will be included. Already some NHS/commercial partnerships exist e.g. exercise on prescription and NHS referral to commercial slimming groups. Could this valuable resource not be included within the scope? The resources required to manage and support people trying to lose weight are enormous. In our experience the NHS would appreciate guidance on the role of commercial organisations. We regularly receive enquiries from healthcare professionals and people with diabetes on the suitability of commercial groups.	Working with the commercial sector is outside the remit of this guidance.
Diabetes UK	4	4.3.2	4.3.2 Areas that will not be covered	We note that the guidance will not cover population based screening. This is a missed opportunity since those who are overweight and obese and those at risk of becoming overweight will need to be identified. Surely identification of those at risk of becoming overweight involves some element of population screening?	Noted and amended. The guidance will consider the evidence for how often children and adults should be weighed and have their BMI recorded in an appropriate setting. The guidance will, however, exclude population-based screening *programmes*.
English Nature	1	General	General	Obesity is caused by lifestyle imbalance – too much rich food eaten for the amount of exercise undertaken. Prevention, and management, of obesity therefore require lifestyle interventions. **We would therefore recommend that the scope of the guidelines should include the role of multi-agency and partnership projects**, such as 'exercise by prescription' activities, community gardening and others. It should also look at public information approaches which have proved successful: eg Australia's cartoon-based 'Life Be In It' campaign. We would like the guidance to provide advice on the best ways of joining up NHS (PCT and hospitals) activities with organisations engaged in open space management like ourselves, and with other relevant partners, to	Noted.

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				promote, manage and resource a range of physical exercise and healthy eating initiatives. Advice on working with local authorities on health impact assessments, in the community strategies context, should be looked at as a basic context for this. Monitoring of the BTCV Green Gyms and Countryside Agency's Walking the Way to Health projects find high retention rates, with participants emphasising sociability and contact with nature as reasons for carrying on – with explicit health objectives ranked very low. There are anecdotal suggestions that once people get hooked on one aspect of healthy lifestyle (eg outdoor exercise), they are more likely to move into a virtuous spiral of identifying with and adopting other healthy choices (eg healthy food). Such 'healthy lifestyles' activities, particularly activities available for free in public open spaces, have been shown to offer significant savings over medical treatments available for the outcomes achieved.	
Faculty of Public Health	1	General	General	These comments are a summary of those provided by several members of the Faculty of Public Health.	Noted.
Faculty of Public Health	2	General	General	The proposal to develop guidance for the NHS in England and Wales on the prevention, identification, assessment, treatment and management of overweight and obesity in children and adults is welcomed. The Faculty of Public Health has already contributed in this area with its Tackling Obesity Toolkit (2000) and its recent report 'Storing Up Problems: the medical case for a slimmer nation' (2003), published jointly with the Royal College of Physicians and the Royal College of Paediatrics and Child Health.	Noted. Thank you.
Faculty of Public Health	3	General	General	We welcome the inclusion of prevention within the remit of the proposed guidance. However, guidance for the NHS (and its partners) on the prevention of overweight and obesity will not of itself be sufficient to stem the current epidemic. National, cross-governmental policy also needs to be developed to support healthier eating habits, increased physical activity and to control the availability and advertising of calorie dense, nutrient poor foodstuffs especially for children and adolescents.	Noted. This is outside the remit of the guidance.

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Faculty of Public Health	4	General	General	Consideration should be given to using a similar format to the Scottish SIGN guidance, including an indication of the strength of the evidence base, which provides an excellent model.	The NICE guideline programme has a comparable process of linking the evidence to the recommendations.
Faculty of Public Health	5	General	General	The evidence base published by the Health Development Agency in their Evidence Briefings for the management of obesity and overweight, the prevention of CHD and the prevention of cancers should also be referred to in the NICE guidance.	Noted.
Faculty of Public Health	6	1	1. Guidance title	Refers to "weight maintenance" of obesity and overweight. We suggest that this be changed to "weight management" as the intention is presumably NOT to maintain weight.	Noted and amended.
Faculty of Public Health	7	1.1	1.1 Short title	Suggest that this should be changed to "Overweight and obesity" as this is the order in which they develop.	Noted and amended.
Faculty of Public Health	8	2	2. Background para a)	Again refers to "weight maintenance", suggest that this be changed to "weight management" (see comment above).	Noted and amended
Faculty of Public Health	9	3	3. Clinical need para a) page 2	Defines obesity and overweight as conditions which have reached the point of "endangering health". This may only be true for morbid obesity – suggest that wording be changed to "reached the point of carrying significant risks to health".	Noted and amended.
Faculty of Public Health	10	3	3. Clinical need para a) page 3	Defines childhood obesity as BMI above the 95th centile and overweight as BMI above the 85th centile but does not identify the reference data which will be used. The 85th and 95th centiles are the commonly accepted cut-off points for childhood overweight and obesity for comparative epidemiological purposes, however the SIGN Guideline no 69 for Scotland recommends that for clinical practice (such as that to which the proposed NICE Guidance is directed) obesity be defined as the 98th centile and overweight as the 91st centile for age and gender using the UK 1990 reference data for BMI in childhood, and indeed these are the centiles shown on the centile charts currently in use in clinical paediatric practice in the UK. These cut-off points	The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues. They will be considered in the guidance (see 4.3.1).

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				are higher than those recommended in the proposed NICE guidance, which would therefore have the effect of reducing the clinical threshold at which overweight and obesity is diagnosed. It is very important that a common definition of childhood overweight and obesity be agreed and in order to bring the NHS into line with internationally accepted definitions it is suggested that, notwithstanding the SIGN guideline for Scotland, the NICE guidance for England and Wales continues to define childhood overweight and obesity at the 85th and 95th centile cut-offs using the UK 1990 reference data and recommends that the centile charts in current use in the UK be printed to show these.	
Faculty of Public Health	11	3	3. Clinical need para a) page 3	The centile charts in current use in the UK have superimposed on them the World Health Organisation/International Obesity Task Force (WHO/OITF) cut-offs for overweight and obesity using reference data derived from pooled international surveys that correspond to the adult cut-offs at age 18 of BMI>25 for overweight and BMI>30 for obesity. In the future this may be accepted as the international definition of childhood overweight and obesity and so it is recommended that these IOTF cut-offs continue to be shown on the UK centile charts.	The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues. They will be considered in the guidance (see 4.3.1).
Faculty of Public Health	12	3	3. Clinical need para a) page 3	Suggest that the sentence beginning "In children, the consequences are similar to those of adults…" be reworded to "In children, the associated morbidities include hypertension, hyperinsulinaemia, …" etc and that "psychological consequences" be deleted and replaced with "psychosocial dysfunction".	Noted and amended.
Faculty of Public Health	13	4.1.1	4.1.1 Groups that will be covered	It might be helpful to make explicit reference to adults and children with learning difficulties (e.g. "including those with learning difficulties").	The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues.
Faculty of Public Health	14	4.1.2	4.1.2 Groups that will not be	Although the paper says that it will not cover the prevention or management of medical conditions "associated with overweight or obesity" it is not clear whether this also includes those conditions which predispose to obesity (e.g. hypothyroidism) as well as those which are consequences of it. It is	Owing to broad scope of guidance it will not be possible to offer detailed guidance on the conditions predisposing to obesity in children. See

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			covered	important that conditions predisposing to obesity be considered and evaluated (especially in childhood) and that appropriate further investigations and management be implemented. This is supported by the existing Royal College of Paediatrics and Child Health/National Obesity Forum (RCPCH/NOF) guideline on the management of overweight and obesity in children in primary care.	4.4 e).
Faculty of Public Health	15	4.1.2	4.1.2 Groups that will not be covered	It is unclear whether or not the guidance will cover drug induced obesity (e.g. steroid induced, some psychotropics).	Noted. This is an area the Guideline Development Group may wish to consider when developing the guidance.
Faculty of Public Health	16	Appendix	Appendix (referral from DoH and Welsh Assembly)	Although it is clearly not within the scope of NICE and the HDA to suggest amendments to the DoH and Welsh Assembly referral, it may be unhelpful to "give appropriate emphasis to exercise" and better to "give appropriate emphasis to activity", since an increase in daily activity (rather than exercise, which carries connotations of gymnasiums and sports fields) across the population is a key factor in controlling the epidemic of obesity and is achievable by all.	Noted.
Food and Drink Federation and the British Hospitality Association	1	General		The organisations contributing to this response are the British Hospitality Association (BHA), also representing the Restaurant Association (RA) and the Food and Drink Federation (FDF), representing UK food manufacturers.	Noted.
Food and Drink Federation and the British Hospitality Association	2	2		**2 Background** The food industry supports NICE's decision to commission the National Collaborating Centre for Primary Care (NCC-PC) and the Health Development Agency (HDA): "to develop clinical guidance on the prevention, identification, assessment, treatment and weight maintenance of obesity and overweight in adults and children for use in the NHS in England and Wales". However, such guidance should take full account of other government	Noted.

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				initiatives in this area, in particular • the Food and Health Action Plan for England being developed by the Department of Health in consultation with FSA and others. • the forthcoming consultations to lead to a White Paper on public health. • the Wanless report on Public Health. • the CMO's report on physical activity. The food industry is concerned that there seems to have been no attempt to join together these government inspired initiatives, leaving aside the other initiatives such as The Health Select Committee's inquiry; the Medical Research Council's report "Towards a Leaner, Fitter Future" and the WHO's prospective Global Strategy. The food industry is committed to playing its part in tackling obesity and wishes to be fully involved in the debate. It believes that the causes of obesity are multi-factorial, and require a range of solutions, delivered by a variety of stakeholders. However, we believe that the work towards solutions and their delivery needs to be coordinated by government.	
Food and Drink Federation and the British Hospitality Association	2	3		**3 Clinical need for the guidance** b) Joint working is crucial, as is highlighted in the draft Scope's introduction. Up to now, Primary Care Trusts (PCTs) and their equivalent in Wales, have not fully explored opportunities to work with the food industry. The Food Industry agrees with the emphasis in the draft Scope document on the need for PCTs to consider the broader environment (schools, workplaces and neighbourhoods) in terms of potential support for behavioural change, not just the clinical setting. It is willing to work with PCTs in these areas and to explore new ways of doing so. c) The Scope calls for national guidance on the prevention and management of obesity and overweight in adults and children. The food industry agrees that such guidance and key messages should be based on sound science	Noted.

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				and clearly expressed so that they can be used by all stakeholders. They should be regularly reviewed as research develops and revised as necessary.	
Food and Drink Federation and the British Hospitality Association	3	4.3.1		**4.3 Clinical management** **4.3.1 Areas that will be covered** The food industry produces food to meet consumer demand and therefore has experience and expertise in communication, understanding consumer needs and product formulation**.** Because of these skills, the food industry believes it can play a role in both the treatment and prevention of obesity in adults and children. In the area of obesity prevention and weight maintenance, industry plays its part in educating consumers on appropriate diets e.g. through labelling and consumer information material.	Noted.
Food and Drink Federation and the British Hospitality Association	4	General		**General Conclusion** NICE has stated that its guidance will provide advice for NHS staff and NHS occupational health services and their potential partners outside the NHS, on effective interventions in the prevention and treatment of overweight and obesity and the maintenance of weight loss. The food industry believes it has a role to play as a partner in helping to tackle the obesity problem. Consumers and NHS patients should hear consistent messages about healthy eating, lifestyle and weight, which are based on sound science. 'Harmonisation' should therefore be sought with messages from organisations such as Food Standards Agency (FSA) and Department of Health (DH). Greater impact can be achieved if everyone speaks the same language. Industry is willing to contribute to this process. Working in partnership with authoritative organisations that encourage healthy lifestyles, including healthy activity, will add impact to any scheme. The food industry already seeks support and consensus on healthy lifestyle activities from external organisations such as the Association for the Study of Obesity, the British Dietetic Association, the British Nutrition Foundation,	Noted.

