# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Alder Hey NHS Foundation Trust | General | General | There is no mention in the proposed draft about medications for the management of childhood obesity. Medical management is a rapidly expanding area in the management of adult obesity and it is likely to have potential benefits in children and young people too. This should definitely be included in the scope of this guideline development | Thank you for your comment.<br>There are currently no medications licensed for obesity in children. The BNFC recommends orlistat for children, but this is off-license use.<br>The updated guideline will have the opportunity to cross-refer to related NICE guidance as needed, including NICE technology appraisal 664 Liraglutide for managing overweight and obesity. Setmelanotide and Semaglutide are the subject of NICE technology appraisals currently in development. |
| All Wales Dietetic Leadership Advisory Group (WDLAG) sub group All Wales Weight Management Dietitians | General | General | We don't have any comments for submission on any additional evidence or interventions to be considered. We welcome the update and amalgamation of other existing guidelines into one document. The scope proposes limited evidence reviews but we welcome specifically the review of how we identify those people living with obesity, the dietary approaches, the evidence around prevention of risk for black, Asian and other minority ethnic groups along with the review of the evidence behind the criteria for bariatric surgery. As a group we look forward to seeing the completed document. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| Association of British Clinical Diabetologists | General | General | ABCD is grateful for the opportunity to respond to the above consultation. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| Association of British Clinical Diabetologists | General | General | We agree that it seems sensible to merge the various clinical guidelines that provide guidance on treating people with obesity, where there is substantial overlap, including guidance relating to BAME communities and before and after pregnancy, as well as the clinical guideline (CG189) and the public health guidance on lifestyle management programmes (PH53). | Thank you for your comment. We welcome your support for this scope and update of the guideline. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | |
| Association of British Clinical Diabetologists | General | General | ABCD understands the importance of public health prevention measures to reduce the increasing prevalence of overweight and obesity in the population, as this will ultimately reduce the prevalence of obesity and type 2 diabetes. We also recognise that if effectively implemented, such strategies could make it easier for people with obesity, many of whom will also have diabetes, to be supported to treat their disease. However, we consider it is important to make a clear distinction between public health strategies to prevent obesity and guidelines designed to support people living with the disease. It would therefore be better to have two guidelines, with one focussed on prevention, and the other on treatment, with clear cross referencing where appropriate. | Thank you for your comment. The potential merits of splitting the guideline into prevention and treatment were considered. However, keeping the guideline as one will tie in with broader government initiatives to adopt a person-centred approach and to recognise the need for a whole-systems approach to addressing overweight and obesity. The guideline committee will consider your views when deciding how best to present and communicate the final guidance. |
| Association of British Clinical Diabetologists | 006 | 0014 - 015 | **Section 1.2**<br>Consider evaluating tools such as the Edmonton Obesity Staging System or the Kings Staging system to help identify people with obesity who are at greatest risk of complications. This will help move us away from a 'BMI centric' definition. | Thank you for your comment. The scope includes a key area that covers assessment. Evidence reviews will be conducted for the key issues described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The measures and tools you refer to will be captured by these review questions. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Association of Paediatric Emergency Medicine | General | General | We are very pleased that the various guides will be amalgamated into one guideline – this will make it much easier to access information and support on the topic | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| Association of Paediatric Emergency Medicine | General | General | We wondered if there will be a section of the guideline for guidance around identification and management of obese and overweight children in the acute healthcare setting, such as emergency departments? We feel that when children access urgent and emergent care it provides an opportunity to highlight and signpost obese and overweight children to appropriate services, and national guidance on this will help normalise the process. | Thank you for your comment. The guideline will cover all settings where publicly funded healthcare services are commissioned and provided.<br>**The scope does include the identification of overweight and obesity in children and young people.** |
| Association of Paediatric Emergency Medicine | General | General | We feel that a significant obstacle to improving management of children's obesity is accessing services both in the community and secondary care. From the scope it appears that little of the evidence in children on this matter is being reviewed and we wondered if NICE need to look into whether more research is needed in this important area. | Thank you for your comment. Issues concerning the geographical variation in access to weight management services was acknowledged by the early recruited committee members and is included in the equality impact assessment. While NICE guidelines identify care that is high quality, good value, and provides the best outcomes for people using health and social care services within the budget available, it is not mandatory.<br>During guideline development recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Besins Healthcare (UK) Ltd | General | General | The draft scope in table 1 of page 6 currently states that there will be no evidence review and NICE will retain recommendations from existing guideline with regards specifically assessment of obesity.<br><br>I wish to draw your attention to data that pertains to question 2 above but also addresses section 3.6 on page 22, specifically morbidity (progression to type 2 diabetes), change in weight and waist circumference and maintenance of weight loss.<br><br>**In January 2021, a new article was published in The Lancet Diabetes & Endocrinology.**<br>https://pubmed.ncbi.nlm.nih.gov/33338415/<br><br>**To summarise the key points:**<br>• This is gold-standard level evidence and represents the largest, randomised, placebo-controlled trial ever conducted on testosterone.<br>• 1007 men aged 50-74.<br>• 2-year study.<br>• All men enrolled were obese.<br>• 80% of men enrolled were prediabetic. 20% were newly diagnosed type 2 diabetic.<br>• All men had total testosterone <14nmol/L as measured by LCMS-MS<br>• All men were enrolled in a lifestyle programme (WW).<br>• 50% of men were also given testosterone therapy. | Thank you for your comment.<br>Identifying underlying causes of obesity and overweight are covered in the recommendations in CG189 Obesity: identification, assessment and management (2014)<br><br>The recommendations from this guideline are to be retained. The guideline committee will consider your views when deciding whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | **Key conclusions:**<br>• Following 2 years of testosterone therapy plus lifestyle programme (WW) there was a significant reduction in total fat mass, abdominal fat mass and waist circumference vs WW plus placebo.<br>• There was also a significant 41% relative risk reduction of developing type 2 diabetes in the testosterone plus WW group vs placebo plus WW.<br>• Safety data was reassuring.<br><br>**Also, and importantly, in 2016 the comprehensive clinical practice guidelines for medical care of patients with obesity from the American Association of Clinical Endocrinologists & American College of Endocrinology were published**.<br>https://pubmed.ncbi.nlm.nih.gov/27219496/<br><br>**Key recommendations:**<br>• R19. All men who have an increased waist circumference or who have obesity should be assessed for hypogonadism by history and physical examination and be tested for testosterone deficiency if indicated; all male patients with hypogonadism should be evaluated for the presence of overweight or obesity (Grade B; BEL 2).<br>• R54. Men with true hypogonadism and obesity who are not seeking fertility should be considered for testosterone therapy in addition to lifestyle intervention because testosterone in these patients results in weight loss, | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | decreased waist circumference, and improvements in metabolic parameters (glucose, A1C, lipids, and blood pressure) (Grade A; BEL 1).<br><br>Other guidelines from the British Society for Sexual Medicine (Hackett G, et al. J Sex Med 2017;14:1504-23 http://www.bssm.org.uk/wp-content/uploads/2018/09/guidelines-on-adult-testosterone-deficiency-with-statements-for-uk-practice.pdf ) and the European Association of Urology (Dohle GR, et al. Guidelines of Male Hypogonadism. European Association of Urology 2018. Available at: https://uroweb.org/guideline/male-hypogonadism/#4 ) both recommended screening of testosterone levels in men with obesity.<br><br>Testosterone is a key metabolic hormone so achieving and maintaining weight loss in men who have a deficiency in testosterone is extremely difficult.<br><br>Testosterone deficiency (TD) is common in men with obesity. The association between TD and obesity is bidirectional; low testosterone is a contributing cause to obesity, and obesity is a contributing cause to low testosterone, creating a vicious cycle.<br><br>Most guidelines recommend weight loss by diet/exercise as the first point of intervention to stop this vicious cycle. However, it requires a large amount of weight loss that is maintained over time. In clinical practice, this is rarely achieved by lifestyle interventions. | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Bariatric surgery is currently the main obesity treatment modality that results in a large amount of weight loss with decent weight loss maintenance. However, bariatric surgery is an invasive and expensive procedure, with risk for complications.<br><br>Considering the high prevalence of TD in men with obesity, a more practical and sustainable approach would be to assess men with obesity for testosterone deficiency and consider treatment in those men with confirmed TD.<br><br>In addition to the gold standard RCT summarised above, real-world evidence has demonstrated that testosterone therapy results in more fat loss and preservation of fat-free mass, compared with diet/exercise interventions alone.<br><br>In contrast to weight loss achieved by diet/exercise and bariatric surgery, testosterone therapy significantly preserves both muscle and bone mass. Further, testosterone therapy has psychological effects that may increase the motivation and ability of men to adhere to diet/exercise programs.<br><br>Real-world evidence studies of long-term testosterone therapy for up to 11 years provide compelling evidence that testosterone therapy should be considered as a treatment option for obesity in men with confirmed testosterone deficiency.<br><br>https://www.liebertpub.com/doi/10.1089/andro.2020.0010 | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | **Summary:**<br>• Testosterone plays a key role in carbohydrate, fat and protein metabolism and has a major influence on male body fat composition and muscle mass.<br>• Obesity is associated with reduced testosterone levels in men.<br>• Guidelines from endocrinology, urology and sexual medicine associations/societies recommend screening obese men for testosterone deficiency.<br>• Randomised clinical trial and real-world evidence shows that long-term testosterone therapy administration in hypogonadal men with overweight and obesity:<br>o Produces clinically meaningful weight loss.<br>o Significantly improves body composition (reduces fat mass and waist circumference)<br>o Ameliorates components of the metabolic syndrome.<br>o Reduces progression to type 2 diabetes by 41%<br>o Improves health-related quality of life.<br><br>Given all of the above, it would be a missed opportunity not to update the assessment recommendations for men with obesity. My recommendation would be as follows:<br><br>**<u>Recommendation for NICE Weight Management Guideline:</u>** | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | **Identification & Assessment:**<br><br>• **All men with obesity should be assessed for hypogonadism by history and physical examination and be tested for a deficiency in testosterone if indicated.**<br><br>Thank you very much for your kind consideration. | |
| BOMSS – British Obesity and Metabolic Surgery Society | 023 | 014 - 016 | In view of the increasing published evidence regarding the cost-effective benefit of weight loss/metabolic surgery in the cardiometabolic profile, quality of life and life expectancy of patients with Class 1 and 2 obesity, BOMSS supports the review of the referral criteria for bariatric surgery.<br>This will ensure that people who have so far not been eligible for referral, get the most effective treatment for their condition. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| British Society of Paediatric Dentistry | General | General | No comments to add | Thank you. |
| Centre for Perioperative Care | General | General | The guidance seems to consider obesity as a stand-alone problem. It would be better to incorporate guidance into other areas of healthcare. For example, the time before an operation is a 'teachable moment' for improvement in health and this should be used to improve outcomes form an operation and start on a future | Thank you for this information. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | healthier lifestyle. It would be better if such examples were highlighted as part of case-finding. | |
| Centre for Perioperative Care | 001 | 007 | It seems sensible to amalgamate many different guidance documents. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| Centre for Perioperative Care | 003 | 012 | It is good to acknowledge that people living with obesity are identified opportunistically and through case-finding and that support is required. | Thank you for your comment. We welcome your support for this scope. |
| Centre for Perioperative Care | 005 | 023 | The preamble is good, about obesity being multifactorial and with socio-economic roots and environmental factors playing a huge role<br>We note you intend to repeat the previous recommendations in these areas:<br>1. Identification and assessment<br>2. Individual level approaches<br>Surely these need updating?<br>Also, it would be better to also commit to making some environmental and institutional recommendations?<br>Just treating obesity as a failure of will-power and individual autonomy will not fix the issues. | Thank you for your comment and this information. The areas you have flagged, identification and assessment, and individual level approaches, are listed in the scope as areas that will be updated with evidence reviews.<br>Through the surveillance process, no new evidence was found that would impact recommendations in areas that are being retained.<br>The guideline committee will assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed.<br><br>PH42 Obesity: working with local communities (2012) and PH6 Behaviour change: general |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | approaches (2007) recommend action to be taken concerning the obesogenic environment.<br>**The settings included in the scope include institutes such as education, early years settings, workplaces and all publicly funded health and social care services.** |
| Centre for Perioperative Care | 006 | 014 - 015 | **Table 1**<br>Why are you not doing an evidence review of dietary interventions? There is a huge new body of literature about low carb /keto / fasting strategies. (Although we note this is included in page 21, line 8) | Thank you for your comment and this information.<br><br>The update will consider the evidence for total or partial diet replacements, intermittent fasting, plant-based, and low-carbohydrate diets. |
| Centre for Perioperative Care | 006 | 014 - 015 | **Table 1**<br>Why are you not doing an evidence review of physical activity? There have been a number of new studies since CG189 was written in 2014. | Thank you for your comment.<br><br>During the scoping of this update and the surveillance reviews no new evidence was identified that would impact on the current physical activity recommendations within CG189.<br><br>The table in the proposed outline for the guideline section of the scope says the recommendations in the section 1.6 will be retained.<br><br>The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines on physical activity as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Centre for Perioperative Care | 020 | 025 | We note the key issues and draft questions are around:<br>1. Identification and assessment and<br>2. Individual-level approaches for prevention of excess weight, weight loss, 8 and maintaining a healthier weight.<br>Please could you add an additional point about environmental approaches to obesity? | Thank you for your comment.<br><br>The approaches you refer to are covered PH42 Obesity: working with local communities (2017). These recommendations are to be retained.<br><br>The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| Centre for Perioperative Care | 023 | 010 | We welcome the drawing together of plans including working with local communities. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| Child Protection Special Interest Group | General | General | Though we completely recognise that this is a highly controversial area I feel that the potential that there is a safeguarding issue in a parent who does not seek out support or fails to follow the advive from a professional with regards to obesity in their child needs to be considered and commented on. There needs to be something within that advises professionals both about the potential that this could have reached a safeguarding threshold and how to respond if it has. I feel you need a community paediatrician on the review group for this guidance to at least consider this option. | Thank you for your comment. The updated guideline will retain the following statement from CG189 Obesity: identification, assessment and management (2014): 'Safeguarding children - Remember that child maltreatment:<br>• is common<br>• can present anywhere, such as emergency departments and primary care or on home visits. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | Be aware of or suspect abuse as a contributory factor to or cause of obesity in children. Abuse may also coexist with obesity. See NICE's guideline on child maltreatment for clinical features that may be associated with maltreatment.<br>This section has been agreed with the Royal College of Paediatrics and Child Health.'<br><br>Please be reassured that there is a paediatric lifestyle weight management specialist on the committee |
| City, University of London | General | General | **Comments**<br>**Relating to CG189 Recommendations 1.1 to 1.2.13 which then relate to all other sections which consider prevention of obesity or weight management**<br>*The National Institute for Health and Clinical Excellence (NICE) published a Surveillance Document on Obesity in 2018 (1) which included a section on the 'Identification and classification of overweight and obesity'. In relation to its previous Clinical Guidance on Obesity (CG189), it noted "the new evidence and expert feedback indicating the superior discriminatory value of waist-to-height ratio (WHtR) as an alternative measure of adiposity has a potential impact on recommendations 1.2.2 and 1.2.3, to review the alternative measures".*<br><br>Body Mass Index (BMI) is a recognised proxy measure for monitoring the underlying increase in health risk due | Thank you for this information.<br><br>The measures and tools you refer to will be captured by these review questions. It will cover cut-offs for different ethnic groups. The scope has been amended accordingly and the update will consider the evidence for children and young people in the key area of identification and assessment.<br><br>The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for the key issues described in the scope which will include all published evidence which meet |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | to excess weight at a population level. It is well known and understood, and we believe that **BMI should not be replaced**. However, there is now overwhelming evidence that central obesity (excess fat accumulation in visceral and ectopic depots), as opposed to total obesity, as assessed by BMI, is associated with the adverse health outcomes [(2)] and for increased mortality [(3)] [(4)]. Our view is that **an additional simple anthropometric index**, **namely waist-to-height ratio (WHtR)**, is essential in the classification of obesity because it is an early indicator of central obesity and, therefore, health risk (Scope Table 1).<br><br>We believe that **WHtR could be used as an additional classifier to BMI.** We suggest that WHtR instead of waist circumference (WC) should be used to complement BMI in the identification of obesity-related health risk (Scope Table 1). This is because:<br><br>1) There is now a substantial body of evidence supporting WHtR as an indicator of early health risk and mortality, better than BMI alone, and as good or better than WC [(3-9)].<br><br>2) WHtR is not more difficult to measure or standardise than WC since height is already measured for BMI, and classification of WHtR is simpler and applicable across gender and ethnic | the review protocols developed for the guideline. The measures and tools you refer to will be captured by these review questions. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | groups [10]. Classification using WC requires a multitude of cut-off values for men and women and certain ethnic groups at higher risk of T2DM. In contrast, the widely accepted simple boundary values for waist to height ratio are 0.5 and 0.6 for all adults and in all ethnic groups [11,12]. NICE have an opportunity, in this overarching guidance, to dispense with previously recommended values for WC for different ethnic groups which caused confusion (Scope Table 3).<br><br>3) The current NICE matrix of BMI against WC has limitations. At present the absence of normal BMI category in the matrix implies that adults with BMI in the normal range have no increased risk whatsoever in their waist circumference. As many studies have shown [13-16], raised WC (and/or WHtR) is a health risk even at normal BMI. As many as one in three adult men and women with normal BMI have high WC or WHtR >0.5 [17], and so using the matrix could result in many adults missing out on advice and treatment. We suggest that the matrix should be expanded to include normal weight adults with high WHtR, who could be offered the appropriate interventions. Alternatively, the matrix could be replaced with boundary values for waist to height ratio [13; 14]. Data from New | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Zealand has also shown that WHtR 0.5 classified more people, particularly men, as being at 'early increased risk' compared with the 'matrix'[18].<br><br>4) From a general reasoning perspective, it is logical that WHtR should be a better measure of central obesity than simply WC since it is not considering WC in isolation, but WC as a proportion of an individual's height. Compared with WC, WHtR is less correlated with height, so thresholds are more uniform across groups [19]. Some researchers have argued that the optimum waist to height ratio should be waist circumference divided by height to the power of 0.5 (waist circumference index or WCI) [20] because the latter's correlation with height is even less than WHtR. In fact, WHtR and WCI are similar in terms of their ability to indicate cardiovascular risk [21]. We believe the more complicated index suggested by Nevill [20] is unwarranted for public health purposes and the prime consideration should be the ease with which indices can be understood and effectively used as simple public health messages (Scope Table 6 and 7).<br><br>5) Routine measurement of waist circumference to allow calculation of WHtR would allow better monitoring of central obesity and more appropriate | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | interventions in both adults and children (Scope Tables 4, 5 and 6).<br><br>6) If NICE decide that this updated guidance should include children and adolescents, there is now good evidence that waist to height ratio has the potential to be an additional measure to classify health risks in these population groups [5; 22-25]. Routine **measurement of waist-to-height ratio (WHtR) in addition to BMI** among children in schools would refine the understanding of changes in girth and height during growth spurts and puberty, and enable better early detection of obesity (Scope Table 4).<br><br>7) WHtR is easily calculated, communicated, and understood and has the potential for self-monitoring (Scope Table 6) and rapid assessment in community settings. It is already recommended for self- monitoring by the Government in Thailand [26].<br><br>**References**<br><br>1. National Institute for Health and Clinical Excellence (2018) Surveillance report 2018 – Obesity: identification, assessment and management (2014) NICE guideline CG189 and BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (2013) NICE guideline PH46. | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
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# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
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# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | 17. Ashwell M, Gibson S (2019) Nearly one third of adults in the 'healthy' BMI range are at early cardiometabolic risk according to their waist-to-height ratio. *Proceedings of the Nutrition Society* **78**, E29.<br>18. Ministry of Health (2015) *Understanding Excess Body Weight.New Zealand Health Survey.* Wellington: Ministry of Health.<br>19. Hwaung P, Heo M, Kennedy S *et al.* (2020) Optimum waist circumference-height indices for evaluating adult adiposity: An analytic review. *Obes Rev* **21**, e12947.<br>20. Nevill AM, Duncan MJ, Lahart IM *et al.* (2017) Scaling waist girth for differences in body size reveals a new improved index associated with cardiometabolic risk. *Scand J Med Sci Sports* **27**, 1470-1476.<br>21. Ashwell M, Gibson S (2020) Comments on the article 'Optimum waist circumference-height indices for evaluating adult adiposity: An analytic review': Consideration of relationship to cardiovascular risk factors and to the public health message. *Obes Rev* **21**, e13074.<br>22. Aeberli I, Gut-Knabenhans I, Kusche-Ammann RS *et al.* (2011) Waist circumference and waist-to-height ratio percentiles in a nationally representative sample of 6-13 year old children in Switzerland. *Swiss Med Wkly* **141**, w13227.<br>23. Brambilla P, Bedogni G, Heo M *et al.* (2013) Waist circumference-to-height ratio predicts adiposity better than body mass index in children and adolescents. *Int J Obes (Lond)* **37**, 943-946.<br>24. Ejtahed HS, Kelishadi R, Qorbani M *et al.* (2019) Utility of Waist Circumference-to-Height Ratio as a Screening Tool for Generalized | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | and Central Obesity among Iranian Children and Adolescents: The CASPIAN-V Study. *Pediatr Diabetes*.<br>25. Khoury M, Manlhiot C, McCrindle BW (2013) Role of the waist/height ratio in the cardiometabolic risk assessment of children classified by body mass index. *J Am Coll Cardiol* **62**, 742-751.<br>26. Thaikruea L, Yavichai S (2015) Proposed Waist Circumference Measurement for Waist-to-Height Ratio as a Cardiovascular Disease Risk Indicator: Self-Assessment Feasibility. *Jacobs Journal of Obesity* **1**, 1-7. | |
| City, University of London | 003 | 009 - 011 | **Refers to CG189 recommendation 1.2.1 and 1.2.2**<br><br>*The National Institute for Health and Clinical Excellence (NICE) published a Surveillance Document on Obesity in 2018 (1) which included a section on the 'Identification and classification of overweight and obesity'. In relation to its previous Clinical Guidance on Obesity (CG189), it noted "the new evidence and expert feedback indicating the superior discriminatory value of waist-to-height ratio (WHtR) as an alternative measure of adiposity has a potential impact on recommendations 1.2.2 and 1.2.3, to review the alternative measures".*<br><br>Measurement of BMI and waist circumference (and the calculation of waist-to-height ratio) should be proactive rather than opportunistic. We suggest routine monitoring in all age groups, not | Thank you for your comment and information. The measures and tools you refer to will be captured by these review questions. The scope has been amended accordingly and the update will consider the evidence for children and young people in the key area of identification and assessment.<br>Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The measures and tools you refer to will be captured by these review questions. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | only middle-aged and older people. Health risks and years of life lost attributable to obesity are greater for younger adults [2; 3; 4]. Waist circumference is an indicator of central obesity, which is more closely associated with health risks than total obesity as assessed by BMI. [4; 5; 6]. It should be routinely measured in adults, including those with BMI in the normal range. However, it should also be used to calculate **waist-to-height ratio (WHtR) which is a better proxy for central obesity and should be used as an additional measure to BMI.**<br><br>1. National Institute for Health and Clinical Excellence (2018) Surveillance report 2018 – Obesity: identification, assessment and management (2014) NICE guideline CG189 and BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (2013) NICE guideline PH46. *https://wwwniceorguk/guidance/ph46/documents/surveillance-review-proposal*.<br>2. Fontaine KR, Redden DT, Wang C *et al.* (2003) Years of life lost due to obesity. *JAMA* **289**, 187-193.<br>3. Ashwell M, Mayhew L, Richardson J *et al.* (2014) Waist-to-height ratio is more predictive of years of life lost than body mass index. *PLOS One* **9** e103483.<br>4. Jayedi A, Soltani S, Zargar MS *et al.* (2020) Central fatness and risk of all cause mortality: systematic review and dose-response meta-analysis of 72 prospective cohort studies. *BMJ* **370**, m3324. | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | 5. Pimenta NM, Cortez-Pinto H, Melo X *et al.* (2017) Waist-to-height ratio is independently related to whole and central body fat, regardless of the waist circumference measurement protocol, in non-alcoholic fatty liver disease patients. *J Hum Nutr Diet* **30**, 185-192.<br>6. Sahakyan KR, Somers VK, Rodriguez-Escudero JP *et al.* (2015) Normal-Weight Central Obesity: Implications for Total and Cardiovascular Mortality. *Ann Intern Med*.163 827-835 | |
| City, University of London | 005 | 006 - 007 | *The National Institute for Health and Clinical Excellence (NICE) published a Surveillance Document on Obesity in 2018 (1) which included a section on the 'Identification and classification of overweight and obesity'. In relation to its previous Clinical Guidance on Obesity (CG189), it noted "the new evidence and expert feedback indicating the superior discriminatory value of waist-to-height ratio (WHtR) as an alternative measure of adiposity has a potential impact on recommendations 1.2.2 and 1.2.3, to review the alternative measures".*<br><br>We are pleased that the updated guideline will cover "People aged over 2 years living with obesity or overweight and those who currently have a healthy body weight".<br><br>In fact, about one third of adults with a healthy body weight (ie within the normal BMI range) have waist-to-height ratio (WHtR) greater than 0.5 and need to be warned about their increased health | Thank you for your comment and this information. The measures and tools you refer to will be captured by these review questions. It will cover cut-offs for different ethnic groups. The scope has been amended accordingly and the update will consider the evidence for children and young people in the key area of identification and assessment.<br><br>Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | risks [2]. **If WHtR is used as an additional measure to BMI**, this warning is possible.<br><br>This statement also suggests that classification of obesity in children will be covered in this updated guideline, but it does not appear to be.<br><br>1. National Institute for Health and Clinical Excellence (2018) Surveillance report 2018 – Obesity: identification, assessment and management (2014) NICE guideline CG189 and BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (2013) NICE guideline PH46. https://wwwniceorguk/guidance/ph46/documents/surveillance-review-proposal.<br>2. Ashwell M, Gibson S (2019) Nearly one third of adults in the 'healthy' BMI range are at early cardiometabolic risk according to their waist-to-height ratio. *Proceedings of the Nutrition Society* **78**, E29. | |
| City, University of London | 006 | 014 - 015 | **Table 1 Refers to CG189 recommendation 1.2.3**<br><br>*The National Institute for Health and Clinical Excellence (NICE) published a Surveillance Document on Obesity in 2018 [1] which included a section on the 'Identification and classification of overweight and obesity'. In relation to its previous Clinical Guidance on Obesity (CG189), it noted "the new evidence and expert feedback indicating the superior discriminatory value of waist-to-* | Thank you for your comment and for this information. The measures and tools you refer to will be captured by these review questions. It will cover thresholds for different ethnic groups. The scope has been amended accordingly and the update will consider the evidence for children and young people in the key area of identification and assessment. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | *height ratio (WHtR) as an alternative measure of adiposity has a potential impact on recommendations 1.2.2 and 1.2.3, to review the alternative measures".*<br><br>Waist-to-height ratio (WHtR) is preferable to waist circumference as a proxy for central obesity because it is less correlated with height [2] and does not require the use of a multitude of cut-offs for men and women or people of different ethnicities [3] [4; 5]. Systematic reviews and meta-analysis have shown that WHtR is a better predictor of cardiometabolic risk factors and mortality than BMI[6; 7; 8; 9]. For adults, a desirable ratio of 0.5 (or under) and an action level of 0.6 is easy to understand and communicate to patients [10].<br>Using WHtR will help identify adults at early risk of cardiometabolic disorders who might otherwise be missed [11].<br><br>**Use of waist-to-height ratio (WHtR) in addition to BMI** may help reduce racial inequalities in treatment resulting from inappropriate cut offs. It is already recommended for self-monitoring by the Government in Thailand [12].<br>It appears that NICE plans to retain existing recommendations relating to classification (1.2.4 to 1.2.13).<br>We urge them to reconsider this; any new recommendations on obesity assessment (for example adoption of waist-to-height ratio (WHtR) as *an additional* measure) will have an impact on classification. Identification, assessment, and classification should be seen as part of the same process. Classification is the driver of the decision on intervention. In this respect, we wish to highlight some difficulties with CG189 para 1.2.9 (the matrix of health risks by | Evidence reviews will be conducted for the key issues described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. Where this evidence in the new evidence reviews impacts on current recommendations these will be considered and amended where necessary. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | BMI and waist circumference). At present the absence of normal BMI category in the table implies that adults with BMI in the normal range have no increased risk whatsoever attributable to their waist circumference (WC). As many studies have shown, raised WC (and/or WHtR) is a health risk even at normal BMI [(11)]. Since as many as one in three adult men and women with normal BMI have high WC or WHtR >0.5, using the matrix could result in many adults missing out on advice and treatment [(13)]. We suggest that the table should be expanded to include adults in the healthy BMI range with high waist circumference (or high WHtR) who should be offered the appropriate interventions. This is in line with DHSC 2020 strategy to expand weight management services in order to reduce the prevalence of obesity and related comorbidities.<br><br>**We would suggest the Scope should include consideration of using waist-to-height ratio (WHtR) in the matrix.**<br><br>Currently the draft scope does not include a review of measures of obesity in children.<br>We suggest that this be reconsidered, and in particular the value of including measurement of waist circumference so that **waist-to-height ratio (WHtR) can be calculated as an additional measure to BMI.** Currently, BMI is assessed with growth charts that provide vital information on growth trajectory, but cannot distinguish between children with different body composition. Evidence now shows that WHtR can provide an early warning of excess adiposity in children and adolescents and may have advantages over waist circumference[(14)] [(15; 16)] [(5)] [(17)]. Routine measurement of waist | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | circumference and the calculation of WHtR should be considered in the National Child Measurement Programme and government health surveys to provide data for research and monitoring trends.<br><br>**References**<br><br>1. National Institute for Health and Clinical Excellence (2018) Surveillance report 2018 – Obesity: identification, assessment and management (2014) NICE guideline CG189 and BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (2013) NICE guideline PH46. *https://wwwniceorguk/guidance/ph46/documents/surveillance-review-proposal*.<br>2. Hwaung P, Heo M, Kennedy S *et al.* (2020) Optimum waist circumference-height indices for evaluating adult adiposity: An analytic review. *Obes Rev* **21**, e12947.<br>3. Ashwell M, Gibson S (2016) Waist-to-height ratio as an indicator of 'early health risk': simpler and more predictive than using a 'matrix' based on BMI and waist circumference. *BMJ Open* **6**, e010159.<br>4. Kazlauskaite R, Avery-Mamer EF, Li H *et al.* (2017) Race/ethnic comparisons of waist-to-height ratio for cardiometabolic screening: The study of women's health across the nation. *Am J Hum Biol* **29**.<br>5. Ejtahed HS, Kelishadi R, Qorbani M *et al.* (2019) Utility of Waist Circumference-to-Height Ratio as a Screening Tool for Generalized and Central Obesity among Iranian Children and Adolescents: The CASPIAN-V Study. *Pediatr Diabetes*. | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | 6. Correa MM, Thume E, De Oliveira ER *et al.* (2016) Performance of the waist-to-height ratio in identifying obesity and predicting non-communicable diseases in the elderly population: A systematic literature review. *Arch Gerontol Geriatr* **65**, 174-182.<br>7. Ashwell M, Gunn P, Gibson S (2012) Waist-to-height ratio is a better screening tool than waist circumference and BMI for adult cardiometabolic risk factors: systematic review and meta-analysis. *Obes Rev* **13**, 275-286.<br>8. Ashwell M, Mayhew L, Richardson J *et al.* (2014) Waist-to-height ratio is more predictive of years of life lost than body mass index. *PLOS One* **9** e103483.<br>9. Jayedi A, Soltani S, Zargar MS *et al.* (2020) Central fatness and risk of all cause mortality: systematic review and dose-response meta-analysis of 72 prospective cohort studies. *BMJ* **370**, m3324.<br>10. Ashwell M (2017) How long is A Piece of String? Less than Half your Height. Five Steps from Science to Screening: A Mini Review. *Adv Obes Weight Manag Contro* **7**, 00191. DOI: 00110.15406/aowmc.02017.00107.00191.<br>11. Gibson S, Ashwell M (2020) A simple cut-off for waist-to-height ratio (0.5) can act as an indicator for cardiometabolic risk: recent data from adults in the Health Survey for England. *Br J Nutr* **123**, 681-690.<br>12. Thaikruea L, Yavichai S (2015) Proposed Waist Circumference Measurement for Waist-to-Height Ratio as a Cardiovascular Disease Risk Indicator: Self-Assessment Feasibility. *Jacobs Journal of Obesity* **1**, 1-7.<br>13. Ashwell M, Gibson S (2019) Nearly one third of adults in the 'healthy' BMI range are at early cardiometabolic risk according to | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | their waist-to-height ratio. *Proceedings of the Nutrition Society* **78**, E29.<br>14. Aeberli I, Gut-Knabenhans I, Kusche-Ammann RS *et al.* (2011) Waist circumference and waist-to-height ratio percentiles in a nationally representative sample of 6-13 year old children in Switzerland. *Swiss Med Wkly* **141**, w13227.<br>15. Khoury M, Manlhiot C, McCrindle BW (2013) Role of the waist/height ratio in the cardiometabolic risk assessment of children classified by body mass index. *J Am Coll Cardiol* **62**, 742-751.<br>16. Ochoa Sangrador C, Ochoa-Brezmes J (2018) Waist-to-height ratio as a risk marker for metabolic syndrome in childhood. A meta-analysis. *Pediatr Obes* **13**, 421-432.<br>17. Brambilla P, Bedogni G, Heo M *et al.* (2013) Waist circumference-to-height ratio predicts adiposity better than body mass index in children and adolescents. *Int J Obes (Lond)* **37**, 943-946. | |
