National Institute for Health and Care Excellence

Quality Standards Advisory Committee 3 meeting

Date: Thursday 21 March 2024

Overweight and obesity management – prioritisation of quality improvement areas

Minutes: UNCONFIRMED

Quoracy: The meeting was quorate.

Attendees

Standing committee members:

Rebecca Payne [Chair], Tim Cooper [Vice Chair], Umesh Chauhan, Jane Dalton, Shorai Dzirambe, Dominika Froehlich-Jeziorek, Kultar Singh Garcha, Keith Lowe, Linda Parton, Kashif Siddiqui, Mark Temple.

Specialist committee members:

Kate Anderson [joined during item 4], Nivedita (Dee) Aswani, Sarah Britton, Sarah Le Brocq, Preetpal Doklu, Omar Khan, Alex Miras, Helen Paretti.

NICE staff

Charlotte Fairclough (CF), Victoria Fitton (VF), Jean Masanyero-Bennie (JB), Mark Minchin (MM), Daniel Smithson (DS), Louise Jones [notes].

NICE observers

Rebecca Boucher, Susan Burlace, Cheryl Hookway, Caroline Mulvihill.

Apologies

Deryn Bishop, Saran Evans, Mariana Gaspar Fonseca, Jane Scattergood, Suzy Taylor.

1. Welcome, introductions objectives of the meeting

The Chair welcomed the attendees and public observers, and the quality standards advisory committee (QSAC) members introduced themselves. The Chair informed the committee of the apologies and outlined the objectives of the meeting, which was to prioritise areas for quality improvement.

2. Confirmation of matter under discussion and declarations of interest

The Chair confirmed that, for the purpose of managing conflicts of interest, the matter under discussion was overweight and obesity management. Specifically:

DRAFT

- General principles of care
- Information and support to help people maintain a healthier weight
- Preventing overweight, obesity and central adiposity in local or regional strategic partnerships
- Behavioural overweight and obesity management interventions
- Planning, delivering, and monitoring services
- Identification, assessment and referral
- Medicines for overweight and obesity
- Surgical interventions.

The Chair asked standing QSAC members and specialist committee members to declare any interests additional to those that were circulated and any interests specifically related to the matters under discussion:

- Nivedita Aswani highlighted recent updates to her declarations, including her roles as Clinical co-investigator on the NIHR HSDR funded ENHANCE study, and Assistant Officer for Nutrition and Obesity, on Health Improvement Committee at RCPCH (direct nonfinancial, personal and professional interests).

- Helen Parretti declared upcoming participation in a meeting with NHSE to advise about tirzepatide (direct nonfinancial, personal and professional interest).

- Umesh Chauhan declared previous publication work relating to weight management for adults with intellectual disabilities (direct nonfinancial, personal and professional interest).

- Alex Miras declared receipt of fees from Novo Nordisk for advisory boards and educational events, and research funding, and fees from Lilly for educational events (direct financial interest).

- Omar Khan declared receipt of fees from Novo Nordisk for educational events (direct financial interest).

The Chair and NICE team confirmed that the interests declared by Helen and Umesh did not prevent them from fully participating in the meeting. Nivedita's declarations had been reviewed prior to the meeting and it was noted that the interests did not prevent her from fully participating in the meeting.

The Chair and NICE team reviewed Alex and Omar's declarations prior to the meeting, and it was agreed that they were excluded from taking part in the general discussions or decision-making related to the medicines discussion item as specialist committee members, as per NICE's DOI policy, which states any standing or specialist committee members with a specific financial interest is excluded from committee discussions for the duration of the relevant item. However, as their particular expertise would otherwise not be available to the committee, they were asked to remain to answer any specific questions posed by the Chair.

3. Minutes from the last meeting

The committee reviewed the minutes of the last QSAC 3 meeting held on 22 February 2024 and confirmed them as an accurate record.

4. Prioritisation of quality improvement areas – committee decisions

DS highlighted that the key development source would be NICE's guideline in development overweight and obesity management (draft guidance), which is an amalgamation and update of several pre-existing guidelines in this area (CG43, CG189, PH27, PH42, PH46, PH47, PH53, NHG7).

It was noted that the new quality standard would replace the existing NICE obesity quality standards Obesity in children and young people: prevention and lifestyle weight management programmes (QS94), Obesity in adults: prevention and lifestyle weight management programmes (QS111) and NICE quality standard for obesity: clinical assessment and management (QS127), and the population would cover children, young people, and adults.