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				Sport England, the NHS Trusts, DH and FSA, as well as the rest of the food chain. It is willing to work with a broader range of partners in order to reduce the burden of obesity.	
Food Standards Agency	1	General	General.	**Explicit inclusion public health aims and outputs** We understand that The Guidance is being drawn up with the HDA and should include public health guidance for the prevention of obesity. How and where public health will be included has not detailed in the Scope, which currently has a clinical/hospital settings focus. Public health elements need to be addressed through out the Scope and emphases given to it as an explicit subsection of the Scope.	Noted. The scope addresses both the clinical and public health aspects of overweight and obesity.
Food Standards Agency	2	4.1	4.1 Population	It is ambitious to aim to cover all age categories over the age of 5 in the time frame allowed for the work. We suggest that the review is split in two – children and adults to aid work management and improve the usefulness of the final Guidance. The age group of children included however should be extended to include the under 5's. Including younger children would be potentially useful as young children are regularly weighed as part of routine health visitor care so opportunities for referral and treatment already exist, the weaning period offers a window of opportunity important for the formation of dietary habits, and there are a number of settings that offer public health opportunities that will be excluded if the age range is not extended e.g. mother and baby clinic, nursery and pre-school groups.	The guidance is required to cover adults and children. Noted and amended. We have lowered the age range for children to 2 and over.
Food Standards Agency	3	General	Additional comments	The process of guidance development It was indicated at the meeting of stakeholders on 2 Feb that the Guidance would be developed using primary data. The literature on this for obesity is immense and much has already been systematically reviewed. We therefore suggest that where ever possible reviews are used as evidence sources. This would save time and resource, and also make the process more manageable.	This is an incorrect report of what was stated. We will use, whenever possible, high quality systematic reviews of existing evidence but there will be some areas where new reviews will be considered. We do not envisage commissioning primary research.
Institute of Sport and Recreation Management	1	General	General	As part of the framework for combating obesity there needs to be specific guidance on the role and significance of physical activity and exercise	Noted.

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International Obesity Task Force / IASO/ Coronary Prevention Group	1	General	General	Important to note that clustering of obesity 'and co-morbidities' already identified in health areas. Therefore guidance should note consequent disparities affecting primary and secondary care services particularly in areas of greatest need. The DOH Social and Community Planning Research (SCPR) division analysis in March 1999 of mid – 90s Health Survey data identified 51 former health areas where obesity rates exceeded the National average, with the two most extreme cases 50% above. (Lambeth, Southwark and Lewisham, and Sandwell)	Noted.
International Obesity Task Force / IASO/ Coronary Prevention Group	2	4.1.1	4.1.1	Must include children aged 0-5yrs as birth size, breast feeding and early weaning and dietary practices with growth rates in this period now considered as potentially important for long-term risk of obesity and the severity of its co-morbidities.	Noted and amended. We have lowered the age range for children to 2 and over.
International Obesity Task Force / IASO/ Coronary Prevention Group	3	4.1.2(a)	4.1.2a	Very unwise not to include the clinical benefit of weight management in relation to hypertension and its role in limiting and preventing hypertension with associated analyses of the interdependence of diet and weight gain	The guidance will advise on weight management in this group, but not on the management of the condition *per se*.
International Obesity Task Force / IASO/ Coronary Prevention Group	4	4.1.2(a)	4.1.2	Clinical value of weight management in heart failure is a new field of potential great clinical importance	Noted.
International Obesity Task Force / IASO/ Coronary Prevention Group	5	4.1.2	4.1.2	Synergy can be identified where similar issues arise in relation to diabetes, the identification of at risk groups for prevention purposes and the role of gestational diabetes and glucose intolerance in relation to offspring's likelihood of excessive weight gain	Noted.
International Obesity Task Force / IASO/ Coronary Prevention Group	6	4.1.2	4.1.2	Issue of infertility and the role of weight management in combating different forms of hormonal disorders associated with infertility important and often neglected clinically	Noted.
International Obesity Task Force / IASO/ Coronary Prevention Group	7	4.1.2	4.1.2	Asthma and other respiratory problems need to have a new focus on the benefits of weight management	Noted.

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International Obesity Task Force / IASO/ Coronary Prevention Group	8	4.1.2(b)	4.1.2b	Reiterating 4.1.1 suggest removing 4.1.2b	Noted and amended. We have lowered the age range for children to 2 and over.
International Obesity Task Force / IASO/ Coronary Prevention Group	9	4.2(c)	4.2.c	Role of health service and primary care trusts in initiating and promoting new approaches at a local authority level for prevention purposes currently neglected. Similar issues in relation to the primary care trust in a pre-school and school setting	Noted.
International Obesity Task Force / IASO/ Coronary Prevention Group	10	4.2(c)		Role of health trusts in initiating broader changes in the food and physical environment and the mechanism for integrating the work of primary care trusts is a big issue with the new devolution of responsibilities to local level	Noted.
International Obesity Task Force / IASO/ Coronary Prevention Group	11	4.2(c)		Role of trusts in determining whether local weight management groups - e.g. weight watchers , Atkins diet groups, local referral to sports centres etc are effective and the criteria needed are important	Noted.
International Obesity Task Force / IASO/ Coronary Prevention Group	12	4.3.2	4.3.2	Population screening may be handled elsewhere but the issue of the routine monitoring of children and adult weights and waist measurement is an important issue for health trusts	Noted and amended. The guidance will consider the evidence for how often children and adults should be weighed and have their BMI recorded in an appropriate setting. The guidance will, however, exclude population-based screening *programmes*.
Johnson & Johnson Medical Ltd	1	General	General	The proposed make-up of the Guideline Development Group 'clinical group' appears weighted towards a primary care & public health specialty. In light of their being a separate 'public health' group, it would appear appropriate if the clinical group also included secondary care specialists such as surgeons involved in treating morbid obesity.	We will seek to ensure appropriate representation from surgeons and others treating morbid obesity. See 4.3.1 d. The NCC-PC and the HDA , in consultation with NICE, will decide on the composition of the GDG.
Johnson & Johnson Medical Ltd	2	4.1	4.1 Inclusion and	Though we agree with the explanations given in principle, they could be clarified. Potential confusion could arise from 4.1.1 that states that patients at risk of obesity will be covered, and 4.1.2 that states that treatment of risk	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-

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			exclusion criteria	groups will not be covered. We also seek clarification that the benefits of directly treating obesity on co-morbidities will be included in the review.	morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2). Noted. This is an area the Guidance Development Group may wish to consider when developing the guidance.
Johnson & Johnson Medical Ltd	3	4.3.1	4.3.1 2) & 3)	These sections indicate that the existing three technology appraisals will be updated and included in the guideline. As a stakeholder in original appraisal no. 46 we have the following questions: • Was there any consultation with stakeholders on incorporating T NICE to respond A no. 46 in to the guideline, rather than the guideline cross-referencing the TA? • Will the Technology Appraisal Committee be involved in the update or will it be the GDG who update? • If the TA's are included in the guideline, do the existing TA's become obsolete? • If the TA's become obsolete, how does the status of the recommendations change, the TA's being 'mandatory' and the clinical guidelines not?	There was a consultation with stakeholders prior to the incorporation of the guidance within the guideline. This information is provided in the NICE guidelines Technical Manual 'Guideline Development Methods', available from the NICE website www.nice.org.uk The guidance will be superseded by the guideline.
Merck Sharp & Dohme Ltd	1	General	General	It is clear that the development of the joint guidance will follow the NICE guidelines development process. It would however be helpful to get further clarification on the definitive and practical differences between "Guidelines" and "Guidance" and how this will be interpreted by the end-users of the "guidance"	We have addressed this issue in 2 a. Please see the NICE guidelines Technical Manual 'Guideline Development Methods', available from the NICE website www.nice.org.uk for further clarification.
Merck Sharp & Dohme Ltd	2	3(a)	3a	Clinical Need: • The Scope document assumes that the fundamental cause of obesity is consuming more calories than are expended in day to day living.	Noted and amended.

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				▪ There is increasing evidence that there are other causes of obesity e.g.genetic that are not linked to lifestyle choices. This may need to be considered when guidance recommendations are being developed.	
Merck Sharp & Dohme Ltd	3	4.1.2	4.1.2	This section "Groups that will not be covered" gives the impression that those patients who are obese and have co-morbidities will not be covered by the guidance. Whilst we agree that the management and treatment of the co-morbidities should not be part of the guidance, it is important to recognise this group as high risk group of individuals. These are the patients which cause most concern to the GP due to ever increasing risk of further disease. These are the patients who need to be motivated to co-operate with their healthcare providers to lose weight to prevent future complications. In particular the guidance should make recommendations about the appropriate use of anti-obesity drug treatment in these groups. Within the guidance it would be helpful to look at measurement criteria such as reduction in overall risk of the patient as well as absolute weight loss.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
Merck Sharp & Dohme Ltd	4	General	General Guideline Development Group	We would recommend that the Clinical Group of the Guideline development team should include a clinical pharmacologist with a special interest in anti-obesity medication. The current Clinical Group seems to be slightly weighted towards Public Health aspects of obesity rather than the clinical aspects. It may be worth considering 2 physicians on the Clinical Group. An endocrinologist would see patients perhaps in the early stages of overweight and obesity and then an obesity specialist who must deal with the complications of obesity.	Noted. The NCC-PC and the HDA, in consultation with NICE, will decide on the composition of the Guideline Development Group.
Move4Health	1	2(b)	2 (b)	Explore the possibility of an NSF for Obesity	This is outside the scope of the obesity guidance.
Move4Health	2	4.1.1	4.1.1 (a), (b) & (c)	A child's activity levels are largely governed by parental/guardian behaviour and attitude to physical activity. This role model effect begins from birth. We would therefore question the validity of excluding children under the age of 5. Evidence from smoking cessation shows that protecting one's children from the harmful effects of smoke provides a strong incentive for the parents to quit. By including guidance to children under the age of 5 it may spur parents into a state of readiness to change their behaviour towards a healthy	Noted and amended. We have lowered the age range for children to 2 and over.

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				lifestyle to protect their children from illnesses such as type 2 diabetes, heart disease and some forms of cancer. Evidence from systematic reviews by the Health Development Agency (as yet unpublished) suggest that in order to achieve longer-term behaviour change strong family/community back up is required, with access to an expert in behaviour change. Therefore, the stronger the individual motivation, backed by community support, the more potential there could be for tackling the obesity epidemic.	
National Healthy School Standard		4.3.1(4)(b)		Will there be reference to supporting children in managing their obesity As well as supporting them to reduce their weight? Any work that will take place within a school setting needs to be done in A whole school approach, the 10 elements of whole school approach in the National Healthy School Standard would serve as a useful framework within A school setting For some children obesity may also be linked to negative self image and Low self esteem and bullying. Therefore it would be important to also Consider the impact of these on children's obesity.	Noted. The scope highlights the relevant important issues. It is inappropriate for it to offer a detailed discussion of these issues.
National Healthy School Standard	1	3(a)	3a.	In reference to 1997 National Diet and Nutrition Survey of young people with greater rates among lower social classes - Further work with this group of children could be linked to the National Healthy School Standard target to work With schools with 20%+ free school meal eligibility by 2006, Free School Meals being used as an indicator of health inequalities.	Noted.
National Healthy School Standard	2	3(b)	3b.	In reference to the need for joint working that goes beyond the clinical setting the National Healthy School Standard would be well placed to disseminate work in schools. This could be in the form of practical guidelines linked to a whole school approach as advocated in the National Healthy School Standard.	The guidance will consider joint working.
National Healthy School Standard	3	4.1.1(a)	4.1.1a.	Children over 5 years – could interventions to engage with young parents Through strategies like Sure Start, be also considered as a way of Starting healthy eating messages as early as possible	Noted. This is an area the Guideline Development Group may wish to consider when developing the guidance.
National Healthy School Standard	4	4.1.1(a)	4.4.1b	In reference to children who are at increased risk of becoming overweight - What indicators will be used to identify these children?	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a

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					healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
National Healthy School Standard	5	4.2(c)	4.4.2c	Providing advice for potential partners outside the NHS, on effective Interventions in the prevention and treatment, will this extend to advice for Schools, and include supporting children's emotional well being in relation To obesity?	Noted. Yes.
National Healthy School Standard	6	4.3.1(a)	4.3.1a 1.	In reference to the interventions: diet, physical activity and behavioural Approaches, the National Healthy School Standard advocates Healthy Eating Physical Activity as key themes schools can prioritise to work on. Schools addressing these areas will be doing this in a whole school approach	Noted.
National Healthy School Standard	7	4.3.1(c)	4.3.1c	Approaches aimed at children to support them in their current weight outside the clinical setting – would schools be a key setting for this? If so clear Guidelines about these approaches will need to be detailed	Noted. This is an area the Guideline Development Group will consider when developing the guidance.
National Obesity Forum	1	General		1.1 The National Obesity Forum welcomes the joint initiative between NICE and the NCC-PC to develop guidance on the prevention, identification, assessment, treatment and weight maintenance of obesity and overweight in adults and children. This is a significant undertaking but one which we feel will have the following benefits: - Create a hierarchy of accepted strategies for the management of these conditions within the context of the NHS - Set obesity-related criteria by which PCTs, hospital and community trusts can be appraised - Critically appraise and 'license' commercial organisations with whom it is appropriate for the NHS to work - develop a database of accepted research on the topic - act as a stimulus for future research	Noted. Thank you.