| City, University of London | 011 | 002 - 003 | **Table 3**<br>*The National Institute for Health and Clinical Excellence (NICE) published a Surveillance Document on Obesity in 2018 [(1)] which included a section on the 'Identification and classification of overweight and obesity'. In relation to its previous Clinical Guidance on Obesity (CG189), it noted "the new evidence and expert feedback indicating the superior discriminatory value of waist-to-height ratio (WHtR) as an alternative measure of adiposity has a potential impact on recommendations 1.2.2 and 1.2.3, to review the alternative measures".* | Thank you for your comment and additional information.<br>We welcome your support for this scope and update of the guideline. Thank you for your comment. The scope includes a key area that covers identification and assessment. It will cover cut-offs for different ethnic groups. Evidence reviews will be conducted for the key issues described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The measures |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | We agree that PH46 should be amalgamated with CG189. This will allow a more consistent approach to identification, assessment, and treatment of obesity. We suggest **use of waist-to-height ratio (WHtR), in addition to BMI,** would enable a more standardised approach to classification across people of all ethnicities. Classification using WC requires a multitude of cut-off values for men and women and certain ethnic groups at higher risk of T2DM. In contrast, the widely accepted simple boundary values for waist to height ratio are 0.5 and 0.6 for all adults and in all ethnic groups [2; 3; 4].<br><br>1. National Institute for Health and Clinical Excellence (2018) Surveillance report 2018 – Obesity: identification, assessment and management (2014) NICE guideline CG189 and BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (2013) NICE guideline PH46. *https://wwwniceorguk/guidance/ph46/documents/surveillance-review-proposal*.<br>2. Dong B, Arnold LW, Peng Y *et al.* (2016) Ethnic differences in cardiometabolic risk among adolescents across the waist-height ratio spectrum: National Health and Nutrition Examination Surveys (NHANES). *Int J Cardiol* **222**, 622-628.<br>3. van Valkengoed IG, Agyemang C, Krediet RT *et al.* (2012) Ethnic differences in the association between waist-to-height ratio and albumin-creatinine ratio: the observational SUNSET study. *BMC Nephrol* **13**, 26. | and tools you refer to will be captured by these review questions. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | 4. Kazlauskaite R, Avery-Mamer EF, Li H *et al.* (2016) Race/ethnic comparisons of waist-to-height ratio for cardiometabolic screening: The study of women's health across the nation. *Am J Hum Biol*. | |
| City, University of London | 012 | 001 | **Table 4**<br>*The National Institute for Health and Clinical Excellence (NICE) published a Surveillance Document on Obesity in 2018 (1) which included a section on the 'Identification and classification of overweight and obesity'. In relation to its previous Clinical Guidance on Obesity (CG189), it noted "the new evidence and expert feedback indicating the superior discriminatory value of waist-to-height ratio (WHtR) as an alternative measure of adiposity has a potential impact on recommendations 1.2.2 and 1.2.3, to review the alternative measures".*<br><br>**In relation to obesity prevention or preventing excess weight gain, it is important to remember that any form of management in all settings (home, schools, community and elsewhere) must focus on the prevention of central obesity. Weight management must always be accompanied by waist management, best monitored by waist-to-height ratio (WHtR).**<br><br>WHtR is preferable to waist circumference as a proxy for central obesity because it is less correlated with height (2) and does not require the use of a multitude of cut-offs for men and women or people of different ethnicities (3) (4; 5). Systematic reviews and meta-analysis have shown that WHtR is a better predictor of cardiometabolic risk factors and mortality than BMI(6; 7; 8; 9). For | Thank you for your comments and additional information. The scope includes a key area that covers identification and assessment. It covers cut-offs for different ethnic groups. A question covering children has been added, which mirrors the question in adults.<br>Evidence reviews will be conducted for the key issues described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The measures and tools you refer to will be captured by these review questions. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | adults, a desirable ratio of 0.5 (or under) and an action level of 0.6 is easy to understand and communicate to patients [10]. Using WHtR will help identify adults at early risk of cardiometabolic disorders who might otherwise be missed [11].<br><br>**Use of waist-to-height ratio (WHtR) in addition to BMI** may help reduce racial inequalities in treatment resulting from inappropriate cut offs. It is already recommended **for self-monitoring** by the Government in Thailand [12].<br><br>Currently the draft scope does not include a review of measures of obesity in children even though management issues in children will be reviewed. We suggest that this be reconsidered, and in particular the value of including measurement of waist circumference so that **waist-to-height ratio (WHtR) can be calculated as an additional measure to BMI in all age groups.** Currently, BMI is assessed with growth charts that provide vital information on growth trajectory, but cannot distinguish between children with different fat distribution. Evidence now shows that WHtR can provide an early warning of excess central adiposity in children and adolescents and may have advantages over waist circumference[13] [14; 15] [5] [16] . Routine measurement of waist circumference and the calculation of WHtR should be considered in the National Child Measurement Programme and government health surveys to provide data for research and **monitoring** trends.<br><br>**References** | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
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| | | | 1. National Institute for Health and Clinical Excellence (2018) Surveillance report 2018 – Obesity: identification, assessment and management (2014) NICE guideline CG189 and BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (2013) NICE guideline PH46. *https://wwwniceorguk/guidance/ph46/documents/surveillance-review-proposal*.<br>2. Hwaung P, Heo M, Kennedy S *et al.* (2020) Optimum waist circumference-height indices for evaluating adult adiposity: An analytic review. *Obes Rev* **21**, e12947.<br>3. Ashwell M, Gibson S (2016) Waist-to-height ratio as an indicator of 'early health risk': simpler and more predictive than using a 'matrix' based on BMI and waist circumference. *BMJ Open* **6**, e010159.<br>4. Kazlauskaite R, Avery-Mamer EF, Li H *et al.* (2017) Race/ethnic comparisons of waist-to-height ratio for cardiometabolic screening: The study of women's health across the nation. *Am J Hum Biol* **29**.<br>5. Ejtahed HS, Kelishadi R, Qorbani M *et al.* (2019) Utility of Waist Circumference-to-Height Ratio as a Screening Tool for Generalized and Central Obesity among Iranian Children and Adolescents: The CASPIAN-V Study. *Pediatr Diabetes*.<br>6. Correa MM, Thume E, De Oliveira ER *et al.* (2016) Performance of the waist-to-height ratio in identifying obesity and predicting non-communicable diseases in the elderly population: A systematic literature review. *Arch Gerontol Geriatr* **65**, 174-182.<br>7. Ashwell M, Gunn P, Gibson S (2012) Waist-to-height ratio is a better screening tool than waist circumference and BMI for adult | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
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# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | 15. Ochoa Sangrador C, Ochoa-Brezmes J (2018) Waist-to-height ratio as a risk marker for metabolic syndrome in childhood. A meta-analysis. *Pediatr Obes* **13**, 421-432.<br>16. Brambilla P, Bedogni G, Heo M *et al.* (2013) Waist circumference-to-height ratio predicts adiposity better than body mass index in children and adolescents. *Int J Obes (Lond)* **37**, 943-946. | |
| City, University of London | 013 | 003 - 004 | **Table 6**<br>*The National Institute for Health and Clinical Excellence (NICE) published a Surveillance Document on Obesity in 2018 (1) which included a section on the 'Identification and classification of overweight and obesity'. In relation to its previous Clinical Guidance on Obesity (CG189), it noted "the new evidence and expert feedback indicating the superior discriminatory value of waist-to-height ratio (WHtR) as an alternative measure of adiposity has a potential impact on recommendations 1.2.2 and 1.2.3, to review the alternative measures".*<br><br>**In relation to obesity prevention or preventing excess weight gain, it is important to remember that any form of management in all settings (home, schools, community and elsewhere) must focus on the prevention of central obesity. Weight management must always be accompanied by waist management, best monitored by waist-to-height ratio (WHtR).**<br><br>WHtR is preferable to waist circumference as a proxy for central obesity because it is less correlated with height (2) and does not | Thank you for your comments and additional information. The scope includes a key area that covers identification and assessment. It covers cut-offs for different ethnic groups. A question covering children has been added, which mirrors the question in adults. Evidence reviews will be conducted for the key issues described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The measures and tools you refer to will be captured by these review questions. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | require the use of a multitude of cut-offs for men and women or people of different ethnicities [3] [4; 5]. Systematic reviews and meta-analysis have shown that WHtR is a better predictor of cardiometabolic risk factors and mortality than BMI[6; 7; 8; 9]. For adults, a desirable ratio of 0.5 (or under) and an action level of 0.6 is easy to understand and communicate to patients [10]. Using WHtR will help identify adults at early risk of cardiometabolic disorders who might otherwise be missed [11].<br><br>**Use of waist-to-height ratio (WHtR) in addition to BMI** may help reduce racial inequalities in treatment resulting from inappropriate cut offs. It is already recommended **for self-monitoring** by the Government in Thailand [12].<br><br>Currently the draft scope does not include a review of measures of obesity in children even though management issues in children will be reviewed. We suggest that this be reconsidered, and in particular the value of including measurement of waist circumference so that **waist-to-height ratio (WHtR) can be calculated as an additional measure to BMI in all age groups.** Currently, BMI is assessed with growth charts that provide vital information on growth trajectory, but cannot distinguish between children with different fat distribution. Evidence now shows that WHtR can provide an early warning of excess central adiposity in children and adolescents and may have advantages over waist circumference[13] [14; 15] [5] [16] . Routine measurement of waist circumference and the calculation of WHtR should be considered in the National Child Measurement | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Programme and government health surveys to provide data for research and **monitoring** trends.<br><br>**References**<br><br>1. National Institute for Health and Clinical Excellence (2018) Surveillance report 2018 – Obesity: identification, assessment and management (2014) NICE guideline CG189 and BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (2013) NICE guideline PH46. *https://wwwniceorguk/guidance/ph46/documents/surveillance-review-proposal*.<br>2. Hwaung P, Heo M, Kennedy S *et al.* (2020) Optimum waist circumference-height indices for evaluating adult adiposity: An analytic review. *Obes Rev* **21**, e12947.<br>3. Ashwell M, Gibson S (2016) Waist-to-height ratio as an indicator of 'early health risk': simpler and more predictive than using a 'matrix' based on BMI and waist circumference. *BMJ Open* **6**, e010159.<br>4. Kazlauskaite R, Avery-Mamer EF, Li H *et al.* (2017) Race/ethnic comparisons of waist-to-height ratio for cardiometabolic screening: The study of women's health across the nation. *Am J Hum Biol* **29**.<br>5. Ejtahed HS, Kelishadi R, Qorbani M *et al.* (2019) Utility of Waist Circumference-to-Height Ratio as a Screening Tool for Generalized and Central Obesity among Iranian Children and Adolescents: The CASPIAN-V Study. *Pediatr Diabetes*.<br>6. Correa MM, Thume E, De Oliveira ER *et al.* (2016) Performance of the waist-to-height ratio in identifying obesity and predicting non- | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | communicable diseases in the elderly population: A systematic literature review. *Arch Gerontol Geriatr* **65**, 174-182.<br>7. Ashwell M, Gunn P, Gibson S (2012) Waist-to-height ratio is a better screening tool than waist circumference and BMI for adult cardiometabolic risk factors: systematic review and meta-analysis. *Obes Rev* **13**, 275-286.<br>8. Ashwell M, Mayhew L, Richardson J *et al.* (2014) Waist-to-height ratio is more predictive of years of life lost than body mass index. *PLOS One* **9** e103483.<br>9. Jayedi A, Soltani S, Zargar MS *et al.* (2020) Central fatness and risk of all cause mortality: systematic review and dose-response meta-analysis of 72 prospective cohort studies. *BMJ* **370**, m3324.<br>10. Ashwell M (2017) How long is A Piece of String? Less than Half your Height. Five Steps from Science to Screening: A Mini Review. *Adv Obes Weight Manag Contro* **7**, 00191. DOI: 00110.15406/aowmc.02017.00107.00191.<br>11. Gibson S, Ashwell M (2020) A simple cut-off for waist-to-height ratio (0.5) can act as an indicator for cardiometabolic risk: recent data from adults in the Health Survey for England. *Br J Nutr* **123**, 681-690.<br>12. Thaikruea L, Yavichai S (2015) Proposed Waist Circumference Measurement for Waist-to-Height Ratio as a Cardiovascular Disease Risk Indicator: Self-Assessment Feasibility. *Jacobs Journal of Obesity* **1**, 1-7.<br>13. Aeberli I, Gut-Knabenhans I, Kusche-Ammann RS *et al.* (2011) Waist circumference and waist-to-height ratio percentiles in a nationally representative sample of 6-13 year old children in Switzerland. *Swiss Med Wkly* **141**, w13227. | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | 14. Khoury M, Manlhiot C, McCrindle BW (2013) Role of the waist/height ratio in the cardiometabolic risk assessment of children classified by body mass index. *J Am Coll Cardiol* **62**, 742-751.<br>15. Ochoa Sangrador C, Ochoa-Brezmes J (2018) Waist-to-height ratio as a risk marker for metabolic syndrome in childhood. A meta-analysis. *Pediatr Obes* **13**, 421-432.<br>16. Brambilla P, Bedogni G, Heo M *et al.* (2013) Waist circumference-to-height ratio predicts adiposity better than body mass index in children and adolescents. *Int J Obes (Lond)* **37**, 943-946. | |
| City, University of London | 013 | 001 | **Table 5**<br>*The National Institute for Health and Clinical Excellence (NICE) published a Surveillance Document on Obesity in 2018 [(1)] which included a section on the 'Identification and classification of overweight and obesity'. In relation to its previous Clinical Guidance on Obesity (CG189), it noted "the new evidence and expert feedback indicating the superior discriminatory value of waist-to-height ratio (WHtR) as an alternative measure of adiposity has a potential impact on recommendations 1.2.2 and 1.2.3, to review the alternative measures".*<br><br>**In relation to obesity prevention or preventing excess weight gain, it is important to remember that any form of management in all settings (home, schools, community and elsewhere) must focus on the prevention of central obesity. Weight management must always be accompanied by waist management, best monitored by waist-to-height ratio (WHtR).** | Thank you for your comments and additional information. The scope includes a key area that covers identification and assessment. It covers cut-offs for different ethnic groups. A question covering children has been added, which mirrors the question in adults. Evidence reviews will be conducted for the key issues described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The measures and tools you refer to will be captured by these review questions. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | WHtR is preferable to waist circumference as a proxy for central obesity because it is less correlated with height [2] and does not require the use of a multitude of cut-offs for men and women or people of different ethnicities [3] [4; 5]. Systematic reviews and meta-analysis have shown that WHtR is a better predictor of cardiometabolic risk factors and mortality than BMI[6; 7; 8; 9]. For adults, a desirable ratio of 0.5 (or under) and an action level of 0.6 is easy to understand and communicate to patients [10]. Using WHtR will help identify adults at early risk of cardiometabolic disorders who might otherwise be missed [11].<br><br>**Use of waist-to-height ratio (WHtR) in addition to BMI** may help reduce racial inequalities in treatment resulting from inappropriate cut offs. It is already recommended **for self-monitoring** by the Government in Thailand [12].<br><br>Currently the draft scope does not include a review of measures of obesity in children even though management issues in children will be reviewed. We suggest that this be reconsidered, and in particular the value of including measurement of waist circumference so that **waist-to-height ratio (WHtR) can be calculated as an additional measure to BMI in all age groups.** Currently, BMI is assessed with growth charts that provide vital information on growth trajectory, but cannot distinguish between children with different fat distribution. Evidence now shows that WHtR can provide an early warning of excess central adiposity in children and adolescents and may have advantages over waist circumference[13] [14; 15] [5] [16] . Routine | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
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# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | 6. Correa MM, Thume E, De Oliveira ER *et al.* (2016) Performance of the waist-to-height ratio in identifying obesity and predicting non-communicable diseases in the elderly population: A systematic literature review. *Arch Gerontol Geriatr* **65**, 174-182.<br>7. Ashwell M, Gunn P, Gibson S (2012) Waist-to-height ratio is a better screening tool than waist circumference and BMI for adult cardiometabolic risk factors: systematic review and meta-analysis. *Obes Rev* **13**, 275-286.<br>8. Ashwell M, Mayhew L, Richardson J *et al.* (2014) Waist-to-height ratio is more predictive of years of life lost than body mass index. *PLOS One* **9** e103483.<br>9. Jayedi A, Soltani S, Zargar MS *et al.* (2020) Central fatness and risk of all cause mortality: systematic review and dose-response meta-analysis of 72 prospective cohort studies. *BMJ* **370**, m3324.<br>10. Ashwell M (2017) How long is A Piece of String? Less than Half your Height. Five Steps from Science to Screening: A Mini Review. *Adv Obes Weight Manag Contro* **7**, 00191. DOI: 00110.15406/aowmc.02017.00107.00191.<br>11. Gibson S, Ashwell M (2020) A simple cut-off for waist-to-height ratio (0.5) can act as an indicator for cardiometabolic risk: recent data from adults in the Health Survey for England. *Br J Nutr* **123**, 681-690.<br>12. Thaikruea L, Yavichai S (2015) Proposed Waist Circumference Measurement for Waist-to-Height Ratio as a Cardiovascular Disease Risk Indicator: Self-Assessment Feasibility. *Jacobs Journal of Obesity* **1**, 1-7.<br>13. Aeberli I, Gut-Knabenhans I, Kusche-Ammann RS *et al.* (2011) Waist circumference and waist-to-height ratio percentiles in a | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
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| City, University of London | 015 | 002 - 003 | **Table 7**<br>*The National Institute for Health and Clinical Excellence (NICE) published a Surveillance Document on Obesity in 2018 (1) which included a section on the 'Identification and classification of overweight and obesity'. In relation to its previous Clinical Guidance on Obesity (CG189), it noted "the new evidence and expert feedback indicating the superior discriminatory value of waist-to-height ratio (WHtR) as an alternative measure of adiposity has a potential impact on recommendations 1.2.2 and 1.2.3, to review the alternative measures".*<br><br>**In relation to obesity prevention or preventing excess weight gain, it is important to remember that any form of management in all settings (home, schools, community and elsewhere) must focus on the prevention of central obesity. Weight** | Thank you for your comments and additional information. The scope includes a key area that covers identification and assessment. It covers cut-offs for different ethnic groups. A question covering children has been added, which mirrors the question in adults. Evidence reviews will be conducted for the key issues described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The measures and tools you refer to will be captured by these review questions. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | **management must always be accompanied by waist management, best monitored by waist-to-height ratio (WHtR).**<br><br>WHtR is preferable to waist circumference as a proxy for central obesity because it is less correlated with height [2] and does not require the use of a multitude of cut-offs for men and women or people of different ethnicities [3] [4; 5]. Systematic reviews and meta-analysis have shown that WHtR is a better predictor of cardiometabolic risk factors and mortality than BMI[6; 7; 8; 9]. For adults, a desirable ratio of 0.5 (or under) and an action level of 0.6 is easy to understand and communicate to patients [10]. Using WHtR will help identify adults at early risk of cardiometabolic disorders who might otherwise be missed [11].<br><br>**Use of waist-to-height ratio (WHtR) in addition to BMI** may help reduce racial inequalities in treatment resulting from inappropriate cut offs. It is already recommended **for self-monitoring** by the Government in Thailand [12].<br><br>Currently the draft scope does not include a review of measures of obesity in children even though management issues in children will be reviewed. We suggest that this be reconsidered, and in particular the value of including measurement of waist circumference so that **waist-to-height ratio (WHtR) can be calculated as an additional measure to BMI in all age groups.** Currently, BMI is assessed with growth charts that provide vital information on growth trajectory, but cannot distinguish between children with different fat distribution. Evidence now shows that WHtR can provide an early warning of | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
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# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
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# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
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| Diabetes UK | General | General | **Learning disabilities and obesity**<br><br>In England, NHS data shows that the prevalence of obesity is higher in adults with learning disabilities (37%) compared to adults without learning disabilities (30.1%). We suggest that specific recommendations for people with learning disabilities be included within the updated weight management guidance. | Thank you for your comment.<br>**People living with obesity and learning disabilities are included in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it.** |
| Diabetes UK | General | General | **Inequalities** | Thank you for your comment.<br>Socioeconomic factors are included in the equality impact assessment form, which is linked to in section |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Consideration needs to be given to the repositioning of obesity and its aetiology and management. The prevalence of obesity is highest in more socially deprived areas and COVID-19 has exacerbated existing inequalities within the UK. The causes of obesity are multifactorial and cannot be simply explained by an imbalance of calories. The impact of inequality and steps to mitigate this, in the context of weight management approaches, need to be explored within this guidance. | 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it. |
| Diabetes UK | General | General | **Type 2 management guidelines**<br><br>Although not included in the scope of the general weight management guidance update, we'd urge that the diet and lifestyle guidance included in the NICE guideline on Type 2 diabetes in adults: management [NG28] be updated to take into account the evidence from the DiRECT and DIADEM-I trials. | Thank you for this information. As you note, the management of type 2 diabetes is covered in a separate NICE guideline, NG28 Type 2 diabetes in adults: management. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG28. |
| Diabetes UK | 013 - 014 | 003 - 004 | **Table 6**<br>**Recommendations from weight management: lifestyle services for overweight or obese adults (PH53)**<br><br>We suggest that the recommended lifestyle services for overweight or obese adults be updated to include the NHS Diabetes Prevention Programme. The NHS Diabetes Prevention Programme's main goals centre around dietary improvements, increased physical activity and weight reduction, so the inclusion of the programme is | Thank you for your comment. Tables under the proposed outline for the guideline section contains areas of the guideline that will be updated. Recommendations contained in those areas will either be updated based on evidence reviews or retained. The guideline committee will consider your views when deciding whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | important to capture the full spectrum of weight management services. | current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE and national guidance as needed.<br>Prevention of type 2 diabetes is out of scope for this guideline. It is covered in PH38 Type 2 diabetes: prevention in people at high risk (2012) |
| Diabetes UK | 007 | 014 - 015 | **Table 1 1.6**<br><br>**Physical activity**<br><br>The existing guidance CG189 encourages adults to meet the UK Chief Medical Officers' recommendations for physical activity, however, the recommendations in this section have not been updated since 2006. We urge that this section should be updated to include the most recently published UK Chief Medical Officers' Physical Activity Guidelines (2019). 1.6.2 should specifically be updated to reflect the CMOs' recommendations for physical activity, which stipulate weekly, rather than daily, amounts of physical activity. The recommended amounts of physical activity should be updated as follows:<br><br>'Each week, adults should accumulate at least 150 minutes (2 ½ hours) of moderate-intensity activity (such as brisk walking or cycling); or 75 minutes of vigorous-intensity activity (such as running); or even shorter durations of very vigorous-intensity activity (such as sprinting or stair | Thank you for your comment. This area was not flagged for update by surveillance as no new evidence that would impact on recommendations was found. Your comments will be passed to the surveillance team for consideration.<br>NICE physical activity guidelines note the 2011 CMO recommendations: https://www.nice.org.uk/guidance/ph44/chapter/2-Public-health-need-and-practice and we will cross reference to this and update as needed |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | climbing); or a combination of moderate, vigorous and very vigorous-intensity activity.' | |
| Diabetes UK | 007 | 014 - 015 | **Table 1 1.7**<br>**Dietary**<br><br>We welcome that NICE is planning to review the evidence and update recommendations for dietary approaches to weight management, as the existing recommendations in CG189 have not been reviewed and updated since 2014 and are clinically out of date. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| Diabetes UK | 008 | 014 - 015 | **Table 1 1.9**<br>**Continued prescribing and withdrawal**<br><br>We are concerned that evidence for continued prescribing and withdrawal is not to be reviewed and that the existing recommendations are to be retained as this section needs reviewing and updating. Given that orlistat is the only medication recommended by CG189, we would urge NICE to include further pharmacological interventions in the updated weight management guidance.<br><br>We suggest the guidance is updated to include liraglutide in line with the recommendations from NICE's Technical Appraisal guidance decision on liraglutide (Saxenda) for managing overweight and obesity [TA664] published in December 2020. TA664 recommends liraglutide as an option for managing overweight and | Thank you for your comment.<br><br>The updated guideline will have the opportunity to cross-refer to related NICE guidance as needed, including NICE technology appraisal 664 Liraglutide for managing overweight and obesity. Setmelanotide and Semaglutide are the subject of NICE technology appraisals currently in development. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | obesity alongside a reduced-calorie diet and increased physical activity in adults who meet the established criteria. Liraglutide has also been shown to delay the development of type 2 diabetes.<br><br>We further suggest that the guidance be updated to reflect new evidence supporting the use of semaglutide. A 2021 study showed that 2.4mg of semaglutide once weekly plus lifestyle intervention was associated with a sustained, clinically relevant reduction in body weight in participants with overweight or obesity. We note that a Technical Appraisal [GID-TA10765] is currently in progress to appraise the effectiveness of semaglutide in addition to a reduced-calorie diet and increased physical activity for the management of people with obesity or overweight with risk factors. With the publication of this guidance, expected to be 30 March 2022, we suggest that the recommendations from this Technical Appraisal be incorporated into the weight management guidance once they are published. | |
| Diabetes UK | 008 | 014 - 015 | **Table 1 1.11**<br>**Bariatric surgery for people with recent-onset type 2 diabetes**<br><br>We are concerned by the decision not to review the evidence in this area, as the current recommendations do not reflect new developments in bariatric surgery. We strongly urge that this section be reviewed and updated.<br><br>Bariatric surgery has been shown to result in substantial and durable weight reduction, and there is now more data on the effect | Thank you for your comment. Surveillance identified no new evidence relating to bariatric surgery and type 2 diabetes that would impact current recommendations. We will pass your comments to the surveillance team for consideration. The new guideline will also cross-refer to other NICE and national guidance as needed.<br><br>This guideline will consider the referral for bariatric surgery. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | of the procedure on type 2 diabetes. Numerous RCTs have demonstrated that surgery is superior to intensive medical and lifestyle therapy in improving glycaemic parameters and reducing medication use. The longest and largest of these trials, STAMPEDE found only 5% of medically managed patients were able to achieve and maintain normoglycaemia after 5 years compared to over 20% of bariatric surgery patients. Medication use for hypertension and hyperlipidaemia also reduced rapidly after surgery and was maintained long-term.<br><br>Remission of type 2 diabetes is a key benefit of bariatric surgery. The UK National Bariatric Surgery Registry reported 65.1% of patients with type 2 diabetes achieved clinical remission by two years post-surgery, rising to 80% after three years. Recent evidence shows an inverse relationship between the duration of type 2 diabetes and remission rates after bariatric surgery, so it is important that eligible people with recent-onset type 2 diabetes should be offered assessment for bariatric surgery sooner rather than later. Timing is crucial; evidence shows that success is markedly greater when surgery is performed within 10 years of type 2 diabetes diagnosis.<br><br>We are hearing from clinicians working within weight management and obesity services that the current tier system is too rigid, not working and is causing a delay in obesity surgery treatment. Current NICE guidance calls for assessment is dependent on people with recent-onset type 2 diabetes receiving or will be receiving | Issues concerning the geographical variation in access to weight management services was acknowledged by the committee and is included in the equality impact assessment. While NICE guidelines identify care that is high quality, good value, and provides the best outcomes for people using health and social care services within the budget available, it is not mandatory.<br>**The new guideline will also cross-refer to other NICE guidance as needed.** |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | assessment in a Tier 3 service (or equivalent). Given that commissioning of medical weight management services (Tier 3) across the UK is variable and, in some areas, absent, these current criteria will not be able to be met many people recently diagnosed with type 2 diabetes.<br><br>Commissioning is variable and less than 1% of people who fulfil the National Institute for Health and Care Excellence (NICE) eligibility criteria for bariatric surgery (Tier 4) can access it. Compared to England, the number of bariatric surgery operations reported from Wales, Scotland and NI are disproportionately lower. In the UK, compared to other countries with similar demographics and disease burden, we perform the lowest number of bariatric surgery operations. NHS funded bariatric surgery operations are declining year on year.<br><br>NICE now has the opportunity to widen access to and provide clarity on bariatric surgery by producing evidence-based guidelines that reflect the most up-to-date data. | |
| Diabetes UK | 017 | 002 - 003 | **Table 8**<br>**Women with a BMI of 30 or more after childbirth**<br><br>We would welcome a review of this section as the recommendations included in PH27 for women with a BMI of 30 or more after childbirth haven't been updated since 2010. This section | During the scoping of this update and the surveillance review of the NICE guideline PH27 Weight management before, during and after pregnancy (2010) no new evidence was identified that would impact on the current recommendations that apply before and after pregnancy. The original |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | should also be updated to include a reference to the NHS Diabetes Prevention Programme. | recommendations remain valid and will appear in the updated guideline.<br><br>The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| Johnson & Johnson | General | General | Johnson & Johnson Medical Ltd. welcome this update and amalgamation of NICE guidelines on obesity and weight management. We consider it appropriately representative of a whole systems approach to weight management by the NHS. Despite positive DSS and NICE recommendations, the provision of bariatric and metabolic surgery remains limited in the UK with less than 1% of people eligible receiving treatment, as NICE has also acknowledged previously. Many patients living with obesity in the UK do not have access to the most effective treatment, and we welcome this review of the NHS management and treatment pathways by NICE with an expectation that this will support further improvements in the management and treatment of obesity within UK. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| Johnson & Johnson | 021 | 014 | We welcome the review question "what referral criteria for bariatric surgery are most effective to achieve weight loss and maintain | Thank you for your comment. We welcome your support for this scope and update of the guideline. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | healthier weight in adults living with obesity", but would like to feedback that bariatric surgery is not only effective to achieve weight loss. As confirmed within the existing suite of NICE guidelines that this update will replace, bariatric surgery also delivers diabetes remission for patients and can reduce progression to other serious disease such as cardiovascular and renal disease. | |
| Ki Performance Lifestyle | 006 | 014 - 015 | **Table 1**<br>With regards to lifestyle interventions, the draft scope indicates that NICE currently plans to retain recommendations from the existing guideline 1.4 in CG189. We agree that an individual's preferences and social circumstances, and their experience with and the outcome of previous treatments should be considered when choosing treatment (including whether there were any barriers). Self-Determination Theory suggests that sustainable behaviour change relies on people internalising the value of the behaviour, knowing how to change, and being supported to have authentic self-choice in doing so (Ryan *et al*., 2008). It focuses the fulfilment of the individual's need for autonomy, competence and relatedness, as drivers for initiating and maintaining changes in behaviour. Thus, interventions grounded in self-determination theory that take in individual approach can achieve successful and sustained behaviour change. As an example, one reason an individual may be reluctant, fearful or disinterested with respect to physical activity behaviour change is due to the narrow messaging around exercise. People have been conditioned to believe that physical activity is | Thank you for your comment and additional information.<br><br>The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. The approaches you refer to are covered in recommendation 6,7 and 8 in PH49. In line with this CG189, rec 1.5.2 states a behavioural programme should include these strategies: cognitive restructuring (modifying thoughts), reinforcement of changes, and relapse prevention. This recommendation is to be retained. The tables in the proposed outline for the guideline section lists whether evidence reviews will be updated, or recommendations will be retained for the guideline areas.<br>The guideline committee will assess whether recommendations in areas that are being retained |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | exercise, which, for many, has negative connotations. To overcome this barrier, it is crucial to shift the narrative and highlight all of the dimensions of physical activity that are important and the vast choice this provides for the individual to incorporate it into their lifestyle to benefit their health. In addition to a new personal understanding of their daily physical activity, putting the individual at the heart of decision making can empower authentic self-choice, motivating sustained behaviour change.<br><br>*Reference*:<br>Ryan, R.M., Patrick, H., Deci, E.L., and Williams, G.C. (2008). Facilitating health behaviour change and its maintenance: Interventions based on Self-Determination Theory. *The European Health Psychologist*, **10(1)**, 2-5. | from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance. |