DS provided a summary of responses received during the overweight and obesity management topic engagement, referred the committee to the full set of stakeholder comments provided in the papers, and the committee then discussed each of the areas in turn. The committee discussed the comments received from stakeholders and specialist committee members at topic engagement **(in bold text below)**.

General principles of care

- **Discussion and communication**
- **Weight stigma**

A committee member highlighted that given the breadth of the population to be covered by this quality standard, it would be important to ensure that the final prioritised list of statements has the right balance, addressing issues affecting children and young people as well as adults.

The committee agreed that general principles of care was a key priority area for inclusion in the quality standard. It was highlighted that weight stigma (and its effects on discussion and communication) is perhaps the main initial barrier to accessing appropriate care, and that experiencing weight stigma in a healthcare situation can result in people avoiding other healthcare contact, with potentially significant negative impact on their wider health, wellbeing, and self-perception. It was noted that destigmatising obesity and overweight for children and young people could have increased long-term impact on these individuals.

The committee discussed what the appropriate terminology and language should be when discussing the conditions of overweight and obesity and use of the phrasing ‘people are living with overweight or obesity’. The committee heard that if a person is told they ‘have excess weight’ this has negative connotations and ‘overweight’ and ‘obesity’ are BMI categorisations so the correct terminology should be used for consistency. It was agreed that using correct terminology is important to align to how other clinical and chronic conditions are described and avoid stigmatising phrasing.

The committee discussed the importance of non-stigmatising language, empathy and respect. It was acknowledged that nomenclature changes over time and that addressing attitude and discrimination behind the use of stigmatising language requires cultural shift. The committee discussed the potential need for training for medical and allied healthcare professionals around language and the need to treat overweight and obesity as a chronic condition. It was noted that the proportion of people with obesity reporting that they had not been treated with respect by healthcare professionals was too high . A specialist committee member highlighted that use of stigmatising language extends wider than healthcare professions (for example, social prescribers), and that every interaction with services should be free from stigma. The NICE team noted that any statement related to training would require work with Health Education England and perhaps relevant Royal Colleges.

The committee highlighted the importance of asking permission before discussing overweight, obesity or central adiposity and before taking measurements. It was noted that that some people may not be aware of the general practice QOF obesity register or that they are on it. The committee agreed that asking permission and use of appropriate language both feed into the broad area of ensuring a person-centred approach to discussion and communication. It was noted that it is important to consider an individual’s wider health, wellbeing and what is important to them, alongside communicating in an age-appropriate manner and with family and carers.

The committee discussed the complexity of measuring a person-centred approach to care and whether it may be necessary to request additional data collection. It was highlighted that the National Obesity Audit targets specialist weight management services and could be a potential data source.

Actions:

- NICE team to prioritise this area, exploring a statement based on recommendations around a non-stigmatising, personalised approach to communication, use of language and asking permission.
- NICE team to consider how to include adults, children, parents and carers

Information and support to help people maintain a healthier weight

- **Accurate information and details of local services**
- **Healthy nutrition and activity levels advice**

The committee reflected that increasing public information about services may not necessarily provide the biggest impact, without also increasing the corresponding impetus and availability to use them.

The committee discussed whether provision of more information and support around healthy eating and weight management may provide a wider health benefit – acting as a preventative measure for overweight and obesity and also impacting positively on areas such as cardiac health. The committee agreed that whilst provision of healthy nutrition and activity levels advice in schools is varied, it would be more impactful to focus on prioritising other areas as NICE's reach in the health and care sector is greater than that in the education sector.

The committee discussed food intolerances, noting that paediatric allergies are more likely to result in underweight rather than overweight, and that intolerances can present due to neurodiversity sensory issues and post-bariatric surgery. The NICE team confirmed that the guideline does not cover food intolerances.

The committee heard that people with learning disabilities (LD) were at greater risk of having obesity than the general population and had poorer outcomes, felt it was important to prioritise a statement specific to supporting this subgroup, due to the potential impact on reducing health inequality. The NICE team agreed to explore the possibility of a statement in this area, as although there were not any immediately identifiable NICE recommendations on which to base a statement, this is an area of concern with relation to health inequality and the LD population are a smaller subset. The committee highlighted that resources may be less accessible to this group and that better coordination across healthcare and social care could be impactful, with annual health assessments an opportunity for information to be shared and embedded within care plans. It was also noted that provision of nutrition training to those delivering care plans for people with learning disabilities could act as a preventative element to support them with making healthy eating choices.

The committee commented that there was variation in the availability of accurate details of local services and felt that both patients and healthcare professionals would benefit from access to an up-to-date directory of services available, so a statement in this area should be prioritised. It was noted that available resources are not always fully accessible – for example, in different languages, suitable for people with low literacy, in digital format for children and young people who are more likely to engage with digital media than printed pamphlets. The committee heard that sometimes information provided by different services can conflict and this can also be a barrier to patients to implement.

The committee agreed that to ensure an accurate directory of services could be made available, both NHS services and councils would both need to input (current practice is varied, with information shared only where services are proactive regarding partnership and engagement). The committee felt that there would be benefit in GPs receiving more feedback about the outcomes of their referrals to

other services, and recording the decisions made by patients about what interventions they agreed would work best for them, as this information would allow them to make more informed suggestions to people about what they may find successful. It was noted that cross-reference to wider NICE guidance on shared decision-making may be useful to include. It was also highlighted that having more information about which services and interventions are making a difference will help to identify what it is beneficial to commission more of, and it could be interesting to see whether increased information flow back to referrers leads to more referrals being made to community providers.

Actions:

- NICE team to prioritise this area
- NICE team to explore development of a statement on providing information and support to people with learning disabilities, potentially utilising accredited non-NICE guidance
- NICE team to explore development on which to base a statement regarding provision of information and details of local services

Preventing overweight, obesity and central adiposity in local or regional strategic partnerships

The committee discussed stakeholder feedback and existing quality statements regarding access to clearly displayed healthy eating choices in local authority and NHS venues. The committee noted that whilst a statement in this area may be low resource, it would likely also be low impact unless it related to policy rather than messaging. They questioned whether affordability of healthy eating choices would be an area worth focus, but highlighted that food policy may already be covered by NHS public food contracts and that the potential benefit of prioritising a statement in this area would be limited.

The committee noted that any statement that removed all unhealthy food choices in healthcare settings could introduce inequalities, as this could negatively impact people who require a high calorie diet, are avoiding tube feeding or are extremely unwell and want to eat a less healthy choice.

The committee felt that children and young people would be the population most likely to benefit from a statement in this area, but that NICE's influence in school policy would be limited and that it would be more impactful to focus on prioritising other areas.

The committee agreed not to draft a quality statement for this area.

Behavioural overweight and obesity management interventions

The committee discussed the importance of follow-up support after treatment by weight management services, to prevent relapse and weight-cycling and support weight maintenance across the full population of children, young people and adults. It was agreed that the most effective long-term impact is gained through provision of a range of intervention options at different times, rather than a single intervention, and that a statement in this area should be prioritised.

The committee noted inequalities in access to specialist weight management services between ICBs and issues with capacity in existing services. They acknowledged that there would be a resource impact associated with additional follow-up appointments but felt that it may be offset by reducing re-presentations. The committee agreed that the potential impact of a statement in this area could be significant and was as important as addressing weight stigma.

The committee noted that it would be helpful to prioritise feedback from commissioners regarding achievability of a statement in this area during the consultation on the draft quality standard. It was agreed that resourcing could be challenging and require restructure of services due to lack of additional funding, however as better follow-up support should lead to reduction in weight-cycling, the positive impact on services and people's wellbeing long-term should counterbalance this.

Actions:

- NICE team to prioritise this area
- NICE team to explore development of a statement on follow up after behavioural weight management interventions and encouraging weight maintenance

Planning, delivering, and monitoring services

- **Multidisciplinary teams** (MDTs).
- **Monitoring and evaluating all local provision.**

The committee heard that weight management MDTs from previous guidelines have not been well implemented. It was noted that MDTs are available through weight management services and that access was subject to geographical area variation and available to people living with obesity and not overweight.

A committee member highlighted that MDTs are important for improving support for vulnerable groups, such as people with learning disabilities, for whom multicomponent interventions are evidenced as having most impact. It was agreed that whilst equal access to MDTs was the key priority, a statement relating to the roles within an MDT may also be of benefit and the committee would confirm whether to proceed with drafting a second statement about this once all discussion areas had been covered.

The NICE team noted that the guideline recommendations relating to access to MDTs were limited and would need to be reviewed to ensure a statement could be proposed within its remit. The committee suggested that a statement could focus on people having equal access to MDTs through provision of local access to specialist weight management services (ideally one in every ICB). They acknowledged that implementation of MDTs in areas they are do not already exist would have high resource impact, but felt that the benefits of having effective MDTs available would reduce pressure in other areas of the NHS and improve outcomes for people in vulnerable groups.

The committee heard that stakeholders felt data collected in overweight and obesity services should be published/made available and collected on a broad range of outcomes, but agreed that a statement in this area was not a priority.

Actions:

- NICE team to explore prioritising a statement regarding equal access to multidisciplinary teams through local services

Identification, assessment and referral

- **Identification and assessment.**
- **Access to weight management services.**
- **Referral to WMS and intervention.**
- **Tailored support.**

The committee discussed the potential benefits of recommending regular waist/height measurement and assessment of BMI for the whole population. It was proposed that this could help with a variety of other diagnoses and avoid stigmatising those living with overweight and obesity as it would be carried out without bias as a general health measure. The importance of asking permission before taking measurements was reiterated and the committee heard that for children and young people early identification of weight issues is beneficial for long-term health and weight-height plotting is a useful measure for paediatrics. It was mentioned that there had been a lot of negativity around weighing children as part of the national child measurement programme.

The committee discussed the high resource impact of prioritising a statement introducing regular measurements for all, and how this could be mitigated or more focused on specific areas of highest impact. A suggestion was made around people being able to submit their own self-measurements to GPs, such as waist measurement, and the opportunity for measurement in other settings not limited to GPs. This may be a way to make this information more accessible and identify health inequalities. It was agreed that annual measurements for all may be too burdensome on the system, however requesting a measurement for all people at least every 5 years would align with the timeframe used to collect blood pressure measurements and the NHS health-check for those aged over 40. Focus could then be given on annual measurements for those at higher risk – those with long-term health conditions or co-morbidities (including those not necessarily related to weight, such as heart failure or COPD).

The committee agreed that referral for comorbidities and diagnostic overshadowing associated with weight was an important area, however decided not to proceed with a specific statement as they were unable to identify a measurable action. It was suggested that guidance notes and supporting information for the statement which would be drafted on weight stigma could mention the need for a whole-person holistic approach, to ensure every health problem is addressed in its own right and not assumed related to a person's weight.

The committee again acknowledged inequalities in access to specialist weight management services, particularly geographically, with referrals unable to take place to services which do not exist, and resulting in long waiting times where services are at capacity/overprescribed. Long waiting times post-referral were identified as problematic, as it is important that people are seen and receive fair treatment in a timely manner. The committee agreed it may be helpful to explore a statement relating to access to specialist weight management services, focusing on a commissioning audience, in order to reduce inequalities in access and timely treatment. They also noted the importance of psychological support for people using specialist weight management services.

The committee noted the importance of examining data on who is being referred/accessing services and outcomes. It was suggested that the National Obesity Audit may be able to provide insight in order to evaluate whether different demographics are receiving treatment in representative proportions, whether there is reflection that different population groups are more vulnerable/have higher risk factors, and whether people are being referred based on the correct BMI threshold for their ethnicity.

Actions:

- NICE team to prioritise a statement regarding regularly recording weight/ BMI / waist to height ratios
- NICE team to explore how to link commissioning of services into a statement and if data is available to determine whether access for specific subgroups should be prioritised to reduce inequalities

Medicines for overweight and obesity

Alex and Omar removed themselves from this discussion.

The committee discussed equity of access to medicines for overweight and obesity, and the variation in practice and logistics between settings in which medication is initially prescribed and then re-prescribed. Specialist committee members noted that a statement could perhaps focus on shared care, however it this may not reflect current commissioning arrangements. The time and effort involved in ensuring continuity of prescription can be difficult to resource; primary care re-prescribes but follow-up and review is not always carried out by specialist/tier 3 services. Some medication cannot currently be prescribed in some areas/primary care settings, which complicates logistics of

follow-up and monitoring.

The committee commented on trends in prescriptions for orlistat, noting that it is now available over-the-counter and therefore accessible outside of NHS services. Specialist committee members noted that those accessing the medicine without prescription were not receiving monitoring and follow-up and noted the potential risk for adverse effects such as nutritional deficiencies. The committee suggested that medicines could be used to support people in maintaining their weight loss and avoiding weight-cycling.

The committee acknowledged that the medicines landscape is fast-moving and that there is an ongoing NICE technology appraisal of tirzepatide. It was agreed that access to medicines is currently limited by access to specialist weight management services and that a statement should be prioritised around ICBs and local health systems needing to work together to ensure access to medicines for people who meet the necessary eligibility criteria. The committee noted that timely access to medicines could prevent build-up of chronic ailments and be life-transforming for patients who are waiting multiple years to receive treatment.

Actions:

- NICE team to explore development of a statement regarding partnership working to improve access to medicines for eligible patients

Surgical interventions

- **Access to bariatric surgery.**
- **Information on bariatric surgery.**
- **Postoperative and longer-term follow-up.**

The committee discussed access to bariatric surgery, noting variation in service availability and procedure rates across ICBs. Specialist committee members highlighted that NICE recommendations regarding tier 3 and 4 obesity management services are not being implemented and that rates of bariatric surgery in other European countries are much higher, with France carrying out 6 times more procedures.

Committee members were concerned that tier 3 services were being used as a barrier to accessing surgery, and heard that long waiting times (3 – 5 years) and frequently changing, inconsistent and/or non-evidence based criteria for referral are directly resulting in increased bariatric tourism and private treatment. It was agreed that the NICE team would explore the available guidance on which to base a potential statement regarding timely access to bariatric surgery, due to the importance of reducing inequalities caused by variation in availability.

The committee agreed with stakeholder concerns over the lack of information on risk and follow-up for people who chose to have bariatric surgery abroad and noted that this was a difficult area for GPs as there is not a shared-care approach and they may not have access to all the information about the treatment and the follow-up needed. A specialist committee member highlighted that there is advice for GPs available on the British Obesity and Metabolic Surgery Society webpage 'GP hub'. The committee concluded that it was important to prioritise a statement aiming to reduce the underlying access issues to surgery, as this should also result in less people opting to go abroad for procedures.

The committee reviewed existing quality statements regarding post-operative care and longer-term follow-up and monitoring (QS127) and agreed this area should be prioritised (suggesting that supporting information should mention the statement also applies for those who have had bariatric surgery abroad). CF advised that there are two separate statements to cover this area within QS127 due to the distinction between settings for the initial postoperative follow-up and the long-term monitoring after discharge from bariatric surgery services. The committee highlighted that people are

not receiving important long-term monitoring as part of a shared-care model of management and asked the NICE team to explore whether a merged statement could be feasible.

Actions:

- NICE team to prioritise this area
- NICE team to review available recommendations on which to base a statement regarding timely access to bariatric surgery
- NICE team to develop a statement on post-operative follow-up and monitoring

5. Additional quality improvement areas suggested by stakeholders at topic engagement

The committee agreed that the following areas would benefit from input of a specialist that is currently not on the committee:

- **Trauma-informed approach.**
- **Disordered eating.**

Specialist committee members highlighted that these areas are of importance, with increasing emphasis on the psychological support side of obesity management. The committee re-visited their earlier discussion regarding the make-up of MDTs and agreed that a quality statement for inclusion of a psychological component/expert within MDTs could improve support, particularly for people with trauma histories and disordered eating.

It was suggested the NICE team consider recruitment of an additional specialist committee member with a psychological specialism, and that liaison with stakeholders such as the British Psychological Society (who have a specialist obesity group) could provide valuable insight at consultation.

Actions:

- Specialist committee members to share evidence base with the NICE team regarding increasing emphasis on the psychological support side of obesity management.
- NICE team to seek additional input from psychological specialist(s).
- NICE team to consult stakeholders on a possible statement relating to the make-up of MDTs.

The following areas were not progressed for inclusion in the draft quality standard as the committee agreed that they are covered by other NICE quality standards:

- **Medicines safety.**
  QS120: Medicines optimisation

- **Promotion of breastfeeding.**
  QS37: Postnatal care
  QS98: Nutrition: improving maternal and child nutrition

The following areas were not progressed for inclusion in the draft quality standard as the committee agreed that they were not suitable areas for the quality standard at this time, due to lack of supporting recommendations or that they are out of the scope for a quality standard:

- **Genetic causes of obesity.**
- **Suggestions for research.**

6. Resource impact

The committee considered the resource impact of the quality standard throughout the meeting and acknowledged the fast-moving landscape in this area and capacity difficulties of the services involved. It was agreed that the consultation on the draft quality standard would explore with stakeholders whether the statements would be achievable by local services given the net resources needed to deliver them, and that that the final statements should be those anticipated to have most impact in reducing inequalities and variation in delivery of care within resource constraints.

7. Equality and diversity

The committee discussed equality and diversity throughout the meeting, and noted the following groups which should be included in the equality and diversity considerations: age; disability; race; socioeconomic status and deprivation; inclusion health and vulnerable groups; geographical area variation. The committee would continue to have opportunity to contribute suggestions as the quality standard is developed, to ensure that the standard supports reducing inequalities for these population groups.

8. AOB

9. Close of the meeting