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National Obesity Forum	2	General	2.1 General comments:	The scope has been drawn very widely. This is likely to create problems in terms of the amount of material which will need to be appraised. We would however, support such a broad review since the strategies for prevention of obesity in children and adults are very similar to those for the management of the established condition.	Noted.
National Obesity Forum	3	General	2.2	We are encouraged by the Chairman's approach to including 'Best Evidence' and not simply Grade 1 evidence (eg RCTs and systematic reviews). Much of the evidence which will need to be appraised will be of 'experiences that have worked in practice' and this is unlikely to be formally structured or available in the form of RCTs. In the experience of the NOF, structured evidence from RCTs is most available from pharmaceutical company and specialist practice. It is important to that NICE appraises evidence from a broader base so as to avoid the process being monopolised by approaches based upon the medical model.	Noted.
National Obesity Forum	4	General	3.1 Constitution of the Guideline Development Group	NOF is broadly in agreement with the constitution of this group and in particular with its emphasis upon management of obesity in community practice and in the public health arena. We feel however, that it will be important to recruit contributions from professional groups not included in the GDG so as to achieve their buy-into the final consensus. The Chair suggested that this could be achieved through co-opting members as required. In addition to those mentioned in the presentations, these should include: - clinicians from specialist practice - GPs involved in developing the General Medical Services and Personal Medical services Contracts - Representatives of commercial groups involved in weight loss programmes - Representatives of Senior Management of Primary Care Trusts, Community Trusts and Hospital Trusts	Noted. We will co-opt other professional representatives as appropriate.
National Obesity	5	4.1	4.	**NOF would support revision of the scope to include children below the**	Noted and amended. We have lowered

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Forum			Population: groups included 4.1 Children under 5	**age of 5 years for the following reasons:** - observations of infant weight are already part of child development and a concern of mothers - it is possible to identify pre-school children with features of the metabolic syndrome who are likely to become obese adults - obese babies are likely to be born into obese families - 'the family' is the most important natural community with an influence on weight - mothers with children of this age are highly motivated to accept heath promotion messages which will affect the whole family.	the age range for children to 2 and over.
National Obesity Forum	6	4.3.1(4)	4.2 Weight Maintenance:	In older obese patients, weight maintenance is often a realistic goal. NOF would like clarification as to whether the scope will include weight maintenance in overweight and obese people.	Noted. Management will include weight maintenance.
National Obesity Forum	7	4.2	5. Settings:	No additional comments	Thank you.
National Obesity Forum	8	4.3	6. Management (1): 6.1	NOF would recommend limiting the scope of review of pharmaceutical therapies, perhaps by restricting this to their place in management and considering their place as one specific strategy. Specific advice on individual products should be the subject of Technology Reviews. Comparison between therapies should be avoided. We believe this is important because: - the process would otherwise become delayed by appeals from individual pharmaceutical companies - product licenses change unpredictably and would threaten credence in the whole guidance - the place of pharmaceuticals is of minor importance compared with the overall strategy - pharmaceuticals are best dealt with by technology appraisals	Thank you for your comment. Please find further information in the NICE guidelines Technical Manual 'Guideline Development Methods', available from the NICE website www.nice.org.uk.
National Obesity Forum	9	4.3	6.2 Manag	See comments on weight maintenance above.	Noted.

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			ement (2)		
National Obesity Forum	10	General	6.3	NOF is concerned that goal 2 (the identification, assessment and management of adults and children in primary and secondary care who are at increased risk of obesity) runs the risk of stigmatising some children. Since two thirds of adults and 13-17% percent of children are now overweight or obese, it might be preferable to include the while population within this category. This would be justified by the view that everyone is at risk of obesity and their individual risk profile 20 years on is indeterminate. NOF also considers that goal 2 would involve some form of screening and this would run contrary to the brief NICE has been given by the government.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see revised 4.1.1). The former will be dealt with under 'clinical management', the latter under 'prevention' (revised 4.3).
National Obesity Forum	11	General	6.4	NOF is concerned that this section is labelled 'Management of adults and children in primary and secondary care'. If this is to be achieved realistically, considerable attention will need to be paid to the **process** of providing care for this group and to the **resource needs** of any recommendations made. Unless this is achieved, the guidance will not be seen as practical.	Noted.
National Obesity Forum	12	4.3	6.5 Management (3)	This excludes complementary therapies. We are uncertain how the distinction between complementary and orthodox treatments will be made and the purpose of this distinction.	Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm).
National Obesity Forum	13	4.4	7. Audit Support 7.1	NOF suggests that consideration be given to incorporating audit measures within revised criteria for the General practice GMS and PMS contracts.	Noted, thank you. This will be considered before the guideline is published.
National Obesity Forum	14	General	8. Conclusions:	The NOF supports the NICE guidance initiative and looks forward to the next stages – ie receipt of the revised scope document and submission of evidence.	Noted.

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National Public Health Service, Wales	1	General	General	On the whole the draft scope appears to address the major concerns that the current increasing prevalence of overweight and obesity is currently presenting us with in 2004. It is important though that the guidance is seen as a workable, long-term strategy to be embraced across the educational, economic, commercial, voluntary, social arena, and not just in the field of healthcare. To work efficiently and meet the needs of the population will therefore require strong strategic support, financial, economic planning and collaboration on a strong regional, national, European and global foundation.	Noted.
National Public Health Service, Wales	2	4.1	4.1.1/4.1.2	**Groups that will/will not be covered** Agree in principle with the three categories of groups addressed by the draft scope but feel the guidance should also include children under the age of five. (Why excluded? The environmental issues that work after age of 5 also apply for those under 5.) The pregnant woman too provides an ideal opportunity to instigate good ante-natal and post-natal advice, health promotion and prevention strategies at a time when she is usually open to suggestions and change and in frequent contact with health-related professionals on a one-to one basis.	Noted and amended. We have lowered the age range for children to 2 and over.
National Public Health Service, Wales	3	4.2(c)	4.2 (c)	**Joint Guidance from NICE/HDA** It is essential that the guidance is fully embraced across all communities, populations and 'official' bodies to succeed. The guidance remit does currently include the NHS and a range of agencies, but it is vital that the guidance will be fully integrated in all aspects of healthy living at strategic levels to ensure its success and importance on agendas relating to planning, economic developments etc. Whilst it is envisaged that Local Health Boards in Wales will be key players in taking forward partnership working, greater emphasis on national/European and Global partnership will also need to be fostered to meet the growing needs of obesity as a problem in the 21st Century.	Noted. The guidance will not make specific recommendations for National policies such as fiscal policy, or food labelling policy. Such policies will be addressed in broader ongoing work for e.g. the forthcoming Food and Health Action Plan (see 4.4).
National Public Health Service, Wales	4	4.3.1	4.3.1	**Areas that will be covered by the guidance-(a) 4- Maintenance of Weight Loss** Greater clarification is required of the methodology, outcomes etc that will be	The scope highlights the relevant important issues. It is inappropriate for it to offer a detailed discussion of these

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				instigated/measured to address these outlined actions.	issues.
Newcastle-under-Lyme PCT	1	General	General	▪ The document looks comprehensive enough in terms of what it is wanting to do and how it will be done.	Noted.
Newcastle-under-Lyme PCT	2	General	General	▪ Presumably the guidance will include example of protocols especially for younger end of the children's age range (e.g. what works for a 5 and 6 year old may be different for 11 to 16 year old)	Noted. This is an area the Guideline Development Group will consider when developing the guidance.
Newcastle-under-Lyme PCT	3	4.4	4.4 Audit support within guidance. Pg 9.	▪ Under audit it states the guidance will include "review criteria and audit advice for primary care and secondary care", is it appropriate to have some for the prevention side? ▪ Would examples of data handling/bench marking issues be included under audit advice?	The guidance will incorporate review criteria and audit advice if appropriate, for areas outside the clinical setting (see 4.5).
Nutrition Society UK	1	General	General	This initiative is strongly supported by the Nutrition Society in view of the rising prevalence of obesity in the UK: we are pleased to have the opportunity of commenting on the draft scope.	Noted.
Nutrition Society UK	2	General	General	The aim of prevention and treatment of obesity by the NHS must be the prevention of related morbidity and mortality. The effectiveness of different treatments in improving risk factors such as blood pressure, cholesterol levels etc. needs to be considered in addition to their effectiveness in producing weight loss. As an example, both sibutramine and physical activity can lead to weight loss, but sibutramine increases blood pressure while physical activity decreases blood pressure.	Noted.
Nutrition Society UK	3	3(a)	3a)	It would be useful to identify the problem of morbid obesity (BMI > 40) separately as the approach to management and effectiveness of treatment may be very different in this group.	Noted. We have done so (4.3.1 d).
Nutrition Society UK	4	3(a)	3a)	It should be made clear that in children obesity is defined by BMI centiles for age and gender (Cole TJ, Freeman JV & Preece MA (1995) Body mass index reference curves for the UK, 1990. *Archives of Disease in Childhood* **73**, 25-29) not as BMI over 25.	The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues. They will be considered in the guidance (see 4.3.1).
Nutrition Society UK	5	4.1.1	4.1.1	It is difficult to see how those at increased risk of becoming overweight or obese will be identified: with present patterns of diet and physical activity the	Noted and amended. The guidance will cover two populations: those who are

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				majority of the UK population are at risk. Population-based approaches to prevention and management will be needed in addition to individual management in a clinical setting. This is particularly important in children as many children who are overweight do not become obese adults while many who are not overweight as young children gain weight in later life. If adult morbidity and mortality are considered as important outcomes of childhood obesity the sensitivity and specificity of targeting obesity in childhood will not be high. The advantages of population-based vs. individual management programmes for childhood obesity should be considered in this light.	overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
Nutrition Society UK	6	4.1.1	4.1.1	Two groups of adults for whom separate guidance might be needed are people over 65y, for whom there is less evidence that weight loss is beneficial to health, and pregnant women, for whom weight loss management advice may need to take into account nutritional needs for fetal growth and development.	We will take account of vulnerable groups where the evidence is available. (see 4.1.1)
Nutrition Society UK	7	4.1.2	4.1.2	We have reservations about the exclusion of children under 5y from primary prevention. Information on whether breast feeding can help prevent obesity in children or promote postnatal weight loss in overweight mothers should also be considered.	Noted and amended. We have lowered the age range for children to 2 and over.
Nutrition Society UK	8	4.2(c)	4.2 c)	We strongly support the suggestion of working beyond the clinical setting alone, particularly in the case of children where school-based programmes are likely to be needed.	Noted. Thank you.
Nutrition Society UK	9	4.3.1(a)	4.3.1 a)	As dietary programmes are always going to have a major part to play in obesity prevention and management it would be useful to specify in more detail the types of programmes which will be covered. We feel that existing NHS dietary advice on weight loss and commercially available programmes (slimming clubs and 'popular' diets e.g. Dr. Atkins' diet) need to be included as these are widely used and, if effective, could support NHS-based initiatives. For physical activity and behaviour-based approaches, guidance on the exact components of these would be very useful.	Noted. Where there is good quality evidence of effectiveness, we will review types of diet and interventions such as 'slimming clubs'.
Nutrition Society UK	10	4.3.2(b)	4.3.2 b)	We would argue that complementary therapies should be included as if they are not NHS staff will be left uncertain as to their effectiveness.	Noted and amended. The guidance will consider the evidence for how often children and adults should be weighed and have their BMI recorded in an

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					appropriate setting. The guidance will, however, exclude population-based screening *programmes*. Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm).
Obesity Management Association	1	General	General	NICE should recommend a greater cooperation between the NHS and private practice	The Institute has a remit to provide guidance only for the NHS; however, the implementation of its guidance to other sectors is always encouraged.
Obesity Management Association	2	4.3.1	4.3.1	The omission of Phentermine and amfepramone from the list of medical interventions reduces the choice of doctors to treat obese patients who for one reason or another cannot be treated with Orlistat or sibutramine This ommission cannot be justified because both Phentermine and Amfepramone are duly licenced products i.e. their safety and efficacy have been proven and tested by the European Court of first Instances and found to be acceptable within the PIL provided by the manufacturers The use of these older preparations indeed reduces the very high cost of medication which the NHS could provide The use of these older anorectics has been found to be highly effective by many of the prescribing doctors who are members of OMA when used in conjunction with the other approved methods of weight management In addition many OMA members find that in addition to weight loss these are valuable treatments for preventing weight gain which is as important as weight loss	The guidance will cover the two pharmacological interventions listed in the *British National* Formulary (orlistat and sibutramine). Neither phentermine or amfepramone are licensed currently.