| Ki Performance Lifestyle | 007 | 014 - 015 | **Table 1**<br>With regards to behavioural interventions, the draft scope indicates that NICE currently plans to retain recommendations for adults from the existing guideline 1.5.2 in CG189. We support the existing guideline 1.5.2 and agree that self-monitoring of behaviour and progress should be included as a strategy in behavioural interventions for adults. However, we would emphasise the importance of access to validated tools that are appropriate for the specific population or setting. Whilst we recognise that objective measures are not currently available in all areas covered by this guidance, accurate and objective measures of physical activity and sedentary behaviour in a free-living environment are available. It is important to note that physical activity is defined as any bodily | Thank you for this information. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed, for example those relating to physical activity and to behaviour change. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | movement produced by skeletal muscles that results in energy expenditure, which can be measured in kilocalories (Caspersen, Powell, and Christenson, 1985). Thus, wearable technologies should capture the totality of physical activity behaviours both accurately and objectively, and provide a personal understanding of these behaviours on health and weight management. Whilst many devices currently available to consumers do not meet the required standards, there is technology currently in use within healthcare that does.<br><br>*Reference*:<br>Caspersen, C.J., Powell, K.E. and Christenson, G.M. (1985). Physical activity, exercise, and physical fitness: definitions and distinctions for health-related research. *Public Health Reports*, **100(2)**, 126-131. | |
| Ki Performance Lifestyle | 007 | 014 - 015 | **Table 1**<br>The draft scope indicates that NICE currently plans to retain recommendations for adults from the existing guideline 1.6 in CG189. We would like to see the physical activity recommendations stated in 1.6.3 in CG189 to promote a more holistic view of physical activity, accounting for the multitude of ways in which people can benefit from physical activity. The emphasis on structured exercise to date has limited access and the focus on prescription, compulsion or payment has delivered little evidence of creating sustained behaviour change for physical activity. Physical activity is defined as any bodily movement produced by skeletal muscles that results in energy expenditure (Caspersen, Powell, and Christenson, 1985). Interventions should focus on providing people with a | Thank you for your comment and information.<br><br>During the scoping of this update and the surveillance reviews no new evidence was identified that would impact on the current physical activity recommendations within CG189. We will pass these comments to the surveillance team for consideration.<br><br>**The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines on physical activity as needed.** |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | personal understanding of their everyday movement and help them to find opportunities to do more physical activity to benefit their health. The ultimate choice of how people add physical activity into their lives should be theirs. Research has shown that when individuals experience autonomy and competence in their treatment, they experience volitional engagement and demonstrate greater maintenance of desirable health behaviours (Ryan *et al*., 2008). Indeed, promoting a holistic view of physical activity and an understanding that any type of voluntary bodily movement contributes to expending energy, improves engagement and accessibility and removes the fear or apprehension individuals may have around exercise to empower self-care and sustained health improvement. This may be critical for individuals at the beginning of their weight loss journey and those who currently inactive, and may prevent disengagement from the intervention.<br><br>*References*:<br>Caspersen, C.J., Powell, K.E. and Christenson, G.M. (1985). Physical activity, exercise, and physical fitness: definitions and distinctions for health-related research. *Public Health Reports*, **100(2)**, 126-131.<br><br>Ryan, R.M., Patrick, H., Deci, E.L., and Williams, G.C. (2008). Facilitating health behaviour change and its maintenance: Interventions based on Self-Determination Theory. *The European Health Psychologist*, **10(1)**, 2-5. | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Ki Performance Lifestyle | 013 | 001 | **Table 5**<br>The draft scope indicates that NICE currently plans to retain recommendations for adults from the existing guideline 8 in NG7. We agree that it is vital to clearly communicate the benefits of gradual improvements to physical activity and dietary habits, however we would also include an emphasise on educating individuals on energy balance. Research indicates that lack of knowledge about energy balance in a contributing factor in weight loss plateauing and often leads to weight gain (Hall *et al*., 2011). When an individual loses weight, there is a concomitant reduction in resting metabolic rate (RMR) that is often greater than would be expected based on the measured changes in body composition (Fothergill *et al*., 2016). This phenomenon of metabolic adaptation is thought to persist for many years following weight loss (Rosenbaum, *et al*., 2008). Thus, education on energy balance and the continued promotion of small, gradual improvements in lifestyle behaviours is essential to achieving a weight loss goal and preventing weight regain.<br><br>We also agree that no single physical activity, food or drink will maintain a healthy weight, and that a combination of actions is needed. We believe it is important to acknowledge that both compensation and substitution behaviours are barriers to weight loss, whereby the introduction of a new behaviour can lead to changes in a pre-existing behaviour. Compensation can occur in physical activity behaviours, where a reduction in energy expenditure has been observed for the rest of the day after taking part in exercise (Thivel *et al*., 2014), and in dietary behaviours | Thank you for your comment and additional information.<br>Energy expenditure/balance and gradual changes are covered in recommendation 1.2.3 in NG7 Preventing excess weight gain (2015). This recommendation is to be retained. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | through an increase in energy intake due to an increase in energy expenditure from exercise (Turner *et al*., 2010). Substitution describes when a new behaviour, such as an exercise session, is carried out at a time when the individual is usually active, resulting in no change in total energy expenditure (Thompson, Peacock & Betts, 2014). Thus, highlighting the importance of clearly communicating that a combination of actions is required for weight management, including education about how these actions are incorporated into the individual's lifestyle.<br><br>*References*:<br>Fothergill, E., Guo, J., Kerns, J.C., Knuth, N.D., Brychta, R., Chen, K.Y., Skarulis, M.C., Walter, M., Walter, P.J., and Hall, K.D. (2016). Persistent metabolic adaptation 6 years after The Biggest Loser competition. *Obesity*, **24(8)**., 1612-1619.<br><br>Hall, K.D., Sacks, G., Chandramohan, D., Chow, C.C., Wang, Y.C., Gortmaker, S.L. and Swinburn, B.A. (2011). Quantification of the effect of energy imbalance on bodyweight. *The Lancet*, **378 9793)**, 826-37.<br><br>Rosenbaum, M., Hirsch, J., Gallagher, D.A., and Leibel, R.L. (2008). Long-term persistence of adaptive thermogenesis in subjects who have maintained a reduced body weight. *American Journal of Clinical Nutrition*, **88(4)**, 906-912.<br><br>Thompson, D., Peacock, O.J., and Betts, J.A. (2014). Substitution and Compensation Erode the Energy Deficit from Exercise | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Interventions. *Medicine and Science in Sports and Exercise,* **46(2)**, 423.<br><br>Turner, J.E., Markovitch, D., Betts, J.A., and Thompson, D. (2010). Nonprescribed physical activity energy expenditure is maintained with structured exercise and implicates a compensatory increase in energy intake. *The American Journal of Clinical Nutrition,* **92(5)**, 1009-16.<br><br>Thivel, D., Aucoutuerier, J., Metz, L., Morio, B., Duche, P. (2014). Is there spontaneous energy expenditure compensation in response to intensive exercise in obese youth? *Pediatric Obesity*, **9(2)**, 147.-154. | |
| King's College Hospital NHS Foundation Trust | General | General | With the introduction of GLP-1 pharmacotherapy, the entire criteria for referral to Tier 3 needs to be redesigned. Also, the same criteria should be applicable within a Tier 4 service for patients who are being considered for primary bariatric surgery but would benefit from medical optimisation preoperatively as this would facilitate surgical outcomes. | Thank you for your comment. Issues concerning the geographical variation in access to weight management services was acknowledged by the early recruited committee members and is included in the equality impact assessment. Referral for bariatric surgery is included in the key issues and draft questions in this scope. While NICE guidelines identify care that is high quality, good value, and provides the best outcomes for people using health and social care services within the budget available, it is not mandatory.<br>The guideline committee will assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | ensure that they meet current editorial standards and reflect the current policy and practice context**.** The new guideline will also cross-refer to other NICE guidance as needed**.** |
| King's College Hospital NHS Foundation Trust | 007 | 014 - 015 | **Table 1 1.8**<br>Pharmacological management should be offered as an adjunct to lifestyle and surgery in in both Tier 3 and 4 services given the proven efficacy of the newer agents | Thank you for your comment.<br>Surveillance identified no new evidence relating to pharmacological management that would impact current recommendations. |
| King's College Hospital NHS Foundation Trust | 023 | 001 | The use of Liraglutide (and subsequently future pharmacotherapy) needs to be made available also within a Tier 4 pathway/service under the appropriate circumstances and following the same recommendations (as within a Tier 3 service) from NICE technology appraisal guidance 664. Many weight management services are commissioned to provide a Tier 4 service only and struggle to provide liraglutide to their patients under the current guidance. It is unethical to deny patients with the same characteristics access to Liraglutide because there is no Tier 3 service locally. A Tier 4 service is a Tier 3 service plus a bariatric surgeon and therefore makes no sense to deny access to pharmacotherapy to patients within this pathway.<br>Referring to a different institution with a Tier 3 pathway in order to start Liraglutide is not good for continuity of care. Liraglutide (Saxenda) can be used as part of optimisation before bariatric surgery in patients with complex obesity as these seen in a Tier 4 service. Patients with T2DM are started on liraglutide (Victoza) to facilitate optimisation before surgery. It makes no sense to be | Thank you for your comment.<br><br>Issues concerning the geographical variation in access to weight management services was acknowledged by the early recruited committee members and is included in the equality impact assessment. While NICE guidelines identify care that is high quality, good value, and provides the best outcomes for people using health and social care services within the budget available, it is not mandatory.<br><br>The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | unable to do the same using Saxenda for patients with obesity and prediabetes plus CVD. Enabling clinicians use this treatment in the appropriate circumstances will facilitate patient experience/outcomes within Tier 4 pathways. | new guideline will also cross-refer to other NICE guidance as needed. |
| King's College Hospital NHS Foundation Trust | 023 | 001 | Liraglutide and future pharmacotherapies should be made available for the management of poor responders to bariatric surgery. There is a growing proportion of patients who weight regain after bariatric surgery and there is currently nothing available for them. Pharmacotherapy should be made available within a Tier 4 service to facilitate poor responders to bariatric surgery until better criteria for selection of good candidates for bariatric surgery are made available. | Thank you for your comment.<br><br>The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context.<br>The updated guideline will have the opportunity to cross-refer to related NICE guidance as needed, including NICE technology appraisal 664 Liraglutide for managing overweight and obesity. Setmelanotide and Semaglutide are the subject of NICE technology appraisals currently in development. |
| Medtronic | 008 | 014 - 015 | **Table 1 _1.11**<br>Existing area CG189 under 1.11 _ Published evidence for patients with severe T2DM recommend bariatric surgery in terms of improvement in disease status, reduction in need for medications and improvement in quality of life. Surgery in this group is both clinically and cost<br>PLoS Med. 2020;17(12):e1003228. | Thank you for your comment and additional information. Surveillance identified no new evidence relating to bariatric surgery and type 2 diabetes that would impact current recommendations. We will pass your comments to the surveillance team for consideration. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Medtronic | 021 | 014 - 016 | As above, evidence citation to support consideration for offering patients with severe T2DM rapid access to assessment to/ consideration for bariatric surgery | Thank you for your comment.<br><br>During the scoping of this update and the surveillance review of the NICE guideline CG189 Obesity: identification, assessment and management (2014) no new evidence was identified that would impact on the current recommendation 1.11' Bariatric surgery for people with recent-onset type 2 diabetes'. The original recommendation remains valid and will appear in the updated guideline. |
| Medtronic | 023 | 005 | **Section 4.2**<br>NICE pathways section _ consider integrated model of care in place of current tier 3 to tier 4 approach for patients who would benefit from pathway optimisation; in relation to rapid access consideration for bariatric surgery | Thank you for your comment.<br><br>The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. The NICE pathways team will be involved in developing the new guidance. |
| National Obesity Forum | General | General | The NOF exists to improve the interface between the healthcare professional and the patient with regard to overweight and obesity, regardless of the reason for the consultation. A person with excess weight should be acknowledged and managed accordingly regardless of whether the initial reason for the appointment was | Thank you for your comment and this information. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | regarding weight. This should apply to primary care, secondary care nurses, pharmacists, midwives, physiotherapists, podiatrists, dental surgeons etc. | |
| National Obesity Forum | General | General | There should be a focus on education of healthcare professionals across the board, from undergraduate, postgraduate and ongoing career education. This should include identification, appropriate engagement and management of the individual | Thank you for your comment.<br><br>While the setting of training curriculums for healthcare professionals is beyond the remit of NICE, the current recommendation 1.1.2 in CG43 Obesity prevention (2015) does cover addressing the training needs of staff involved in preventing and managing obesity.<br><br>During the scoping of this update and the surveillance review of the NICE guideline CG43 Obesity prevention (2015) no new evidence was identified that would impact on the current recommendation 1.1.2. |
| National Obesity Forum | General | General | The NOF is supportive of all evidence-based approaches to weight loss, providing it is sustainable in the long term. | Thank you for your comment and this information. |
| National Obesity Forum | 007 | 014 - 015 | **Table 1 1.8**<br>Pharmacotherapy should be the subject of more education, but is not appropriate for prevention of excess weight except following weight loss from previous levels of obesity | Thank you for your comment and this information. |
| National Obesity Forum | 008 | 014 - 015 | **Table 1 1.9** | Thank you for your comment. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Bariatric surgery is a brief technological interlude in the lifetime management process in the community. Healthcare professionals plus relatives and carers should have the opportunity to consider the option of surgery, and in particular primary care professionals should be aware of the approaches and guidelines prior to surgery, the different rtecniques and associated risks, and most importantly the lifelong care starting at day one following hospital discharge at which time diabetes, blood pressure and general cardiovascular risks may be diminishing | |
| NHS England and NHS Improvement | General | General | There are no specific recommendations for GPs, general medical practice or primary care. There are some comments about the role of community settings and we would encourage a wider holistic social and community approach to obesity and weight management. The main focus appears to be drawing together a number of guidelines with no review of evidence, it seems sensible to draw them together but I do think an opportunity may be missed to strengthen guidance for children and young people as it is a particularly challenging area to address in primary care as little specific resource and guidance is available. I would like to see some specific and more detailed guidance on the actions to support challenging and managing cultural and social factors in CYP obesity and the more deprived communities – as ever this remains a marker of health inequalities and that dimension should be much stronger. It is hard to give much specific comment as so few evidence reviews are planned. (PC) | Thank you for your comment and this information.<br><br>The update will consider the evidence for the key issues identified in the guideline scope as well as amalgamating and incorporating existing guidance. Questions on measurement and overweight and obesity identification for children and young people, and on obesity stigma have been added.<br><br>In addition, the guideline committee will assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE and national guidance as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | **Socio-economic factors are included in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it.** |
| NHS England and NHS Improvement | General | General | The NHS Diabetes Prevention Programme has supported weight loss in over 750,000 people. As commissioner, NHS England and Improvement holds comprehensive data on the effectiveness and cost-effectiveness of weight management interventions. Where such data may be deemed valuable during evidence reviews we would considering making some available to NICE for this purpose. (ODP) | Thank you for your comment and this offer of data, we will pass on this information to the NICE guideline developer. |
| NHS England and NHS Improvement | 004 | 003 | Should read "more people living with obesity and a diagnosis of Type 2 Diabetes, or hypertension, or both, to attend weight management services" (ODP) | Thank you for your comment, we have amended this section accordingly. |
| NHS England and NHS Improvement | 005 | 012 | PH27 was published in 2010 and an update is due. Whilst weight management before and after pregnancy will be included in this guidance, weight management during pregnancy is being considered in the Maternal and Child Nutrition PH11 guidance. Addressing maternal obesity is incongruous in PH11, which primarily focuses on routine advice. We believe weight management during pregnancy should be included in the same guidance document as weight management during and after pregnancy, and other obesity related guidance, to ensure adequate consideration by those with expertise in obesity. This will also promote ease of access and give reassurance to users that the issue of maternal obesity has been given appropriate consideration given its influence | Thank you for your comment.<br><br>Pregnant women are excluded from the scope of this guideline update as they require different management and are covered by separate NICE guidance.<br>The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | on poor pregnancy outcomes. Inclusion within this guidance would facilitate appropriate consideration of pregnancy in relation to relevant topics within wider obesity guidance (for example ethnicity specific BMI, weight management interventions etc), and for which clarity on whether there is read across has raised queries. The evidence base on weight loss during pregnancy and thresholds for weight gain during pregnancy warrants review at this time. (ODP) | |
| NHS England and NHS Improvement | 006 | 014 - 015 | **Table at 14/15**<br>Lifestyle interventions, behavioural interventions and physical activity should also take into account the wider determinants of health and wellbeing, providing support to address what is important to the person and may be a cause of unhealthy behaviours contributing to weight gain. Social prescribing can provide referrals to supportive groups such as walking groups, cookery classes, gardening groups etc. These can support people's wider wellbeing, align with individual goals and motivation, encourage supportive networks, and encourage more active and healthy lifestyle choices.<br><br>For evidence – Moffatt S, Steer M, Lawson S, et al (2017), Link Worker social prescribing to improve health and well-being for people with long-term conditions: qualitative study of service user perceptions, BMJ Open 2017;7:e015203. doi: 10.1136/bmjopen-2016-015203<br><br>"The Link Worker social prescribing programme engendered feelings of control and self-confidence, reduced social isolation and led to positive physical changes such as weight loss, increased physical activity, improved long-term condition management and | Thank you for your comment. The approaches you refer to are covered in recommendation 1 in PH42. These recommendations are to be retained.<br>The tables in the proposed outline for the guideline section lists whether evidence reviews will be updated, or recommendations will be retained for the guideline areas.<br>The guideline committee will assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | mental health, greater resilience and effective coping strategies to manage relapses." (PCG) | |
| NHS England and NHS Improvement | 006 | 015 | Current CG 189 (1.3.6) advocates fasting lipid samples. We would ask that NICE guidance is consistent with current best practice: generally non-fasting lipids are encouraged in clinical settings due to ease for patients. (ODP) | Thank you for your comment. The guideline committee will assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| NHS England and NHS Improvement | 006 | 015 | Also in CG 189, section 1.3.6 the comorbidities used as examples include: type 2 diabetes, hypertension, cardiovascular disease, osteoarthritis, dyslipidaemia and sleep apnoea. We would suggest the inclusion of non-diabetic hyperglycaemia. (ODP) | Thank you for your comment. The guideline committee will assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE and national guidance as needed. |
| NHS England and NHS Improvement | 006 | 015 | Current guidance supports providers to engage with the National Bariatric Surgery Registry. By the time this guidance refresh is published we expect that a National Obesity Audit (as part of the National Clinical Audit Programme) will have been launched which will seek to drive quality improvement in all WMS (adult and child) in England (by collecting person level data on all adults and children accessing weight management services in England). We would be grateful if NICE would promote engagement with this audit and any others in this guidance refresh. (ODP) | Thank you for your comment. The guideline committee will assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context.<br>NICE is aware that this audit launch is planned. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| NHS England and NHS Improvement | 006 | 015 | There is large variation in the commissioning of tier 3 and 4 weight management services and the eligibility criteria applied in local areas. In this guideline review we would ask that NICE considers what evidence exists to support (or refute) the current tiered approach and how guidance might best be used to drive greater consistency in the commissioning of tier 3 and 4 services.<br><br>NHS England have received funding, through the Spending Review, for specialist weight management services. As part of this we will likely ask ICSs to map specialist weight management services, make proposals for how services might expand and transform (including considering bringing tier 3 and 4 services into a single specialist service) over the coming years and offer limited money for in-year expansion/ creation of new services. If relevant we may be able to share summary data on variation in commissioning of services with NICE. (ODP) | Thank you for your comment and offering information.<br>Evidence supporting or refuting the current tiered approach is out of scope for this guideline. As you note, geographical variation in access to NHS weight management services are included in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it.<br><br>While NICE guidelines identify care that is high quality, good value, and provides the best outcomes for people using health and social care services within the budget available, it is not mandatory.<br><br>The new guideline will also cross-refer to other NICE guidance as needed. |
| NHS England and NHS Improvement | 006 | 015 | With regard to tier 3 services we recognise that there are a number of sources of guidance and would recommend these all being brought together/ referenced consistently in the updated guidance. These include CG 189, 1.3.7 (2014), updated in 2017 (which makes differing recommendations regarding eligibility), and NICE accredited commissioning guidance which was produced by BOMSS and subsequently accredited by NICE. (ODP) | Thank you for your comment. Geographical variation in access to NHS weight management services are included in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it.<br>The guideline committee will assess whether recommendations in areas that are being retained |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. |
| NHS England and NHS Improvement | 006 | 015 | We would ask whether NICE might consider making specific mention of the NHS Diabetes Prevention Programme as a behavioural weight management option for people with non-diabetic hyperglycaemia. (ODP) | Thank you for your comment. Diabetes prevention is out scope for this guideline. |
| NHS England and NHS Improvement | 011 | 003 | Amended thresholds for obesity based on ethnicity are mentioned in numerous pieces of NICE guidance. Messaging on these thresholds for specific ethnic groups is at times confusing and seemingly contradictory. We would ask that this guidance draw clarity and consistency in this messaging and provide guidance which is applicable in day-to-day clinical settings. (The NHS Digital Weight Management Programme (https://www.england.nhs.uk/digital-weight-management/), which offers services to those living with obesity plus either diabetes, or hypertension, or both, has set a threshold of 27.5 for obesity in BAME groups.)<br><br>Further to this we are aware of some evidence to support differential thresholds for the diagnosis of high BMI in South Asian children based on ethnicity. We would ask that this be considered during evidence review. (ODP) | Thank you for this information.<br><br>The scope includes a key area that covers identification and assessment. It covers cut-offs for different ethnic groups in adults and children. Evidence reviews will be conducted for the key issues described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The measures and tools you refer to will be captured by these review questions. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| NHS England and NHS Improvement | 021 | 012 | We welcome the consideration of new evidence to support wider use of low calorie total diet replacement programmes in individuals with Type 2 diabetes following two high quality RCTs and the commitment in the NHS LTP to pilot at scale delivery of programmes such as these for individuals who are overweight / obese and recently diagnosed with Type 2 diabetes, with the aim of delivering significant weight loss and achieving remission from their diabetes. The real-world implementation of these programmes is already being tested through the delivery of the NHS Low Calorie Diet Programme which is being piloted in ten systems in England with good uptake and retention on programmes since services launched in September 2020. Referrals will be accepted into the pilot programme for 2 years, with services being delivered for 3 years until 2023. A full qualitative and economic evaluation has been commissioned by the National Institute for Health Research alongside a quantitative evaluation which is being undertaken by NHS England and NHS Improvement.<br><br>This implementation pilot is based on the Diabetes Remission Clinical Trial (DiRECT) (https://core.ac.uk/download/pdf/327360094.pdf), which found that some people with Type 2 diabetes (46% in intervention group) can achieve remission, at least for a period, reducing their HbA1c levels by 9.6 mmol/mol and losing 10kg in weight, and the Doctor Referral of Overweight People to Low Energy Treatment (DROPLET) (https://bmjopen.bmj.com/content/7/8/e016709) trial, which found that those who are obese (with or without Type 2 diabetes) had a | Thank you for your comment. We welcome your support for this scope and update of the guideline.<br><br>Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during development. The aim for this guideline is weight management instead of diabetes outcomes. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | similar weight loss of 10.7kg at 1 year, and in those with Type 2 diabetes a weight loss of 13kg.<br><br>We suggest that any recommendations, depending on scope, may sit most coherently alongside other recommendations for "Bariatric surgery for people with recent-onset type 2 diabetes".<br><br>Further information on the pilot programme is provided if helpful: Primary care refer eligible patients into the nationally commissioned service with patients receiving a full assessment of eligibility and a medication review prior to referral. Eligible patients will all have been recently diagnosed (within the last 6 years), be aged 18-65 and have a BMI of 27 or higher (25 or higher for ethnic minorities (excluding white minorities)) and a number of other eligibility criteria will be considered. Three delivery models are being assessed in the pilots; one to one, group based and digital delivery (all models have been adapted to be delivered fully remotely during Covid-19). (ODP) | |
| NICE GP reference panel | 006 - 017 | 014 | Please comment on the most effective weight loss strategies: calorie restriction, exercise, specific food group restriction? | Thank you for your comment.<br>The key issues in the scope identified individual approaches as an area for update. Evidence will be reviewed in this area to inform the guideline update. Physical activity is covered by the NICE Physical activity guidelines. |
| NICE GP reference panel | 005 - 006 | 014 - 004 | The GP reference panel were asked to comment on the barriers to implementation of weight management guidance. This is a summary of their collated thoughts: | Thank you for your comment and this information. The content of the e-referral system is out of remit for NICE. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Barriers to implementation:<br><br>*Funding* of services is insufficient, so implementation is patchy.<br>*Time*: dietary advice is time-intensive for nurses and doctors.<br>*Accessibility* to support for patients: convenience is important (use GP surgeries for service delivery?) and interventions should be free or cheap.<br>*Opportunities for exercise*: set realistic goals and build up gradually but availability of this resource is patchy and it may be expensive.<br>*IT resources*. We need: 1) better online information on healthy eating/lifestyle; 2) the ability for patients to download home monitoring data to IT systems.<br>*Skill set*? On the one hand, clinicians' advice may be more effective, but on the other hand dietary advice often doesn't need medical skills.<br>*Get it right the first time*: patients are more reluctant to give interventions a go the second time around.<br>*Give a simple message*: eat less (not the widely touted idea to 'eat differently').<br>*Obesity is the new normal:* some people think a BMI > 30 is ok.<br>*GP knowledge*: of the full impact of obesity on chronic diseases. Increase education.<br>*Dietician/ Psychological input:* both can be a great help but there is a lack of (or variable) availability<br>*Social prescribing opportunities are limited:* e.g. learn to cook healthy food | The guideline committee will assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Referrals:<br><br>Bear in mind:<br>• Self-referral leads to a higher 'failure to engage' rate<br>• Personalised programmes are most appreciated. Many patients dislike group settings<br>• Pre-requisites of surgical referral for some procedures require weight loss. These stimulate action and can sometimes be 'curative' (e.g. modifying joint pain)<br>Please:<br>Clarify the referral pathway for obesity and make it searchable on the e-referral system | |
| NICE GP reference panel | 005 | 010 | We question why pregnancy is dealt with separately, as this is a crucial time to deliver health messages | Thank you for your comment.<br><br>Pregnant women are excluded from the scope of this guideline update as they require different management and are covered by separate NICE guidance. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |
| NICE GP reference panel | 007 | 014 - 015 | **Table 1.5**<br>Re-CG189 1.5.2-3<br>Stimulus control is important but difficult for patients. Please elaborate on this and explain what this term actually means, perhaps with an example. | Thank you for your comment. The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. The terms used in the guideline will be updated and definitions added where needed. |
| NICE GP reference panel | 007 | 014 - 015 | **Table 1.8**<br>Orlistat. Please clarify the guidelines. Implementation is patchy at present. | Thank you for your comment. The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| North Middlesex University Hospital | Page 10 | 002 - 003 | This section should include running/cycling to commute between school and home. | Thank you for this information. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines on physical activity as needed. |
| Novo Nordisk | 002 | 029 | Obesity is recognised by the World Obesity Federation as a chronic relapsing progressive disease process (5). Novo Nordisk suggests recognition of the relapsing and progressive nature of obesity through replacement of *'Overweight and obesity are chronic conditions characterised by excess body fat associated with an increased risk of morbidity and mortality'* in the draft scope with *'Overweight and obesity are chronic, relapsing, and progressive conditions characterised by excess body fat associated with an increased risk of morbidity and mortality'*. Novo Nordisk also suggests that this definition is used in the subsequent guideline. | Thank you for your comment, the scope has been amended and relapsing added. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Novo Nordisk | 005 | 001 - 002 | The equality impact assessment recognised a range of demographic and socioeconomic factors that must be considered when developing the guideline. As part of this, Novo Nordisk welcomes NICE's recognition of the geographical variation in the availability of weight management services in the equality impact assessment (page 3):<br>*'Geographical variation in access to NHS weight management services: a lack of universal commissioning of Tier 3 services (intensive weight loss programmes) means that not all those living with obesity can access tier 4 services (bariatric surgery), owing to access to the former being a prerequisite to surgery.'*<br><br>However, while NICE states that the lack of universal commissioning of Tier 3 services (specialist weight management services [led by a multidisciplinary team]) can prohibit patient ability to access Tier 4 services (surgical interventions), it does not recognise that specialist weight management services can provide support for people with obesity beyond acting primarily as a gateway to surgical interventions. Specialist multidisciplinary weight management services can help people with severe and complex obesity to reduce and manage their weight with pharmacotherapy, a preferred option to surgery for some people with the condition. Furthermore, these specialist weight management services, and pharmacotherapeutic options, provide an option for patients who may be eligible for surgical interventions, but do not receive them due to limitations in availability (6). This will be particularly important in light of the COVID-19 pandemic, which has resulted in many cancellations of elective bariatric surgery in the UK (7). This is likely | Thank you for this information.<br><br>The scope sets out the areas the guideline will consider.<br>Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others. We will keep in mind the issues you have raised when developing the guideline.<br><br>As you note, geographical variation in access to NHS weight management services are included in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it.<br><br>Issues concerning the geographical variation in access to weight management services was acknowledged by the early recruited committee members and is included in the equality impact |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | to have a longer-term impact on access to surgery due to the backlog of postponed surgeries.<br><br>Therefore, Novo Nordisk suggests revising the statement to: *'Geographical variation in access to NHS weight management services: a lack of universal commissioning of Tier 3 services (intensive weight loss programmes) means that specialist weight management services may not be accessible to all who may benefit from them. In addition, variation in the availability of Tier 3 services may mean that not all those living with obesity can access Tier 4 services (bariatric surgery), owing to access to Tier 3 services being a prerequisite to surgery.'*<br><br>In addition, Novo Nordisk would like to ask the following questions related to the equality impact assessment:<br><br>1) Did NICE review the accessibility of specialist weight management services (led by a multidisciplinary team) for children as part of its equality impact assessment?<br><br>2) Given the recognition of the barriers that can be experienced across the current weight management pathway (8), how does NICE plan to review this to simplify, embed flexibility and ensure all patients can access the most appropriate treatment for them at the precise time of need? | assessment. While NICE guidelines identify care that is high quality, good value, and provides the best outcomes for people using health and social care services within the budget available, it is not mandatory.<br>The guideline committee will assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | How will NICE be including recommendations in the final guideline as to what advice healthcare professionals can give patients in the absence of an accessible specialist weight management service (led by a multidisciplinary team) in their locale? | |