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Pharmacy HealthLink	1	3(b)	Section 3 b	There is evidence that community pharmacists interventions are effective in managing obesity in patients and this professional group's potential contribution to obesity management should be included in the scope of this consultation.	Noted. The guidance will take account of the role of community pharmacists and they will be invited to contribute to the guidance development process. ***[Is***
Pharmacy HealthLink	2	4.1.2	Section 4.1.2	Some explanation needs to given why guidance is not being considered for children under 5 years of age as there may be isolated examples where guidance is needed, for example, a consultant paediatrician at a recent National Obesity Forum conference presented a case study of a one year old with a BMI of 30.	Noted and amended. We have lowered the age range for children to 2 and over.
Pharmacy HealthLink	3	4.3.1(d)	Section 4.3.1d	Whilst the actions listed in 4.3a-c will play a role in primary and secondary prevention some consideration should be given to issuing guidance on other primary prevention approaches where there is evidence to support these, for example, the effectiveness of food policies and advertising standards on energy-dense foods. This particularly applies to situations where the NHS may act with other agencies on primary prevention, e.g. Local Strategic Partnerships to improve access to fruit and vegetables.	Noted. This is an area the Guideline Development Group will consider when developing the guidance.
Pharmacy HealthLink	4	4.3.2(a)	Section 4.3.2. a and b	We are not convinced that these areas should be excluded where there is evidence to support their effectiveness. There is possibly merit in considering screening. It would be important to establish if complementary therapy approaches show evidence of efficacy. Such approaches might be more suitable for some individuals than therapeutic or surgical interventions.	Noted and amended. The guidance will consider the evidence for how often children and adults should be weighed and have their BMI recorded in an appropriate setting. The guidance will, however, exclude population-based screening *programmes*. Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm).

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ROCHE	1	General	General including guidance title	Roche strongly believes that the proposed scope of the guidelines is too broad, aiming to incorporate every aspect of obesity prevention and management of both children and adults. This attempt to be 'all things to all people', we believe, will not be deliverable. Roche strongly recommends that this guideline is divided into two. One guideline to cover **prevention** and the other to cover **management**. This proposal would also enable a clearer delineation of responsibilities to be achieved between the HPA and the NCCPC / NICE and also recognise the very different standard and quality of evidence available between prevention and management interventions. Importantly, a single guideline focussing only on management aspects will enable stronger linkages to be achieved with the co-morbidities of obesity which otherwise might be lost potentially resulting in a "de-medicalisation" of obesity.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
ROCHE	2	4.1.1(a)	4.1.1 a, b & c	Due to the differences in management between adults and children, these populations must be dealt with separately. It is well-recognised that moderate weight loss has very beneficial effects on adults' health. However, the aim of weight management of growing children is usually not weight loss but weight maintenance, which, due to their rapid growth and increasing height has the net effect of improvement in BMI. This is an aim confirmed in most recent studies of adolescents. Most clinical studies have been conducted in adults over the age of 18, while studies in adolescents have involved patients from 12 - 16 years generally. We strongly recommend that adult and childhood management guidelines are kept separate to ensure clarity of message and protect children's health.	The guidance is required to cover adults and children. We intend that the recommendations for adults and children as far as clinical management is concerned will be dealt with separately.
ROCHE	3	4.1.1(b)	4.1.1 b	Every adult and child in the UK is at risk of becoming overweight and obese, as the epidemiological studies of the past 25 years have shown. Further all those whose weight increases are also at significantly increased risk of developing chronic conditions and co-morbidities.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former

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					will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).

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ROCHE	4	4.1.1(c)	4.1.1 c	Including people of healthy weight takes these guidelines into the remit of public health and social policy. We firmly believe that prevention of overweight and obesity is such a wide-ranging topic, requires a separate guideline from management of overweight and obesity.	We have been tasked to develop guidance to cover both management of overweight and obesity AND prevention.
ROCHE	5	4.1.2(a)	4.1.2 a	The management of weight-related chronic conditions, such as type 2 diabetes, can have a bearing on the ability of a patient to lose weight. For example, some drugs actually cause weight increase. However, weight loss can have a positive effect on disease management, improving prognosis and affecting treatment needs. It is very important that the guideline addresses these issues, particularly given the very high correlation between some of these chronic conditions, such as hypertension, type 2 diabetes and overweight and obesity.	The guidance will advise on weight management in these groups, but not on the management of the condition *per se*.
ROCHE	6	4.2(a)	4.2 a	The statement, 'those who are at increased risk of becoming overweight or obese and / or for whom becoming overweight or obese would increase the risk of developing other chronic conditions' encompasses nearly every individual in England and Wales as almost everyone is at risk of becoming overweight or obese and every overweight and obese person is at increased risk of developing associated co-morbidities. Clearly, the NHS has a pivotal role to play in public health but, as previously stated, the guidance would be much more practical both to develop and implement if divided into two separate guidelines on prevention and management.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
ROCHE	7	4.2(c)	4.2 c	Clearly the public health issues associated with increasing levels of overweight and obesity in the UK are wide ranging, and addressing them will require partnership and cooperation between the NHS and many other agencies. To try to address these as well as the treatment and management issues of overweight and obesity will be extremely difficult. Again, we believe this is a clear indication that the diverse problem of obesity prevention should be separated from obesity management.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
ROCHE	8	4.3.1(a)(1)	4.3.1 a 1)	It is clear that all management interventions, whether they are non-pharmacological (such as exercise, weight loss classes etc) or	Noted.

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				pharmacological (such as anti-obesity drugs) if recommended for use by the NHS, should be evaluated using the same standards of evidence.	

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ROCHE	9	4.3.1(a)(2)	4.3.1 a 2)	It is likely that Roche will wish to submit information to the guideline developers which at the time of submission is commercial-in-confidence in support of the re-appraisal of orlistat. We would seek clarification as to whether this will be acceptable?	Information can be submitted in accordance with the NICE guidelines Technical Manual 'Guideline Development Methods', available from the NICE website www.nice.org.uk.
ROCHE	10	4.3.1(b)	4.3.1. b	As stated previously, nearly every individual in England and Wales could be considered to be at risk of becoming overweight or obese and every overweight and obese person is at increased risk of developing associated co-morbidities. We do agree though that certain populations, such as Indo-Asians, are at even greater risk of developing weight related co-morbidities at a lower BMI and deserve special consideration.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
ROCHE	11	4.3.1(c)	4.3.1 c	This is inconsistent given that the scoping document states earlier that the guidance will 'not make specific recommendations regarding services outside of the NHS'.	The guidance will provide recommendations for the NHS and advice for settings outside the NHS, as outlined in 4.2 c).
ROCHE	12	4.3.1(d)	4.3.1.d	Weight maintenance is an important factor within weight management, given the natural progression of weight gain with time. However, strategies for weight maintenance following weight loss are likely to be different from strategies required for weight maintenance in someone who has not previously been overweight. The issue therefore needs to be addressed separately, within both prevention and management guidelines.	Noted. This is an area the Guideline Development Group will consider when developing the guidance.
ROCHE	13	4.3.2	4.3.2	Any person who registers with a General Practice, or secondary care clinic (especially diabetic or cardiovascular), should have their BMI recorded. The guideline will need to encourage this as best practice, given the clear association between excess weight, morbidity and mortality, and the resultant burden on the NHS.	Noted and amended. The guidance will consider the evidence for how often children and adults should be weighed and have their BMI recorded in an appropriate setting. The guidance will, however, exclude population-based screening *programmes*.

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ROCHE	14	General	General comments	In summary, to ensure that the very important health issue of overweight and obesity is dealt with adequately in order to make a difference to the health of the UK population, it is our belief that the guideline should be split into two: one that covers the management pathways for overweight and obesity, and one that covers the prevention of the problem. Given the very different treatment requirements for adults and children, these patient groups must be dealt with separately within the management guidance. We believe it is important that co-morbidities are included within the management guidance, as the presence of co-morbid disease will affect the management (particularly in relation to timing and choice of intervention) as well as the potential outcomes of overweight and obesity. To not do this risks "de-medicalising" obesity and undoing much of the work that has gone on over at least the last five years in establishing obesity as a very serious medical problem.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
Royal College of General Practitioners	1	General	General	The contributory elements to this problem are substantial and wide-ranging, including diet, food marketing, child development, and exercise to mention just a few. Effective response needs to be similarly wide-ranging and extend far beyond health care to embrace education, food retailing and marketing, social incentives to exercise as well as healthcare. Policy statements from relevant government departments issued in parallel with the NICE guideline would increase its impact, and widen its remit. In addition, please do not hesitate to contact myself if NICE wish further discussions on the wider social questions around obesity.	Noted. This is outside the remit of the guidance (see 4.4) but some of these issues will be addressed by broader ongoing work, e.g. by the forthcoming Food and Health Action Plan and the Activity Coordination Team.
Royal College of General Practitioners	2	4.3.1(a)(1)	4.3.1 a)1	Minor point: behavioural interventions are not separate from diet and physical activity (these are the behaviours targeted)	Noted.
Royal College of General Practitioners	3	4.3.2(a)	4.3.2 a)	Since the remit of the scope is large i.e. not just obese but those at risk of becoming obese surely the issues surrounding screening are very important, and should be included. Primary care also need this advice since we are being advised to weigh patients.	Noted and amended. The guidance will consider the evidence for how often children and adults should be weighed and have their BMI recorded in an

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				I cannot also see the rationale for not including complementary treatments	appropriate setting. The guidance will, however, exclude population-based screening *programmes*. Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm).

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Royal College of General Practitioners	4	General	general	Obesity as defined by BMI may be less important than abdominal obesity – should the document include some acknowledgement of this?	The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues. Noted. They will be considered in the guidance GDG (see 4.3.1a (ii)).
Royal College of Nursing	1	General	General	Our colleague with special interest in obesity has read through the scope and is happy with its contents.	Noted. Thank you.
Royal College of Nursing	2	General		We look forward to the next draft and to the future as healthcare professionals will find it extremely useful to be offered guidance to ensure best practice in obesity management.	Noted.
Royal College of Paediatrics and Child Health	1	General	General	The RCPCH welcomes the inclusion of children in this national guideline, particularly in the light of the RCP document "storing up problems, the medical case for a slimmer nation". It strongly supports the inclusion of primary prevention within the scope. The joint college document should be referred to when considering the college's response, as it provides support for many of the comments below.	Noted.
Royal College of Paediatrics and Child Health	2	4.1.2(b)	4.1.2b)	The decision to exclude children under 5 years of age is bizarre. The prevalence of obesity in 2 to 4 year olds has almost doubled in a decade (5% to 9% between 1989 and 1998). It is inappropriate to restrict consideration of strategies to the over 5 year olds, when obesity is already evident and increasingly common in children younger than this age. Patterns of eating and exercise are established in this age group. It also removes the opportunity for Health Visitors to deliver health promotion to a population that in most parts of the country is currently regularly weighed, measured and examined. It should also be noted that eating in the under 5's is much more closely monitored, and that most attend nursery groups.	Noted and amended. We have lowered the age range for children to 2 and over.

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				Consideration of the role of breastfeeding in preventing obesity must form part of the scope of an evidence-based guideline on obesity.	Noted.

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Royal College of Paediatrics and Child Health	3	4.3.2(a)	4.3.2a)	The exclusion of consideration of any population surveillance for obesity is a serious omission. Children in many areas are still routinely weighed and measured, and the evidence for benefit in terms of identifying obese children for targeted interventions must be given consideration.	Noted and amended. The guidance will consider the evidence for how often children and adults should be weighed and have their BMI recorded in an appropriate setting. The guidance will, however, exclude population-based screening *programmes*. Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm).
Royal College of Paediatrics and Child Health	4	4.2	4.2	In children, there are small numbers of morbidly obese children with rare causes who need tertiary care. In addition, there needs to be guidance on the role of secondary care, and whether any intervention at that level has been shown to be effective in established obesity. The scope should also cover the investigation of children for the relatively rare causes of secondary obesity. It is critical that the guideline development group has representation from a paediatrician with special interest in obesity, as well as secondary care professionals.	Noted. This is an area the Guideline Development Group may wish to consider when developing the guidance. Owing to broad scope of guidance it will not be possible to offer detailed guidance on this topic. See 4.4. Noted and agreed.
Royal College of Paediatrics and Child	5	4.2(c)	4.2c)	The RCPCH agrees that the guidance should go beyond the NHS. Although it is understandable that NICE has to confine itself to the NHS, it is important	NICE were tasked by the DoH to work with the HDA to develop guidance to

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Health				that the scope includes environmental changes that can help individuals and communities. Otherwise the report will end up implying that obesity and overweight are the province of health professionals only and will continue to put the heaviest responsibility on individuals and parents for doing something about it. Environmental changes are going to be crucial.	cover both management of overweight and obesity AND prevention. The HDA's remit goes beyond the NHS.
Royal College of Paediatrics and Child Health	6	4.3.1(a)(1)	4.3.1a. 1)	It might be helpful to add that the interventions considered should include clinical and non-clinical settings.	Noted. The guidance will make advice regarding *prevention* outside the clinical setting.
Royal College of Paediatrics and Child Health	7	4.3.1(a)(2)	4.3.1a 2)	It will be important to point out the need for research to support the extension of licensed indications for the existing available drugs for use in children and adolescents.	Noted. This is an area the Guideline Development Group may wish to consider when developing research recommendations for the guidance.
Royal College of Physicians, Edinburgh and Glasgow		4.3.1(a)(4)	Page 8, 4) –	I think it might be worth considering adding a point 5 "Prioritised management of specific individual cardiovascular risk factors because of multiplicative effect of overweight on heart disease". Point 6 should be to specify identification of individuals with Metabolic Syndrome to define the aims of management and criteria for intervention for patients with Metabolic Syndrome and a final point is a need to consider the increasing problem and costs of obesity, and the obstacles to its management, in the growing elderly sector of the population.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2). The guidance will advise on weight management in people with metabolic syndrome, but not on the management of the condition *per se.*
Royal College of Physicians, Edinburgh and Glasgow		4.3.2(b)	Page 9, 4.3.2 b)	I see no reason to exclude "complementary therapy" if it is effective in management of overweight and obesity. In fact I think you should go further than this by removing this bullet point altogether, but specifying that any treatments whether they are considered complementary or not should be considered equally on the basis of evidence for their efficacy and safety.	Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldscte

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					ch/123/12301.htm).
Royal College of Physicians, Edinburgh and Glasgow	1	1	1. Guidance title	I am a little unhappy with the word treatment here. I think we moved on from treatment to management a few years ago as did the Americans and most European countries. Management includes weight loss, weight maintenance and addressing specific related risk factors.	Noted and amended.
Royal College of Physicians, Edinburgh and Glasgow	2	2	2. Background	I am unsure exactly how NICE operates in general, but I think it is noteworthy that no specific organisation with clinical or public health responsibility for obesity is included in this work at a formal level. Would this be the usual approach of NICE? I would have expected, for example, that consultation on heart disease might have included formal representation from a cardiology body. The final sentence of a) in the background section indicates that "the guidance will provide recommendations for good practice". This requires formal clinical input which is not included in the team commissioned to make the report. The Royal Colleges are the usual bodies responsible for making recommendations for good practice.	The appropriate professional bodies will be involved with the development of this guidance. Full details of the NICE guideline development process can be downloaded from the NICE website (www.nice.org.uk).
Royal College of Physicians, Edinburgh and Glasgow	3	3	3. Clinical need for the guidance	I think it is important to stress, even at this very early stage, that obesity is a disease with an ICD code (ICD – E-66) and that disease is best defined as the underlying disease process of excess fat accumulation. The term "defined" in the next sentence BMI of 25 – 29.9 equals overweight, BMI greater than 30 equals obesity are not definitions of obesity, but epidemiological cut-offs to identify people who have advanced stages of the disease process.	It should be noted that obesity is considered to be a disorder of lifestyle as well as a 'disease' and an important risk factor for the development of diseases such as diabetes. We have amended this section to reflect this.
Royal College of Physicians, Edinburgh and Glasgow	4	3	Page 3, 2nd paragraph	Has a list which includes some of the clinical complications of obesity but omits others. Importantly it omits depression and I wonder if it might be better to include a fairly full list here.	The scope must of necessity be selective in what it covers.
Royal College of Physicians, Edinburgh and Glasgow	5	3(b)	Page 4, point B	I would make the point that clinical approaches to obesity will always be fighting a losing battle until or unless a primary prevention strategy is firmly in place. Clinical methods will always be perceived as worthless unless we are doing our best at a population-directed level.	We agree with this statement.
Royal College of Physicians, Edinburgh and	6	3(c)	Page 5, 1st bullet	Perhaps an extra bullet point to specify the cost of obesity	Covered in 3a). The economic cost of obesity will be considered in the literature review for the full guidance.

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Glasgow			point		
Royal College of Physicians, Edinburgh and Glasgow	7	4.3.1(a)(1)	Page 7, 4.3.1 a) 1)	This applies to all interventions but within the field of obesity where the diagnosis is publicly on view and where the patient needs to lose weight, firstly to improve health prospects and secondly because they want to look and feel better. There are insurmountable problems with many aspects of randomised controlled trials. For some areas of research on obesity the RCT is not the best design and this applies particularly to studies which are researching secondary outcomes of weight loss, such as falls in blood lipids, blood pressure, or improvements in diabetic control.	Noted.
Royal College of Physicians, Edinburgh and Glasgow	8	4.3.1(a)(2)	Page 7, 4.3.1 a) 2)	It seems likely that the license indications for anti-obesity drugs will be varied very soon to take away the clinically very damaging limitation to duration of treatment. I think you should allow this process to examine the wisdom of stopping treatment after one or two years as per licensed indications. This is one of the areas where the involvement of representative clinicians would be of value.	All relevant evidence will be considered. Representative clinicians will be included on the GDG.
Royal College of Physicians, London	1	1	1.	Please refer consistently throughout the document to overweight and obesity – one needs to be overweight prior to becoming obese. 'Weight management' not 'weight maintenance' of obesity. Weight maintenance is not the aim of treatment! Treatment aims to produce weight loss and weight loss maintenance best summarised as 'weight management'.	Noted and amended.
Royal College of Physicians, London	2	2(a)	2a)	As in 1, it is unclear what is meant by weight maintenance – is this weight management or the maintenance of a lowered body weight?	Noted and amended.
Royal College of Physicians, London	3	2(b)	2b)	There is no mention of the NSF for children and young people.	It is stated that the guidance will support the implementation of published National Service Frameworks. The NSF for children and young people is currently in development and is unpublished.
Royal College of Physicians, London	4	3(a)	3a)	Reference should be made to a shortened life expectancy associated with increasing degrees of overweight and obesity (ref. Peeters et al Ann Intern Med 2003;138:24-32), particular association with colonic and endometrial cancers (ref. Calle et al NEJM 2003;348:1625) and the low self esteem and	The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues.

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				depression often associated with obesity (Doll et al Obesity Res 2000;8:160-70). We are surprised that no mention is made of obstructive sleep apnoea which is a common and under-recognised complication of obesity NICE should consider the effect of ethnicity on the classification of overweight and obesity. The IOTF document 'The Asia-Pacific perspective: Redefining obesity and its treatment' produced by the International Diabetes Institute, a World Health Organization Collaborating Centre for the Epidemiology of Diabetes Mellitus and Health Promotion for Noncommunicable Diseases, http://www.idi.org.au/downloads/obesity_report.pdf provides important information on SE Asian ethnicity influences on obesity as a disease, although the precise obesity cut-point definitions have not yet been agreed.	Noted. A fuller review of the mortality and morbidity of obesity and overweight will appear in the full guidance.
Royal College of Physicians, London	5	3(a)	3a)	We would take issue that '…the fundamental cause of obesity is consuming more calories than are expended in day-to-day living'. This is a mechanism; we know little about the causes. Amplification of the increased mortality of obesity would also be appropriate eg Obesity and Mortality from Cancer. Hans-Olov Adami, M.D., and Dimitrios Trichopoulos, M.D. N Engl J Med. 348;1623-24, 2003; Overweight, Obesity, and Mortality from Cancer in a Prospectively Studied Cohort of U.S. Adults. Eugenia E. Calle, Ph.D., Carmen Rodriguez, M.D., M.P.H., Kimberly Walker-Thurmond, B.A., and Michael J. Thun, M.D. N Engl J Med. 348;1625-38, 2003.; Obesity in Adulthood and Its Consequences for Life Expectancy: A Life-Table Analysis. Anna Peeters, PhD; Jan J. Barendregt, PhD; Frans Willekens, PhD et al. Ann Intern Med. 2003;138:24-32.	Noted and amended. The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues. A fuller review of the mortality and morbidity of obesity and overweight will appear in the full guidance.
Royal College of Physicians, London	6	3(a)	3a) page 4 para 2	To be pedantic: it was estimated in 2001 from data of 1998.	Noted. The reference is correctly cited as 2001.
Royal College of Physicians, London	7	4.1.1.(b)	4.1.1 b) page 5	The document should define what is meant by 'at increased risk' – presumably this relates to a family history either of obesity or its associated complications.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a

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					healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
Royal College of Physicians, London	8	4.1.1(c)	4.1.1 c)	The inclusion of health promotion is an enormous amount of very challenging work across many governmental agencies – to do this well needs a completely different approach. To do it poorly will be to include it within guidance about the clinical management of overweight and obesity – We are fearful that it will also detract from the important focus on developing cost-effective programmes for treating those unfortunate individuals with an established weight problem.	Noted.
Royal College of Physicians, London	9	4.2	4.2 a) and c)	To include those who are at increased risk of becoming overweight or obese… in effect includes the whole UK population. This is a huge remit for NICE and suggests involvement with socio-political issues such as transport policy, education etc which seems incompatible with the statement under 4.2c) that guidance will not make specific recommendations regarding services outside of the NHS. We suggest that the latter is left for a subsequent report.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2). NICE were tasked to work with the HDA to develop guidance to cover both management of overweight and obesity AND prevention. The HDA's remit goes beyond the NHS.
Royal College of Physicians, London	10	4.3.1	4.3.1 b) and c)	These two areas are covered by our comments above – b) highlights the importance of defining who is at risk	Noted.
Royal College of Physicians, London	11	4.3.2(b)	4.3.2 b)	The distinction between complementary therapy and many commercially promulgated diets is grey. It will be important for popular and 'fad' diets to be included in the guidance.	Noted and amended. The guidance will consider the evidence for how often children and adults should be weighed and have their BMI recorded in an appropriate setting. The guidance will, however, exclude population-based

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					screening *programmes*. Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm). We will review the evidence for generic types of diet.
Royal College of Physicians, London	12	General	General comment	We suggest that the document will be helped if there is a clearer focus on the level of intervention – ie those treatments that will largely emanate from primary care, those from secondary care and those that may require a tertiary centre.	Noted.

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Royal College of Psychiatrists	1	4.3	4.3 (Clinical Management)	A proportion (perhaps 30%) of people with obesity trying to lose weight have eating disorders, usually Binge Eating Disorder, which require treatment.	The guidance will link to the NICE Eating Disorders guideline as appropriate.
Royal College of Psychiatrists	2	4.3		Some treatments for obesity (notably dietary restriction) lead to the development of eating disorders, mostly Binge Eating Disorder, but also Bulimia Nervosa and even Anorexia Nervosa	The guidance will link to the NICE Eating Disorders guideline as appropriate.
Royal College of Psychiatrists	3	4.3		Psychological treatments have been demonstrated as being effective in obesity, including Family therapy in childhood obesity, and Cognitive Behavioural Therapy in obesity generally. There is a passing mention of "behavioural approaches" in the document, but this is insufficient: it is important that that proper attention should be paid to the variety of interventions that have been investigated	Noted and amended. The term 'psychological' rather than 'behavioural' is used to reflect broader range of therapies.
Royal College of Psychiatrists	4	General	General	The conclusions from these observations are first that the lack of an eating disorders specialist is a serious impediment to the working of this group, and secondly, that the scope, by apparently paying no attention to Eating Disorders, is failing to acknowledge the established causal links between these disorders and Obesity. We would recommend most firmly that a specialist in Eating Disorders, preferably a psychiatrist, be co-opted onto the Guidelines Working Group.	Reference will be made to the NICE Eating Disorders guideline as appropriate. Noted. The NCC-PC and the HDA, in consultation with NICE, will decide on the composition of the Guideline Development Group. We will co-opt other professional representatives as appropriate.
Royal Pharmaceutical Society	1	3(b)	Section 3 b	There is evidence that community pharmacists interventions are effective in managing obesity in patients and this professional group's potential contribution to obesity management should be included in the scope of this consultation.	Noted. The guidance will take account of the role of community pharmacists and they will be invited to contribute to the guidance development process.
Royal Pharmaceutical Society	2	4.1.2	Section 4.1.2	Some explanation needs to given why guidance is not being considered for children under 5 years of age as there may be isolated examples where guidance is needed, for example, a consultant paediatrician at a recent National Obesity Forum conference presented a case study of a one year	Noted and amended. We have lowered the age range for children to 2 and over

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				old with a BMI of 30.	
Royal Pharmaceutical Society	3	4.3.1(d)	Section 4.3.1d	Whilst the actions listed in 4.3a-c will play a role in primary and secondary prevention some consideration should be given to issuing guidance on other primary prevention approaches where there is evidence to support these, for example, the effectiveness of food policies and advertising standards on energy-dense foods. This particularly applies to situations where the NHS may act with other agencies on primary prevention, e.g. Local Strategic Partnerships to improve access to fruit and vegetables.	Noted. This is an area the Guideline Development Group will consider when developing the guidance.
Royal Pharmaceutical Society	4	4.3.2	Section 4.3.2. a and b	We are not convinced that these areas should be excluded where there is evidence to support their effectiveness. There is possibly merit in considering screening. It would be important to establish if complementary therapy approaches show evidence of efficacy. Such approaches might be more suitable for some individuals than therapeutic or surgical interventions.	Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm).