| Novo Nordisk | 005 | 008 – 009 | There is a growing evidence base identifying links between obesity and positive COVID-19 test, hospitalisation for COVID-19, advanced levels of treatment for COVID-19, and death due to COVID-19 (1). Among the groups that should be covered in this guideline, NICE should consider inclusion of people with obesity who may be more vulnerable to contracting COVID-19 and developing complications.<br><br>Therefore, Novo Nordisk suggests that the text *'Specific consideration will be given to the groups identified in the equality impact assessment'* in the draft scope should be replaced with *'Specific consideration will be given to the groups identified in the equality impact assessment, and those identified as vulnerable to contracting COVID-19 and experiencing severe outcomes'.* | Thank you for your comment.<br>COVID-19 management and treatment are out of scope for this guideline. People recovering from COVID-19 has been added to the equality impact assessment because they may need additional support with some weight management interventions. |
| Novo Nordisk | 006 | 014 - 015 | **Table 1: 1.1 Generic principles of care: adults**<br>While obesity is a chronic and relapsing condition requiring long-term care, it has been recognised that people with the condition are experiencing stigma in a healthcare setting, which could be acting as a barrier to engagement with healthcare professionals (1). The importance of person-centred language that is free from judgement or negative connotation has been identified as key in helping to promote conversations between healthcare professionals and people with obesity (2). | Thank you for this information.<br><br>The scope has been amended accordingly by adding a draft review question which covers obesity stigma. Keeping the guideline as one was felt to tie in with broader government initiatives to adopt a person-centred approach and to recognise the need for a whole-systems approach to addressing overweight and obesity. The guideline committee will consider |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Novo Nordisk suggests that the National Institute for Health and Care Excellence (NICE) review Section 1.1 of the existing Clinical Guideline 189 (CG189) (currently marked as 'No evidence review: retain recommendations from existing guideline') to ensure that evidence around stigma as a barrier to engagement between healthcare professionals and people with obesity is assessed and included.<br><br>Novo Nordisk also suggests review of all NICE documents to ensure that person-first and non-stigmatising language is used consistently. | your views when deciding how best to present and communicate the final guidance. |
| Novo Nordisk | 006 | 014 - 015 | **Table 1: 1.1 Generic principles of care: adults**<br><br>Given that general practitioners (GPs) and primary care professionals are generally the first interactions people with obesity have with healthcare professionals, they should be equipped with the knowledge to support these people appropriately and respectfully.<br><br>1) The Royal College of General Practitioners (RCGP) has developed an online obesity hub (3), which can be accessed for free and provides information to GPs and others working on primary care on a range of topics related to the management of obesity, including the science of the condition, the care pathway and how to have non-stigmatising conversations with patients. | Thank you for providing this information.<br><br>NICE also produces tools and signposts to other support that can help organisations put guideline recommendations into practice ensuring that the guidance is implementable.<br><br>When developing the final updated guideline, the guideline committee will consider the most appropriate way to present the recommendations and also to cross-refer to other NICE and guidance and appropriate external resources as needed. The |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | 2) Guidelines for managing obesity in primary care have been developed by a multidisciplinary expert panel to help promote effective conversations in a primary care setting (4). This is based on the principles of 5 As (Ask, Assess, Advise, Agree, Assist).<br><br>How does NICE plan to link to external resources in the guideline to help primary care professionals to understand obesity, and to initiate effective conversations with people with the condition?<br><br>How does NICE plan to bring together all relevant information from all guidance available on weight management, including Quality Standards (QS) such as QS127 (and, specifically, the *List of quality statements* on page 8 of QS127, including Statement 2), into one comprehensive document? | quality standards will be updated when this guideline is updated and amalgamated. |
| Novo Nordisk | 007 | 015 | **Pharmacological interventions: adults**<br>1) Since the development of CG189, pharmacotherapies for managing overweight and obesity have become available, or clinical trials are advanced and TAs are currently being scheduled (9).<br><br>The evidence indicating that people with obesity are vulnerable to experiencing severe illness from COVID-19 underlined the need for a range of treatment options to be available to assist those with severe and complex forms of the condition, for whom lifestyle interventions would be insufficient. Healthcare professionals must be informed of the treatment options available to them to support people with obesity to reduce their | Thank you for your comment.<br><br>The updated guideline will have the opportunity to cross-refer to related NICE guidance as needed this will include as they are published during the development of this guideline. NICE technology appraisal 664 Liraglutide for managing overweight and obesity. Setmelanotide and Semaglutide are the subject of NICE technology appraisals currently in development.<br>There are currently no medications licensed for obesity in children. The BNFC recommends orlistat for children, but this is off-license use. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | weight and to prevent the onset of obesity-related conditions and complications.<br><br>The NICE pathway on obesity management in adults has been updated to include Liraglutide 3.0mg as a potential drug treatment for adults with obesity in accordance with the Technology Appraisal Guidance (TAG) published in December 2020. The pathway also states that naltrexone-bupropion is currently not recommended for managing overview and obesity.<br><br>While NICE has indicated it will not be updating CG189 (s.1.8) could NICE please clarify how the new guideline will include, in the relevant section, a link to the new pathway on obesity management in adults, and how it will signpost to the Technology Appraisal Guidance (TAG) for Liraglutide 3.0mg? For example, will it be referenced directly in the guideline (per NICE Guideline 28 [NG28], where Technology Appraisal 288 [TA288] is referenced) or will it be referenced on the main page of the NICE website (per CG186 where there is a specific comment and link to the NICE multiple sclerosis pathway including relevant TAs)? Will NICE also link to any relevant ongoing TAs taking place during the guideline's development within this guideline (per NG28)?<br><br>**Pharmacological interventions: children and adolescents**<br>2) In CG189 (s.1.8.6) NICE recommends the use of pharmacotherapy (specifically orlistat) in children aged 12 and | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | over only if physical co-morbidities are present (such as orthopaedic problems or sleep apnoea) or severe psychological comorbidities are present.<br><br>There is an established link between childhood and adolescent obesity and adult obesity, and early intervention could help to reduce the number of adolescents with the condition living with severe forms in adulthood. Accessing treatment options as soon as possible would mitigate the risk of them developing more costly and complex complications in adulthood. Given bariatric surgery is infrequently offered to this age group, pharmacotherapy as an adjunct to lifestyle interventions could be beneficial.<br><br>The current recommendations relate directly to the use of one pharmacotherapy, orlistat, which is only recommended for use when a narrow range of co-morbidities are present. There would be benefit in developing general criteria for the use of pharmacological interventions in adolescents with obesity, for whom lifestyle interventions alone have not been sufficient, to prevent the development of co-morbidities. This would also ensure that any new medical innovations could be used most effectively.<br>In addition, the update of this guideline would provide a timely opportunity to review new treatments becoming available for this patient population in which pharmacotherapy options are limited to only one treatment, in specific circumstances. Since the development of CG189, Liraglutide 3.0mg has received a | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | positive opinion from the Committee for Medicinal Products for Human Use (CHMP) for the treatment of adolescents aged ≥12 years with a body weight >60 kg and a body mass index (BMI) corresponding to 30 kg/m² or greater for adults (10), evidence for which has been published in the New England Journal of Medicine (11). The treatment will provide an additional pharmacotherapeutic option for adolescents with obesity in whom lifestyle interventions alone have proved insufficient.<br><br>Novo Nordisk suggests that it is appropriate to consider updating CG189 (s.1.8.6) to provide health care professionals with further guidance on the use of pharmacological treatments for adolescents and to account for new innovations that will become available during the guideline development. If s.1.8.6 of CG189 will not be updated, how will new innovations that become available during the course of the guideline development be incorporated? | |
| Novo Nordisk | 008 | 015 | NICE has committed to an evidence review of CG189 (s.1.10.1) (surgical interventions) as needed, but no other area of the section on surgical interventions.<br><br>1) On CG189 (s.1.10.8), how will NICE signpost to the recent TAG for Liraglutide 3.0mg as an option to help people with obesity reduce weight prior to surgery?<br><br>Given that CG189 (s.1.10.12) states that surgical intervention is not generally recommended for children, how will NICE be outlining | Thank you for your comment.<br><br>The updated guideline will have the opportunity to cross-refer to related NICE guidance as needed, including NICE technology appraisal 664 Liraglutide for managing overweight and obesity. Setmelanotide and Semaglutide are the subject of NICE technology appraisals currently in development. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | pharmacotherapy, as an adjunct to lifestyle interventions, as an alternative? | |
| Obesity Group of the British Dietetic Association | General | General | We agree that update of the guidance for weight management is needed. It will be helpful to coordinate them to make information easier to find for users. However, we would like to see a clear distinction made between those living with overweight or obesity and treatment options/ service provision for them, and public health issues such as prevention strategies. | Thank you for your comment. While the potential merits of splitting the guideline into prevention and treatment were considered, on reflection it was felt that splitting the guideline would not impact on the guideline development process. Keeping the guideline as one was felt to tie in with broader government initiatives to adopt a person-centred approach and to recognise the need for a whole-systems approach to addressing overweight and obesity. The guideline committee will consider your views when deciding how best to present and communicate the final guidance. |
| Obesity Group of the British Dietetic Association | General | General | We would like to see People First language used throughout this and cross-referenced documents in relation to those living with overweight and/or obesity. | Thank you for your comment. The guideline adopts a person-centred approach and a recognition of the need for a whole-systems approach to addressing those living with overweight and obesity. |
| Obesity Group of the British Dietetic Association | 013 - 015 | 004 | **(Table 6)**<br><br>We agree that the current existing guidance should be retained. However, we note that current Tier 2 services are lacking so adherence to this guidance in practice will be very difficult. This is particularly true for those with mental health issues including learning difficulties. Although service provision is outside the scope of this guidance, in our view there should be coordination between recommendations on ideal practice and adequate service provision. | Thank you for your comment. Issues concerning the geographical variation in access to weight management services was acknowledged by the committee and is included in the equality impact assessment. While NICE guidelines identify care that is high quality, good value, and provides the best outcomes for people using health and social care services within the budget available, it is not mandatory. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | The guideline will assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. People with mental health problems and learning difficulties are included in the equality impact assessment. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it. |
| Obesity Group of the British Dietetic Association | 016 - 017 | 002 | **(Table 8)**<br><br>We note that there is poor provision of services for women with overweight or obesity in relation to maternity, including the special needs of women who become pregnant post bariatric surgery. | Thank you for your comment.<br><br>Pregnancy is beyond the remit of this scope and will be covered in a separate NICE guideline. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidance as needed. |
| Obesity Group of the British Dietetic Association | 015 - 016 | 003 | **(Table 7)**<br><br>We note the proposal to retain these recommendations as they are and agree with that. However, we note that funding difficulties result in differences locally in the extent to which the guidance can be followed. Adequate funding for weight management services at all levels are needed, in order to follow the guidance. | Thank you for your comment.<br>Tables under the proposed outline for the guideline section contains areas of the guideline that will be updated. Recommendations contained in those areas will either be updated based on evidence reviews or retained. Issues concerning the geographical variation in access to weight management services was acknowledged by the |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | committee and is included in the equality impact assessment. While NICE guidelines identify care that is high quality, good value, and provides the best outcomes for people using health and social care services within the budget available, it is not mandatory.<br>The guideline committee will consider your views when deciding whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| Obesity Group of the British Dietetic Association | 007 - 008 | 015 | **(Table 1)**<br><br>We note the intention to retain 1.8 as is. However, we would like to see cross reference with new pharmacological agents (e.g. Saxenda). | Thank you for your comment.<br><br>The updated guideline will have the opportunity to cross-refer to related NICE guidance as needed, including NICE technology appraisal 664 Liraglutide for managing overweight and obesity. Setmelanotide and Semaglutide are the subject of NICE technology appraisals currently in development. |
| Obesity Group of the British Dietetic Association | 005 | 012 | We have concerns that excluding pregnant women from this guidance misses an opportunity to intervene at a key stage of life in terms of risk. We would like a statement included to the effect that pregnancy and maternity are important risk stages for weight gain | Thank you for your comment.<br><br>Pregnant women are excluded from the scope of this guideline update as they require different |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | and excess weight retention in women, with cross-referencing to specific guidance for pregnancy. | management and are covered by separate NICE guidance.<br>The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |
| Obesity Group of the British Dietetic Association | 005 | 013 | We would like to see a link made to the monitoring of weight and growth in children from birth since early adiposity rebound is a risk factor for childhood obesity. Excluding children below the age of 2 years risks missing those with early onset of excess weight gain. | Thank you for your comment. Monitoring of weight in children under the age of 2 years is covered in a separate NICE guideline, PH11 Maternal and Child Nutrition. PH11 is currently being updated and will include recommendations supporting the promotion of healthy eating behaviours (in line with government advice) in children from 2 to 5 years. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. The topic experts in the NICE committees on weight management and maternal and child nutrition considered weight management in under 2s an area that currently lacked specific interventions. They felt that weight management in this population group could be appropriately addressed by regular weight monitoring and by health professionals implementing existing advice on healthy eating behaviours. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of the weight management guideline. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Obesity Group of the British Dietetic Association | 006 | 015 | **(Table 1)**<br>We agree that 1.2.1 -1.2.3 should be reviewed. In our view, 1.2.1 should specify the 6 week post birth check-up of women as a key opportunity to identify weight issues and discuss them with women. With relation to 1.2.2, we agree that BMI should be interpreted with caution and would like this to cross-reference with health risks at lower BMI in those from specific ethnic groups. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| Obesity Group of the British Dietetic Association | 006 | 015 | **(Table 1)**<br>We would like 1.2.7 and 1.2.9 to be reworded to reflect the potential health risks for those from different ethnic groups at lower cut-off points for BMI and WC (respectively) to be acknowledged. | Thank you for your comment. The scope includes a key area that covers identification and assessment. It covers cut-offs for different ethnic groups. |
| Obesity Group of the British Dietetic Association | 006 | 015 | **(Table 1)**<br>We would like to see cross-referencing of the level of intervention to discuss with patients (1.2.11) with the Edmonton Obesity Staging System (EOSS). | Thank you for your comment.<br><br>The scope includes this topic under the key area identification and assessment. The scope includes a key area that covers identification and assessment. Evidence reviews will be conducted for the key issues described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The measures and tools you refer to will be captured by these review questions. |
| Obesity Group of the British | 006 | 015 | **(Table 1)**<br>We agree with the retention of 1.3 as is; however, we would like the potential utility of using evaluated frameworks to have conversations | Thank you for your comment. NICE guideline PH49 Behaviour change: individual approaches covers |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Dietetic Association | | | about weight to be recognised. In our view, an additional point about the sensitivity of such conversations and the importance of having a structured framework within which to hold them, needs to be acknowledged.<br>In addition, skills-based training of healthcare professionals in behaviour change conversations is needed.<br>In relation to 1.3.7, we would highlight that many individuals with BMI ≥35kg/$m^2$ are likely to have complex disorders and therefore to be eligible for Tier 3 referral. We are also of the view that Tier 3 services are ideal for understanding the underlying causes of obesity due to the psychology component. | how to discuss approaches with people and the training that should be delivered.<br>People living with overweight or obesity with a BMI over 35 are not excluded from accessing tier 3 services according to 1.3.7. The recommendation advises that tier 3 should be accessed if the underlying causes of being overweight or obese need to be assessed or the person has complex disease states or needs that cannot be managed adequately in tier 2. |
| Obesity Group of the British Dietetic Association | 006 | 015 | **(Table 1)**<br>Although section 1.4 is to be retained as is, in our view some amendments are needed as follows:<br>1.4.1 should read 'increase physical activity AND reduce inactivity' (not 'or').<br>1.4.5 states that healthcare professionals should have relevant competencies but these are not identified.<br>1.4.6 People First language should be included | Thank you for your comment. The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| Obesity Group of the British Dietetic Association | 007 | 015 | **(Table 1)**<br>Although section 1.5.1. is to be retained, we note that it is unclear what is meant by 'an appropriately trained professional'. | Thank you for your comment. The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Obesity Group of the British Dietetic Association | 007 | 015 | **(Table 1)**<br>1.5.3 currently specifies only a small number of possible approaches which may be used in behavioural interventions with children. It is unclear why this is limited (e.g. by comparison with 1.5.2), in particular since many weight management interventions with children involve working with their parents or carers. | Thank you for your comment and this information.<br><br>The update will consider the evidence for multicomponent interventions and approaches as part of weight management programmes. |
| Obesity Group of the British Dietetic Association | 007 | 015 | **(Table 1)**<br>We note the proposal to retain section 1.6 as is; however, this section does not currently include the importance of exploring barriers to being physically active.<br>In addition, it excludes the need to reduce time spent in sedentary behaviours (this is specified for children but not for adults). We need these are importance omissions which need to be addressed. | Thank you for your comment. Surveillance identified no new evidence relating to physical activity that would impact current recommendations. The new guideline will also cross-refer to other NICE guidance as needed. We will pass your comments to the surveillance team for consideration. |
| Obesity Group of the British Dietetic Association | 007 | 015 | **(Table 1)**<br>We agree that section 1.7 should be reviewed. In particular, we would like the evidence for 600 calorie diets, low and very low energy diets to be reviewed and updated. We would also like inclusion of meal replacements, very low and low carbohydrate diets and approaches such as intermittent fasting, including definitions of both.<br>Evidence relating to use of dietary approaches in different settings, in different ethnic groups and under different levels of supervision should be included. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Obesity Group of the British Dietetic Association | 007 | 015 | **(Table 1)**<br><br>We note the intention to retain 1.7.12 to 1.7.14 as is. However, we note in relation to 1.7.14 that for children and young people with overweight or obesity, TEI<TEE will result in weight loss which is not always the aim of the intervention with children. | Thank you for your comment.<br>The guideline committee will assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. |
| Obesity Group of the British Dietetic Association | 008 | 015 | **(Table 1)**<br><br>We agree that 1.10.1 should be reviewed. In relation to it, we note that the inadequate and variable provision of Tier 3 and Tier 4 services across England will make equity of access a significant issue unless it is addressed, regardless of what NICE may recommend. We realise this is outside the scope of this work however, in our view joining up of recommendations and service provision is needed. | Thank you for your comment.<br><br>Issues concerning the geographical variation in access to weight management services was acknowledged by the early recruited committee members and is included in the equality impact assessment. While NICE guidelines identify care that is high quality, good value, and provides the best outcomes for people using health and social care services within the budget available, it is not mandatory.<br><br>The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Obesity Group of the British Dietetic Association | 008 | 015 | **(Table 1)**<br><br>We note the intention to retain 1.11 as is. However, we note that many Tier 3 services will not accept patients with BMI <35kg/$m^2$, even with a recent diagnosis of Type 2 diabetes.<br>In addition, in relation to 1.12 we would like to see follow up of weight management included | Thank you for your comment.<br><br>Issues concerning the geographical variation in access to weight management services was acknowledged by the early recruited committee members and is included in the equality impact assessment. While NICE guidelines identify care that is high quality, good value, and provides the best outcomes for people using health and social care services within the budget available, it is not mandatory.<br>During the scoping of this update and the surveillance review of the NICE guideline no new evidence was identified that would change the recommendations, though they will be assessed to ensure that they reflect current context and may be edited.<br><br>The new guideline will also cross-refer to other NICE guidance as needed. |
| Obesity Group of the British Dietetic Association | 009 | 003 | **(Table 2)**<br><br>We agree that recommendation 3 should be updated as needed. We would like behaviour change to include the maintenance of newly adopted healthier behaviours in the longer term to be added for example. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Obesity Group of the British Dietetic Association | 009 | 003 | **(Table 2)**<br><br>We agree that recommendations 4 (tailored plan) & 5 (encouraging adherence) should be updated as needed. In relation to encouraging adherence, modes of service provision should be considered e.g. digital provision may be an option for some. | Thank you for your comment. We welcome your support for this scope and update of the guideline.<br><br>The guideline will cover all settings where publicly funded healthcare services are commissioned and provided. |
| Obesity Group of the British Dietetic Association | 010 | 003 | **(Table 2)**<br><br>We note the intention to retain recommendation 10 (providing ongoing support). However, we would like to see options expanded to include digital delivery. | Thank you for your comment. The guideline will cover all settings where publicly funded healthcare services are commissioned and provided.<br>During the scoping of this update and the surveillance review of the NICE guideline no new evidence was identified that would change the recommendations, though they will be assessed to ensure that they reflect current context and may be edited. |
| Obesity Group of the British Dietetic Association | 010 | 003 | **(Table 2)**<br><br>We note the intention to retain recommendation 15 (monitoring & evaluating programmes). However, we think the addition of the following data is important: data on results by mode of delivery and the impact of any longer term support offered. | Thank you for your comment. The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| Obesity Group of the British | 011 | 003 | **(Table 3)** | Thank you for your comment. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Dietetic Association | | | We do not agree that CG43 will cover BMI assessment, multicomponent interventions and best practice standards, and in our view this should be retained. | Recommendation 2 'BMI assessment, multi-component interventions and best practice standards' in PH46 states that recommendations 1.2.3, 1.2.4 and 1.1.7 in CG43 obesity prevention (2006) should be followed. The first two recommendations have since been superseded by CG189 obesity: identification, assessment and management (2014) and the third has been superseded by PH53 weight management: lifestyle services for overweight or obese adults (2014). Both CG189 and PH53 are to be included within this updated guideline. Table 3 has been amended to clarify this. |
| Obesity Group of the British Dietetic Association | 012 | 001 | **(Table 4)**<br><br>1.1.6.2 refers to existing Food Standards Agency guidance. This needs to be updated; it is unclear what guidance is being referred to here since the FSA currently does not deal with healthy eating/public health issues apart from food safety, hygiene and allergies. | Thank you for your comment. The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| Obesity Group of the British Dietetic Association | 013 | 001 | **(Table 5)**<br><br>We agree with the general principle that existing guidance be retained. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Obesity Group of the British Dietetic Association | 014 | 003 | **(Table 5)**<br><br>Point 2: Ensure services do no harm. Although we recognise the intention to retain this as is, in our view evidence needs to be reviewed in a number of areas. These include psychological therapies (e.g. acceptance & commitment therapy, trauma informed services), the impact of stigma in children and adults and body weight terminology, the use of People First language and impact on outcomes should be reviewed. | Thank you for this information.<br><br>The scope has been amended to include evidence on approaches to address the effect of stigma. |
| Obesity Group of the British Dietetic Association | 016 | 003 | **(Table 8)**<br><br>We agree with the principle. However, we would like an explicit link made to women from ethnic minority groups who may face difficulty at lower BMI. We also note that there is no easily identifiable mechanism to identify women with BMI at and above 30kg/$m^2$ in order to talk about weight with them, unless they attend clinic for counselling. Unless there is a formal programme by which weight in adults is regularly monitored, emphasis should be placed on all healthcare professionals taking opportunistic opportunities to monitor weight. | Thank you for your comment.<br><br>The scope includes a key area that covers identification and assessment. It covers cut-offs for different ethnic groups. Evidence reviews will be conducted for the key issues described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The measures and tools you refer to will be captured by these review questions. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. Differences in the prevalence of overweight and obesity by ethnicity and the risk of resulting ill health is noted in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Obesity Management Association | 021 | 011 | It would be preferable to replace 'plant-based' with 'whole food plant-based'. It is possible to eat a plant-based diet that is still full of unhealthy junk food, so for nutrition and weight loss a plant-based should also be 'whole food'. A whole food plant-based diet is sustainable, and has considerable benefits for improving morbidity and mortality. | Thank you for your comment, the early recruited committee members agreed that a preface was not necessary. |
| Obesity Management Association | 021 | 012 | There is a risk that this draft will legitimise low-carbohydrate diets, when several large cohort studies in North America and Europe report increased mortality with low carbohydrate intake: Mazidi M., Katsiki N., Mikhailidis D.P., Sattar N., Banach M. Lower carbohydrate diets and all-cause and cause-specific mortality: a population-based cohort study and pooling of prospective studies. Eur Heart J. 2019;40:2870–2879. This study reports increased overall mortality, cerebrovascular, cardiovascular and cancer mortality.<br><br>Lagiou P, Sandin S, Weiderpass E, et al. Low carbohydrate-high protein diet and mortality in a cohort of Swedish women. J Intern Med 2007; 261: 366–74.<br><br>Li S, Flint A, Pai JK, Forman JP, Hu FB, Willett WC, Rexrode KM, Mukamal KJ, Rimm EB. Low carbohydrate diet from plant or animal sources and mortality among myocardial infarction survivors. J Am Heart Assoc 2014;3:e001169. | Thank you for your comment and additional information.<br>The scope includes a list of the main outcomes, including adverse events, that the guideline may consider. The guideline committee will define the outcomes that will be considered in the evidence reviews through development of the review protocols.<br><br>Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during development. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Nilsson LM, Winkvist A, Eliasson M, et al. Low-carbohydrate, high-protein score and mortality in a northern Swedish population-based cohort. Eur J Clin Nutr 2012; 66: 694–700.<br><br>Trichopoulou A, Psaltopoulou T, Orfanos P, Hsieh CC, Trichopoulos D. Low-carbohydrate-high-protein diet and long-term survival in a general population cohort. Eur J Clin Nutr 2007; 61: 575–81. Noto H, Goto A, Tsujimoto T, Noda M. Low-carbohydrate diets and all-cause mortality: a systematic review and meta-analysis of observational studies. PLoS One 2013; 8: e55030.<br><br>Some studies have analysed the source of protein and reported that low carbohydrate intake is associated with increased mortality, but only if the carbohydrate is replaced with animal sources of protein and fat. If carbohydrate is replaced with plant-based sources there is a reduced mortality: Fung TT, van Dam RM, Hankinson SE, Stampfer M, Willett WC, Hu FB. Low-carbohydrate diets and all-cause and cause-specific mortality: two cohort studies. Ann Intern Med 2010; 153: 289–98.<br><br>Seidelmann SB, Claggett B, Cheng S, et al. Dietary carbohydrate intake and mortality: a prospective cohort study and meta-analysis. Lancet Public Health. 2018;3(9):e419–e428. doi:10.1016/S2468-2667(18)30135-X<br><br>The risks of very low carbohydrate diets need to be fully elucidated: a comprehensive review of low-carbohydrate diets by the National | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Lipid Association in 2019 examines the risks: Kirkpatrick, C.F.; Bolick, J.P.; Kris-Etherton, P.M.; Sikand, G.; Aspry, K.E.; Soffer, D.E.; Willard, K.E.; Maki, K.C. Review of current evidence and clinical recommendations on the effects of low-carbohydrate and very-low-carbohydrate (including ketogenic) diets for the management of body weight and other cardiometabolic risk factors: A scientific statement from the National Lipid Association Nutrition and Lifestyle Task Force. J. Clin. Lipidol. 2019, S1933–S2874. I quote directly from the review here:<br><br>"*With VLCHF/KDs, gastrointestinal complaints tend to be the most common adverse effects, including constipation, nausea, and abdominal pain, which are experienced in the first few weeks.13 Some individuals may experience symptoms described as the "keto flu" within 2 to 4 days of beginning a VLCHF/KD, which may occur as the body adapts to using ketone bodies for fuel, may last a few days to one week, and include light-headedness, dizziness, fatigue, difficulty exercising, poor sleep, and constipation.1 Other adverse effects that have been reported in individuals strictly following VLCHF/KDs include headache,30, 45 skin rash,45 muscle cramps, weakness, diarrhoea, dehydration, hypoglycaemia,100 increased levels of blood uric acid, and vitamin/mineral deficiencies.30 Increased urination can lead to reduced levels of electrolytes, including sodium, magnesium, and potassium, and may be associated with symptoms of hypovolemia, as well as dizziness* | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | *related to the need to reduce hypertension and/or hyperglycaemia medications*."<br><br>"*Caution in patients with ASCVD, risk of atrial fibrillation, and a history of heart failure, kidney disease, and liver disease Close medical supervision is essential for individuals with ASCVD, risk of atrial fibrillation, or the presence or history of heart failure, kidney disease, or liver disease who choose to follow a very-low-CHO diet or KD. • VLCHF/KDs are contraindicated in patients with a history of hypertriglyceridemia-associated acute pancreatitis, severe hypertriglyceridemia, or inherited causes of severe hypercholesterolemia. • Individuals with T2D should receive medical supervision and cardiometabolic monitoring while on very-low-CHO diets or KDs. • Low-CHO and very-low-CHO diets can lead to hypoglycaemia or hypotension and may require adjustment in diabetes or hypertension medications. Kirkpatrick et al 2019 • Patients taking SGLT2 inhibitors should avoid very-low-CHO KDs because of an in-creased risk of SGLT2 inhibitor–associated ketoacidosis. •<br><br>*More frequent monitoring of vitamin K–dependent anticoagulation therapy may be required with very-low-CHO diets due to the potential change in vitamin K bioavailability and its effect on anticoagulation therapy. • Both low- and high-CHO intake has been associated with a higher risk of mortality in the general population;* | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | *moderate-CHO intake has been associated with the lowest risk of mortality in the general population."*<br><br>Low-carbohydrate diets would not be the first choice for children because the brain needs around 130g of carbohydrate a day, and consumption less than that can have an adverse effect on concentration and mood. | |
| Obesity UK | General | General | Obesity UK would have welcomed have welcomed an undertaking on the need to address weight stigma in health care. We believe that the language used is important in changing the narrative. | Thank you for this information.<br><br>The key issues in the scope have been amended accordingly. |
| Obesity UK | General | General | Obesity UK would have liked to have seen an emphasis on the link between deprivation and services for people living with obesity. | Thank you for your comment.<br><br>**Socio-economic factors are included in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it.** |
| Obesity UK | General | General | Obesity UK would like reassurance that the reduction guideline development groups does not lead to a reduction and dilution of input from People living with Obesity. | Thank you for your comment.<br>Please be reassured that there will be representation on the committee from people living with obesity. The NICE Public Involvement Programme will support these members to understand NICE process and to get their voices heard. The committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | recommendations can be made to practitioners, commissioners of services and others. |