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Sanofi-Synthelabo UK	1	4.3.1	4.3.1, paragraph a)2 Pharmacological interventions	During the development timeframe of this guidance, it is projected that the following trial programme will report.
				
				ACOMPLIA™ (rimonabant) Phase III programme in obesity and smoking cessation: seven studies including > 13,000 patients
				
				• The rimonabant in obesity programme (RIO) comprises > 6,600 patients in four Phase III studies all of which have completed recruitment
				
				  • RIO North America – 2-year treatment – Reporting April 2004
				  • RIO Europe – 2-year treatment – Reporting June 2004
				  • RIO Lipids – 1-year treatment – Reporting March 2004
				  • RIO Diabetes – 1-year treatment – Reporting April 2004
					Thank you for your comment. Please refer to the section on licensing in the NICE guidelines Technical Manual "Guideline Development Methods, available from the NICE website

Sanofi-Synthelabo UK	2	4.3.1(a)(2)	4.3.1, paragraph a)2	Such wide-ranging guidance will no doubt involve a time-intensive schedule, not only in its initial development but also in subsequent review cycles. Even if a review date of only two years post issue is specified, new data that miss the cut-off date for submission in 2004 might not be implemented into a first revision until 2009 or 2010. With this in mind, will The Institute be developing a process by which the significance of newly available data can be determined on an ad hoc basis, with the aim of incorporating truly impactful developments into the guidance without prolonged and unnecessary delay? Guidance of such importance to the Public Health should be updated on a rolling basis rather than within a restrictive fixed timetable.	The review process for updating guidelines is described in the Technical Manual. The inclusion of new evidence during the development phase is at the discretion of the developers, within the boundaries outlined in the Technical Manual and the Guideline Development Process manual (also available on www.nice.org.uk).
Slim Fast Foods Limited	1	General	General	Slim Fast Foods manufactures weight management products already covered by European legislation (Directive 96/8/EC on foods intended for use in energy restricted diets for weight reduction) and implemented into UK legislation as S.I. 2182, 1997. Meal replacement products have an extensive history of clinical and cost efficacy in both clinical and unsupervised use. These comments seek to ensure the inclusion of appropriate commercial systems, including meal replacements for weight control, in the NICE/HDA review and guidance.	Noted.

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Slim Fast Foods Limited	2	1	1. Guidance Title	We suggest a clearer title would be: Identification, assessment, treatment, weight loss maintenance and prevention of obesity and overweight in adults and children	Noted and amended.
Slim Fast Foods Limited	2	General	General	We understand there has been comment to the effect that the Scope is too broad, and that prevention of weight gain and management of overweight and obesity should be considered separately. Slim Fast Foods supports this comment.	We have been tasked to develop guidance to cover both management of overweight and obesity and prevention in children and adults. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
Slim Fast Foods Limited	3	3	3. Clinical need for the guidance a)	We suggest including reference to waist circumference as an independent risk factor: Excess body fat in the abdomen, disproportionate to total body fat, is considered an independent risk factor associated with obesity. In general those at risk are men with a waist circumference >40in (102cm) and women >35in (88cm).	Noted. The most appropriate way to measure overweight and obesity will be considered in the guidance (4.3.1).
Slim Fast Foods Limited	4	3	3. Clinical need for the guidance c)	We suggest adding a fourth bullet point to the list of reasons why the guidance is needed: Health care practitioners are frequently asked by patients for information about commercial weight management systems – guidance would help them give accurate advice about what is clinically effective and cost effective, and help patients avoid the pitfalls of unsubstantiated fad diets.	Noted. We have summarised the reasons for guidance as identified by the National Audit Office Report.
Slim Fast Foods Limited	5	4.2	4.2 Healthcare settings a)	We suggest changing line 2 to read: …..who have direct contact with, give advice to, and make decisions concerning…..	Noted and agreed.
Slim Fast Foods Limited	6	4.2	4.2 Healthc	We suggest changing line 7 to read: …..on effective interventions, including commercially available products and	The existing wording does not require amending.

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			are settings c)	systems, in the prevention…..	
Slim Fast Foods Limited	7	4.2	4.2 Healthcare settings c)	We suggest changing line 20 to read: …..the voluntary, private and commercial sectors…..	The existing wording does not require amending.
Slimming World	1	General	general	It should be ensured that within the scope consideration is made of the best use of available NHS resources including workforce, as stated in the initial referral from the Department of Health and Welsh Assembly Government.	Noted.
Slimming World	2	General	general	It would be important to consider sustainability of interventions within the guidance.	Noted.
Slimming World	3	General	general	The guidance should also include a small section addressing health practitioners' attitudes and beliefs about overweight and obesity, in particular there needs to a recognition that a whole range of factors may predispose to obesity and subsequent success at weight loss. People may be vulnerable at the point at which they ask for help to lose weight. This may be due to humiliation, a health scare or loss of self-esteem. Services should be sensitive to this vulnerability and not respond with judgement or blame. Equally, it should be acknowledged that patients need help to move through the stages if change towards a successful weight loss attempt, rather than being pressurised to lose weight before they are ready.	Noted. This is an area the Guideline Development Group will consider when developing the guidance.
Slimming World	4	2(a)	2a	The guidance will provide recommendations for good practice that are based on the best available evidence for effectiveness, including cost-effectiveness (and best use of NHS resources including workforce).	The scope does not specify the best use of NHS resources including workforce.
Slimming World	5	3(c)	3c	The evidence that certain interventions can be successful in enabling people to lose weight (and maintain weight loss in a sustained approach).	Noted.
Slimming World	6	4.1.1	4.1.1	Consideration needs to be made as to how to best engage with the hard to reach groups of the population e.g. men aged 18-45.	Noted. This is an area the Guideline Development Group may wish to

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					consider when developing the guidance.
Slimming World	7	4.1.1(b)	4.1.1b	It should be made clear how this group is defined. It will be important to also offer help to those who are at risk of becoming obese and who are motivated to make lifestyle changes at this point in time. People who self-refer or are about to self-refer need a mechanism to access appropriate support at the appropriate moment in time.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
Slimming World	8	4.1.2(b)	4.1.2b	In terms of prevention, it would be beneficial to include children under 5 in the guidance or at least consider family-based approaches. Sure Start or Early Years could be represented as stakeholders.	Noted and amended. We have lowered the age range for children to 2 and over.
Slimming World	9	4.2(c)	4.2c	Again there should be emphasis on the need to recommend interventions in the treatment of overweight and obesity and the maintenance of weight loss which are sustainable and cost effective.	Noted.
Slimming World	10	4.3.1(a)(1)	4.3.1a1	Good evidence of effectiveness should also include cost-effectiveness and sustainability.	Noted.
Slimming World	11	4.3.1(a)(4)	4.3.1a4	It should be recognised that relapse and weight regain can be a normal feature of a long term weight loss programme and services should be available to allow for people to return after weight regain. Ideally services should have a tracking system to monitor long term weight maintenance and / or be placed to register weight regain.	Noted.
Slimming World	12	4.3.2(b)	4.3.2b	Could complementary therapy approaches be defined?	Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldscte

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					ch/123/12301.htm).
Slimming World	13	4.4	4.4	The management of obesity is also relevant to the NSF for Mental Health. With respect to the effectiveness of programmes an improvement in mental health well-being should be considered positively.	Noted.

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Society for Endocrinology	1	General	General	The scope of the guidelines is too broad. As commented on below, it could include every individual in the UK. There is a danger that the public health components on prevention will swamp the clinical guidelines for overweight and obesity management that are the 'natural' scope for such a document, and could be implemented by the NHS and its agencies.	We have been tasked to develop guidance to cover both management of overweight and obesity and prevention in children and adults. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
Society for Endocrinology	2	1	1	Overweight and obesity is the preferred terminology; also 'weight management' not 'weight maintenance' of obesity. Weigh maintenance is not the aim of treatment! Treatment aims to produce weight loss and weight loss maintenance best summarised as 'weight management'.	Noted and amended.
Society for Endocrinology	3	3(a)	3a	NICE should consider the effect of ethnicity on the classification of overweight and obesity. The IOTF document 'The Asia-Pacific perspective: Redefining obesity and its treatment' produced by coordinated by the International Diabetes Institute, a World Health Organization Collaborating Centre for the Epidemiology of Diabetes Mellitus and Health Promotion for Noncommunicable Diseases, http://www.idi.org.au/downloads/obesity_report.pdf provides important information on SE Asian ethnicity influences on obesity as a disease, although the precise obesity cut-point definitions have not yet been agreed.	Noted. This issue will be considered in the guidance (see 4.3.1).
Society for Endocrinology	4	3	3a, p3, para 2	We would take issue that '…the fundamental cause of obesity is consuming more calories than are expended in day-to-day living'. This is a mechanism; we know little about the causes, but in, for example, leptin-deficient obesity the fundamental cause or aetiology is a mutation in either the leptin or leptin-receptor gene. It is important that NICE does not oversimplify the science of disorders of energy balance, especially when this risks pandering to commonly held prejudices against obesity as a disease. 'many', not 'some' cancers.	Noted. We have amended the wording slightly to address this issue. Noted and amended.

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				A statement of the increase mortality of obesity would also be appropriate e.g. Obesity and Mortality from Cancer. Hans-Olov Adami, M.D., and Dimitrios Trichopoulos, M.D. N Engl J Med. 348;1623-24, 2003; Overweight, Obesity, and Mortality from Cancer in a Prospectively Studied Cohort of U.S. Adults. Eugenia E. Calle, Ph.D., Carmen Rodriguez, M.D., M.P.H., Kimberly Walker-Thurmond, B.A., and Michael J. Thun, M.D. N Engl J Med. 348;1625-38, 2003.; Obesity in Adulthood and Its Consequences for Life Expectancy: A Life-Table Analysis. Anna Peeters, PhD; Jan J. Barendregt, PhD; Frans Willekens, PhD et al. Ann Intern Med. 2003;138:24-32.	Noted. This will be addressed in the literature review for the guidance.

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Society for Endocrinology	5	3(a)	3a, p4 para 2	To be pedantic: it was estimated in 2001 from data of 1998	Noted. The reference is correctly cited as 2001.
Society for Endocrinology	6	4.1.1(c)	4.1.1 c)	See initial general comments	Noted.
Society for Endocrinology	7	4.2	4.2 a) and c)	To include those who are at increased risk of becoming overweight or obese… in effect includes the whole UK population. This is a huge remit for NICE and suggest involvement with socio-political issues such as transport policy, education etc. which seems incompatible with the statement under 4.2c that guidance will not make specific recommendations regarding services outside of the NHS.	We have been tasked to develop guidance to cover both management of overweight and obesity AND prevention.
Society for Endocrinology	8	4.3.2(b)	4.3.2 b)	The distinction between complementary therapy and many commercially promulgated diets is grey. It will be important for popular and 'fad' diets to be included in the guidance.	Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm). We will review the evidence for generic types of diet.
Society for Endocrinology	9	General	General Comment	The guidelines will need to address who should be delivering treatment: i.e. what treatment should be the responsibility of primary care doctors, and what should be offered within secondary care. As regards the latter, it will be important to recognise that most obesity-related disease presents to non-obesity specialists (there are <10 in the UK) such as cardiologists, rheumatologists etc. The incorporation of overweight and obesity management into care of associated diseases is essential, and should not be excluded (4.1.2 a)). There is a need for greater medical academic/clinician input to the Guideline	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2). Noted. The NCC-PC and the HDA, in

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				development group, both for balance and to allow what will be an onerous workload to be shared.	consultation with NICE, will decide on the composition of the Guideline Development Group.
Sustain: The Alliance for Better Food and Farming	1	3(c)	3 c.	In the list which demonstrates the need for national guidance on the prevention and management of obesity, it is important to recognise that the Food Standards Agency have published the most comprehensive systematic review to date which concludes that food promotions influence children's food choices. We recommend in this section the addition of the following bullet point (written in similar style to others in this section): "the evidence that industry food promotions targeted at children affect their food preferences and food choices". (For your information: Sustain co-ordinates a campaign, supported by 106 national organisations, which is calling for legislation to protect children from unhealthy food advertising and promotion – for further information see: www.sustainweb.org).	Noted. We will review and summarise this evidence as part of the full guidance. However, section 4.4 highlights that the guidance will not make specific recommendations for National policies such as fiscal policy, or food labelling policy. Such policies will be addressed broader ongoing work, for example in the forthcoming *Food and Health Action Plan.*
Sustain: The Alliance for Better Food and Farming	2	4.1.1	4.1.1 and 4.1.2 b	We can see no reason why children younger than 5 years should be excluded. If the above comment is accepted, then it should also be accepted that the younger the children, the more vulnerable they are when exposed to TV advertising of fatty and sugary foods: children of this age group often cannot recognise advertising and certainly do not have any concept of its purpose. Promotion and advertising aside, surely NICE should be looking at prevention in the under-5s, as some children will already be overweight by this age. This seems like a significant omission – is there a rationale for this?	Noted and amended. We have lowered the age range for children to 2 and over.

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Sustrans	1	General	General	Sustrans believes that the prevalence of certain non-communicable diseases is a symptom of the way we have planned our physical environment and transport systems to encourage sedentary lifestyles. Significant benefits to health could be achieved by changing the environment so as to encourage people to participate regularly in physical activity – especially in their travel choices.	Noted.
Sustrans	2	General	General	Sustrans believes that the promotion of healthy behaviour, as a way of improving the health of the nation, is likely to be more effective, and more cost-effective, than providing medical attention to treat the results of an inactive, unhealthy lifestyle. We welcome the comment on the areas that will be covered including: The Identification, assessment and management of adults and children who are at increased risk of becoming overweight or obese and at increased risk of developing other chronic conditions.(4.3.1.b)	Noted.
Sustrans	3	General	General	Walking is the most widely available form of physical activity as a means of transport, and therefore highly equitable. It is the dominant form of transport for journeys under one mile at 80%[i]. A systematic review of physical activity promotion strategies concluded that walking, the activity most widely available should be prioritised in measures to improve public health. The authors noted that in order to increase the attractiveness of walking: "attention will need to be paid to environmental factors which influence personal safety and convenience"[ii]. In June 2003 the UK Department for Transport issued a discussion paper which seeks views on how conditions for pedestrians might be improved and to increase the number of journeys made on foot[iii].	Noted.
Sustrans	4	General	General	While walking is more widely available to the population, the health benefits of cycling are somewhat greater on account of the higher intensity of effort[iv]. The Copenhagen Heart study, which involved 13,375 women and 17,265 men aged between 20 and 93, found that cycling has a strong protective function. It concluded that: "even after adjustment for other risk factors, including leisure time physical activity, those who did not cycle to work experienced a 39% higher mortality rate than those who did"[v].	Noted.

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Sustrans	5	General	General	Dutch research has demonstrated that cycling as part of normal daily activities can yield much the same improvements in physical performance as specific training programmes. The higher the total distance cycled during the six-month trial period of activity, the higher the gain in maximal external power and maximal oxygen uptake. For those with a low initial fitness level, cycling just 3 kilometres, four days per week is enough to improve physical performance[vi]. This confirms that the greatest health gains are to be achieved when the least active individuals become moderately active[vii].	Noted.
Sustrans	6	General	General	A good example (of cycling and walking) should be set by leaders in politics, the health sector and other areas. Adult role models are particularly important to young people. Active on-going promotion is needed of healthy and active behaviour, using promotional and media campaigns.	Noted.
Sustrans	7	General	General	Sustrans would like to see a greater allocation of research resources, towards disease prevention and health promotion, in the areas of physical activity and general public health.	Noted.
Sustrans	8	General	General	We should like to see greater resource allocation within the NHS to the promotion of healthy lifestyles, through advice to patients and staff as well as environmental changes. We are concerned in particular that many front-line health professionals may not be adequately trained in the promotion of physical activity and would like to see specific training programmes and budgets established to address this.	Noted.
Sustrans	9	General	General	The Danish National Action Plan Against Obesity, listing a range of possible interventions across sectors, remarks that "the greatest potential (in motivating a change to more active behaviour) is the possibility of making people walk or cycle for short trips rather than use their car"[viii].	Noted.
Sustrans	10	General	General	Star ratings for trusts should, we feel, include a significant component related to success in promoting and achieving increased levels of physical activity – and indeed for other public health and health promotion measures. Future foundation trusts, especially foundation PCTs, should be set demanding health promotion targets, including those for the promotion of lifestyle physical activity. These targets, for all trusts, should include elements relating to trip generation, staff travel and patient transport.	Noted.
Sustrans	11	Genera	Genera	It is worth pointing out that not all good practice comes from England. In	Noted.

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		I	I	particular, Scotland and Wales have developed strategies for cycling, walking and physical activity promotion including: • Sport and Active Recreation in Wales – "Climbing Higher" Strategy. Welsh Assembly Government, July 2003 • Walking and Cycling Strategy for Wales - Welsh Assembly Government • A Walking Strategy for Scotland: Scottish Executive • Lets make Scotland more active - Physical Activity Task force **Any and all of these could contribute to good policy making in England and UK-wide.**	
Sustrans	12	References		References [1] DETR, 2000: Encouraging walking: Advice to local authorities [1] Hillsdon, M. and Thorogood, M. 1996: A Systematic Review of Physical Activity Promotion Strategies, British Journal of Sports Medicine, 30, pp. 84-89) [1] Department for Transport, 2003: On the move: by foot. A discussion paper [1] Oja, P., Vuori, I. and Paronen, O. 1998: Daily walking and cycling to work: their utility as health-enhancing physical activity, Patient Education and Counselling, 33, S87-S94 [1] Andersen, L., Schnohr, P., Schroll, M. and Hein, H. 2000: All-cause mortality associated with physical activity during leisure time, work, sports, and cycling to work, Archives of Internal Medicine, 160, pp. 1621-1628 [1] Hendriksen, I. 1996: The Effect of Commuter Cycling on Physical Performance and on Coronary Heart Disease Risk Factors, Amsterdam: Free University [1] Blair, S., Kohl, H., Barlow, C., Paffenbarger, R., Gibbons, L. and Macera, C. 1995: Changes in Physical Fitness and All-Cause Mortality: A prospective study of healthy and unhealthy men, Journal of the American Medical Association, 273, pp. 1093-1098. [1] Danish National Board of Health, 2003: National Action Plan Against Obesity	Noted.

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Tanita UK Ltd	1	3(a)	3 a)	Whilst BMI is a well-established method it has limitations and perhaps other methods are now more suited to an accurate and ongoing medical diagnostic environment. A M Prentice and S A Jebb. Beyond Body Mass Index. Obesity reviews (2001) 2, 000-000. D Gallagher et al, How useful is BMI for comparison of body fatness across age, sex and ethnic groups? American Journal of Epidemiology 1996;146:228-39 M Ohno et al, BMI, percent body fat and normal weight obesity. International Journal of obesity and related metabolic disorders Vol22, suppl3, Aug 1998.	The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues. They will be considered in the guidance (see 4.3.1).
The Counterweight Programme	1	1	1	Should read “Weight maintenance after loss”	Noted. Title now amended.
The Counterweight Programme	2	4.3.1(a)	4.3.1 (a)	A full systematic review of non pharmacological interventions in the management and treatment of obesity was recently carried out for NHS Research & Development Health Technology Assessment 99/02/02 entitled “Systematic review of the long term effects and economic consequences of treatments for obesity and implications for health improvement”. This should be included in the reference material. A copy can be supplied if required. Full HTA monograph will be published in 2004.	Noted. Thank you. We would like to see this documentation.
The Counterweight Programme	3	4.4	4.4	The Counterweight Programme has the largest ever cross-sectional survey of obesity in Primary Care in the UK and this audit data is available and will be published in April 2004 in the Journal of Human Nutrition and Diabetes (copies of the paper can be provided)	Noted. We would like a copy of this reference.
The Counterweight Programme	4	General	General	The scope seems appropriate although evidence for prevention strategies may be difficult. The impact of lack of Physical education in schools has recently been reported to the Scottish Executive in “The Report of the Physical Activity Taskforce” (report can be made available)	Noted.
THE NATIONAL CENTRE FOR EATING DISORDERS	1	4.1.1(b)	4.1.1.B	Groups that will be covered, adults who are at risk of significantly increased risk to health as a result of becoming obese. Too broad- obesity poses a significant health risk to everyone.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former

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					will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
THE NATIONAL CENTRE FOR EATING DISORDERS	2	4.1.2(a)	4.1.2.a	This guidance will need to link to the guidance on eating disorders	Noted.
THE NATIONAL CENTRE FOR EATING DISORDERS	4	4.3.1	4.3.1	Areas to cover Most people would like to see primary prevention approached but I wonder if this will make our brief too large since many aspects will be outside the remit of the NHS, e.g. The Department of Education.	Noted.
THE NATIONAL CENTRE FOR EATING DISORDERS THE NATIONAL CENTRE FOR EATING DISORDERS	3	General	general	I would like the guidance to recommend screening for people who are unsuitable for weight loss (readiness) as a result of eating disorder, emotional pathology etc and recommend other pathways for care.	Reference will be made to the NICE Eating Disorders guideline as appropriate.
The Obesity Awareness & Solutions Trust	1	2(a)	2 a)	There is some evidence that prevention is being given more attention than treatment. Finding strategies to halt the pandemic is vital and to be applauded. But what about the 10 million already obese in the UK, and the 10 million overweight waiting to become obese. To not give enough attention to treatment means the ten million already obese being put on the scrap heap! That is the equivalent of 25,000 jumbo jets full of passengers. That's the total populations of Birmingham, Manchester, Leeds, Liverpool, Bristol, Edinburgh, Newcastle, Brighton and Portsmouth, all being put on the back shelf of healthcare.	Noted. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
The Obesity Awareness & Solutions Trust	2	General		Efficacy and cost effectiveness are crucial considerations, but it may be necessary to sometimes take a 'spend to save' attitude. Can we afford not to treat?	Noted.
The Obesity	3	3(a)	3 a)	Please note that although obesity is more prevalent among lower socio-	Noted.

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Awareness & Solutions Trust				economic and lower income groups there are still millions in the higher groups. Many obese of all income groups are dieting experts; it is how to put that knowledge into action, which is one of the major problems. Too much emphasis on education at the expense of other approaches may distract from creating the most effective guidelines.	
The Obesity Awareness & Solutions Trust	4	General		Aetiology: To simply define overweight and obesity by size alone is too simplistic an approach. There is a need to investigate further the different phenotypes of overweight and obesity; the complexity of the problem. For example the overweight and obese need also to be understood in terms of psychological profile. The complexity of the problem is highlighted when talking with obese and post obese individuals. Reasons for an unhappy relationship with food include using food to cope with difficult times, an awareness that food helps block out problems, in a similar way to the person who has a drink problem and uses drinking to get through the day. Many remember being miserable as a young child and being cheered up/kept quite with sweets and biscuits and continuing as an adult to look for solace in food.	Noted.
The Obesity Awareness & Solutions Trust	5	General		A one-size fits all approach will not solve the problem. We suggest the development of a computerised profiling system available in public places such as libraries, surgeries, sports centres, shopping centres and schools that will enable large amounts of data to be collected requiring relatively small numbers of personnel. This system could also supply feedback and information to the user.	Noted.
The Obesity Awareness & Solutions Trust	6	4.1.1	4.1.1 a) and b) and c)	We believe everyone should be covered, including all children under 5. “Give me the child until he is 7 and I will give you the man.” 50% of our belief system is created by the time we are 5. There is further evidence to support the importance of including under 5s, which other stakeholders will provide.	Noted and amended. We have lowered the age range for children to 2 and over.
The Obesity Awareness & Solutions Trust	7	4.1.2(a)	4.1.2 a)	We believe that at least elements of treating co-morbidities need to be reflected in the guidelines. Some of the medications used for treating diabetes, for example, actually increase appetite and exacerbate the problem. Successfully treating excess weight, even by reducing weight by as little as 10% should be a front line treatment for some of the co-morbidities.	The guidance will advise on weight management in these groups, but not on the management of the condition *per se*.

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				Obesity is a chronic problem, and as with many other chronic conditions, treatment should be seen as an ongoing process and weight regain should not be considered a failure but rather a signal for further treatment.	
The Obesity Awareness & Solutions Trust	8	4.1.2(b)	4.1.2 b)	See 4.1.1 above	Noted.
The Obesity Awareness & Solutions Trust	9	4.2(c)	4.2 c)	We are pleased to see that joint working is to be considered. Although we understand that the guidance will be for use within the NHS and will not make specific recommendations regarding services outside of the NHS it is important to recognise that with an overweight and obesity epidemic already effecting over half the population, the NHS cannot work alone. Links with the private and commercial sectors need to be orchestrated. The geriatric model may be of some use where the NHS treats the co-morbidities and others take care of day-to-day management. Particular attention needs to be given to maintenance strategies. Millions of excess stones have been lost by millions of people. Keeping the weight off is the more difficult task. The skills of weight maintenance are different to the skills of weight loss.	Noted.
The Obesity Awareness & Solutions Trust	10	4.3.1(a)	4.3.1 a)	National guidance needs to include all successful types of known treatment, even those currently not provided through the NHS (referral to other agencies may be necessary). One example could follow the 'Exercise on Prescription' model and refer patients to 'Stress Management on Prescription'. There are few people whose eating and/or drinking behaviour is not affected by stress, whether that is over or under consumption. It is interesting to note that stress levels have risen in parallel with the rise in obesity; so has drinking in females Many patients would be prepared to fund or part fund such treatment if they were guided to effective programmes. Other common triggers to excess eating, the treatment of which could be outsourced in the same way include low self-esteem, anger, loneliness and addictive reactions.	Noted.