| Obesity UK | General | General | Obesity UK would like to see a reflection of the needs from some least heard comminities. Including but not limited to<br>People living with learning difficulties and obesity.<br>People living with severe and enduring mental illness.<br>People living with autism and obesity and the particular challenges they face accessing weight management services. | Thank you for your comment.<br><br>People living with obesity and autism have been added to the equality impact assessment form, which is linked to in section 2 of the scope. People living with obesity and learning difficulties and/or severe mental health problems are already included in the equality impact assessment form. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it. |
| Obesity UK | General | General | Obesity UK would like weight management services moving away from care based on episodes and towards supporting a life long chronic disease management approach | Thank you for your comment.<br>The guideline will tie in with broader government initiatives to adopt a person-centred approach and to recognise the need for a whole-systems approach to addressing overweight and obesity. The guideline committee will consider your views when deciding how best to present and communicate the final guidance. |
| Obesity UK | 017 | 004 | Obesity UK would have to have seen Eating Disorders included especially BED<br>(Binge Eating Disorder ) and ARFID (Avoidant Restrictive Food Intake Disorder) | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |
| Overeaters Anonymous | General | General | We note that NICE are not considering reviewing the evidence base for recommendations in CG189, PH47, CG43, PH53, PH 42, and PH 27.<br>We believe that there is emerging evidence to regarding the usefulness of 12 step programmes like OA in the treatment/management/ solution to long term eating disorders and addictive eating behaviour. We feel this evidence should form part of the review as much of this work is post 2014. Eg Kelly JF, Humphreys K, Ferri M. Alcoholics Anonymous and other 12-step programs for alcohol use disorder. Cochrane Database of Systematic Reviews 2020, Issue 3. Art. No.: CD012880. DOI: 10.1002/14651858.CD012880.pub2.<br>We also believe that the role of spirituality in the management and solution to health concerns is another field of emerging evidence and this is particularly relevant to the BAME community where much of this research has been carried out. EG<br>Koenig, H. G. (2000). Religion, Spirituality, and Medicine: Application to Clinical Practice. JAMA, 284(13), 1708–1708. https://doi.org/10.1001/jama.284.13.1708-JMS1004-5-1 | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | We also contend that their is significant evidence of the role of Peer to Peer support in address and maintaining health issue as evidenced by the National Voices Peer Support Hub<br><br>We would suggest strongly to NICE the need to review the evidence in these areas which will affirm and underlie the importance of 12 step fellowships such OA in the solution of Overweight, obesity, and food additions where weight is a symptom. That consequent to this evidence review that NICE considers amending and augment the recommendations in the above guidance and related quality standards. | |
| Overeaters Anonymous | 011 - 013 | 003 - 004 | **Table 6**<br>Lines 29 and 30 read: 'Ensure staff are aware of evidence on the effect of dietary habits and physical activity on weight gain, loss and maintenance'. Consider including alongside this awareness of evidence for the effects of emotional, behavioural, spiritual and cultural factors including the presence of an eating disorder and/or dependence syndrome upon weight gain, loss and maintenance. Staff should also be aware of the growing evidence-base around the role of relational factors upon weight gain, loss and maintenance, | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed.<br>During the scoping of this update and the surveillance review of the NICE guideline PH53 Weight management: lifestyle services for overweight and obese adults, no new evidence was |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | specifically that benefit of peer-support and 12-step fellowships for weight gain, loss and maintenance.<br><br>PAGE 22<br>Lines 1-4 read: 'Ensure staff are aware of the practical skills and behaviours that can help someone lose or maintain their weight. This includes, for example, shopping and cooking skills, understanding food labels and knowing what constitutes an appropriate portion of food. It also includes being able to identify opportunities to be less sedentary and more physically active'. Note that OA has an approved list of 'tools for recovery', which provide various examples of useful methods of support that are over and above those listed. Consider making reference to this here.<br><br>Lines 5 to 7 read: 'Train staff to identify when a participant should be referred to their GP for potential onward referral to other services (for example, specialist weight management or other specialist services, such as alcohol counselling)'. Consider including OA in this CPD/training as standard either through co-production, as co-facilitators. Consider including the OA Fifteen Questions as a means of identifying referral to the GP may be required for potential onward referral to other services or for signposting to OA directly.<br><br>Lines 11 and 12 read: 'Train staff to identify any gaps in their own knowledge, confidence or skills and ensure they know how to get these gaps addressed through further training'. Consider including OA in this CPD/training as standard either through co-production, as co-facilitators. | identified that would impact on the current recommendations. These will be retained during this update and assessed to ensure they reflect current context and may be edited or removed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | PAGE 37<br>OA should be included as an intervention arm for RCTs into any of the proposed research on lifestyle weight management programmes. | |
| Overeaters Anonymous | 013 - 015 | 003 - 004 | **Table 6**<br>Additionally while the existing guidance does encourage working with local services, we feel that specifically referencing the potential benefit of community and peer support groups (as evidenced above) would also be useful<br><br>Lines 13, 14 and 15 state: 'Clinical judgement will be needed to determine whether they are suitable for people with conditions that increase the risk of, or are associated with, obesity or who have complex needs'. Consider adjusting to reflect individual's awareness and agency in understanding and determining what may be 'right' for them (in line with the NICE Guidelines being for adults who are overweight or obese, their families and other members of the public, as well as commissioners, health professionals and service providers).<br>Lines 13, 14 and 15 state: 'Clinical judgement will be needed to determine whether they are suitable for people with conditions that increase the risk of, or are associated with, **obesity** or who have complex needs'. Consider adjusting to ensure that that there is reference to eating disorders alongside/within obesity.<br>Line 18 reads: 'The guideline may also be of interest to overweight and **obese** adults, their families and other members of the public'. | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed..<br>During the scoping of this update and the surveillance review of the NICE guideline PH53 Weight management: lifestyle services for overweight and obese adults, no new evidence was identified that would impact on the current recommendations. These will be retained during this update and assessed to ensure they reflect current context and may be edited or removed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Consider adjusting to ensure that that there is reference to eating disorders alongside/within obesity.<br><br>PAGE 9<br>Line 3 reads: 'Systems should be in place to allow people to be referred to, or receive support from (or across) the different service tiers of an obesity pathway, as necessary.<br>Line 5 reads: 'This includes referrals to and from lifestyle weight management programmes'. Consider adjusting this statement so that it reflects that not all programmes require access via a means as formal as referral'.<br>Lines 7, 8 and 9 read: 'Identify local services, facilities or groups that could be included in the local obesity pathway, meet the needs of different groups and address the wider determinants of health. Examples include community walking groups or gardening schemes'. Consider including OA as an example here.<br><br>PAGE 10<br>Lines 1 and 2 state: 'Be aware of the effort needed to lose weight, prevent weight regain or avoid any further weight gain'. Consider adding that, there is acknowledgement that, for some individuals, this is associated with a complex interplay of medical, emotional, physical, behavioural, spiritual and cultural factors including the presence of an eating disorder and/or dependence syndromes. | |
| Overeaters Anonymous | 013 - 015 | 003 - 004 | **Table 6**<br>Lines 23 and 24 read: 'The range of lifestyle weight management programmes that could be commissioned locally (see | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | recommendation 12)'. Consider including OA in this list of programmes.<br>Lines 25 and 26 read: 'Continuing professional development or training opportunities on weight management (see recommendation 14).' Consider including OA in this CPD/training as standard.<br><br>PAGE 11<br>Line 7 reads: 'The range of local lifestyle weight management services available'. Consider including OA as a standard source of support alongside these services'<br>Line 10 reads: 'Continuing professional development or training opportunities on weight management'. Consider including OA in this CPD/training as standard.<br>Line 13 reads: 'Ensure sources of information and advice about local lifestyle weight management services are included in any communications about being overweight or obese'. Consider including OA in this list of lifestyle weight management services as standard.<br>Line 21 reads: 'The range of lifestyle weight management services available locally'. Consider including OA in this list of lifestyle weight management services as standard.<br><br>PAGE 12<br>Lines 3, 4 and 5 read: 'Raise the issue of weight loss in a respectful and non-judgemental way. Recognise that this may have been raised on numerous occasions and respect someone's choice not to discuss it further on this occasion'. Consider adding that GPs and other health and social care professionals who give advice about or | opportunity to cross-refer to related NICE guidelines as needed.<br>During the scoping of this update and the surveillance review of the NICE guideline PH53 Weight management: lifestyle services for overweight and obese adults, no new evidence was identified that would impact on the current recommendations. These will be retained during this update and assessed to ensure they reflect current context and may be edited or removed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | refer people to lifestyle weight management programmes should acknowledge that for some individuals, weight may be associated with a complex interplay of medical, emotional, physical, behavioural, spiritual and cultural factors including the presence of an eating disorder and/or dependence syndrome.<br>Lines 21 and 22 read: 'Refer people to a group rather than an individual programme if they express no preference because, on average, group programmes tend to be more cost effective.'<br>Consider adding here e.g. OA, which has a nationwide network of groups for this population.<br>Lines 25, 26 and 27 read: 'Provide them with sources of information about how to make gradual, long-term changes to their dietary habits and physical activity levels (for example, NHS Choices)'.<br>Consider adjusting to read: … to their dietary habits, physical activity levels and more aware of their emotional and spiritual needs'. | |
| Overeaters Anonymous | 013 - 015 | 003 - 004 | **Table 6 PAGE 13**<br>Lines 7 and 8 read: 'Discuss the importance and wider benefits of adults who are overweight or obese making gradual, long-term changes to their dietary habits and physical activity levels'. Consider adjusting to read: … to their dietary habits, physical activity levels and becoming more aware of their emotional and spiritual needs'<br>Lines 7 and 8 read: 'Discuss the importance and wider benefits of adults who are overweight or obese making gradual, long-term | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. During the scoping of this update and the surveillance review of the NICE guideline PH53 Weight management: lifestyle services for |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | changes to their dietary habits and physical activity levels'. Consider adjusting to read: … to their dietary habits, physical activity levels and becoming more aware of their emotional and spiritual needs'.<br>Lines 7 and 8 read: 'Discuss the importance and wider benefits of adults who are overweight or obese making gradual, long-term changes to their dietary habits and physical activity levels'. Consider adjusting to read: … to their dietary habits, physical activity levels and becoming more aware of their emotional and spiritual needs'.<br>PAGE 14<br>Line 1 reads: 'Discuss other local services that may provide additional support (for example, local walking or gardening groups).' Consider adding OA with these examples.<br>Line 1 reads: 'Discuss other local services that may provide additional support (for example, local walking or gardening groups).' Consider adding OA with these examples.<br>Lines 9 and 10 read: 'Other local services that may provide additional support (for example, local walking or gardening groups)'. Consider adding OA with these examples.<br>Line 11 reads: 'Discuss any financial costs (including any costs once a funded referral period has ended)'. Note OA is self-supporting through its own contributions.<br>Lines 12, 13 and 14 read: 'Explore with participants any issues that may affect their likelihood of benefiting from the programme. Discussions should take place at the outset and at other times, if someone is having difficulty attending or participating in the programme'. Consider making reference to using meeting contacts for OA groups as a means of continuing such conversations.<br>PAGE 15 | overweight and obese adults, no new evidence was identified that would impact on the current recommendations. These will be retained during this update and assessed to ensure they reflect current context and may be edited or removed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Lines 1 to 4 read: 'If it has not been possible to resolve someone's difficulties with the programme (for example, their attendance or participation), agree what should happen next. For example, they could be referred to another service, leave the programme at an agreed time, or think about being re-referred at a future date'. Consider such difficulties as another opportunity to introduce individuals to the possibility that to their dietary habits and/or physical activity levels might also reflect their emotional and spiritual needs' and to the OA Programme. | |
| Overeaters Anonymous | 013 - 015 | 003 - 004 | **Table 6**<br>Lines 7 and 8 read: 'Are multi-component that is, they address dietary intake, physical activity levels and behaviour change'. Consider adjusting this to include: emotional and spiritual needs.<br>Lines 9 and 10 read: 'Commissioners of lifestyle weight management services should commission or recommend lifestyle weight management programmes that: Are developed by a multidisciplinary team. This includes input from a registered dietitian, registered practitioner psychologist and a qualified physical activity instructor'. Consider the benefits of including programmes that are co-produced, co-facilitated with people who have recovered from compulsive overeating/food behaviours i.e. members of OA.<br>Lines 11 and 12 read: 'Ensure staff are trained to deliver them and they receive regular professional development sessions'. Consider including CPD from OA as standard.<br>Lines 14 and 15 read: 'Last at least 3 months, and that sessions are offered at least weekly or fortnightly and include a 'weigh-in' at each session'. Consider adding: For some individuals, the 'weigh-in' may represent a barrier to joining or persisting with a programme. For | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. During the scoping of this update and the surveillance review of the NICE guideline PH53 Weight management: lifestyle services for overweight and obese adults, no new evidence was identified that would impact on the current recommendations. These will be retained during this update and assessed to ensure they reflect current context and may be edited or removed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | these individuals note that emotional and spiritual needs may be a greater priority at that time. OA offers weekly peer-support weekly sessions which do not include a 'weigh-in' and may provide a more acceptable alternative.<br><br>PAGE 16<br>Line 7 reads: '…affect weight; and feedback on performance'. Note that OA has an approved list of 'tools for recovery', which provide various examples of useful methods of support that are over and above those listed. Consider making reference to this here.<br>Line 14 reads: 'Adopt a respectful, no-judgemental approach'. Consider making reference to using meeting contacts for OA groups as a means of continuing such conversations.<br><br>PAGE 17<br>Lines 3 to 6 read: 'Fostering independence and self-management (including self-monitoring). Discussing opportunities for ongoing support once the programme or referral period has ended. Sources of ongoing support may include the programme itself, online resources or support groups, other local services or activities, and family or friends. Note that fostering independence and self-management may not suit the needs of all individuals with weight management problems, particularly those for whom food represents dependence syndrome (ICD-10). For these (and other) individuals, a peer-support programme such as OA may be an alternative approach/recommendation. | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Overeaters Anonymous | 013 - 015 | 003 - 004 | **Table 6** PAGE 18<br>Lines 7 to 11 read: Providers of lifestyle weight management programmes (public, private or voluntary organisations) should demonstrate that their programmes: Are effective at 12 months or beyond. (The following programmes currently available in the UK have been shown to be effective at 12 to 18 months: [in alphabetical order] Rosemary Conley, Slimming World and Weight Watchers.) Could we add at this point we would encourage health care providers at levels to consider engaging with 12 step organisations to develop collaborative practices and research.<br><br>PAGE 19<br>Lines 12 to 14 read: 'Consider commissioning additional services to prevent weight regain. For example, consider providing support to establish or expand local support groups or networks that may encourage self-management'. Consider raising CCGs, health and wellbeing boards and local authorities awareness of OA's abilities in this respect.<br><br>PAGE 20<br>Lines 23 to 25 read: 'Ensure professional development training on weight management is available for health and social care professionals'. Consider including OA in this CPD/training as standard either through co-production, as co-facilitators and/or via signposting for further support.<br><br>PAGE 21 | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. During the scoping of this update and the surveillance review of the NICE guideline PH53 Weight management: lifestyle services for overweight and obese adults, no new evidence was identified that would impact on the current recommendations. These will be retained during this update and assessed to ensure they reflect current context and may be edited or removed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Lines 1 to 4 read: 'Develop training for lifestyle weight management programme staff with qualified professionals such as registered practitioner psychologists, registered dietitians and qualified physical activity specialists. Ensure this training addresses staff attitudes to, and any concerns about, their own weight'. Consider including OA in this CPD/training as standard either through co-production, as co-facilitators and/or via signposting for further support.<br><br>Lines 12 and 13 read: 'Train staff to deliver multicomponent programmes that cover weight management, dietary habits, safe physical activity and behaviour-change strategies'. Consider including OA in this CPD/training as standard either through co-production, as co-facilitators and/or via signposting for further support. Consider adjusting this to include: emotional and spiritual needs.<br><br>27 and 28 read: 'Ensure staff are aware of the common medical and psychological problems associated with being overweight or obese'. Consider adjusting to include awareness of the complex interplay of various medical, psychological, emotional, physical, behavioural, spiritual and cultural factors including the presence of an eating disorder and/or dependence syndrome. | |
| Overeaters Anonymous | 016 - 017 | 002 - 003 | **Table 8**<br>The draft scope proposes to retain recommendations from existing guidelines. We feel that this should be reviewed as the current | Thank you for this information.<br>Tables under the proposed outline for the guideline section contains areas of the guideline that will be |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | guidelines do not encourage a holistic approaches that encompass broader healthy food behaviours and emotional wellbeing. We also believe that the functioning of OA means tat it is of no cost to the NHS, but provides long term solutions for may individuals with compulsive food behaviours and addictive food behaviours.<br>In particular with respect to PH 27 we raise the following points:<br>Page 11 Line 10<br>As part of advice to reduce weight prior to planned pregnancy if more than BMI 30, could consider referral to/provide information about Overeaters Anonymous (OA), particularly if an individual has had repeated failed attempts with conventional diet programs. While not advocating specific food plans, the individual is encouraged to get abstinent from compulsive eating and compulsive food behaviours while working towards a healthy body weight. The individual is encouraged to follow a 12 step program, similar to that of Alcoholics Anonymous to address reasons for overeating, ands provide mental and spiritual recovery.<br>Attendance at OA meetings does not preclude other measures mentioned, in fact should compliment such interventions.<br>Page 14<br>Recommendation 3 - post partum, line 15<br>Information about OA could be provided as a community based service that is free, and provides peer group support and help in addressing unhealthy or addictive eating behaviours.<br>Page 16<br>Recommendation 4 - post partum women with BMI>30. Line 3, line 6 | updated. Recommendations contained in those areas will either be updated based on evidence reviews or retained.<br>Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. During the scoping of this update and the surveillance review of the NICE guideline PH53 Weight management: lifestyle services for overweight and obese adults, no new evidence was identified that would impact on the current recommendations. These will be retained during this update and assessed to ensure they reflect current context and may be edited or removed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | As above. Information about OA could be provided for women who wish to change their behaviour, particularly if describing an addictive or dysfunctional relationship with food and/or body image.<br>12 step programs are widely recognised as being successful in helping individuals abstain from addictive behaviours, and providing emotional support and physical and spiritual recovery. | |
| Overeaters Anonymous | 016 - 017 | 002 - 003 | **Table 8**<br>Recommendation 5 - community based services, line 14 in this section<br>OA meetings are affordable - OA meetings are self supporting with individuals contributing what they can afford. As an organisation, OA refuses outside contributions. There are no dues or fees to pay.<br>OA meetings are widely available, particularly since the pandemic, where a large amount of online activity worldwide means an individual can access meetings from their own home at times of day or night to suit them.<br><br>Recommendation 6 - professional skills. Lines 14 and 17<br>Professionals should be aware of OA as a resource and local service and have some awareness about those that might most benefit, namely patients with compulsive, addictive components to their eating, patients who have repeatedly failed with conventional methods regardless of their current weight.<br><br>Generally<br>Consider eating disorders as preexisting eating disorders can be exacerbated by hormonal imbalances and additional psychological stress experienced during pregnancy and after birth | Thank you for this information.<br>Tables under the proposed outline for the guideline section contains areas of the guideline that will be updated. Recommendations contained in those areas will either be updated based on evidence reviews or retained.<br>Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. During the scoping of this update and the surveillance review of the NICE guideline PH53 Weight management: lifestyle services for overweight and obese adults, no new evidence was identified that would impact on the current recommendations. These will be retained during this update and assessed to ensure they reflect current context and may be edited or removed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Overeaters Anonymous | 003 | 019 - 023 | We believe that being overweight can be a symptom of many underlying causes, physical, emotional, and spiritual. That the weight is a symptom and weight loss in as of itself does not remedy then issues that are present for the individual. We use a 12 step model based on the many of the same principles of other Twelve Step Fellowships, like Narcotics Anonymous, Alcoholics Anonymous. We believe in a three fold recovery from being overweight ( Compulsive eater) as being physical emotional and spiritual. The growing evidence of the spiritual dimension to health is cited in the attached literature review. The growing evidence of the effectiveness of 12 step fellowships for adults who have problems with eating ( Including those being long term obese, or morbidly obese). Our members will be individuals who have successively failed in dealing with their eating issues in other pogrammes. Including commercial die† programs, medically overseen eating programmes, bariatric and similar surgery. | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |
| Overeaters Anonymous | 004 | 023 - 027 | Having reviewed the equalities impact assessment we do not think it reflects the complexities and interdependencies of the protected traits. There is no consideration of the use of co-produced, person centred solutions for individuals which respects the individuals narrative and truth about their current situation, however couples they be. | Thank you for your comment.<br><br>The equality impact assessment form is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it. The guideline will tie in with broader government initiatives to adopt a person-centred approach and to recognise the need for a whole-systems approach to addressing overweight and obesity. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Overeaters Anonymous | 005 | 014 - 018 | Individual groups of Overeaters Anonymous can never be publicly funded as that would be against the ethos of the organisation. Yet we provide in a peer to peer holistic environment support and solutions for individuals who have issues with eating and being overweight or underweight. The validity and importance of 12 step fellowships were specifically recognised within the emergency legislation around COVID as being exempt from some of the social distancing measures. We were able to meet physically if we wanted during the various lockdowns across all four nations. | Thank you for your comment and this information. |
| Overeaters Anonymous | 005 | 024 | We believe that someone's weight is but a symptom of a possible addictive relationship that person can have with food. These addictive relationships with eating and food can be the result of trauma or other threat or similar for the individual. That the weight a person carries is but a symptom of a life out of balance. We believe that the health services should consider an assessment of the individual circumstances not just what a person weighs. | Thank you for your comment. |
| Overeaters Anonymous | 005 | 025 | We believe that OA is a good solution for individuals who have repeatedly failed at more mainstream ways to deal with they eating habits and excess weight. This is because we offer a three pronged programme of recovery which deals with the individual in their entirety, Their physical, emotional and spiritual health. | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |
| Overeaters Anonymous | 006 | 014 - 015 | **Table 1.3 - Adults**<br>Consider ruling out eating disorder or disordered eating such as binge eating disorder and bulimia. Consider using the Yale food | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | addiction scale and refer to mental health services as appropriate and give advice on support groups for Overeaters Anonymous for continued peer support | weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. **The tables in the proposed outline for the guideline section lists whether evidence reviews will be updated, or recommendations will be retained for the guideline areas.** |
| Overeaters Anonymous | 006 | 014 - 015 | **Table 1.4.4** Advise Overeaters Anonymous may be a basis for free on-going continued community peer support | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. **The tables in the proposed outline for the guideline section lists whether evidence reviews will be updated, or recommendations will be retained for the guideline areas.** |
| Overeaters Anonymous | 006 | 014 - 015 | **Table 1.4.3** Continue onward referral to Social Prescribers to help with meeting the goals discussed and community options available | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. **The tables in the proposed outline for the guideline section lists whether evidence reviews will be updated, or recommendations will be retained for the guideline areas.** |
| Overeaters Anonymous | 006 | 014 - 015 | **Table 1.5.2** Consider making participants aware of Overeaters Anonymous as additional support adjunct to therapies given by health care professionals | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. The tables in the proposed outline for the guideline section lists whether evidence reviews will be updated, or recommendations will be retained for the guideline areas. |
| Overeaters Anonymous | 006 | 014 - 015 | **Table 1.10.1** Including ruling out eating disorder such as binge eating disorder or bulimia, consider a trial of Overeaters Anonymous | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. **The tables in the proposed outline for the guideline section lists whether evidence reviews will be updated, or recommendations will be retained for the guideline areas.** |
| Overeaters Anonymous | 006 | 014 - 015 | **Table 1.10.10** Overeaters Anonymous can support the patients psychologically pre and post operatively and have special focus groups especially dedicated to those who have had or are going to have bariatric surgery | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. **The tables in the proposed outline for the guideline section lists whether evidence reviews will be updated, or recommendations will be retained for the guideline areas.** |
| Overeaters Anonymous | 006 | 014 - 015 | **Table 1.12.1** Overeaters Anonymous can support the patients psychologically pre and post operatively and have special focus groups especially dedicated to those who have had or are going to have bariatric surgery | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. **The tables in the proposed outline for the guideline section lists whether evidence reviews** |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | **will be updated, or recommendations will be retained for the guideline areas.** |
| Overeaters Anonymous | 006 | 014 - 015 | **Table 2.5 in original report CG189**<br>Fellows of Overeaters Anonymous report that they have found it easier to stick to a prescribed diet given to them from HCP or commercial weight loss groups with the additional psychological and peer group support provided in OA | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. **The tables in the proposed outline for the guideline section lists whether evidence reviews will be updated, or recommendations will be retained for the guideline areas.** |
| Overeaters Anonymous | 011 | 002 - 003 | **Table 3**<br>In the PH46 Guidance; Page 7<br>Line 4 and 5 read: '…as a trigger for lifestyle interventions to prevent conditions such as diabetes, myocardial infarction or stroke'. Consider adjusting to ensure that that there is also reference to obesity as a condition here, and eating disorders alongside/within obesity. | Thank you for your comment. The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| Overeaters Anonymous | 011 | 002 – 003 | **Table 3**<br>In the PH 46 Guidance: Page 8<br>Line 5 does not have a bullet point, and, as such, may be regarded as an afterthought by NICE. Consider revising to be included as a sixth bullet point, to read: 'People from black, Asian and other | Thank you for your comment. The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | minority ethnic groups living in England and other members of the public'. | policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| Overeaters Anonymous | 011 | 002 – 003 | **Table 3**<br>In the PH46 Guidance Page 11,Box Bullet Point 2<br>Bullet point 2 reads: 'Identifying people at risk of developing type 2 diabetes using a staged (or stepped) approach'. Consider providing this population with information on and signposting to OA **at all stages** of a stepped approach. | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |
| Overeaters Anonymous | 011 | 002 – 003 | **Table 3**<br>In the PH46 Guidance Page 12 Box 1 Bullet Point 2<br>Lines 3 and 4 read: 'Raise awareness of the need for lifestyle interventions at a lower BMI threshold for these groups to prevent type 2 diabetes. Please see feedback from OA on Weight management: lifestyle services for overweight or obese adults NICE PH53 for considerations about raising awareness of the need for lifestyle interventions for all communities. | Thank you for this information. |
| Overeaters Anonymous | 011 | 002 – 003 | **Table 3**<br>In the PH46 Guidance Page 12 Box 1 All<br>Bullet point 1 reads: 'Clinicians should assess co-morbidities, diet, physical activity and motivation along with referral to specialist care if required'. Consider extending this to add 'the complex interplay of medical, emotional, physical, behavioural, spiritual and cultural factors including the presence of an eating disorder and/or dependence syndrome (ICD-10), specifically the use of food as a | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | substance for misuse and eating disorders'. One simple way of establishing the role of some of the above in relation to overeating is to include the OA Fifteen Questions as part of the assessment. This would then facilitate further exploration of the above, provide a guide for whether referral to the GP may be required for potential onward referral to other services or for signposting to OA directly. | NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |
| Overeaters Anonymous | 011 | 002 – 003 | **Table 3**<br>In the PH46 Guidance Page 12 Box 1<br>Bullet point 2 reads: 'Weight management programmes should include behaviour-change strategies to increase people's physical activity levels or decrease inactivity, improve eating behaviour and the quality of the person's diet and reduce energy intake'. Consider adjusting this to also include: explore and support people's emotional and spiritual needs. OA is a programme that focuses on these two key issues and should therefore be included as an alternative alongside traditionally recommended weight management programmes. Please see feedback from OA on Weight management: lifestyle services for overweight or obese adults NICE PH53 for further, associated comments. | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. During the scoping of this update and the surveillance review of the NICE guideline no new evidence was identified that would change the recommendations, though they will be assessed to ensure that they reflect current context and may be edited. |
| Overeaters Anonymous | 011 | 002 – 003 | **Table 3**<br>In the PH 46 Guidance Page 13 Box 1<br>Consider using OA through co-production and/or as co-facilitators to support the implementation of awareness raising, in line with the various recommendations listed. | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |
| Overeaters Anonymous | 011 | 002 – 003 | **Table 3**<br>In the PH46 Guidance Page 19 Para 3.2 Line 5<br>Line 5 reads: 'However, they may not respond in the same way to behaviour-change interventions as white populations'. This needs to be qualified with a statement, which refers to the many reason(s) that this may be the case, including need to ensure 'behaviour-change' interventions for people from black, Asian and other minority ethnic groups ensure language and cultural differences are appropriately supported, if/where required. | Thank you for your comment. The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| Overeaters Anonymous | 011 | 002 – 003 | **Table 3**<br>In the PH46 Guidance Page 19 Para 3.4<br>Line 1 reads: 'PHIAC noted that there are 125ecognized differences in terms of health outcomes within ethnic groups'. This needs to be qualified with a statement, which refers to the many reason(s) that this may be the case, including need to ensure 'behaviour-change' interventions for people from black, Asian and other minority ethnic groups ensure language and cultural differences are appropriately supported, if/where required. | Thank you for your comment. The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| Overeaters Anonymous | 011 | 002 – 003 | **Table 3**<br>In the PH46 Guidance Page 20 Para 3.6<br>Lines 16 to 19 read: 'It also advised that healthcare professionals should '…use clinical judgement when considering risk factors in these groups, even in people not classified as overweight or obese using the classification in recommendation'. Consider adjusting to | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | reflect individual's awareness and agency in understanding and determining what may be 'right' for them. Consider adjusting to ensure that that there is reference to eating disorders alongside/within obesity. | NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |
| Overeaters Anonymous | 011 | 002 – 003 | **Table 3**<br>In the PH46 Guidance P24<br>The following could be added to the 'recommendations for research' section: OA should be included as an intervention arm for RCTs into any of the proposed research on lifestyle weight management programmes, specifically establishing how effective the intervention is for members of the BAME community compared to monitoring BMI/waist measurements. | Thank you for this information.<br>Research recommendations are developed during guideline development. They include areas the committee identified as needing guidance but currently lacks evidence that would inform recommendations.<br>Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |
| Overeaters Anonymous | 011 | 014 - 015 | **Table 1**<br>In the PH46 Guidance Page 6<br>Lines 2 to 4 read: 'The aim was to determine whether lower cut-off points should be used for these groups as a trigger for lifestyle interventions to prevent conditions such as diabetes, myocardial infarction or stroke'. Consider adjusting to ensure that that there is also reference to obesity as a condition here, and eating disorders alongside/within obesity. | Thank you for your comment. The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed.<br>Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |
| Overeaters Anonymous | 012 | 001 | **Table 4 1.1.2**<br>Consider including religious and faith-based settings mosques, temples, churches, etc | Thank you for your comment. Recommendation 1.1.2 in CG43 Obesity prevention notes: 'Primary care staff should engage with target communities, consult on how and where to deliver interventions and form key partnerships and ensure that interventions are person centred.'<br>This recommendation is to be retained.<br><br>In addition, PH42 obesity: working with local communities (2012), recommendation 4, 'Coordinating local action', highlights the need to engage with religious groups to support a community-wide approach to combating obesity. In addition, PH42 includes in its 'guiding principle' the need for cultural appropriateness which takes account of religious beliefs. |
| Overeaters Anonymous | 012 | 001 | **Table 4 1.1.2.5**<br>Raise awareness of eating disorders within obesity | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |
| Overeaters Anonymous | 012 | 001 | **Table 1.1.3.3**<br>Raise awareness of eating disorders within obesity | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |
| Overeaters Anonymous | 012 | 001 | **Table 1.1.6.1**<br>Raise awareness of eating disorders within obesity | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |
| Overeaters Anonymous | 012 | 001 | **Table 1.1.6.2**<br>Raise awareness of eating disorders within obesity | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |
| Overeaters Anonymous | 012 | 001 | **Table 4**<br>The draft scope proposes to retain recommendations from existing guidelines. We feel this should be reviewed as the current guidelines do not encourage healthcare professionals to assess or review service users for potentially disordered/unhealthy food behaviours that could lead to obesity and weight gain. While poor | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | diet and low levels of physical activity can cause obesity, OA is aware that certain food behaviours such as eating quickly, eating until feeling uncomfortably full, or having feelings of shame/embarrassment around food can also lead to similar weight based issues. There are numerous accredited assessment tools for disordered food behaviours (such as the Yale food addiction scale) as well as other non-accredited tools (such as the OA fifteen questions). We would encourage this NICE consultation to conduct a review on the evidence available on intervening when disordered food behaviours are identified early on. | NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |
| Overeaters Anonymous | 012 | 001 | **Table 4**<br>The draft scope proposes to retain recommendations from existing guidelines. We feel this should be reviewed as the current guidelines do not encourage sports and leisure providers to intervene when they are aware of customers engaging in unsustainable or potentially damaging exercise behaviours. There is a significant body of evidence that NICE refers to in this guidance and others which shows that physical activity must be sustainable in order to encourage long-term weight management. Should sports and leisure providers be working with healthcare teams and accepting referrals from service users on weight based management programmes, we believe they should be supported and trained to encourage their customers to adopt sustainable exercise programmes, and therefore to support those engaging in potentially risky or damaging exercise behaviours to seek specialist support where needed. We would encourage this NICE consultation to apply the existing know evidence available on intervening when | Thank you for this information.. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines on physical activity as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | disordered exercise behaviours are identified in order to encourage sustainable physical activity. | |
| Overeaters Anonymous | 013 | 001 | **Table 5.1**<br>The draft scope proposes to retain recommendations from existing guidelines. We feel this should be reviewed as the current guidelines do not encourage service users to use community groups and other peer-based support resources, including OA, in order to continue to maintain their emotional and physical wellbeing. There is a growing body of evidence which shows that support from within communities can have significant health outcomes in relation to both intervention and self-management of various health conditions and concerns. Some examples of this evidence are as follows:<br>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5344138/<br>https://www.dovepress.com/benefits-of-peer-support-groups-in-the-treatment-of-addiction-peer-reviewed-fulltext-article-SAR<br>https://www.annfammed.org/content/13/Suppl_1/S2.long<br>We would encourage this NICE consultation to conduct a review on the evidence available on peer support being used to effectively self-manage an individual's health and wellbeing. | Thank you for this information.<br><br>During the scoping of this update and the surveillance review of the NICE guideline PH53 Weight management: lifestyle services for overweight or obese adults (2014) no new evidence was identified that would impact on the current recommendation 10 'Commission programmes that include the core components to prevent weight regain'. This recommendation states that opportunities for ongoing support once the programme or referral period has ended should be discussed. It states that sources of ongoing support may include the programme itself, online resources or support groups, other local services or activities, and family or friends. The original recommendation remains valid and will appear in the updated guideline.<br><br>The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | |
| Overeaters Anonymous | 013 | 001 | **Table 5.3**<br>The draft scope proposes to retain recommendations from existing guidelines. We feel this should be reviewed as the current guidelines do not encourage healthcare professionals to assess or review service users for potentially disordered or damaging attitudes or food behaviours. While the existing recommendations on dietary habits may be very helpful for some who are maintaining weight loss or preventing weight gain, OA is aware that some of these food behaviours can also encourage existing disordered eating behaviours or unsustainable activity. We would encourage healthcare professionals to offer suggestions on diet having assessed that the service user is not at risk or vulnerable to these suggestions. Accredited assessment tools for disordered food behaviours (such as the Yale food addiction scale) as well as other non-accredited tools (such as the OA fifteen questions) may be of use in situations like this. | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |
| Overeaters Anonymous | 013 | 001 | **Table 5.6**<br>The draft scope proposes to retain recommendations from existing guidelines. We feel this should be reviewed as the current guidelines do not encourage a holistic approach to self-monitoring that encompasses broader healthy food behaviours and emotional wellbeing. While monitoring weight, physical activity level and food/drink intake can be helpful, OA is aware that addressing other food behaviours and emotions connected to those activities is needed to ensure a sustainable way forward. We would encourage this NICE consultation to broaden what people should be encouraged to monitor to consider a service users' wellbeing and | Thank you for your comment. A holistic approach to self-monitoring is covered in recommendations 1.3.4, 1.3.6 and 1.3.9 in CG189. These recommendations are to be retained. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | therefore encourage healthcare professionals to intervene should it become clear that someone in their care is developing damaging attitudes to food and/or their body. | |
| Overeaters Anonymous | 013 | 001 | **Table 6**<br>The draft scope proposes to retain recommendations from existing guidelines. We feel that this should be reviewed as the current guidelines do not encourage a holistic approaches that encompass broader healthy food behaviours and emotional wellbeing.<br>In Particular we raise the following considerations for the review;<br><br>In the PH53 guidance P 7<br><br>Lines 1 and 2 state: 'This guideline covers multi-component lifestyle weight management services including programmes, courses, clubs or groups provided by the public, private and voluntary sector. Consider including '12-step fellowships such as OA'.<br>Lines 2, 3 and 4 state: 'The aim is to help people lose weight and become more physically active to reduce the risk of diseases associated with obesity'. Consider adjusting to read: 'The aim is to help people lose weight, become more physically active and more aware of their emotional and spiritual needs'.<br>Lines 3 and 4 read: 'The aim is to help people lose weight and become more physically active to reduce the risk of diseases associated with **obesity**'. Consider adjusting to ensure that that there is reference to eating disorders alongside/within obesity.<br>Lines 4 and 5 read '. This includes coronary heart disease, stroke, type 2 diabetes and various cancers'. Consider adding here | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. During the scoping of this update and the surveillance review of the NICE guideline no new evidence was identified that would change these recommendations, though they will be assessed to ensure that they reflect current context and may be edited. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | dependence syndrome (ICD-10), specifically the use of food as a substance for misuse and eating disorders.<br>In the PH53 guidance P 8<br><br>Lines 2 and 3 state: 'It covers weight management programmes, courses, clubs or groups that aim to change someone's behaviour to reduce their energy intake and encourage them to be physically active'. Consider including the phrase 'fellowships'.<br>Lines 5, 6 and 7 state: 'These include helping reduce the risk of the main diseases associated with **obesity**, for example: coronary heart disease, stroke, hypertension, osteoarthritis, type 2 diabetes and various cancers (endometrial, breast, kidney and colon)'. Consider adjusting to ensure that that there is reference to eating disorders alongside/within obesity.<br>Lines 8 and 9 read: 'The focus is on lifestyle weight management programmes that: accept self-referrals or referrals from health or social care practitioners'. Consider adjusting this statement so that it reflects that not all programmes require access via a means as formal as referral'<br><br>Lines 12 and 13 read: 'Usually known as 'tier 2' services (see Tiers of weight management services), these programmes are just one part of a comprehensive approach to preventing and treating<br><br>**obesity**'. Consider adjusting to ensure that that there is reference to eating disorders alongside/within obesity. | |
| Overeaters Anonymous | 015 | 002 - 003 | **Table 7** | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | The draft scope proposes to retain recommendations from existing guidelines. We feel that this should be reviewed as the current guidelines do not encourage a holistic approaches that encompass broader healthy food behaviours and emotional wellbeing. We also believe that the functioning of OA means tat it is of no cost to the NHS, but provides long term solutions for may individuals with compulsive food behaviours and addictive food behaviours. With respect to PH42 we would like the review to consider the following<br>2-3 3. Supporting leadership at all levels<br>Commissioning groups and service providers to identify and work with "champions" i.e Overeaters Anonymous or other voluntary and charitable organisations who have a specific in preventing obesity and managing the disease to promote a healthy weight.<br>2-3 5.Communication<br>Directors of public health local government leads Commissioning groups, Service providers especially at primary care level are aware of the significant contribution that can be made by volunteers (health champions or peer mentors )but their effectiveness may be limited by the willingness of health professional to make referrals to voluntary and charitable sector namely OA due to a lack of understanding as to how the 1 Step programme works with people with compulsive eating disorders including over eating<br>2-3. 9 Local authorities and NHS as exemplars of good practice<br>Example being Tameside NHS Trust :Slimpod approach, an alternative to diet clubs . This is just one example that has taken a different approach to addressing obesity within its workforce. | disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | 2-3 Existing guideline10.11. Planning, Implementing, monitoring and evaluating functions<br>Establish links with academic networks, Primary care and OA programes to be able to plan implement and evaluate .Service users stories are one way this could be achieved. Stories from existing OA users and those who may be referred to the service in the future | |
| Overeaters Anonymous | 020 | 007 - 008 | In "1 Recommendation 2 BMI assessment, multi-component interventions and best practice standards" consider assessing for eating disorders disordered eating such as binge eating, bulimia or periods of uncontrolled eating. | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |
| Overeaters Anonymous | 020 | 007 - 008 | In "1 Recommendation 3 General awareness raising" if suspicion of eating disorder is present consider self-help/peer support groups such as Overeaters Anonymous, bring awareness that there are also groups for people of colour or BEAT and refer to mental health services | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |
| Overeaters Anonymous | 020 | 007 - 008 | In "3. Considerations" consider discussing the prevalence of eating disorders amongst population groups who are overweight and obese to raise awareness of eating disorder in this population group and change the views of practitioners who consider ED to only affect the underweight | Thank you for your comments. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |
| Overeaters Anonymous | 020 | 007 - 008 | In "4. Recommendations for research" consider suggesting the prevalence of ED with in the BAME overweight/obese population group | Thank you for your comment. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |
| Oviva UK Limited | General | General | As a provider of digitally-enabled 100% remote behaviour change services, it is disappointing there is not an evidence review of such services included within this guideline review. For example Omada Health in the USA has just completed a randomised control trial to show a digitally-enabled 100% remote diabetes prevention programme is superior vs. control. Furthermore, NHS England have published data on the digital diabetes prevention programme pilot in the UK dramatically increasing access in working age populations. This could be included at multiple points through the UK weight management guidelines, e.g. commissioners should consider commissioning digitally-enabled 100% remote behaviour change services as a way of increasing accessibility.<br>We are happy to provide the papers and evidence to help in this review process. | Thank you for your comment. Preventing type 2 diabetes is out of scope for this guideline. We will pass your comments to the surveillance team.<br>The scope for this guideline does include methods and thresholds to assess health risk. |
| Oviva UK Limited | 015 | 003 - 004 | **Table 6** | Thank you for your comment and additional information. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Area in existing guideline PH53: 12 Provide a national source of information on effective lifestyle weight management programmes – this states 'No evidence review'.<br>Oviva has a published evaluation in the Journal of Clinical Obesity to show we are an effective weight management programme at 12 months and beyond, and we would request there is an evidence review completed so this can be included in the NICE guideline.<br>Oviva is happy to provide our paper and evidence for this review process. | During the scoping of this update and the surveillance review of the NICE guideline PH53 Weight management: lifestyle services for overweight or obese adults (2014) no new evidence was identified that would impact on the current recommendation 12 'Provide a national source of information on effective lifestyle weight management programmes'. The original recommendation remains valid and will appear in the updated guideline. |
| Pfizer | General | General | **We propose that the guideline committee consider input from NICE Connect to ensure that the information is provided in a way that meets the evolving demands of HCPs**<br><br>Coordination and management of comorbidities should be called out under the generic principles of care as obesity is a complex disease that raises the risk of multiple other diseases such as heart disease, type 2 diabetes and high blood pressure. Given the requirement to read and integrate large amounts of information when treating these patients, the guideline review should seek input from the NICE Connect programme to ensure new ways of integrating the multiple guidelines are considered for obesity to ensure the output is readable and enables better HCP/patient discussions in real time. | Thank you for your comment and suggestion.<br><br>When developing the final updated guideline, the guideline committee will consider the most appropriate way to present the recommendations in the final combined guideline, taking into account the needs of the readers of the guideline and the health and social care service. |
| Pfizer | 007 - 008 | 014 - 015 | **Table 1** | Thank you for your comment. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | **We propose section 1.8 and 1.9 of CG189 is reviewed and updated in line with the latest recommendations from NICE and regulatory authorities to include approved anti-obesity medicines**<br><br>With reference to section 1.8 (Pharmacological Interventions) and 1.9 (Continued prescribing and withdrawal) in the existing CG189 Guideline, we note that NICE do not plan on conducting an evidence review and will retain recommendations from existing guideline. According to the *Surveillance report 2018 – Obesity: identification, assessment and management (2014) NICE guideline CG189 and BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (2013) NICE guideline PH46*, 2018, "Pharmacological Interventions", relating to section 1.8 in CG189, should be updated.<br><br>As stated in the surveillance report, Liraglutide (Saxenda) was not licensed at the time of developing NICE guideline CG189 and has since received a marketing authorisation for use in adults with obesity. Liraglutide has also received a positive recommendation from NICE (TA664) as an option for managing overweight and obesity alongside a reduced-calorie diet and increased physical activity in adults who meet specific criteria as specified in the recommendation. Section 1.9 of CG189, "Continued prescribing and withdrawal" refers to the ongoing management of pharmacological interventions and therefore may also warrant an update, including details of any monitoring requirements associated with this medicine. We therefore propose the new guideline is reviewed and | The updated guideline will have the opportunity to cross-refer to related NICE guidance as needed, including NICE technology appraisal 664 Liraglutide for managing overweight and obesity. Setmelanotide and Semaglutide are the subject of NICE technology appraisals currently in development. These will be cross referred to in this guidance where appropriate. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | updated accordingly to ensure the availability of approved anti-obesity medicines are communicated in this guideline update. | |
| Pfizer | 006 | 014 - 015 | **Table 1**<br>**We propose that section 1.3.6 of CG189 signposts to Public health guideline PH38 (*Type 2 diabetes: prevention in people at high risk).***<br><br>With reference to section 1.3 in CG189, a number of comorbidities and lifestyle factors are listed for evaluation as part of the initial assessment (1.3.6), using clinical judgement to determine which are appropriate (1.3.1). Type 2 diabetes is currently listed as a comorbidity that should be assessed and any risk factors based on measurements such as HbA1C.<br><br>According to public health guidance PH38, *Type 2 diabetes: prevention in people at high risk*, it encourages specific cohorts of people to have a risk assessment for type 2 diabetes and of those groups, obesity is specifically called out as a condition which can increase the risk of type 2 diabetes. We therefore suggest that within this section there is a signpost to PH38 which provides comprehensive guidance on how to identify adults at high risk of developing type 2 diabetes. | Thank you for this information. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |
| Pfizer | 007 | 014 - 015 | **Table 1**<br>**Section 1.5 Behavioural interventions. We propose signposting to *NG183: Behaviour change, digital and mobile health interventions (2020)*** | Thank you for this information. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | NG183 advocates consideration of digital and mobile health interventions as an option alongside other behaviour change services as these interventions may help people to reduce their weight. We therefore suggest signposting to NG183 to ensure awareness of the latest evidence with regards to digital and mobile health interventions in behaviour change. | |
| Pfizer | 008 | 014 - 015 | **Table 1**<br>**We propose that section 1.11 in CG189 is reviewed and updated to include information regarding the availability of pharmacological agents which have demonstrated weight loss benefits in the management of Type 2 Diabetes.**<br><br>With reference to section 1.11, (Bariatric Surgery for people with recent-onset Type 2 Diabetes) we wish to highlight that there have been a number of pharmacological agents that have shown weight loss benefits in patients with Type 2 Diabetes. Section 1.10.1 (Surgical Interventions) states "*All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss*". We propose to highlight in section 1.11 the availability of type 2 diabetes pharmacological agents that have shown an improvement in weight loss and have been recommended by NICE Guidance 28. Specifically, the use of a GLP-1 receptor agonist is recommended in NG28 in combination therapy with metformin and a sulfonylurea, for adults with type 2 diabetes who: | Thank you for your comment.<br><br>The updated guideline will have the opportunity to cross-refer to related NICE guidance as needed, including NICE technology appraisal 664 Liraglutide for managing overweight and obesity. Setmelanotide and Semaglutide are the subject of NICE technology appraisals currently in development. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | 1. have a BMI of 35kg/m2 or higher (adjust accordingly for people from black, Asian and other minority ethnic groups) and specific psychological or other medical problems associated with obesity or<br>2. have a BMI lower than 35 kg/m2 and: — for whom insulin therapy would have significant occupational implications or — weight loss would benefit other significant obesity-related comorbidities | |
| Pfizer | 013 | 003 - 004 | **Table 6**<br>**It is proposed that an evidence review is conducted on the effectiveness of weight management services across the UK**<br><br>NICE does not plan on conducting an evidence review on lifestyle weight management programmes (commonly referred to as Tier 2) and will retain recommendations from existing guideline. As mentioned in comment 1, we propose that a review is conducted on the effectiveness of lifestyle interventions including lifestyle weight management programmes to ensure recommendations reflect the latest evidence.<br><br>The NHS Commissioning Board recommends a 4-tiered weight management approach including a multidisciplinary weight management service for patients requiring specialised management of obesity (Tier 3) and Tier 4 for those being considered for bariatric | Thank you for your comment.<br><br>During the scoping of this update and the surveillance review of the NICE guideline PH53 Weight management: lifestyle services for overweight or obese adults (2014) no new evidence was identified that would impact on the current recommendations. The original recommendation remains valid and will appear in the updated guideline.<br><br>Issues concerning the geographical variation in access to weight management services was acknowledged by the early recruited committee members and is included in the equality impact assessment. While NICE guidelines identify care that is high quality, good value, and provides the best outcomes for people using health and social care |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | surgery. While these are not included in the scope of PH53, we propose that an evidence review is conducted on the implementation and effectiveness of weight management services to assess the equitable provision of these services across the UK and to ensure they are meeting the requirements of the changing obesity landscape, including the introduction of new anti-obesity medicines. | services within the budget available, it is not mandatory.<br><br>The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| Pfizer | 013 | 001 | **Table 5**<br>**Propose a review of NG7 to include an acknowledgement of the complex mechanisms that contribute to the development of Obesity in order to improve the health-care experience of people living with obesity and reduce the stigma associated with it across the health-care system**<br><br>We suggest that there is recognition of the stigma that people living with obesity experience during interactions within the health-care system. By acknowledging the complex underlying causes of obesity, health-care professionals can use language that improves the experience of patients and supports long-term benefits. | Thank you for this information.<br><br>The scope has been amended accordingly to include evidence relating to the approaches to address the effect of stigma. |
| Pfizer | 006, 013 | 014 - 015, | **Table 1 and Table 6**<br>**We propose that an evidence review is conducted on CG189, section 1.4 Lifestyle interventions *(Obesity: identification,*** | Thank you for your comment and this information. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | 003 - 004 | ***assessment and management)*** **and PH53 (*Weight management: Lifestyle services for overweight or obese adults)* to ensure the new guideline incorporates the latest evidence and technologies**<br><br>We support the robust review and update of the NICE Guidelines on Weight Management.<br>Given the complexity of lifestyle interventions, including dietary, physical activity and other lifestyle behaviours, we suggest that an evidence review is conducted to ensure the guidance is based on the most up to date evidence to optimise the impact of lifestyle changes on weight loss and other outcomes such as prevention of cardiovascular disease, type 2 diabetes and improvement of mental wellbeing. | During the scoping of this update and the surveillance reviews for NICE guideline PH53 Weight management: lifestyle services for overweight or obese adults (2014) and CG189 Obesity: identification, assessment and management (2014) no new evidence was identified that would impact on the current recommendations on 'lifestyle interventions'. The original recommendations remain valid and will appear in the updated guideline.<br><br>The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| Public Health England | General | General | Obesity is a chronic long-term relapsing condition and this needs to be acknowledged throughout the documents. Thinking around how to support people with less complex and more complex needs should be done. How to support the range of needs and at different BMIs. Are we content with our current cut-offs for accessing services? | Thank you for your comment.<br>People with complex needs are included in the equality impact assessment. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it.<br>The scope includes review questions that will consider the evidence for measuring health risk associated with overweight and obesity. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | |
| Public Health England | General | General | Existing guidance in CG129 1.2.8. may deter clinicians from referring older adults to relevant services. It would be helpful for new guidance to either determine whether this is the case, or do more to flag the benefits of weight loss (at the moment guidance presents this issue without explaining the need to weigh up the benefits weight loss may have, and may unwittingly nudge clinicians towards not intervening). | Thank you for your comment.<br><br>The guideline committee assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed.<br><br>Older people are included in the equality impact assessment form, which is linked to in section 2 of the scope. We have amended the section on older people to take account of the points you raise. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it. |
| Public Health England | General | General | In the context of an ageing population, many older adults will be both frail and obese at the same time. For these older adults, weight loss may help to restore functional capacity and reduce frailty. It would be helpful for new guidance to consider the evidence around this issue, in particular around behaviour change and effective interventions. | Thank you for your comment.<br><br>Older people are included in the equality impact assessment form, which is linked to in section 2 of the scope. We have amended the section on older people to take account of the points you raise. This assessment will be used during development to |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | ensure that recommendations meet the needs of the groups listed within it. |
| Public Health England | General | General | Seems like there is an opportunity to incorporate more information on mental health across the levels of intervention and ages e.g. weight management and the impact on/consideration of mental health; bariatric surgery and importance of mental health support | Thank you for your comment.<br>In CG189 Obesity: identification, assessment and management (2014), 1.3.6 recommends assessing adults for any psychosocial distress, psychological problems and medical problems. 1.3.9 recommends assessing children for any psychosocial distress, psychological problems, and medical problems. 1.10.3 recommends choosing a bariatric surgery with the person taking into account comorbidities.<br>The scope includes a list of the main outcomes that the guideline may consider, one of which is comorbidities that can include mental health outcomes. The guideline committee will define the outcomes that will be considered in the evidence reviews through development of the review protocols. The guideline committee will consider your comment when developing the evidence review protocols. |
| Public Health England | General | General | To be aware that the Scientific Advisory Committee on Nutrition (SACN) is conducting a risk assessment on nutrition and maternal health, focusing on maternal outcomes during pregnancy, childbirth and up to 24 months after delivery. Preconception will be considered from a biological perspective, as the critical period spanning from days to weeks before embryo development. | Thank you for your comment and this information.<br>NICE is aware of the work of SACN and has, and will continue, to liaise accordingly to ensure our work is complementary and not duplicative.<br>Pregnant women are out of scope for this guideline. They will be included in the NICE guideline PH27 |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Therefore, diet and nutrition during the preconception period will only be considered when clearly linked to pregnancy-related outcomes.<br><br>A range of maternal health outcomes during pregnancy, childbirth and up to 24 months after delivery will be considered when clearly linked to nutrition. These will include weight loss, weight gain and weight retention during pregnancy (gestational weight) and up to 24 months after delivery.<br><br>It would be useful to have good communication between PHE and NICE regarding the scope of work and evidence identified to help ensure that work is complementary and does not duplicate. | Weight management before, during and after pregnancy (2010). |
| Public Health England | 005 | 001 | While the update will 'look at' groups as outlined in lines 1-2, will people with those lived experiences be consulted during the update? | Please be reassured that there will be committee members who are living with obesity. The NICE Public Involvement Programme will support these members to understand NICE process and to get their voices heard. The committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others. |
| Public Health England | 012 | 001 | **Table 4 1.15**<br>Schools: consider including in whole-system approach | Thank you for your comment, we have amended this section accordingly and added in whole-system approaches. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Public Health England | 013 | 002 | Service causes no harm: Recommend weight bias/stigma and discrimination are essential components in causing no harm principles – consider strengthening to impart their importance in the role of health care provision | Thank you for this information.<br><br>The scope has been amended accordingly to include evidence on approaches to address the effect of stigma. |
| Public Health England | 021 | All | The guidance focusses mainly on Children and Young People. Older Adults, as a population, are more likely to be obese/overweight and to have co-morbidities. They are also more likely to be experiencing functional loss. The same questions that are specific to children (2.3, 2.4) should therefore be asked of the older adult population. | Thank you for your comment.<br><br>The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed.<br>During the scoping of this update and the surveillance review of the NICE guideline no new evidence was identified that would change to the current recommendations for adults, though they will be assessed to ensure that they reflect current context and may be edited.<br><br>Older people are also included in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it. We have |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | amended the section on older people to take account of the points you raise |
| Public Health England | 023 | 001 - 004 | The proposal doesn't include consideration of BMI growth charts and appropriateness of clinical and population cut offs for Asian and Black children. There is emerging research in this space which suggests it might be worth reviewing, though it may not be robust enough yet.<br><br>http://www.nature.com/ijo/journal/vaop/ncurrent/abs/ijo201775a.html<br>https://www.nature.com/ijo/journal/vaop/naam/abs/ijo2017272a.html<br>https://pubmed.ncbi.nlm.nih.gov/31779606/<br><br>Review ethnic-specific evidence on child BMI and/or adiposity and health risk using metabolic risk factors concerning BME children<br><br>For BME adults, NICE has issued guidance and recommendations on lower BMI thresholds as a trigger to intervene to prevent ill health and is planning to review this evidence, using the following draft questions in the scope – these should also be considered for children;<br><br>1.1 What are the most accurate and suitable methods of measuring the 1 health risk associated with overweight and obesity, including adiposity, in 2 adults?<br>1.2 What are the most effective and cost-effective approaches for identifying overweight and obesity in adults, particularly those in black, Asian and minority ethnic group | Thank you for your comment and additional information.<br>The scope has been amended accordingly and now includes a question for children and BMI cut-offs for different ethnic groups. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| RCGP | 006 | 014 - 015 | **Table 1 1.4 lifestyle interventions**<br><br>Can the committee consider reviewing the evidence on lifestyle interventions paying particular attention to<br>1. the preservation of muscle mass whilst loosing weight, particularly in those with co-morbidities (e.g. COPD)<br>2. Sleep and it's effects on appetite<br>Having reviewed the guidance to be drawn together, these aspects do not appear to feature in detail. | Thank you for your comment.<br>The tables in the proposed outline for the guideline section lists whether evidence reviews will be updated, or recommendations will be retained for the guideline areas. The areas you list are being retained. The guideline committee will assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context.<br><br>. |
| RCN | General | General | No comments to add | Thank you. |
| Royal College of Paediatrics and Child Health | General | General | The guideline for the management of obesity should mention the impact of the pandemic, particularly in regard to childhood obesity. Measures that applied in the previous guideline must be adjusted and re-evaluated. During the pandemic, family-based behavioural interventions have demonstrated to be effective and safe in the prevention and treatment of childhood obesity and should be considered as a first-line treatment option. | Thank you for your comment and this information.<br>The guideline will cover all publicly funded healthcare services and approaches that are commissioned and provided. The review questions cover effective approaches for children and young people living with overweight and obesity as part of a weight management programme.<br>The evidence base will include the most recently published evidence relating to the interventions. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Royal College of Paediatrics and Child Health | General | General | Obesity causes severe complications in both children and adults. It is associated with increased insulin resistance and insulin-like growth factor 1 levels, inflammatory markers, polycystic ovarian syndrome in females and the metabolic syndrome (1).<br><br>References:<br>James, WPT, Davies, HL, Balies, S et al. (1978) Elevated metabolic rates in obesity. Lancet 1, 1122.CrossRefGoogle ScholarPubMed | Thank you for your comment and this information. |
| Royal College of Paediatrics and Child Health | General | General | The guideline should note that complications of type 2 diabetes in children and adolescents progress faster than in adults including hypertension, dyslipidaemia, CVD, renal disease and psychosocial problems (2,3).<br><br>References:<br>1. Dart, AB, Martens, PJ, Rigatto, C et al. (2014) Earlier onset of complications in youth with type 2 diabetes. Diab Care 37, 436–443.CrossRefGoogle ScholarPubMed<br>Rames, LK, Clarke, WR, Connor, WE et al. (1978) Normal blood pressures and the evaluation of sustained blood pressure elevation in childhood: the Muscatine study. Paediatrics 61, 245–251.Google ScholarPubMed | Thank you for your comment.<br>Younger people living with obesity are included in the equality impact assessment form, which is linked to in section 2 of the scope.<br>Thank you for the references. |
| Royal College of Paediatrics and Child Health | General | General | The 'Pickwickian syndrome' is a serious complication in children with obesity; this is a combination of severe obesity associated with somnolence, sleep apnoea and hypoventilation. The hypoventilation results from increased oxygen requirements due to their large size, upper airways obstruction due to fatty tissue in the upper airways, and inefficient respiratory movement and collapsed areas of the lungs. This can result in pulmonary hypertension, cardiac failure and | Thank you for your comment. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | possibly sudden death. Orthopaedic side effects may occur with slipped femoral epiphyses, knock-knees and flat feet. As well as this, there can also be psychosocial outcomes that also need to be addressed in the guideline. | |
| Royal College of Paediatrics and Child Health | General | General | The reviewers were happy with this draft scope. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| Royal College of Physicians | General | General | The RCP is grateful for the opportunity to respond to the above consultation. In doing so we would like to endorse the response submitted by the Obesity Group of the British Dietetic Association. We have also liaised with our Advisory Group on Nutrition, Weight and Health, and would like to comment as follows. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| Royal College of Physicians | General | General | We agree that it seems sensible to merge the various clinical guidelines that provide guidance on treating people with obesity, where there is substantial overlap, including guidance relating to BAME communities and before and after pregnancy, as well as the clinical guideline (CG189) and the public health guidance on lifestyle management programmes (PH53). | Thank you for your comment. We welcome your support for this scope and update of the guideline. The update will refer to other NICE guidance where appropriate. |
| Royal College of Physicians | General | General | The RCP understands the importance of public health prevention measures to reduce the increasing prevalence of overweight and obesity in the population. We also recognise that if effectively implemented, such strategies could make it easier for people with obesity to be supported to treat their disease. However, we consider it is important to make a clear distinction between public health | Thank you for your comment. While the potential merits of splitting the guideline into prevention and treatment were considered, on reflection it was felt that splitting the guideline would not impact on the guideline development process. Keeping the guideline as one was felt to tie in with broader |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | strategies to prevent obesity and guidelines designed to support people living with the disease. It would therefore be better to have two guidelines, with one focussed on prevention, and the other on treatment, with clear cross referencing where appropriate. | government initiatives to adopt a person-centred approach and to recognise the need for a whole-systems approach to addressing overweight and obesity. The guideline committee will consider your views when deciding how best to present and communicate the final guidance. |
| Royal College of Physicians | 006 | 014 - 015 | **Section 1.2**<br>Consider evaluating tools such as the Edmonton Obesity Staging System or the Kings Staging system to help identify people with obesity who are at greatest risk of complications. This will help move us away from a 'BMI centric' definition. | Thank you for your comment. The scope includes a key area that covers identification and assessment. Evidence reviews will be conducted for the key issues described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The measures and tools you refer to will be captured by these review questions. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update.<br><br>. |
| Royal Pharmaceutical Society | General | General | We welcome the update and in particular the amalgamation of the several existing guidelines that are already in place to support weigh management support and services. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | Bringing together these guidelines into one document will benefit clinicians, allowing them more time to engage with their patients, rather than searching through various documents. | |
| Royal Pharmaceutical Society | General | 001 | One important point that is not covered in the proposed scope is the potential for health professionals to offer opportunistic weight management advice when engaging with patients on different issues.<br><br>Pharmacists across all settings are well placed to do this. An additional section on providing effective opportunistic weight management advice and how to go about doing so in a respectful and sensitive manner would strengthen the proposed guideline. | Thank you for your comment.<br>Draft review questions included in the scope will search for evidence on approaches for weight management that will include all settings, including opportunistic advice. |
| Royal Pharmaceutical Society | General | 001 | Community pharmacy teams are ideally placed to provide weight management services due to their access, location and informal environment. This is evidenced by a systematic review for community pharmacy-delivered interventions for public health priorities including weight management published in the BMJ . The review concluded that community pharmacy is a feasible option for weight management interventions and that given the potential reach, effectiveness and associated costs of these interventions; commissioners should consider using community pharmacies to help deliver such services.<br><br>Examples of this service that have been commissioned locally are available on the PSNC online services database found here. | Thank you for your comment and this information. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Royal Pharmaceutical Society | 006 | Table 1 | The recommendations included in the proposed outline for the guideline in table 1 are sensible.<br><br>We have reviewed and considered the proposals relating the two areas that will be of particular relevance to our pharmacist membership; 'pharmacological interventions) (1.8) and 'continued prescribing and withdrawal (1.9). In both cases NICE plans to "retain recommendations from the existing guideline". Having reviewed the recommendations from the existing guideline, we are satisfied that they are appropriate, therefore we support the proposal to retain the recommendations in their current form. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| Slimming World | General | General | We welcome the review into the guidelines and the suggested amalgamation of all of the guidelines listed. We feel this will make navigating the NICE guidelines much easier and it makes sense to have them all pulled together into one place. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| Slimming World | 005 | 012 | We note that pregnant women will be excluded from the guideline. We'd be interested to know why pregnancy is considered as needed to be viewed separately from the rest of the guidance. We acknowledge that some advice/support may differ for women during pregnancy but overall the advice to eat healthily and remain active remains relevant to this group also. If they are to be pulled out as a separate group, we'd like to see the pregnancy guideline updated within a similar time frame with clear cross referencing between the two. This will help to ensure that support for pregnant women doesn't get left behind or seen as an area or time where managing | Thank you for your comment.<br><br>Pregnant women are excluded from the scope of this guideline update as they are covered by separate NICE guidance, PH27.<br>The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | weight healthily isn't key as the evidence suggests this is an important time to be providing support for women. | |
| Slimming World | 006 | 014 - 015 | **Table 1, row 1.2**<br><br>It's highlighted that the evidence around identification and assessment will be reviewed. We welcome a review into the evidence for the best possible assessment methods and would like to highlight that it's key that any new proposed methods need to be considered in terms of the practicalities of the suggested methods, in all settings (ie primary care and also within weight management service delivery). It's vital that measurements are realistic, practical and acceptable to service users within a variety of settings to ensure that accurate data can be captured and consistently so. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| Slimming World | 007 | 014 - 015 | **Table 1, row 1.7**<br>For the evidence review into dietary approaches for weight management we'd like to highlight some key research.<br><br>The Solutions for Weight through Psychology, Satiation and Satiety study, led by the University of Leeds and published in the Journal of Nutrition, demonstrated the effectiveness of an ad libitum low energy dense diet for weight management.<br><br>The full paper can be accessed here<br>https://academic.oup.com/jn/article/148/5/798/4990764 | Thank you for your comment and this information.<br><br>Evidence reviews will be conducted for each of the key issues described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Tees, Esk and Wear Valleys NHS Foundation Trust | 018 | 007 | Please add "Psychosis and Schizophrenia in adults: prevention and management (2014) NICE guideline CG178" to the list of published related NICE guidance in relation to its recommendations on the treatment options and the associated impact on weight and waist circumference. | Thank you for your comment, we have amended this section to include CG178. |
| The British Polio Fellowship | General | General | We welcome the rationalisation of the weight management guidelines | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| The British Polio Fellowship | 003 | 009 | People who have had polio have a different body composition due to lower muscle mass for a given weight; use of BMI underestimates the total body fat mass compared to healthy controls and can render them ineligible for some treatments such as bariatric surgery - Chang, K.-H., Lai, C.-H., Chen, S.-C., Hsiao, W.-T., Liou, T.-H., & Lee, C.-M. (2011). Body Composition Assessment in Taiwanese Individuals With Poliomyelitis. *Archives of physical medicine and rehabilitation, 92*(7), 1092-1097. doi: 10.1016/j.apmr.2011.01.019 | Thank you for your comment.<br><br>People living with a physical disability are included in the equality impact assessment form, which is linked to in section 2 of the scope. We have amended the section on people living with a physical disability to take account of the points you raise. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it. |
| The British Polio Fellowship | 003 | 013 | We feel that people with physical disabilities who are overweight should be identified proactively but with discretion taking into consideration the likelihood that they may have lived with overweight for decades and tried to lose weight many times - thus being exhausted with and defensive about the topic | Thank you for your comment.<br><br>People living with a physical disability are included in the equality impact assessment form, which is linked to in section 2 of the scope. We have amended the section on people living with a physical disability to take account of the points you raise. This assessment will be used during development to |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | ensure that recommendations meet the needs of the groups listed within it. |
| The British Polio Fellowship | 005 | 001 | We strongly welcome the inclusion of disability in this scope | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| The British Polio Fellowship | 005 | 014 | Settings; we feel that food retailers and outlets such as restaurants should be covered. For many people with disabilities the ability to eat out with friends is a key social need where they meet on an equal footing and there should be a better provision of healthy, discreetly labelled choices | Thank you for your comment. The new guideline will cross-refer to national policy as needed, such as the national obesity strategy: Tackling obesity: government strategy. |
| The British Polio Fellowship | 005 | 025 | We welcome the inclusion of individual approaches as people with disabilities have highly varied needs | Thank you for your comment. We welcome your support for this scope and update of the guideline. |
| The British Polio Fellowship | 006 | General | We feel that assessment of overweight/obesity needs to be reviewed as this is where many people with polio who seek help have difficulties due to the current measures such as BMI underestimating total fat. Also about 10% of our members have a degree of scoliosis which would make alternatives such as waist or waist/hip measures also inaccurate or impossible. | Thank you for your comment.<br><br>People living with a physical disability are included in the equality impact assessment form, which is linked to in section 2 of the scope. We have amended the section on people living with a physical disability to take account of the points you raise. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| The British Polio Fellowship | 007 | 014 - 015 | **Table 1.6**<br>Physical activity: these recommendation are largely inapplicable to polio survivors due to mobility issues and neuromuscular fatigue and the risk of injury to weakly supported joints | Thank you for your comment.<br><br>People living with a physical disability are included in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it.<br>We will pass your comments onto the surveillance team for consideration. |
| The British Polio Fellowship | 021 | 001 | This question should include reference to situations where body composition is not as expected, in polio survivors the muscle mass is reduced and body fat can be underestimated. About 10 % of polio survivors have a degree of scoliosis which can make some measures inapplicable and different solutions need to be offered | Thank you for your comment.<br><br>**People living with a physical disability are included in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it.** |
| The British Polio Fellowship | 021 | 014 | This question should include asking for criteria for people with physical disabilities that affect body composition or musculoskeletal shape. | Thank you for your comment.<br><br>**People living with a physical disability are included in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it. We have amended the section on people living with a physical disability to take account of the points you raise.** |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| The British Polio Fellowship | 022 | 001 | Outcomes: for polio survivors and others with physical disabilities excess weight can cause long term pain and reduction in mobility - outcome measure of pain reduction or improved mobility or physical activity level should be added | Thank you for your comment. The scope includes a list of the main outcomes that the guideline may consider. The guideline committee will define the outcomes that will be considered in the evidence reviews through development of the review protocols. |
| Total Diet & Meal Replacements Europe (TDMR Europe) | General | General | Total Diet & Meal Replacements (TDMR) Europe is the European trade body for manufacturers and distributors of total diet replacements (TDRs) and meal replacements (MRPs), which provide weight loss and weight management programmes for the overweight and obese.<br><br>TDRs, which include very low-calorie diets (VLCDs) and low calorie diets (LCDs), are specifically formulated programmes that are based around formula foods that aim to replace the whole of the daily diet. These formula foods are nutritionally balanced with key vitamins, minerals, high quality protein, essential fats, fibre and other nutrients, and are designed to replace conventional foods for a period to facilitate optimal weight loss. Meal replacements are products presented as a replacement for one or more meals of the daily diet. They are used alongside conventional food, as part of an energy restricted diet, to facilitate and maintain weight loss. | Thank you for your comment and this information, we will pass on this information to the NICE guideline developer. |
| Total Diet & Meal Replacements | 001 | 007 | TDMR Europe fully supports the proposal to develop guideline "*GID-NG10182 on Weight Management*" which updates and combines previous NICE guidelines on obesity and weight management. | Thank you for your comment. We welcome your support for this scope and update of the guideline. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Europe (TDMR Europe) | | | | |
| Total Diet & Meal Replacements Europe (TDMR Europe) | 006 | 014 - 015 | TDMR Europe welcomes NICE's decision to review the dietary advice for adults given in guideline *CG189 Obesity: identification, assessment and management*, and would like to specifically point out the need to review the below advice:<br><br>*1.7.6 Consider low-calorie diets (800–1600 kcal/day), but be aware these are less likely to be nutritionally complete. [2006, amended 2014]*<br>*1.7.7 Do not routinely use very-low-calorie diets (800 kcal/day or less) to manage obesity (defined as BMI over 30). [new 2014]*<br>*1.7.8 Only consider very-low-calorie diets, as part of a multicomponent weight management strategy, for people who are obese and who have a clinically assessed need to rapidly lose weight (for example, people who need joint replacement surgery or who are seeking fertility services). Ensure that:*<br>• *the person following the diet is given ongoing clinical support. [new 2014]*<br><br>TDMR Europe would like to dispute the claim that low calory diets (LCDs) are less likely to be nutritionally complete. The latest research on LCDs and very low calorie diets (VLCDs), as described below, prove that both LCDs and VLCDs are safe. These diets are specifically formulated to meet nutritional daily requirements while keeping the products under 1.200 calories. Companies manufacturing and commercialising the products take great effort to ensure that they provide consumers with the daily required intake of | Thank you for your comment and this information.<br><br>The update will consider the evidence in the key area individual-level approaches for prevention of excess weight, weight loss, and maintaining a healthy weight. Table 1 in the scope shows that evidence reviews for recommendations 1.7.1 to 1.7.11 will be updated. Total and partial meal replacement and low- and very-low calorie diets are included in this area.<br>Diabetes prevention and treatment is not scope for this guideline. Your information on this matter will be given to the surveillance team for consideration. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | macronutrients, vitamins and minerals, and are required to do so by EU and UK regulations.<br><br>There is misuse of terminology within previous recommendations. There was no review of evidence for use of TDRs 800kcal/d and above yet the use of 'VLCDs' was used as synonymous with TDRs which it is not.<br><br>TDMR Europe would like to qualify the advice to not routinely use VLCDs to manage obesity. Scientific research on TDRs has extensively proven that they are effective and safe methods to help obese individuals lose weight. Individuals should use TDRs for a set period of time, and then gradually reintroduce regular food into their daily diet. Nothing in the scientific literature suggests that individuals should not go back to using a TDR for a new set period of time, as many times as needed, to help them manage their weight.<br><br>TDRs should also not only be considered for people who have a clinically assessed need to rapidly lose weight, nor should they necessarily need to be provided with clinical supervision. Counselling and behavioural advice should be offered to individuals embarking on a VLCD – and companies commercialising these products indeed provide this through individual support, groups and one on one advice – but this support does not need to be provided under a clinical setting. | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | For an overview of the recent research proving the safety and effectiveness of TDRs and supporting the points made above please see below:<br><br>• The Diabetes Remission Clinical Trial (DiRECT) showed that a high proportion of people would engage with a total diet replacement weight loss programme for up to 20 weeks and that a good proportion maintained their weight loss and diabetes remission. [Lean MEJ, Leslie WS, Barnes AC, Brosnahan N, Thom G, McCombie L, et al. Primary care-led weight management for remission of type 2 diabetes (DiRECT): an open-label, cluster randomised trial. The Lancet. December 2017. https://doi.org/10.1016/S0140-6736(17)33102-1] [Lean MEJ, Leslie WS, Barnes AC, Brosnahan N, Thom G, McCombie L, et al. Durability of primary care-led weight-management intervention for remission of type 2 diabetes: 2 year results of the DiRECT open-label, cluster-randomised trial. The Lancet Diabetes & Endocrinology. March 2019. https://doi.org/10.1016/S2213-8587(19)30068-3]<br><br>• The results of the Doctor Referral of Overweight People to Low Energy total diet replacement Treatment (DROPLET) trial showed that GP referrals to a commercial provider offering a weight loss and maintenance programme, based on TDR with individual behavioural support, led to an average weight loss of 10.7 kg after 1 year (7.2kg more than usual weight-loss programmes offered in primary | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | care). This was associated with significant reductions in CVD risk. [Astbury NM, Aveyard P, Nickless A, Hood K, Corfield K, Lowe R, Jebb SA. Doctor Referral of Overweight People to Low Energy total diet replacement Treatment (DROPLET): pragmatic randomised controlled trial. Nuffield Department of Primary Care Health Sciences, University of Oxford, UK. August 2018. http://dx.doi.org/10.1136/bmj.k3760]<br><br>• The Prevention of diabetes through lifestyle Intervention and population studies in Europe and around the World (PREVIEW) research team has presented results on weight maintenance over three years in over two thousand overweight people with pre-diabetes who begin their risk-reduction with an 800kcal/d total diet replacement (TDR) diet given with a behaviour change intervention. The overall mean weight loss after 8 weeks was 10.7 + 0.4kg (10.8% of body weight). After the initial weight loss period those who achieved 8% weight loss were entered into a randomised trial of higher and lower dietary protein intake, higher and lower dietary glycaemic index levels and higher and lower physical exercise activity intensity levels for three years. The results of the three year maintenance outcomes showed that both diets and both exercise strategies were equally effective for weight-loss maintenance. [ Christensen P, Larsen TM, Westerterp-Plantenga M, Macdonald I, Alfredo Martinez J, Handjiev S, Poppitt S, et al. Men and women respond differently to rapid weight loss: Metabolic | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | outcomes of multi-centre intervention study after a low-energy diet in 2500 overweight, individuals with pre-diabetes (PREVIEW). Diabetes, Obesity and Metabolism, A Journal of Pharmacology and Therapeutics. August 2018. https://doi.org/10.1111/dom/13466] Raben A et al PREVIEW – Results from a 3-year randomised 2 x 2 factorial multinational trial investigating the role of protein, glycemic index and physical activity for prevention of type- 2 diabetes. Diabetes Obes Metab. 2021;23:324–337. doi:10.1111/dom.14219<br><br>It is important to note that public health authorities are becoming increasingly aware of the effectiveness and safety of TDRs for weight loss and the management of related diseases. NHS Scotland and NHS England have launched a programme supporting TDRs for obese people with type 2 diabetes, which builds on the approaches of the DiRECT trial, and the DROPLET trial, reflecting the evidence bases developed by both of these trials.<br><br>TDMR Europe would finally like to recommend that meal replacements (products substituting 1 or 2 main meals per day) should also be included under the guideline's dietary advice as a useful method to lose and manage weight. A systematic review and meta-analysis of the effectiveness of meal replacements for weight loss (MRPs) shows that programmes incorporating MRPs as part of their dietary intervention resulted in greater weight loss at one year than those not incorporating MRPs. Specifically, those participants | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | who had included MRPs in their diet had lost an additional 1.49 kg at one year compared with those participants whose diet did not include MRPs. The review also showed that this greater weight loss was maintained over the longer term with data being reported after four years showing a more significant degree of weight loss maintenance in participants who had undertaken programmes incorporating MRPs. [Astbury, NM, Piernas, C, Hartmann-Boyce, J, Lapworth, S, Aveyard, P, Jebb, SA. A systematic review and meta-analysis of the effectiveness of meal replacements for weight loss. *Obesity Reviews*. 2019; 20: 569– 587. https://doi.org/10.1111/obr.12816]<br><br>This review supports the increasingly widely held views of both medical professionals and nutrition experts, as well as that of the industry, who believe that MRPs should be provided and included as an option in national health guidance for those overweight and obese individuals looking to lose weight. | |
| UK Association for the Study of Obesity | General | General | The scope and guidance need to consistently use people first language and conform with position statements on stigma and discrimination: ASO Position Statement: Weight stigma and discrimination \| The Association for the Study of Obesity | Thank you for your comment. The guideline adopts a person-centred approach and a recognition of the need for a whole-systems approach to those living with addressing overweight and obesity. |
| UK Association for the Study of Obesity | General | General | For Page 8 section 1.11, Bariatric Surgery for people with PCOS should be added as per Royal College of Obs & Gynae Greentop Guidelines "Bariatric Surgery for those with PCOS and Severe Obesity BMI 40 kg/m$^2$ or more or 35 kg/m$^2$ with a high risk obesity related condition if standard weight loss strategies have failed. | Thank you for your comment. NICE guideline CG189 Obesity: identification, assessment and management (2014) section 1.10 recommends bariatric surgery for |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | people with a BMI above 35 if they have other significant disease:<br>"Bariatric surgery is a treatment option for people with obesity if all of the following criteria are fulfilled:<br><br>They have a BMI of 40 kg/m2 or more, or between 35 kg/m2 and 40 kg/m2 and other significant disease (for example, type 2 diabetes or high blood pressure) that could be improved if they lost weight."<br><br>The table in the proposed outline for the guideline section of the scope says the recommendations in the section 1.10 will be retained. |
| UK Association for the Study of Obesity | General | General | No review is suggested for pharmacological treatment - recent evidence would suggest progress in this area and that perhaps a review of medical management is warranted e.g. semaglutide. | Thank you for your comment.<br><br>The updated guideline will have the opportunity to cross-refer to related NICE guidance as needed, including NICE technology appraisal 664 Liraglutide for managing overweight and obesity. Setmelanotide and Semaglutide are the subject of NICE technology appraisals currently in development. This guidance will cross refer to NICE technology appraisals where appropriate. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| UK Association for the Study of Obesity | General | General | With the introduction of GLP-1 pharmacotherapy, the entire criteria for referral to Tier 3 needs to be redesigned. Also, the same criteria should be applicable within a Tier 4 service for patients who are being considered for primary bariatric surgery but would benefit from medical optimisation preoperatively as this would facilitate surgical outcomes. | Thank you for your comment.<br><br>The guideline committee will assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed.<br><br>Issues concerning the geographical variation in access to weight management services was acknowledged by the early recruited committee members and is included in the equality impact assessment. While NICE guidelines identify care that is high quality, good value, and provides the best outcomes for people using health and social care services within the budget available, it is not mandatory. |
| UK Association for the Study of Obesity | General | General | In the document pertaining to supporting women in pregnancy, the advice is to advise women to seek advice from a 'reliable source'. What is meant by this? Weight and diet advice is not consistent around the country and some lay organisations have excellent nutritionists who can give advice. Is it appropriate to refer individuals to these organisations? | Thank you for this information. Weight management in pregnancy will be covered in a separate NICE guideline PH27 weight management before, during and after pregnancy (2010). The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| UK Association for the Study of Obesity | General | General | The scope is too broad but treatment and prevention are equally important. Combining treatment and prevention together is likely to compromise any real focus on treatment, and it is for treatment where best evidence exists (RCTs and SRs) and the demand for and use of weight management services across the country is overwhelming. This situation is being replicated in the private sector. People really want to lose weight and just see no clear paths of support. | Thank you for your comment. While the potential merits of splitting the guideline into prevention and treatment were considered, on reflection it was felt that splitting the guideline would not impact on the guideline development process. Keeping the guideline as one was felt to tie in with broader government initiatives to adopt a person-centred approach and to recognise the need for a whole-systems approach to addressing overweight and obesity. The guideline committee will consider your views when deciding how best to present and communicate the final guidance. |
| UK Association for the Study of Obesity | General | General | Weight regain after obesity surgery is becoming a real unmet need and we have no guidance on how to manage these patients who are forming an ever-larger proportion of consultations. | Thank you for your comment. The early recruited committee members stated that existing guidance on weight loss would also be appropriate for people who have regained weight. |
| UK Association for the Study of Obesity | General | General | Pregnancy isn't included in this guideline but preconception and postnatal is. The pregnancy recommendations are probably going to be moved to the NICE antenatal guidelines, but there also needs to be consistency throughout the reproductive health phases as they are related (e.g. weight management in the preconception period can impact on pregnancy health, weight management in pregnancy can impact on postnatal health, postnatal weight management is preconception weight management for parous women who go on to have subsequent pregnancies. Some examples of the evidence for | Thank you for this information.<br><br>As you note, pregnancy will be covered in a separate NICE guideline, PH27 weight management before, during and after pregnancy (2010). The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | this are given below relating to interventions delivered during pregnancy:<br><br>• Weight management interventions delivered in pregnancy can reduce postnatal weight retention, which is also a preconception period for women who go on to have subsequent pregnancies (Hayes et al., Nutrients 2021:13, 3, pp1036).<br><br>• Similarly, behaviour change interventions delivered during pregnancy can result in improved weight management-related behaviours in the postnatal period (Geyer et al., Nutrients 2021: 13, 4, pp1310 and Stephenson et al., Lancet 2018: 319, 10132, pp 1830-1841).<br><br>There are also the following gaps in the existing PH27 guidelines:<br><br>• the importance of inter-pregnancy weight management (where postnatal and pre-conception join into one category for parous women). (Timmermans et al., Obesity Reviews 2020: 21, 3, e12974)<br>• the additional preconception nutritional needs of women who have had bariatric surgery (likely to still have a BMI>30 in most cases) to address nutritional deficiency-related risks to fetal development. (Shawe et al., Obesity Reviews 2019; | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | 20, 11, pp 1507-1522. Ahkter et al., PLOS Medicine doi.org/10.1371/journal.pmed.1002866)<br><br>the restriction of access to fertility treatment for women with a BMI>30 (some areas >35) is an issue if there is no weight management services available / long waiting lists given the influence of age on chances of successful treatment outcomes (Sneed et al., Human Reproduction 2008: 23, 8). This is an old paper but very relevant in relation to current practice of restricting access to treatment based on BMI and something that has been raised by patient representatives at EASO and ASO conferences/training events. | |
| UK Association for the Study of Obesity | 001 | 020 | The scope document does not update the guidance on weight management during pregnancy. This will be provided separately but it would be more helpful if this was not separated. | Thank you for your comment.<br><br>As you note, pregnancy will be covered in a separate NICE guideline. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines and national guidance as needed. |
| UK Association for the Study of Obesity | 002 | 007 | It would be valuable if some reference were made to source of these costs; in reality, if 28% of people are living with obesity and a further 34% are overweight, it beggars belief that the costs are less than 5% of annual NHS budget. To repeat without source is unhelpful and likely masks the full cost. | Thank you for your comment,<br>The source of this figure is Scarborough, P et al (2011) This figure is also quoted in the 2020 report on childhood obesity by the National Audit Office. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| UK Association for the Study of Obesity | 002 | 010 | The draft scope makes no mention of Covid-19 recovery, and perhaps that is purposeful. However, the current situation is an additional factor which makes this new work even more important - why the update is needed. i.e. not only is there new evidence of interventions, but the situation (obesity prevalence) is possibly worse than it was pre-pandemic. | Thank you for your comment. |
| UK Association for the Study of Obesity | 004 | 001 | There is surprisingly little mention of inequalities in the scope, particularly socioeconomic factors "The guideline will look at inequalities relating to age, disability, race, sex, sexual orientation, socioeconomic factors, other health conditions." Given the stark and increasing social patterning of obesity in both children and adults, the scope should include more effort and energy in addressing this important issue - reach and effectiveness of interventions in different socioeconomic groups, and intervention-generated inequalities. | Thank you for your comment.<br><br>Socioeconomic factors are included in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it. |
| UK Association for the Study of Obesity | 005 | 012 | The draft scope seems to excluding pregnant women, and yet elsewhere indicates that the scope will replace guidance for pregnant women. PH27 | Thank you for your comment.<br><br>As you note, pregnancy will be covered in a separate NICE guideline. The updated weight management guidance will incorporate from PH27 only the recommendations that apply before and after pregnancy; the recommendations on weight management during pregnancy will be covered in a separate guideline. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |
| UK Association for the Study of Obesity | 006 | 015 | The current guidelines do not mention anything around monogenic obesity or ways to identify and assess patients with genetic diseases of obesity. With the current commissioned service for genetic testing for obesity, this should now be considered along with the potential of treatment available for these patients where there is an unmet need | Thank you for your comment.<br>Identifying underlying causes of obesity and overweight are covered in the following recommendations in CG189 Obesity: identification, assessment and management (2014). We will pass this information to the surveillance team for consideration. |
| UK Association for the Study of Obesity | 010 | 006 | Raising awareness of lifestyle weight management programmes etc. There should be a duty of care of commercial weight management programmes to provide full details of efficacy (or not) or their programmes especially for those with severe obesity. This would mean patients are fully informed in their decision making on which service is best/more efficacious for them. Consideration should be given to health related quality of life, morbidity and adverse events. | Thank you for your comment. This area is out of scope for this guideline. |
| UK Association for the Study of Obesity | 011 | 002 | Although the draft includes a focus on race (and some other protected characteristics), there is no focus on faith/religion. There is increasing evidence of the importance of considering specific interventions (in terms of reach and impact) for certain faiths/religions. | Thank you for your comment.<br><br>During the surveillance review of the NICE guideline PH42 obesity: working with local communities (2012) no new evidence was identified that would impact on the current recommendation 4 'Coordinating local action', which highlights the need to engage with |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | religious groups to support a community-wide approach to combating obesity. In addition, PH42 includes in its 'guiding principle' the need for cultural appropriateness which takes account of religious beliefs. The original recommendation remains valid and will appear in the updated guideline. |
| UK Association for the Study of Obesity | 012 | 001 | It is difficult to see where the draft scope will include information about the impact of online interventions from non NHS sources, such as the Food Industry and other companies and retailers, and the promotion of interventions through industry marketing, celebrities and Vloggers etc. It is appreciated that the 'best evidence' for most of the evidence in this regard is weak. | Thank you for your comment. When conducting the evidence reviews, the best available evidence will be considered. According to NICE guidelines: the manual, randomised controlled and systematic reviews of randomised controlled trials are considered the best available evidence. If there is not an adequate number of trials, then non-randomised studies will be considered, then observational studies and data, and lastly case series. |
| UK Association for the Study of Obesity | 014 | 003 - 004 | **Table 6 Sections 2 & 3**<br>Ensure services cause no harm ie. All services must involve screening for Eating Disorders (including commercial programmes) and have carried out risk assessments.<br><br>Raise awareness of local WM issues among commissioners - Need to ensure equity of access to Weight Management Services across all of UK. | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69.<br><br>Geographical variation in access to NHS weight management services is noted in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it. |
| UK Association for the Study of Obesity | 015 | 003 - 004 | **Sections 17 & 18**<br>Use evaluation of services to inform theTier system – i.e. not offering less effective methods to those with severe obesity/bypass earlier Tiers. | Thank you for your comment.<br><br>NICE guidelines identify care that is high quality, good value, and provides the best outcomes for people using health and social care services within the budget available. Guidelines are recommended best practice, but they are not mandatory. Healthcare practitioners are encouraged to use professional judgement to provide appropriate care to each individual's needs. |
| UK Association for the Study of Obesity | 016 | 002 - 003 | **Section 1. Preparing for Pregnancy to Section 6.**<br>Ensure women with PCOS are not stigmatised/harmed by being targeted for interventions that may cause harm.<br>Needs to be a more holistic approach to care - focus on health and foetal health rather than "weight" only. Screen for Eating Disorders/Mental Health Problems and avoid stigma. | Thank you for this information. The guideline will reflect broader government initiatives to adopt a person-centred approach. The guideline committee will consider your views when deciding how best to present and communicate the final guidance. How to discuss appropriate interventions for people is covered in CG189 Obesity: identification, |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | assessment and management recommendations 1.3.4 and 1.3.6. |
| UK Association for the Study of Obesity | 023 | 001 | The use of Liraglutide (and subsequently future pharmacotherapy) needs to be made available also within a Tier 4 pathway/service under the appropriate circumstances and following the same recommendations (as within a Tier 3 service) from NICE technology appraisal guidance 664. Many weight management services are commissioned to provide a Tier 4 service only and struggle to provide liraglutide to their patients under the current guidance. It is unethical to deny patients with the same characteristics access to Liraglutide because there is no Tier 3 service locally. A Tier 4 service is a Tier 3 service plus a bariatric surgeon and therefore makes no sense to deny access to pharmacotherapy to patients within this pathway.<br>Referring to a different institution with a Tier 3 pathway in order to start Liraglutide is not good for continuity of care. Liraglutide (Saxenda) can be used as part of optimisation before bariatric surgery in patients with complex obesity as these seen in a Tier 4 service. Patients with T2DM are started on liraglutide (Victoza) to facilitate optimisation before surgery. It makes no sense to be unable to do the same using Saxenda for patients with obesity and prediabetes plus CVD. Enabling clinicians use this treatment in the appropriate circumstances will facilitate patient experience/outcomes within Tier 4 pathways. | Thank you for your comment.<br><br>The updated guideline will have the opportunity to cross-refer to related NICE guidance as needed, including NICE technology appraisal 664 Liraglutide for managing overweight and obesity. Setmelanotide and Semaglutide are the subject of NICE technology appraisals currently in development. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| University of Oxford-NDPCHS | General | General | Amalgamation of prevention, treatment, and identification into one guideline is too broad of a scope. Suggest following WHO approach to consolidated guidelines for each category of guidance-prevention, treatment, diagnosis, screening, etc. | Thank you for your comment. While the potential merits of splitting the guideline into prevention and treatment were considered, on reflection it was felt that splitting the guideline would not impact on the guideline development process. Keeping the guideline as one was felt to tie in with broader government initiatives to adopt a person-centred approach and to recognise the need for a whole-systems approach to addressing overweight and obesity. The guideline committee will consider your views when deciding how best to present and communicate the final guidance. |
| University of Oxford-NDPCHS | 007 - 008 | 004 - 005 | **1.8 Pharmacological interventions**<br>Should be reviewed in light of the semaglutide trials published since the guideline's publication in 2014:<br>• Wilding et al New England Journal of Medicine 2021 (DOI: 10.1056/NEJMoa2032183)<br>• Davies et al Lancet 2021 (https://doi.org/10.1016/S0140-6736(21)00213-0)<br>• Wadden et al JAMA 2021 (doi:10.1001/jama.2021.1831)<br>• Rubino et al JAMA 2021 (doi:10.1001/jama.2021.3224) | Thank you for your comment.<br><br>The updated guideline will have the opportunity to cross-refer to related NICE guidance as needed, including NICE technology appraisal 664 Liraglutide for managing overweight and obesity. Setmelanotide and Semaglutide are the subject of NICE technology appraisals currently in development. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| University of Oxford-NDPCHS | 006 | 004 - 005 | **1.4 Lifestyle Interventions**<br>Should be reviewed in light of the TDR trials, the new NHS Better Health initiative, and the NHS Diabetes prevention programme published since the guideline's publication in 2014. | Thank you for your comment and this information. Type 2 diabetes prevention is out of scope for this guideline. |
| University of Oxford-NDPCHS | 007 | 004 - 005 | **1.7 Dietary**<br>Should be reviewed – especially points 17.5 17.6 and 17.7 in light of TDR trials published since the guideline's publication in 2014:<br>• Lean et al Lancet 2018 (https://doi.org/10.1016/S0140-6736(17)33102-1)<br>• Astbury et al BMJ 2018 (https://doi.org/10.1136/bmj.k3760)<br>• Seimon et al JAMA Netw Open 2019 (doi:10.1001/jamanetworkopen.2019.13733)<br>• Ard et al Obesity 2019 (https://doi.org/10.1002/oby.22303) | Thank you for your comment and this information. Type 2 diabetes prevention and treatment is out of scope for this guideline. The scope includes a key area that covers total meal replacement diets. Evidence reviews will be conducted for the key issues described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The literature you refer to will be captured by these review questions. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. |
| University of Oxford-NDPCHS | 008 | 004 - 005 | **1.11 Bariatric surgery for people with recent-onset type 2** diabetes<br>Should be reviewed in light of new evidence available since the guideline's publication in 2014:<br>• Courcoulas et al JAMA 2015 (doi:10.1001/jamasurg.2015.1534) | Thank you for your comment and additional information. Surveillance identified no new evidence relating to bariatric surgery and type 2 diabetes that would impact current recommendations. We will pass your comments to the surveillance team for consideration. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | • Schauer et al New England Journal of Medicine 2017 (doi: 10.1056/NEJMoa1600869)<br>• Aung et al JAMA 2016 (doi:10.1001/jamasurg.2016.1130) | |
| University of Oxford-NDPCHS | 009 | 002 - 003 | **3 Lifestyle weight management programmes: core components**<br>This should be reviewed in light of the TDR trials published since the guideline's publication in 2013. | Thank you for your comment and this information. Type 2 diabetes prevention and treatment is out of scope for this guideline. |
| University of Oxford-NDPCHS | 010 | 002 - 003 | **8 Formal referrals to lifestyle weight management programmes**<br>Should be reviewed in light of new evidence published since the guideline's publication in 2013:<br><br>Aveyard et al Lancet 2016 (doi: 10.1016/S0140-6736(16)31893-1) | During the scoping of this update and the surveillance review of the NICE guideline PH47 weight management: lifestyle services for overweight or obese children and young people (2013) no new evidence was identified that would impact on the current recommendation 8 'Formal referrals to lifestyle weight management programmes'. The original recommendation remains valid and will appear in the updated guideline.<br><br>The new guideline will also cross-refer to other NICE guidance as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| University of Oxford-NDPCHS | 021 | 004 - 007 | These are two very different questions blended in one. Suggest separating them. Also suggest framing as a question exploring barriers. | Thank you for your comment. The guideline committee will refine the review questions through development of the review protocols. |
| University of Oxford-NDPCHS | 021 | 010 - 013 | Important to preface 'plant-based' and 'low-carbohydrate' with 'low-calorie' or 'low-energy'.<br>There is already substantial evidence since the last review regarding total diet replacement programmes which should be reviewed as part of this update. | Thank you for your comment, the early recruited committee members agreed that the preface was not needed for these diets. |
| University of Oxford-NDPCHS | 021 | 001 - 003 | "Most accurate" is not the right wording, as the most accurate measurement is not feasible. Recommendations can be made to enhance the accuracy of current suitable methods (e.g. BMI) by wearing light clothes, removing shoes, etc. Given its practicality and cost-effectiveness, it is unlikely that BMI will be replaced by other more accurate and suitable measures. | Thank you for your comment. The guideline committee will refine the review questions through development of the review protocols. |
| University of Oxford-NDPCHS | 021 | 014 - 016 | Perhaps the more needed question is on management post-surgery, so 'how can patients be best supported after bariatric surgery?' to manage weight regain and, nutritional deficiencies. | Thank you for your comment. The recommendations on follow-up after bariatric surgery from CG189 section 1.12 are being retained,they will be assessed to ensure that they reflect current context and may be edited. |
| University of Oxford-NDPCHS | 022 | 001 - 014 | Unclear if the outcomes listed will cover long-term impact (i.e. Weight regain?), and whether experience measures will be included. | Thank you for your comment. The scope includes a list of the main outcomes that the guideline may consider. The guideline committee will define the |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | outcomes that will be considered in the evidence reviews through development of the review protocols. |
| University of Oxford-NDPCHS | 022 | 004 - 005 | Outcomes of mortality and morbidity are hard endpoints that may be futile to base a review on based on availability of evidence. Suggest focusing on upstream, prognostic markers such as CVD risk, diabetes, etc. | Thank you for your comment. The scope includes a list of the main outcomes that the guideline may consider. The guideline committee will define the outcomes that will be considered in the evidence reviews through development of the review protocols. |
| University of Wolverhampton | General | General | If we consider the patient in Tier 3 or 4 – they present several complexities and co-morbidities e.g., Diabetes, history of trauma, binge eating disorder. These guidelines seem to 'clean up' the presentation of obesity to an extent that obesity is not being considered in the way that it presents in the clinic, this is not helpful to practitioners working with these individuals as they cannot easily find the guidance that it relevant to their patient. Guidelines for prevention are seemingly 'easier' to clean up and present in a clear and unified manner – perhaps an argument towards keeping prevention and treatment separate as guidelines?<br><br>Some complexities to consider including for the purpose of better representing the patients: | Thank you for your comment. The potential merits of splitting the guideline into prevention and treatment were considered. However, keeping the guideline as one was felt to tie in with broader government initiatives to adopt a person-centred approach and to recognise the need for a whole-systems approach to addressing overweight and obesity. The guideline committee will consider your views when deciding how best to present and communicate the final guidance.<br><br>Endocrine disorders have been added to the equality impact assessment form, which is linked to in section |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | • The use of medications which enhance weight gain e.g., contraception, antidepressants and antipsychotics.<br>• Food affordability and school menus (Diet, nutrition and obesity \| Topic \| NICE)<br>• Endocrine disorders such as type 2 diabetes and hypothyroidism.<br>Binge Eating disorder | 2 of the scope. Socio-economic factors and use of medications which enhance weight gain are already included in the equality impact assessment form. The committee will use this form throughout guideline development. |
| University of Wolverhampton | General | General | More emphasis is needed on maintenance of healthy weight in those who have lost weight and also maintenance of healthy weight in those who are at risk of gaining weight. How do we help people to maintain a healthy weight once they have lost weight? How do we 'check in' and help those who are at risk of gaining weight to maintain their healthy weight and ensure that weight gain does not go unnoticed? | Thank you for your comment, we have amended the question accordingly. |
| University of Wolverhampton | 009 - 010 | 002 - 003 | **Table 2 para 5-7**<br>Review - measurable and specific decision points are made, currently they are subjective and sound as commentary rather than informative, 'encouraging and increasing awareness' require healthcare professionals or the person delivering the service skills and attitude, so they need to have training or specialised services needs to be involved and all others have structured brief intervention style followed by referral. | Thank you for your comment. Tables under the proposed outline for the guideline section contain areas of the guideline that will be updated. Recommendations contained in those areas will either be updated based on evidence reviews or retained. The guideline committee will assess whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| University of Wolverhampton | 005 | 001 | Consideration should be given to people with dementia, intellectual disability, learning disability and Autistic Spectrum Disorder. | Thank you for your comment.<br><br>People living with a learning disability, physical disability or severe mental health problems are included in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it. |
| University of Wolverhampton | 005 | 007 | Need to add at the end 'who are at risk of weight gain' or consider people with normal weight under separate point 'prevention' | Thank you for your comment, we have amended this section accordingly. |
| University of Wolverhampton | 005 | 012 | Can we be sure that pregnant women are considered elsewhere as this is a key time for weight gain, fear of weight gain and change in eating behaviour. It is also a good time to target behavioural change if a mother is obese before being pregnant.<br><br>Ensure it is clear that 'pregnant women' does NOT include when trying for a pregnancy and when breastfeeding. It is worth specifying this clearly. | Thank you for your comment.<br><br>Pregnant women are limited to women who are pregnant and not pre-pregnancy, i.e. women trying to get pregnant, and post-pregnancy, i.e. women who are breastfeeding. Pregnant women are excluded from the scope of this guideline update as they are covered by separate NICE guidance, PH27.<br><br>The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. |
| University of Wolverhampton | 005 | 013 | Are people with dementia included or excluded? | People living with dementia are included within the scope of this guideline and have been added to the |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | equality impact assessment. This assessment will be used during development to ensure that recommendations meet the needs of the groups listed within it.<br>The updated weight management guideline will also have the opportunity to cross-refer to related NICE guidelines as needed, such as NG97 Dementia: assessment, management and support for people living with dementia and their carers |
| University of Wolverhampton | 006 - 021 | 014 - 015 | **Table 1. Line 1**<br><br>1.2 and 1.3 – evidence to contribute to the development of this guideline as specifically requested of Prof Nevill (University of Wolverhampton). PDFs of publications can be provided on request. We note attachments are not accepted at this stage.<br><br>*Extract: Recent research by Ashwell et al (2012) suggests that the waist-to-height ratio is the strongest predictor of cardiometabolic risk (CMR) in adults. Nevill et al. (2017) show that a new ratio, waist divided by height^0.5 (WHT.5R), is not only independent of stature (using allometry) but also a stronger predictor of CMR compared with a wide range of other anthropometric indices including BMI, waist-to-hip ratio (WHR), and waist-to-height ratio (WHTR). The likely explanations are twofold; (1) waist girth is the most sensitive dimension to detect changes in adiposity, certainly better than BMI that might reflect changes in muscle mass as well as adiposity, and (2) using height^0.5 to normalize or scale waist girth for individuals of* | Thank you for your comment and additional information. The scope includes a key area that covers this identification and assessment. Evidence reviews will be conducted for the key issues described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The measures and tools you refer to will be captured by these review questions. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update.<br><br>. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | *different body size is more suitable, since WHT.5R will be independent of stature but also height0.5 is unaffected by changes in adiposity, unlike hip girth that is used to normalise WHR. In other words, unadjusted WC penalizes the taller subjects (for obvious reasons) BUT WC/Height penalizes the shorter subjects (height over scales WC). The only WC-by-height ratio that removes the effect of height from WC completely is WC/(Height^0.5), i.e., it correctly scales WC for differences in height.*<br>*If for some reason waist circumferences were unavailable and height and weight were the only body-size dimensions available, inverse BMI (iBMI) rather than BMI is the better index to adopt. This is because (1) iBMI is a stronger predictor of body fat (%) and most body-fat associated cardio-metabolic risk factors, and (2) iBMI is more symmetric and hence more normally distributed (Nevill et al. 2011)*<br>*References*<br>*Ashwell M, Gunn P, Gibson S. Waist-to-height ratio is a better screening tool than waist circumference and BMI for adult cardiometabolic risk factors: systematic review and meta-analysis. Obes Rev. 2012: 13: 275-286.*<br>*Nevill, A.M, Stavropoulos-Kalinoglou A., Metsios G.S., Koutedakis Y., Holder R.L., Kitas G.D. Mohammed M.A (2011) Inverted BMI rather than BMI is a better proxy for percentage of body fat. Annals of Human Biology. 38(6) 681-684 DOI: 10.3109/03014460.2011.606832.*<br>*Nevill A.M., Duncan M.J., Lahart I and Sandercock G. (2017)*<br>*Scaling waist girth for differences in body size reveals a new* | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | *improved index associated with cardiometabolic risk. Scand J Med Sci Sports DOI: 10.1111/sms.12780* | |
| University of Wolverhampton | 006 | 003 | Which service? Health or health and social? | Thank you for your comment, we have amended this section by adding "health and social care" to the appropriate setting. |
| University of Wolverhampton | 007 | 014 - 015 | **Table 1.8**<br>Should be reviewed as it is repetitive for both children and adults, and not specific with a period of time where the decision can be made, e.g., a year of physical activities, or behaviour or diet or it is based on the risk to the person general health, i.e., one starting point will not suite every scenario and will not save lives. | Thank you for your comment. The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| University of Wolverhampton | 012 | 001 | **Section 1.1.3**<br>Include recommendations for 'healthy cities' if not already included within 'local authorities and partners in the community' review. Likewise, 'healthy universities' may be a useful organisation to link up with in dissemination of preventative measures. | Thank you for your comment. The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| University of Wolverhampton | 012 | 002 | Access to services should be considered, not everyone goes to school or work, or even to the GP. Can we think more broadly about settings, taking into consideration the possibilities offered by digital content, social media, and stakeholder groups who may be active in the community with the target populations. | Thank you for your comment. The guideline will cover all settings where publicly funded healthcare services are commissioned and provide. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| University of Wolverhampton | 013 | 001 | These are very loose words, the way people are approached especially when they are asked to change behaviour, require skills, leaving this to be done without training, or with minimal training, the HCP or providers may not see a great return for their time, or at worst may see negative outcomes (e.g., patient being retaliative/withdrawing from services due to perception of 'being told what to do'). | Thank you for your comment. Addressing the training needs of health professionals are covered in recommendations 1.1.2.5 in CG43 Obesity prevention (2015) . These recommendations are to be retained.<br><br>The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| University of Wolverhampton | 016 | General | There's nothing that relates to paternal weight gain; please consider including. | Thank you for your comment.<br>Identifying underlying causes of obesity and overweight are covered in the following recommendations in CG189 Obesity: identification, assessment and management (2014):<br><br>1.3.1Make an initial assessment (see recommendations 1.3.6 and 1.3.8), then use clinical judgement to investigate comorbidities and other factors to an appropriate level of detail, depending on the person, the timing of the assessment, the degree |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | of overweight or obesity, and the results of previous assessments. **[2006]**<br>1.3.6Take measurements (see recommendations in section 1.2) to determine degree of overweight or obesity and discuss the implications of the person's weight. Then, assess:<br>• any presenting symptoms<br>• any underlying causes of being overweight or obese<br><br>These recommendations are to be retained. The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed. |
| University of Wolverhampton | 017 | 004, 006 | We disagree with excluding point 2 and 4. Most obese individuals who have been traumatised during the process of losing weight, end up on the other side of the spectrum, i.e., eating disorders and if this not taken into account and prevented during the weight loss period, we may have negative outcomes. | Thank you for this information. Eating disorders are covered in a separate NICE guideline, NG69 Eating disorders: recognition and treatment. The updated weight management guideline will have the opportunity to cross-refer to related NICE guidelines as needed. We will also forward your comments to |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | NICE's surveillance team for consideration at the next surveillance review of NICE guideline NG69. |
| University of Wolverhampton | 021 | 017 - 023 | Please consider the cost to the consumer not just the health services<br>We also suggest considering:<br>1. Patient cognition and education impact on their ability to follow the plans.<br>Culture and religion impact on patients' ability to follow the plans. | Thank you for your comment.<br><br>Patient cognition is covered in recommendations 1.3.4 and 1.3.6 in CG189 Obesity: identification, assessment and management (2014). These recommendations are to be retained.<br><br>The guideline committee will consider whether recommendations in areas that are being retained from the existing guidelines need to be edited to ensure that they meet current editorial standards and reflect the current policy and practice context. The new guideline will also cross-refer to other NICE guidance as needed.<br><br>**People living with a learning disability and people living with severe mental health problems are included in the equality impact assessment form, which is linked to in section 2 of the scope.** |
| University of Wolverhampton | 021 | 010 | Unless this is supplied to the patient, not everyone will be able to afford it. | Thank you for your comment.<br><br>Socioeconomic factors are included in the equality impact assessment form, which is linked to in section 2 of the scope. This assessment will be used during |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | | development to ensure that recommendations meet the needs of the groups listed within it. |
| University of Wolverhampton | 021 | 010 | In considering effectiveness, the psychological processes underpinning eating behaviour should be considered.<br>(1) If someone is being invited to use quite rigid rules with their eating, and they are using food for emotional coping, then the new rules will take away their way of coping. Working with them to develop alternative coping strategies, and thereby reducing use of food for coping will help with weight maintenance in the long term e.g., see- https://onlinelibrary.wiley.com/doi/pdf/10.1002/oby.22685.<br>(2) motivation for change should be addressed to increase the probability of long-term change coming about.<br>(3) individual differences need to be examined in relation to this question. Not all options are equally effective for all populations. Not all options are feasible and acceptable. | Thank you for your comment. The scope includes a list of the main outcomes that the guideline may consider. The guideline committee will define the outcomes that will be considered in the evidence reviews through development of the review protocols. |
| University of Wolverhampton | 021 | 014 | It would be useful to specify (a) what we mean by 'weight loss' here – how is this to be defined? (b) the length of time being referred to by 'maintain'.<br><br>What is the scope of referral criteria here? Will use of food for emotional coping be included in the assessment? Patients we have interviewed found that their use of food for coping was not addressed and so their option for this as a coping strategy was removed after surgery, resulting in either turning to other harmful ways of coping (e.g., alcohol or self-harm) or tried to eat and in doing so brought about a need for further surgery. Use of food for emotional coping is a key aspect to address pre-surgery. Alternative | Thank you for your comment. The scope includes a list of the main outcomes that the guideline may consider. The guideline committee will define the outcomes that will be considered in the evidence reviews through development of the review protocols. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | coping strategies will be needed, and the patient will need a good understanding of their use of food for emotional coping. | |
| University of Wolverhampton | 021 | 021 | We would encourage an exploration of efficacy and effectiveness here. Acceptability needs adding to this question. https://bjsm.bmj.com/content/50/6/323 | Thank you for your comment, we have amended this section to add acceptability. |
| University of Wolverhampton | 022 | 001 | Intermediate outcomes could also consider psychological variables known to impact on weight loss, eating behaviour and long-term health behaviour maintenance. If we see a change in coping for example, it can result in a long-term change in weight or maintenance of a healthier weight. https://onlinelibrary.wiley.com/doi/pdf/10.1002/oby.22685 | Thank you for your comment. The scope includes a list of the main outcomes that the guideline may consider. The guideline committee will define the outcomes that will be considered in the evidence reviews through development of the review protocols. |
| University of Wolverhampton | 022 | 011 | Mental health should appear here. | Thank you for your comment. The scope includes a list of the main outcomes that the guideline may consider. The guideline committee will define the outcomes that will be considered in the evidence reviews through development of the review protocols. |
| Versus Arthritis | 003 | 018 | Obesity increases both a person's risk of developing type 2 diabetes and of developing osteoarthritis[i], which may be relevant to the black, Asian and other minority communities mentioned here. | Thank you for your comment and this information. |
| Versus Arthritis | 021 | 003 | In assessing the most accurate and suitable methods of measuring the health risks associated with overweight and obesity, assessing the risk to long-term musculoskeletal (MSK) health should be included as part of any such risk assessments. | Thank you for your comment. The scope includes a list of the main outcomes that the guideline may consider. The guideline committee will define the outcomes that will be considered in the evidence reviews through development of the review protocols. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | **Context:** MSK conditions are one of the biggest health risks to people who are obese: 7 in 10 people who report living with a long-term MSK condition are overweight or obese.[ii]<br><br>For example, obesity is a significant risk factor for knee osteoarthritis. When the impact of an ageing population and a growing obese population is considered, by 2035 there are expected to be 8.3 million people living with knee osteoarthritis[iii].<br><br>Recently published research has revealed the relationship between obesity and the clinical consequences of knee osteoarthritis, showing a progressive correlation between the degree of obesity based on BMI and the clinical consequences[iv]. In this analysis, participants with a higher BMI had higher pain scores, had a higher degree of disability and they were more likely to report anxiety and depression; this concurs with the findings of other research. In addition, the higher the obesity stage, the less participants undertook physical activity, which further increased their risk of leading a sedentary lifestyle. The average BMI of individuals undergoing a knee replacement in 2019 was 30.9 which is classified as obese.[v]<br><br>Clearly obesity, levels of physical activity and the progression of osteoarthritis are closely linked and this dynamic needs to be reflected in the scope and content of the NICE Guideline on weight management. | |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | The relationship between weight and MSK health is also seen in the data collected on other MSK conditions and their underlying risk factors. Compared to people of a healthy body weight, people who are obese are:<br>• Twice as likely to develop gout and develop it earlier in the life course[vi].<br>• Between 1.5 and 2.5 times more likely to experience back pain[vii] [viii].<br>More likely to experience poor disease outcomes and comorbidities for rheumatoid arthritis[ix]. | |
| Versus Arthritis | 022 | 005 | Add after cardiovascular disease "or long-term MSK problems such as osteoarthritis."<br><br>**Context:** Obesity directly damages weight-bearing joints. For people with osteoarthritis, relatively modest weight loss, particularly when combined with increased physical activity, reduces pain and disability, and improves quality of life[x]. | Thank you for your comment, we have amended this section to add musculoskeletal . |
| Versus Arthritis | 022 | 011 | Suggest providing examples here such as: 'being able to work, undertake exercise and live without joint or muscle pain.' | **Thank you for your comment. The scope includes a list of the main outcomes that the guideline may consider. The guideline committee will define the outcomes that will be considered in the evidence reviews through development of the review protocols.** |
| Versus Arthritis | 022 | 014 | Provide examples – such as the cost-benefits of not requiring hip or knee replacement surgery and associated rehabilitation. For example, based on the number of knee replacement operations undertaken each year by the NHS in England[xi] and the average cost | Thank you for your comment. The scope includes a list of the main outcomes that the guideline may consider. The guideline committee will define the outcomes that will be considered in the evidence |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| | | | per operation[xii], knee replacement surgery alone costs the NHS over £600m every year. | reviews through development of the review protocols. |
| Weight Watchers | General | General | In addition to your comments below, we would like to hear your views on: Are there any cost saving interventions or examples of innovative approaches that should be considered for inclusion in this guideline?<br><br>WW welcomes the review and consolidation of the existing weight management guidelines. WW ask if the scope can explicitly include digital and blended approaches, particularly in light of the pandemic. Although the scope does identify that digital approaches are covered separately in *Behaviour change: digital and mobile health interventions [NG183]* and this was published October 2020, and the delivery of weight management programmes using digital and online formats has changed significantly for both the NHS and commercial providers in a very brief period of time. It is highly probable that all providers will continue to use digital and blended approaches, therefore evidence review and guidance on this would be invaluable. Digital and blended interventions are proving to be innovative and cost saving, and it is unlikely that any providers will return solely to the pre-pandemic traditional face-to-face groups. These approaches also have many benefits for individuals in terms of accessibility, connectedness and accountability but also raise equality issues (e.g. based on sociodemographic status and digital literacy), all of which would benefit from consideration by NICE. | **Thank you for your comment. The guideline will cover all publicly funded healthcare services and approaches that are commissioned and provided.** |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Weight Watchers | 003 | 009 | During the Stakeholder Consultation Workshop the issue of measurement was discussed extensively, specifically with regard to staging systems versus BMI. Clearly there are benefits from staging systems, for example the EOSS aligns with other methods of clinical diagnosis including (in the case of EOSS) metabolic, mechanical and mental health risk factors. WW would welcome an evidence review on this, especially with the links to lower BMI and risk of long term health conditions at a lower BMI amongst people from BAME communities. However, whilst BMI is clearly a measure of excess weight and not adiposity (and therefore not perfect) it is simple, quick, inexpensive, and therefore is fully scalable, which a staging system is not. Therefore guidance from NICE on this would be invaluable. | Thank you for this information.<br><br>The measures and tools you refer to will be captured by these review questions. The scope will consider the evidence for adults, children, and young people in the key area of identification and assessment. |
| Weight Watchers | 003 | 014 | WW welcome the recognition that there are challenges in relying on opportunistic identification, rather than active case finding. We hope this can be more fully explored. | Thank you for your comment. We welcome your support for this scope. |
| Weight Watchers | 005 | 014 | WW question if 'settings' is the most fitting descriptor and if this encapsulates the digital and blended intervention landscape we are now in, particularly in light of the pandemic. Most providers including the NHS have switched to some form of digital provision during the pandemic and are unlikely to return to wholly physical delivery, which setting does imply. We would welcome this definition to be broadened to digital in all its formats video group/individual, apps, web-based platforms. | Thank you for your comment. The guideline will cover all settings where publicly funded healthcare services are commissioned and provided. |

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

| Stakeholder | Page no. | Line no. | Comments | Developer's response |
|---|---|---|---|---|
| Weight Watchers | 005 | 018 | Should all government funded education be included, e.g. further and higher education? For many young people this is a key transition stage with regards diet, activity and behaviour. Weight management support from relevant educational providers could be key. | Thank you for your comment, we have amended this section to include further and higher education. |
| Weight Watchers | 005 | 018 | Please can workplaces be added to this section? It is mentioned on p.12, bottom of Table 4. | Thank you for your comment, we have amended this section to include workplaces. |
| Weight Watchers | 010 | 011 - 014 | Staff are developing and delivering interventions online and this requires a particular skill set that is different to physical development and delivery. WW would welcome the inclusion of this in scope. | Thank you for your comment. The guideline will cover all settings where publicly funded healthcare services are commissioned and provided, this includes via digital format. |
| Weight Watchers | 022 | 001 | Please could the scope explicitly include mental health/wellbeing under outcomes. This could be a separate item or added in parenthesis after health related quality of life (line 11). | **Thank you for your comment. The scope includes a list of the main outcomes that the guideline may consider. The guideline committee will define the outcomes that will be considered in the evidence reviews through development of the review protocols.** |

[i] Arthritis Research UK (now part of Versus Arthritis) Musculoskeletal conditions and multimorbidity, 2015. Available here: https://www.versusarthritis.org/media/2078/msk-conditions-and-multimorbidity-report.pdf, Accessed 4 May 2021.
[ii] Versus Arthritis, The State of Musculoskeletal Health, 2019. Available here https://www.versusarthritis.org/media/14594/state-of-musculoskeletal-health-2019.pdf Accessed 5 May 2021.

# Weight management

## Consultation on draft scope
## Stakeholder comments table

## 09/04/21 to 07/05/21

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[iii] Arthritis Research UK (now part of Versus Arthritis) Musculoskeletal conditions and multimorbidity, 2015. Available here: https://www.versusarthritis.org/media/2078/msk-conditions-and-multimorbidity-report.pdf, Accessed 4 May 2021.
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[v] National Joint Registry. NJR 17th Annual Report, 2020. Available here: https://reports.njrcentre.org.uk/Portals/0/PDFdownloads/NJR%2017th%20Annual%20Report%202020.pdf, Accessed 5 May 2021
[vi] M. McAdams DeMarco et al. Younger age at gout onset is related to obesity in a community-based cohort. Arthritis Care & Research, vol. 63, no. 8, pp. 1108-1114, 2011. Available here: https://onlinelibrary.wiley.com/doi/epdf/10.1002/acr.20479, Accessed 5 May 2021.
[vii] Smuck M, Kao MC, Brar N, Martinez-Ith A, Choi J, Tomkins-Lane CC. Does physical activity influence the relationship between low back pain and obesity? Spine J. 2014 Feb 1;14(2):209-16. doi: 10.1016/j.spinee.2013.11.010. Epub 2013 Nov 12. PMID: 24239800, Available here: https://pubmed.ncbi.nlm.nih.gov/24239800/, Accessed 5 May 2021.
[viii] Heuch I, Heuch I, Hagen K, Zwart JA. Body mass index as a risk factor for developing chronic low back pain: a follow-up in the Nord-Trøndelag Health Study. Spine (Phila Pa 1976). 2013 Jan 15;38(2):133-9. doi: 10.1097/BRS.0b013e3182647af2. PMID: 22718225, Available here: https://pubmed.ncbi.nlm.nih.gov/22718225/, Accessed 5 May 2021.
[ix] Ajeganova, S., Andersson, M.L., Hafström, I. and BARFOT Study Group, 2013. Association of obesity with worse disease severity in rheumatoid arthritis as well as with comorbidities: a long-term followup from disease onset. Arthritis care & research, 65(1), pp.78-87, Available here: https://pubmed.ncbi.nlm.nih.gov/22514159/, Accessed 5 May 2021.
[x] Arthritis Research UK (now part of Versus Arthritis) Musculoskeletal conditions and multimorbidity, 2015. Available here: https://www.versusarthritis.org/media/2078/msk-conditions-and-multimorbidity-report.pdf, Accessed 4 May 2021.
[xi] Royal College of Surgeons, Surgery and the NHS in Numbers, Available here: https://www.rcseng.ac.uk/news-and-events/media-centre/media-background-briefings-and-statistics/surgery-and-the-nhs-in-numbers/, Accessed 5 May 2021.
[xii]NICE, Resource Impact Report, Joint replacement (primary): hip, knee and shoulder (NG157), June 2020, Available here: https://www.nice.org.uk/guidance/ng157/resources/resource-impact-report-pdf-8708810221, Accessed 5 May 2021.