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				The full range of effective low and very low calorie diets, exercise, counselling, groups, medication, and surgery treatments need to be included in the guidelines. It is also worth noting that all treatments are often more effective when used in conjunction with counselling, such as Cognitive Behavioural Therapy.	Noted. We will review these when there is good quality evidence of effectiveness.
The Obesity Awareness & Solutions Trust	11	4.3.2(b)	4.3.2 b)	What does the scope mean by complementary approaches? Standard treatments have not been effective in halting the epidemic. At this stage in the process we believe all types of therapy should at least be identified and the evidence explored. At the first meeting of the Health Select Committee investigating obesity on 12th June 2003, John Austin MP asked Imogen Sharp, Business Area Head for the Department of Health, "We know that in some areas like dealing with drug addiction, for example, some of the complimentary and alternative therapies have been seen to be very effective when used in conjunction with other forms of treatment. For example, I think, with acupuncture in the drug rehabilitation programme. Has any research been done about the value of complimentary and alternative therapies in dealing with obesity?" She replied, "I understand that's something the Health Development Agency review will incorporate. So the answer is yes." Why has this now been changed?	Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm). We will review the evidence for generic types of diet.
The Obesity Awareness & Solutions Trust	12	General		On the point of evidence we believe the common practice of scientific journals rejection of anything other than quantative research means that some very good research gets ignored. Qualitative research, especially when dealing with the complexities of human behaviour and emotions can be very insightful.	Noted. We will consider both quantitative and qualitative research evidence as appropriate.

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The Obesity Awareness & Solutions Trust	13	4.4	4.4	In the Coronary Heart Disease NSF, hidden deep in the middle of the document are a couple of pages that mention milestones for obesity. April 2001 and 2002 are the target dates for the milestones. Nobody has been able to give us information on the achievement of these milestones. Our own investigation suggests that most GPs don't even know the milestones exist. The specific publication of overweight and obesity guidelines will help this situation but we suggest that achievement of milestones etc. will be better facilitated if they are recognised in GP contracts, for example. It seems there is little point in setting such milestones without a monitoring process in place	Noted.
The Royal College of Pathologists	1	1	1. Guidance title	Prevention of obesity. Identification, assessment and treatment of overweight or obese adults and children. Maintenance of healthy weight in adults and children of normal body weight.	Noted and amended.
The Royal College of Pathologists	2	1.1	1.2 Short title	Prevention and treatment of obesity	Noted and amended.
The Royal College of Pathologists	3	3(a)	3 a	Obesity is a serious medical condition associated with a number of critical complications. The body mass index (BMI) is defined as height (m) / (weight (kg))^2 is a measure of body weight which takes account of height. Adults with a BMI of 25-29.9 kg/m^2 are classified as overweight and adults with a BMI greater that 30 kg/m^2 are classified as obese. The prevalence of obesity is increasing. In England in 1980, 8% adult women and 6% adult men were classified as obese. By 2001 these figures had trebled with 24% women and 21% men found to be obese. Moreover in 2001 47% men and 33% women were overweight. Thus in 2001 nearly two thirds of men and over a half of women in England were either overweight or obese (need a ref for the 2001 data). In Wales … (need equivalent data from 1985 i.e. actual percentages) and % overweight as well as obese in 1998. It's a shame that the time interval is shorter in the Wales Data (13 years versus 21 years in England comparison making things sound better in Wales!) These findings have important implications on the health of the nation.	Noted.

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				The risk of developing obesity is dependent on age, socio-economic status and ethnic group. In 2001 the NAO found that obesity …as in text Children (paragraph 2 page 3 as in text).	
The Royal College of Pathologists	4	3(a)	Page 3 last para	The fundamental cause of weight increase is consuming more calories than are expended in day to day living. Our environment poses a high risk of obesity. High calorie foods are readily available to the majority of adults and children in England and Wales and there is a limited need for regular exercise. Obesity in adults is associated with significant morbidity and mortality, which can be attributed to increased risk of a number of medical conditions[1] including Type II diabetes, hypertension and coronary heart disease, the most common cause of premature mortality in the obese population. Obesity is also associated with several cancers including breast, endometrial, uterine, cervical, ovarian, prostate and bowel cancer[2]. Obesity predisposes to osteoarthritis particularly in the large weight bearing joints and to respiratory problems including obstructive sleep apnoea. Obese women are at increased risk of carrying children with congenital abnormalities even allowing for the higher prevalence of diabetes[3]. Thus obesity poses an immense and increasing public health burden. Obesity in children is associated with hypertension and metabolic disturbances such as hyperinsulinameia and dyslipidaemia. Obese children have a higher incidence of psychological disturbance and may be subjected to teasing at school[4]. Most concerning is the persistence of obesity into adulthood.	Noted. Noted. Noted.
The Royal College of Pathologists	5	3(b)	Page 4 pa	Obesity is a considerable economic burden. The National Office of Statistics has declared the obesity is the major cause of premature mortality in the UK (ref)…Around 1000 people per week die prematurely in the UK because of	Noted. Thank you for these references.

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			r a g r a p h 2	obesity (ref) 1. Kopelman,P.G. Obesity as a medical problem. *Nature* **404**, 635-643 (2000). 2. Daling,J.R. *et al.* Relation of body mass index to tumor markers and survival among young women with invasive ductal breast carcinoma. *Cancer* **92**, 720-729 (2001). 3. Shaw,G.M., Nelson,V. & Moore,C.A. Prepregnancy body mass index and risk of multiple congenital anomalies. *Am. J. Med. Genet.* **107**, 253-255 (2002). 4. Eisenberg,M.E., Neumark-Sztainer,D. & Story,M. Associations of weight-based teasing and emotional well-being among adolescents 1. *Arch. Pediatr. Adolesc. Med.* **157**, 733-738 (2003).	
UK Public Health Association	1	4.1.1	4.1.1	Children under 5 should be included. There is no reason given.	Noted and amended. We have lowered the age range for children to 2 and over.
UK Public Health Association	2	4.2	4.2	This is a good beginning but potential interventions should not be restricted in scope.	Noted.
UK Public Health Association	3	4.3.1	4.3. 1	The balance of interventions is on the pharmacological side. Most of the research highlights the limited success – and side effects – pharmacological approaches. The limitations of clinical and pharmacological interventions need to be set out.	The scope highlights the relevant important issues. It is inappropriate for it to offer a detailed discussion of these issues.
UK Public Health Association	4	General	General	Guidance is especially welcome – but there is insufficient emphasis on primary prevention and obesity is still predominantly emphasised as a individual issue when the data presented in the report shows the impact of strong social class, ethnicity variables. Guidance needs to be fully joined up with a food and physical activity model applied to groups (and individuals).	Noted.

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UK Public Health Association	5	General		There is no analysis of the cause of obesity. Obviously the mismatch of input and output is the immediate cause, but practitioners need to be informed of the wider causes of obesity.	Noted. The scope highlights the relevant important issues. It is inappropriate for it to offer a detailed discussion of these issues.
UK Public Health Association	6	General		Additionally, it is not clear what obesity actually is. Perhaps the document should state that it is both a lifestyle disorder and a disease and syndrome (in that it is connected with other diseases, such as diabetes). This is useful knowledge for practitioners because the disease types associated with obesity may themselves be reversible, at least to some degree.	Noted and amended.
Weight Watchers	1	General		Weight Watchers has carefully considered the Draft Scope on Obesity. We welcome its very broad coverage because the obesity epidemic clearly affects almost all sectors of the population. Although this makes for a very ambitious task, we feel this broad scoping is necessary and appropriate for the development of guidance on obesity. We particularly welcome the fact that advice will be made for health professionals about partnership working with agencies outside the immediate clinical setting. As a stakeholder in this process, Weight Watchers very much looks forward to the opportunity to submit evidence to NICE in the development of the Obesity Guidance. We wish the team luck in what is clearly a massive endeavour!	Noted. Thank you.
World Cancer Research Fund (WCRF)	1	General	General	The World Cancer Research Fund (WCRF) is pleased to have the opportunity to comment on the scope for these guidelines. WCRF is dedicated to the prevention of cancer by means of healthy diets and lifestyles. We are committed to reducing cancer risk and promoting good health through high quality research and education programmes. Recent papers have highlighted the importance of obesity to cancer risk. For example, Julian Peto's paper 'Cancer epidemiology in the last century and the next decade' Nature. 2001 May 17; 411 (6835):390-5	Noted.

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World Cancer Research Fund (WCRF)	2	3		**Detailed comments** **3. Clinical need for the guidance** We are pleased that the scope includes children but are concerned that the definition of 'obesity' in childhood, and the implications of a child having a BMI above a certain centile, need to be clear. The implications of a high BMI in childhood might be immediate, reflecting current psychosocial problems or diabetes for example, or they may come later, such as obesity in adulthood, or obesity-related disease. These need to be differentiated.	The scope summarises current thinking in this area. It is inappropriate for it to offer a detailed discussion of these issues. They will be considered in the guidance (see 4.3.1).
World Cancer Research Fund (WCRF)	2	General		The value of childhood BMI at different ages as a predictor of current or future health needs to be assessed, including testing such identification against the criteria for any screening test (as that is effectively what is being done) – that is appropriate sensitivity, specificity (and predictive value) and evidence of effective intervention.	Noted. The best way to identify overweight and obesity will be considered in this guidance. See 4.3.1.
World Cancer Research Fund (WCRF)	3	General		The term 'obesity', defined in adults as a BMI of 30 or more, categorises individuals in terms of health risk. The definition in children is quite different, simply identifying those with the highest BMI in a group, with cut offs set in a normative fashion based on usual population reference values. This does not carry any inherent implication of risk to the individual child (though of course increasing numbers above the cut offs reflect a general increase in fatness in children, as a group, which is indeed of concern.) The use of the same term for both excess adult fatness and the fattest children in a group is a source of confusion.	Noted. The best way to identify overweight and obesity will be considered in this guidance. See 4.3.1.
World Cancer Research Fund (WCRF)	4	3	Pg 3	Regarding (at the end of page 3) the persistence of obesity from childhood into adulthood, and in paragraph (c) on page 4 the need for national guidance on the prevention of obesity and overweight in adults and children. The assumption of a high level of tracking between childhood obesity and adult obesity is not necessarily justified. Being fat in childhood does increase the risk of later obesity, but not enough to identify reliably which particular children are at risk, especially in younger children (Guo et al, Am J Clin Nutr 2002; 76; 653-8).	Noted. This is an area the Guideline Development Group may wish to consider when developing the guidance.

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World Cancer Research Fund (WCRF)	5	3(c)		On 3c, the third bullet point (on page 5) needs to encompass weight maintenance.	Noted and amended.
World Cancer Research Fund (WCRF)	6	4.1	4.1 Population 4.1.1 Groups that will be covered	**4. The guidance** 4.1.1 b) Adults and children who are at increased risk of becoming overweight or obese and/or for whom becoming overweight or obese would significantly increase the risk of developing other chronic conditions. It is not clear how these groups will be identified, especially in children. The most likely way to do this reliably may well be to find children (of whatever BMI) with 2 overweight or obese parents.	Noted and amended. The guidance will cover two populations: those who are overweight and obese (with/without co-morbidities) and those currently of a healthy weight (see 4.1.1). The former will be dealt with under 'clinical management' (4.3.1), the latter under 'prevention' (4.3.2).
World Cancer Research Fund (WCRF)	7	4.3	4.3 Clinical management	Again, we would make the general point that childhood 'obesity' is a different thing to adult obesity.	Noted.
World Cancer Research Fund (WCRF)	8	4.3.2	4.3.2 Areas that will not be covered	a) Population-based screening for overweight or obesity Will population based approaches other than screening be addressed? The identification of 'at risk' groups, as described at point 4.1.1, seems actually to be screening. The exclusion of population-based screening for overweight or obesity needs to be clear – and justified. b) Complementary therapy approaches This exclusion seems odd. It would be valuable for NICE to advise on the state of evidence for less conventional approaches – both to prevention and to treatment. Again, the exclusion needs to be justified. Neither of these exclusions seems warranted on first principles.	Noted and amended. The guidance will consider the evidence for how often children and adults should be weighed and have their BMI recorded in an appropriate setting. The guidance will, however, exclude population-based screening *programmes*. Complementary therapy is a difficult term to define. We have revised the scope in line with the House of Lords Select Committee Report on Complementary & Alternative Therapies (http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm).