

**NATIONAL INSTITUTE FOR HEALTH AND CARE
EXCELLENCE**

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Obesity: prevention and management in adults

Output: Prioritised quality improvement areas for development.

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1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for the prevention and management of obesity in adults. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development source(s) referenced in this briefing paper is:

- [Managing overweight and obesity in adults – lifestyle weight management services \(2014\)](#) NICE guideline PH53

1.3 Other sources that may be used

- [Assessing body mass index and waist circumference thresholds for intervening to prevent ill health and premature death among adults from black, Asian and other minority ethnic groups in the UK](#) (2013) NICE guideline PH46
- [Obesity: working with local communities](#) (2012) NICE guideline PH42
- [Exercise referral schemes to promote physical activity](#) (2014) NICE guideline PH54

2 Overview

2.1 Focus of quality standard

This quality standard will cover public health strategies to prevent overweight and obesity among adults (aged 18 and over), and the delivery of tier 2 weight management interventions. This quality standard does not cover specialist management interventions (tier 3) or bariatric surgery (tier 4).

2.2 Definition

Adults are assessed to see if they are overweight or obese using their Body Mass Index (BMI). The following table shows the cut-off points for a healthy weight or being overweight or obese:

Classification	BMI (kg/m ²)
Healthy weight	18.5–24.9
Overweight	25–29.9
Obesity I	30–34.9
Obesity II	35–39.9
Obesity III	40 or more

BMI is a less accurate indicator of adiposity in adults who are highly muscular, so it should be interpreted with caution in this group. Waist circumference can also be used to assess whether someone is at risk of health problems because they are overweight or obese (up to a BMI of 35, see recommendation 1.2.2.9 in [Obesity, NICE clinical guideline 43](#)).

Tier 2 lifestyle weight management programmes are just one part of a comprehensive approach to preventing and treating obesity. Tier 2 multi-component programmes for overweight and obese adults aim to reduce a person's energy intake and help them become more physically active by changing their behavior. They may include weight management programmes, courses or clubs that:

- accept adults through self-referral or referral from a health or social care practitioner

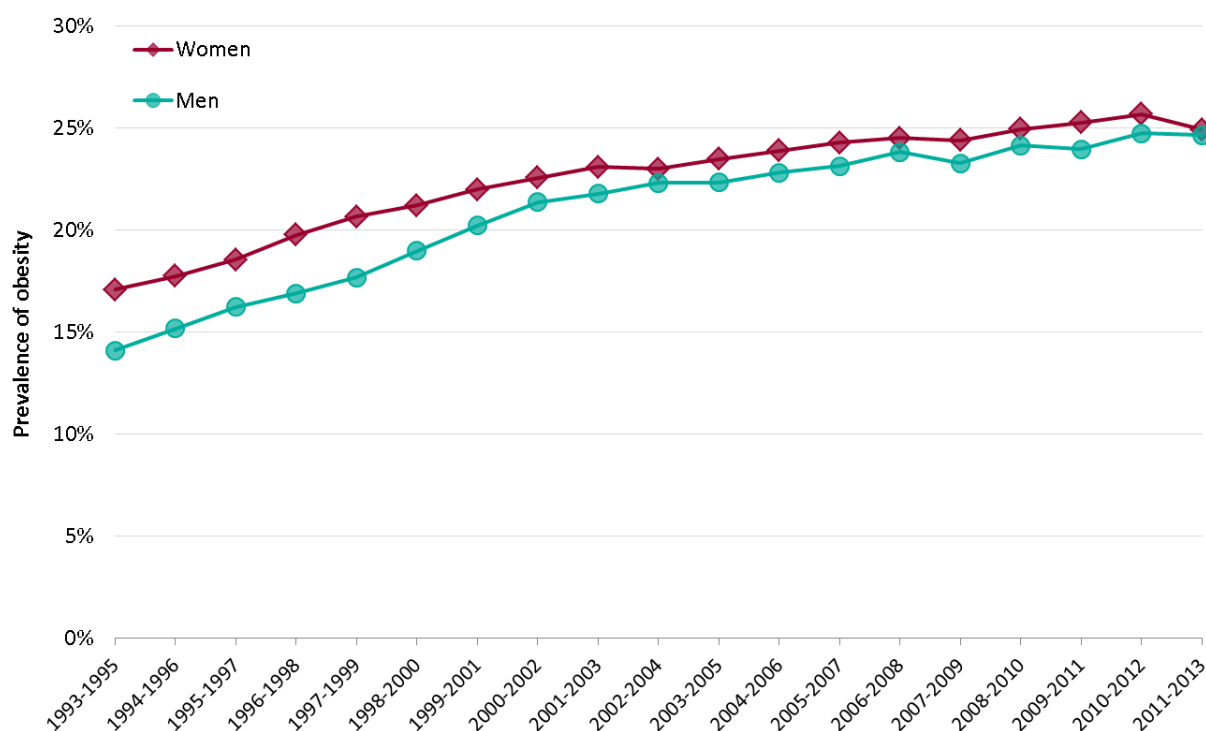
- are provided by the public, private or voluntary sector
- are based in the community, workplaces, primary care or online.

Generally, the more weight an adult loses as part of a lifestyle weight management programme, the more health benefits they are likely to gain. Observed weight losses from multicomponent lifestyle weight management programmes are unlikely to be associated with unintended or adverse effects.

2.3 Incidence and prevalence

In 2012, around a quarter of adults in England (24% of men and 25% of women aged 16 or older) were classified as obese ([body mass index \[BMI\] 30 kg/m² or more](#)). A further 42% of men and 32% of women were overweight (BMI 25 to 30 kg/m²) ([Statistics on obesity, physical activity and diet: England 2014](#), Health and Social Care Information Centre 2014). (See Figure 1).

Figure 1. Trend in obesity prevalence among adults. Health Survey for England 1993-2013 (3-year average)¹



¹ Public Health England (accessed 2015) [Slide sets for adult and child obesity](#)

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Although there are people in all population groups who are overweight or obese, obesity is related to social disadvantage ([Fair society, healthy lives: strategic review of health inequalities in England post-2010](#), The Marmot Review 2010).

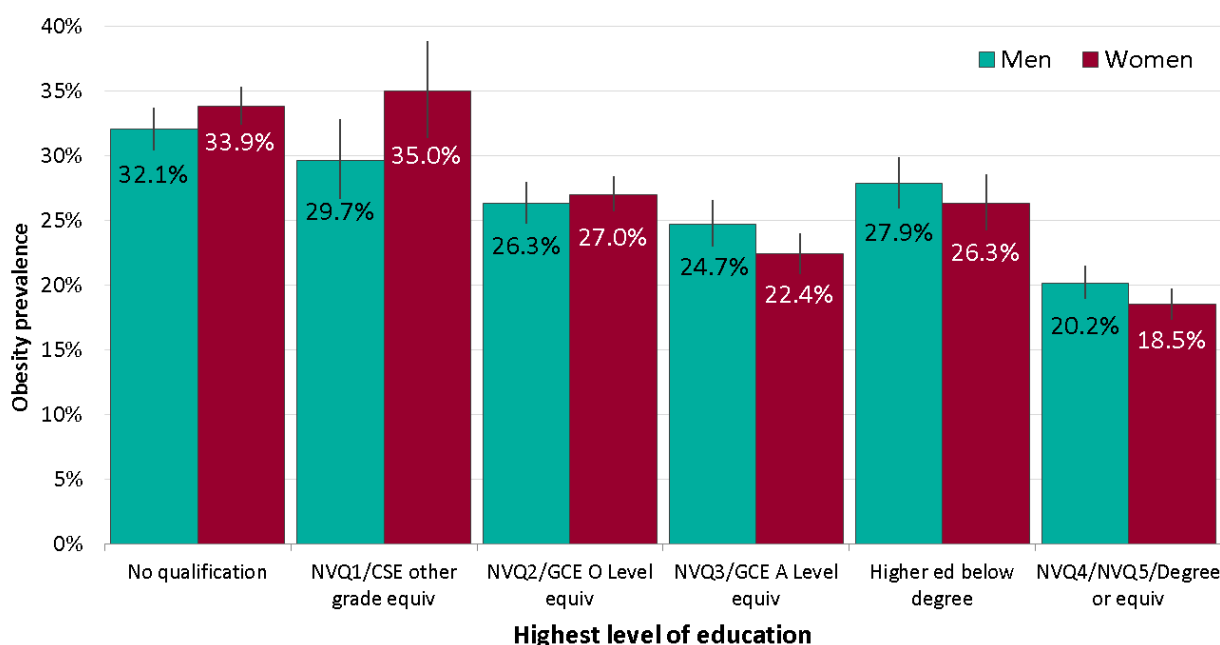
Prevalence varies by population characteristics (for example see [Public Health England briefing papers](#)). For women, obesity prevalence increases with greater levels of deprivation, regardless of the measure used. For men, only occupation-based and qualification-based measures show differences in obesity rates by levels of deprivation.

For both men and women, obesity prevalence decreases with increasing levels of educational attainment. Around 32% of men and 33% of women with no qualifications are obese compared to 20% of men and 18% of women with a degree or equivalent (see figure 2) ([Statistics on obesity, physical activity and diet: England](#), Health and Social Care Information Centre 2010).

Obesity is also linked to ethnicity: it is most prevalent among black African women (38%) and least prevalent among Chinese and Bangladeshi men (6%) ([Statistics on obesity, physical activity and diet: England](#), The NHS Information Centre 2006).

Being overweight or obese can lead to both chronic and severe medical conditions ([Tackling obesities: future choices – project report](#), Foresight 2007). It is estimated that life expectancy is reduced by an average of 2 to 4 years for those with a BMI of 30 to 35 kg/m², and 8 to 10 years for those with a BMI of 40 to 50 kg/m² ([Briefing note: obesity and life expectancy](#), National Obesity Observatory 2010).

Figure 2. Adult obesity prevalence by education. Health Survey for England 2009-2013²



Women who are obese are estimated to be around 13 times more likely to develop type 2 diabetes and 4 times more likely to develop hypertension than women who are not obese. Men who are obese are estimated to be around 5 times more likely to develop type 2 diabetes and 2.5 times more likely to develop hypertension than men who are not obese ([Statistics on obesity, physical activity and diet: England, 2011](#), Health and Social Care Information Centre 2011; [Tackling obesity in England](#), National Audit Office 2001). People who are obese may also experience mental health problems as a result of [stigma](#) and bullying or discrimination in the workplace (Puhl and Heuer 2009).

2.4 Management

The cost to society and the economy of people being overweight or obese was estimated at almost £16 billion in 2007 (more than 1% of gross domestic product). It

² Public Health England (accessed 2015) [Slide sets for adult and child obesity](#)

could rise to just under £50 billion in 2050 (based on 2007 prices), if obesity rates continue to rise unchecked ([Healthy lives, healthy people: a call to action on obesity in England](#), Department of Health 2011).

The government's obesity strategy 'Healthy lives: a call to action on obesity in England' (Department of Health 2011) aimed to reduce, 'the level of excess weight averaged across all adults by 2020'. It advocated a range of local interventions that both prevent obesity and treat those who are already obese or overweight.

In many areas, public, private or voluntary organisations are commissioned to provide individual or group lifestyle weight management services. People can also self-refer to commercial or voluntary programmes, for example, by attending a local class or 'club' or joining an online programme.

Local policies vary but generally, funded referrals to a lifestyle weight management programme (in tier 2 services) lasts for around 12 weeks or 12 sessions.

2.5 National Outcome Frameworks

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 [The Adult Social Care Outcomes Framework 2015–16](#)

Domain	Overarching and outcome measures
<p>1 Enhancing quality of life for people with care and support needs</p>	<p>Overarching measure 1A Social care-related quality of life* Outcome measures People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs. 1B Proportion of people who use services who have control over their daily life 1C Proportion of people using social care who receive self-directed support, and those receiving direct payments Carers can balance their caring roles and maintain their desired quality of life. 1D Carer-reported quality of life</p>
<p>2 Delaying and reducing the need for care and support</p>	<p>Overarching measure 2A. Permanent admissions to residential and nursing care homes, per 100,000 population When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence. 2C. Delayed transfers of care from hospital, and those which are attributable to adult social care</p>
<p>3 Ensuring that people have a positive experience of care and support</p>	<p>Overarching measure People who use social care and their carers are satisfied with their experience of care and support services. 3A. Overall satisfaction of people who use services with their care and support 3B. Overall satisfaction with social services of carers Placeholder 3E: Effectiveness of integrated care</p>
<p>4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm</p>	<p>4A. The proportion of people who use services who feel safe (PHOF 1.19) Outcome measures Everyone enjoys physical safety and feels secure. People are free from physical and emotional abuse, harassment, neglect and self-harm. People are protected as far as possible from avoidable harm, disease and injuries. People are supported to plan ahead and have the freedom to manage risks the way that they wish. 4B. The proportion of people who use services who say that those services have made them feel safe and secure Placeholder 4C: Proportion of completed safeguarding referrals where people report they feel safe</p>
<p>Aligning across the health and care system * Indicator complementary ** Indicator shared</p>	

Table 2 [NHS Outcomes Framework 2015–16](#)

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	<p><i>Overarching indicators</i></p> <p>1a Potential years of life lost (PYLL) from causes considered amenable to healthcare</p> <p>i Adults ii Children and young people</p> <p>1b Life expectancy at 75</p> <p>i Males ii Females</p> <p><i>Improvement areas</i></p> <p>Reducing premature mortality from the major causes of death</p> <p>1.1 Under 75 mortality rate from cardiovascular disease (PHOF 4.4*)</p> <p>1.2 Under 75 mortality rate from respiratory disease (PHOF 4.7*)</p> <p>1.3 Under 75 mortality rate from liver disease (PHOF 4.6*)</p> <p>Reducing premature death in people with mental illness</p> <p>1.5 i Excess under 75 mortality rate in adults with serious mental illness (PHOF 4.9*)</p> <p>ii Excess under 75 mortality rate in adults with common mental illness</p>

<p>2 Enhancing quality of life for people with long-term conditions</p>	<p>Overarching indicator</p> <p>2 Health-related quality of life for people with long-term conditions**</p> <p>Improvement areas</p> <p>Ensuring people feel supported to manage their condition</p> <p>2.1 Proportion of people feeling supported to manage their condition**</p> <p>Improving functional ability in people with long-term conditions</p> <p>2.2 Employment of people with long-term conditions (ASCOF 1E** & PHOF 1.8*)</p> <p>Reducing time spent in hospital by people with long-term conditions</p> <p>2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)</p> <p>Enhancing quality of life for carers</p> <p>2.4 Health-related quality of life for carers (ASCOF 1D**)</p> <p>Enhancing quality of life for people with mental illness</p> <p>2.5 i Employment of people with mental illness (ASCOF 1F** & PHOF 1.8**)</p> <p>ii Health-related quality of life for people with mental illness (ASCOF 1A** & PHOF 1.6**)</p> <p>Improving quality of life for people with multiple long-term conditions</p> <p>2.7 Health-related quality of life for people with three or more long-term conditions (ASCOF 1A**)</p>
<p>3 Helping people to recover from episodes of ill health or following injury</p>	<p>Overarching indicators</p> <p>3a Emergency admissions for acute conditions that should not usually require hospital admission</p> <p>3b Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11*)</p> <p>Improvement areas</p> <p>Improving outcomes from planned treatments</p> <p>3.1 Total health gain as assessed by patients for elective procedures</p> <p>i Physical health-related procedures</p> <p>ii Psychological therapies</p> <p>iii Recovery in quality of life for patients with mental illness</p>

<p>4 Ensuring that people have a positive experience of care</p>	<p>Overarching indicators 4a Patient experience of primary care i GP services ii GP out-of-hours services 4b Patient experience of hospital care Improvement areas Improving people’s experience of outpatient care 4.1 Patient experience of outpatient services Improving hospitals’ responsiveness to personal needs 4.2 Responsiveness to in-patients’ personal needs Improving access to primary care services 4.4 Access to i GP services Improving experience of healthcare for people with mental illness 4.7 Patient experience of community mental health services Improving people’s experience of integrated care 4.9 People’s experience of integrated care (ASCOF 3E**)</p>
<p>5 Treating and caring for people in a safe environment and protecting them from avoidable harm</p>	<p>Overarching indicators 5a (previously 5c) Deaths attributable to problems in healthcare 5b Severe harm attributable to problems in healthcare Improvement areas</p>
<p>Alignment across the health and social care system * Indicator is shared ** Indicator is complementary</p>	

Table 3 [Public health outcomes framework for England, 2013–2016](#)

Domain	Objectives and indicators
1 Improving the wider determinants of health	<p>Objective Improvements against wider factors that affect health and wellbeing and health inequalities</p> <p>Indicators Social isolation</p>
2 Health improvement	<p>Objective People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</p> <p>Indicators Diet Excess weight in adults Proportion of physically active and inactive adults</p>
4 Healthcare public health and preventing premature mortality	<p>Objective Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities</p> <p>Indicators Mortality from causes considered preventable Mortality from all cardiovascular diseases (including heart disease and stroke) Mortality from cancer Mortality from liver disease Mortality from respiratory diseases</p>
<p>Alignment across the health and social care system</p> <p>* Indicator shared with the NHS Outcomes Framework.</p> <p>** Complimentary indicators in the NHS Outcomes Framework</p> <p>† Indicator shared with the Adult Social Care Outcomes Framework</p> <p>†† Complementary to indicators in the Adult Social Care Outcomes Framework</p>	

3 Summary of suggestions

3.1 Responses

In total 13 stakeholders responded to the 2-week engagement exercise 10/02/15-24/02/15.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee.

NHS England's patient safety division did not submit any data for this topic.

Full details of all the suggestions provided are given in appendix 1 for information.

Table 4 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Identification of at risk populations <ul style="list-style-type: none"> • Identification of obese adults • Specific at risk populations 	Diab, DOM, RCP, SCM, NOF
Communication of information <ul style="list-style-type: none"> • Awareness of local programmes 	COT, Diab, DOM, SCM, SW, WW
Occupation therapist involvement	Diab, COT, RCP
Commissioning of Services <ul style="list-style-type: none"> • Provision of Services • Length of lifestyle weight management programmes 	RCP, SCM, WW
Content of lifestyle weight management services <ul style="list-style-type: none"> • Action plans 	SCM, WW
Equality of access <ul style="list-style-type: none"> • Equality of access 	RCP, SW, WW
Family involvement in managing obesity	SW
Change in practice	DOM, RCP
Data collation and evaluation <ul style="list-style-type: none"> • Sharing data and outcome evaluation 	COT, DOM, SCM, WW
Additional areas	
COT, College of Occupational Therapists Diab, Diabetes UK DOM, Diabetes in Obesity Management RCP, Royal College of Physicians RCPE, Royal College of Physicians Edinburgh SCM, Standing Committee Member SW, Slimming World Sus, Sustans NOF, National Obesity Forum WW, Weight Watchers	

4 Suggested improvement areas

4.1 *Identification of at risk populations*

4.1.1 Summary of suggestions

Identification of obese adults

Stakeholders commented that the identification and subsequent engagement of obese adults by GP's is essential to help individuals address their weight, aid them to lose weight and ultimately prevent people from developing secondary illnesses. Stakeholders highlighted that the annual health check can be a key time to identify adults as obese and to refer them for evidence based interventions.

Stakeholders commented that every contact with every patient should be seen as a chance to prevent obesity and related comorbidities (e.g. diabetes) and to use these opportunities to give brief advice on how to lose weight.

Specific at risk populations

Stakeholders highlighted that for specific at risk populations, referrals to weight management services should be considered at a lower BMI or at lower waist circumference cut off points. Specific populations include Asian (South Asian and Chinese) who are at increased risk of ill health and diseases such as, cardiovascular disease and Type 2 diabetes at lower levels of body fat in comparison to Caucasians. Comments further stated that adults identified to be at higher risks of Type 2 diabetes are referred to the National Diabetes Prevention Programme.

4.1.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Identification of obese adults	Refer overweight and obese adults to a lifestyle weight management programme NICE PH53 Recommendation 6
Referrals for specific at risk populations	Refer overweight and obese adults to a lifestyle weight management programme NICE PH53 Recommendation 6

Identification and engagement of obese patients

Referrals for specific at risk populations

NICE PH53 Recommendation 6

GP practices and other health or social care professionals who give advice about, or refer people to, [lifestyle weight management programmes](#) (see [Who should take action?](#)) should:

- 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.
- Identify people eligible for referral to lifestyle weight management services by measuring their body mass index (BMI). Also measure waist circumference for those with a BMI less than 35 kg/m². Consider any other locally agreed risk factors.
- For funded referrals, note that:
 - programmes may particularly benefit adults who are obese (that is, with a BMI over 30 kg/m², or lower for those from black and minority ethnic groups) or with other risk factors (comorbidities such as type 2 diabetes)
 - where there is capacity, access for adults who are overweight should not be restricted (that is, for people with a BMI between 25 to 30 kg/m², or lower for those from black and minority ethnic groups) or with other risk factors (comorbidities such as type 2 diabetes)
 - there should be no upper BMI or upper age limit for referral.

See [NICE Guideline PH53](#) for full recommendation.

4.1.3 Current UK practice

Obesity accounts for 80-85% of the overall risk of developing Type 2 diabetes. 2.7 million people were diagnosed with Type 2 diabetes in 2012, accounting for approximately 6% of the population in England. It is estimated that by 2025 more than 4 million people in England will have diabetes. Almost 90% of people diagnosed with Type 2 diabetes are overweight and so preventing or reducing obesity will reduce the number of people with Type 2 diabetes. The majority of people with either Type 1 or Type 2 diabetes had their weight measured in 2012-2013; however it is unclear what support was offered to people who could benefit from losing weight. The variation in weight management referrals is evident in England and the State of the Nation Diabetes 2014 Audit suggested the GP and other healthcare professionals should identify obese people at risk of Type 2 diabetes and offer referrals to the appropriate services.

4.2 **Communication of information**

4.2.1 **Summary of suggestions**

Awareness of local programmes

Comments stated that raising awareness of local programmes among healthcare professionals and local populations, combined with the publication of locally available services will enable potential service users to take responsibility for their own health, encourage self-referral and contribute to reducing anxiety or concerns that may be associated with their GP raising the issue of their weight.

4.2.2 **Selected recommendations from development source**

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 6 to help inform the Committee’s discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Awareness of local programmes	<p>Raise awareness of lifestyle weight management services among health and social care professionals NICE PH53 Recommendation 4</p> <p>Raise awareness of lifestyle weight management services among the local population NICE PH53 Recommendation 5</p>

Awareness of local programmes

NICE PH53 Recommendation 4

Raise awareness of lifestyle weight management services among health and social care professionals

Clinical commissioning groups, health and wellbeing boards, hospital and community trusts, local authorities, NHS England and Public Health England should:

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- Ensure health and social care professionals in contact with [adults who are overweight or obese](#) are made aware of:
 - the local obesity pathway and the local strategic approach to preventing and managing obesity
 - the range of local lifestyle weight management services available
 - national sources of accurate information and advice, such as NHS Choices and Change4life
 - continuing professional development or training opportunities on weight management (see [recommendation 14](#)).

NICE PH53 Recommendation 5

Local authorities and Public Health England should:

- Ensure sources of information and advice about local lifestyle weight management services are included in any communications about being overweight or obese. This includes information provided by health and social care professionals working with adults (such as GPs, practice nurses, health visitors and pharmacists).

Public Health England, local authorities, health and wellbeing boards and clinical commissioning groups should ensure the local adult population is aware of:

- The health benefits for [adults who are overweight or obese](#) of losing even a relatively small amount of weight and keeping it off in the long term (or avoiding any further weight gain). (See [recommendation 7](#).)
- The range of lifestyle weight management services available locally.
- Local sources of information and advice such as GPs, practice nurses, health visitors and pharmacists.
- National sources of accurate information and advice such as [NHS Choices](#) and [Change4life](#).

4.2.3 Current UK practice

An audit³ conducted in an NHS trust to assess if occupational health services were implementing NICE guidance found that there was good management of overweight in occupational health however, there was no obesity policy or coordinated protocols. Many clinicians were unaware of current obesity guidance and this was compounded by lack of training and significant barriers to address the issues raised in the guidance. The NHS Trust's occupational health manager was aware of the guidance and prioritised public health elements to make improvements in catering and exercise facilities.

³ Dalton, M. B. "Implementing NICE obesity guidance for staff: an NHS trust audit." *Occupational Medicine* 65.1 (2015): 78-85.

4.3 Occupational therapist involvement

4.3.1 Summary of suggestions

Occupational therapist involvement

Stakeholders suggested that a wide range of healthcare professionals including occupational health therapists can contribute to prevention and management of obesity in adults. Stakeholders stated that if the occupational health workforce is harnessed correctly there could be improvements in physical activity levels, dietary intake and a reduction in obesity.

4.3.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 7 to help inform the Committee’s discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Occupational therapist involvement	No recommendations were identified for this improvement area

Occupational therapist involvement

No recommendations were identified for this improvement area

4.3.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

4.4 Commissioning of lifestyle weight management services

4.4.1 Summary of suggestions

Provision of Services

Local programmes require commissioning to ensure that there are services to suit the needs of local populations and individuals rather than adopting a generic approach to population level intervention implementation. This will potentially reduce the progression to more costly higher tiers of interventions.

Length of lifestyle weight management programmes

Stakeholders stated that patients should be supported by services for at least 12 weeks. It was felt that extended programmes should be explored because of emerging evidence that continuing support may benefit participants.

4.4.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 8 to help inform the Committee’s discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Provision of Services	Commission programmes that include the core components for effective weight loss NICE PH53 Recommendation 9
Length of lifestyle weight management programmes	Commission programmes that include the core components for effective weight loss NICE PH53 Recommendation 9

Provision of Services

Length of lifestyle weight management programmes

NICE PH53 Recommendation 9

Commission programmes that include the core components for effective weight loss

Commissioners of lifestyle weight management services (see [Who should take action?](#)) should commission or recommend [lifestyle weight management programmes](#) that:

- Are multi-component that is, they address dietary intake, physical activity levels and behaviour change.
- Are developed by a multidisciplinary team. This includes input from a registered dietitian, registered practitioner psychologist and a qualified physical activity instructor.
- Ensure staff are trained to deliver them and they receive regular professional development sessions.
- Focus on life-long lifestyle change and the prevention of future weight gain.
- Last at least 3 months, and that sessions are offered at least weekly or fortnightly and include a 'weigh-in' at each session.
- Ensure achievable goals for weight loss are agreed for different stages – including within the first few weeks, for the end of the programme or referral period (as appropriate) and for 1 year (see recommendation 8).

See [NICE Guideline PH53](#) for full recommendation.

4.4.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.5 **Content of lifestyle weight management services**

4.5.1 **Summary of suggestions**

Action plans

Stakeholders highlighted that components of lifestyle weight management services are an area for quality improvement. This includes the commissioning of lifestyle weight management programmes that specifically include action plans for patients who are referred to the service. Strategic action plans for patients will allow individuals to cope with challenging situations, provide essential social support and establish new healthy routines. Stakeholders commented that an improvement in this area could contribute to a reduction in obesity prevalence.

4.5.1 **Selected recommendations from development source**

Table 9 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 9 to help inform the Committee’s discussion.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Action plans	Commission programmes that include the core components to prevent weight regain NICE PH53 Recommendation 10

Action focused services NICE PH53 Recommendation 10

Commissioners should:

- Commission or recommend [lifestyle weight management programmes](#) that address the prevention of [weight regain](#) by:
 - 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.

- Stressing the importance of maintaining new dietary habits and increased physical activity levels in the long term to prevent weight re-gain and discussing strategies to overcome any difficulties in maintaining the new behaviours.
- Encouraging dietary habits that will support weight maintenance and are sustainable in the long term. For example, programmes should emphasise how following national advice on healthy eating can support weight management. (For example, see NHS Choices.)
- Promoting ways of being more physically active and less sedentary that are sustainable in the long term (for example, walking). The wider benefits of physical activity should also be emphasised.

4.5.1 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience

Stakeholders commented that there is huge variability across the country in terms of the type of services, referrals to specific services and the level of quality of services. Further comments suggest that local innovation and choice is vital to provide high quality care, albeit care proven to be effective as well as based on evidence.

4.6 *Equality of access*

4.6.1 Summary of suggestions

Equality of access

Stakeholders commented that an area for quality improvement is access to and equability of services for low income or vulnerable groups. Services need to be acceptable to all people including minority populations such as specific ethnic groups, people with disabilities and people with ‘protected characteristics’.

Stakeholders highlighted that psychiatric comorbidity is high in obese people and healthcare professional acknowledgement of mental health issues associated with obesity and access to multidisciplinary treatments via an integrated care pathway would help with obesity management.

Stakeholders also stated that services provided through the NHS and local authorities are inconsistent across the country, therefore some adults have access to lifestyle weight management services while others have fewer or limited options. Comments suggested the need for commissioning service on a scale that meets local demands to promote equal access to effective and evidence based weight management services across the country is an area for quality improvement.

4.6.2 Selected recommendations from development source

Table 10 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 10 to help inform the Committee’s discussion.

Table 10 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Equality of access	Ensure contracts for lifestyle weight management programmes include specific outcomes and address local needs NICE PH53 Recommendation 13

Equality of access

NICE PH53 Recommendation 13

Ensure contracts for lifestyle weight management programmes include specific outcomes and address local needs

Clinical commissioning groups, health and wellbeing boards and local authorities should:

- Commission a range of lifestyle weight management programmes. For example, both group and individual programmes might be needed to meet the needs and preferences of different groups).
- Use the Department of Health's best practice guidance for weight management services. In particular, commission programmes that:
 - at least 60% of participants are likely to complete
 - are likely to lead to an average weight loss of at least 3%, with at least 30% of participants losing at least 5% of their initial weight.

See [NICE Guideline PH53](#) for full recommendation.

4.6.3 Current UK practice

A population based cohort study conducted by Booth *et al*⁴ using CPRD data assessed patient's access to appropriate weight reduction interventions. Authors ascertained comorbidity status as well as, smoking and socio-economic status. Weight management interventions were classified as lifestyle advice and referrals for weight management using medical read codes available in CPRD. Results from this study found that the majority of patients didn't receive a weight management intervention during the study period of 7 seven years, with only 40% of morbidly obese patients and 20% of patients with non-severe obesity had a record of weight management. Moreover, of those that received an intervention, advice was the most

⁴ Booth, Helen P., A. Toby Prevost, and Martin C. Gulliford. "Access to weight reduction interventions for overweight and obese patients in UK primary care: population-based cohort study." *BMJ open* 5.1 (2015): e006642.

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common and Type 2 diabetes tended to be associated with a weight loss intervention. The authors concluded that there was substantial variation between practices in recording obesity management interventions. These results may indicate a lack of patient access to appropriate services.

4.7 *Family involvement in managing obesity*

4.7.1 Summary of suggestions

Stakeholders highlighted that lifestyle weight management services should encourage a family approach in the prevention and management of obesity. Services supporting and adopting a family based approach will encourage physical activity and dietary changes to lifestyle that can benefit the wider family.

4.7.2 Selected recommendations from development source

Table 11 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 11 to help inform the Committee’s discussion.

Table 11 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Family involvement in managing obesity	Address the expectations and information needs of adults thinking about joining a lifestyle weight management programme NICE PH53 Recommendation 13

Family involvement in managing obesity

NICE PH53 Recommendation 13

Address the expectations and information needs of adults thinking about joining a lifestyle weight management programme

- GPs and other health or social care professionals advising or referring adults to [lifestyle weight management programmes](#), and providers advising people who are thinking about joining programmes (see [Who should take action?](#)) should:
- 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.
 - Discuss what the programme does and does not involve.

- Discuss realistic weight-loss goals. People should be aware that:
- The more weight they lose, the greater the health benefits, particularly if someone loses more than 5% of their body weight and maintains this for life.
- On average, people attending a lifestyle weight management programme lose around 3% of their body weight, but this varies a lot.
- Preventing future weight gain and maintaining a lower [weight trajectory](#) leads to health benefits.
- Discuss the effort and commitment needed to lose weight and prevent weight regain, and the benefit of receiving long-term support. Discuss sources of long term support, such as from the practice nurse, pharmacist, local support group or weight management programme, online groups or networks, and friends or family.

See [NICE Guideline PH53](#) for full recommendation

4.7.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.8 Change in practice

4.8.1 Summary of suggestions

Stakeholders suggested workplaces including the NHS should offer lifestyle support to maintain healthy weight.

Stakeholders also commented that in order to reduce purchases of calorific, sugary and high fat containing food and drink products, retailers should take a ‘healthy till’ approach and remove such items from checkout points.

4.8.1 Selected recommendations from development source

Table 12 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 12 to help inform the Committee’s discussion.

Table 12 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Change in practice	Not directly covered in NICE PH53 and no recommendations are presented

4.8.2 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

4.9 Data collation and evaluation

4.9.1 Summary of suggestions

Sharing data and outcome evaluation

Stakeholders commented that outcome data for lowering weight management services should be collated and shared. The sharing of optimal strategies will ensure that best practice is adopted and rolled out.

Stakeholders highlighted that certain data such as the characteristics of service users and attendance rates, which are collected locally and then are compared nationally will enable the evaluation of the equability of lifestyle weight management programmes.

4.9.2 Selected recommendations from development source

Table 13 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 13 to help inform the Committee’s discussion.

Table 13 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Sharing data and outcome evaluation	<p>Improve information sharing on people who attend a lifestyle weight management programme NICE PH53 Recommendation 16</p> <p>Monitor and evaluate local provision NICE PH53 Recommendation 18</p>

Sharing data

NICE PH53 Recommendation 16

Improve information sharing on people who attend a lifestyle weight management programme

- Commissioners of lifestyle weight management services should work with all referrers and providers to put systems in place to share any relevant information, in confidence, about people referred to [lifestyle weight management programmes](#). (Examples of relevant information include details

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of someone's weight at baseline, programme end and at 12 months.) This should be in line with the Department of Health's information governance and data protection requirements (for example, see [Public Health Services Contract 2014/15: guidance on the non-mandatory contract for public health services](#)).

- Referrers to, and providers of, lifestyle weight management programmes should seek the consent of participants to share between them any relevant information (see above) on the participant's progress. Explain that this information will be used to help monitor and evaluate the service.

Outcome evaluation

NICE PH53 Recommendation 18

Monitor and evaluate local provision

Commissioners of lifestyle weight management services, health and wellbeing boards and local authorities should:

- Regularly review lifestyle weight management services for adults to ensure they meet local needs (as identified by the joint strategic needs assessment), any gaps in provision should be identified and adherence and outcomes should be reported to agreed standards.
- Monitor awareness of the programmes among health and social care professionals and potential users (see recommendations [4](#) and [5](#)).
- Collect data on referral routes to identify geographical areas where awareness of available programmes is low and where referral rates might be increased.
- Collate the results of routine monitoring and programme expenditure. Analyse these results in relation to the characteristics of the local population (for example, urban versus rural groups and between the general population and minority ethnic groups).
- Amend, improve or decommission programmes based on these findings.

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4.9.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience

4.10 Additional suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise however they were felt to be outside the remit of quality standards or are addressed by other NICE quality standard topics.

This quality standard will cover public health strategies to prevent overweight and obesity among adults, and the delivery of lifestyle weight management interventions. It will not cover the clinical assessment and management of obesity in individual adults. This will be the focus of a separate healthcare quality standard.

Awareness campaigns and screening

Stakeholders commented that public awareness needs to be raised, including, information about reducing sugary drinks intake, reducing portion sizes and limiting alcohol consumption.

Extending screening and monitoring of all people and not just those who look overweight and obese will encourage healthy ideals to be promoted nationally.

Discrimination and stigmatisation of patients

Stakeholders also commented that stigmatisation is a major barrier in accessing care in obese patients. Open discussion about lifestyle choice and weight is needed to engage patients. Patients with learning difficulties, mental health issues or from lower socio-economic groups suffer additional stigma and so using appropriate language with empathy and compassion should be part of every consultation.

Skills training for healthcare professionals

Stakeholders highlighted that people can feel anxious when visiting their doctor or healthcare professionals for fear of being judged. Stakeholders suggested that equipping healthcare professionals with the skills and consistent training on how to approach patients in a sensitive and supportive manner is a key area for quality improvement.

Development of specialists

A stakeholder suggested a developmental area of emergent practice is through the development of physicians who specialise in obesity and are also hospital

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champions. This will ensure that obese patients receive the most appropriate care in primary and secondary settings.

Tier 3 and 4 services

Stakeholders suggested the appropriate use of pharmacotherapy and the further development of tier 3 and 4 services. Additional comments suggested earlier referral for bariatric interventions.

Appendix 1: Suggestions from stakeholder engagement exercise – registered stakeholders

	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	NHS England	Thank you for the opportunity to comment on the above Quality Standard. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.			
	Royal College of Nursing	This is to inform you that the RCN has no comments to submit to inform on the above topic engagement.			
1	Slimming World	Improve the links between public health campaigns on obesity and alcohol by raising awareness of how drinking too much alcohol can impact on weight-affecting lifestyle behaviours.	Obesity and excessive alcohol consumption are recognised, alongside smoking, as the lifestyle factors having the greatest impact on public health in the UK today. While there is a commitment to reducing obesity and to raising awareness of the dangers of excessive drinking, more needs to be done to raise awareness among the general population of the link between the two.	Campaigns encourage people to eat healthily and different campaigns warn of the dangers of excessive drinking - yet these campaigns fail to point out the link between the two.	Not only are alcoholic drinks highly calorific, once someone starts drinking they are far more likely to lose their resolve to make healthy lifestyle changes. Please see the full report on 'The missing link between alcohol and obesity' which highlights findings of some recent research into this area www.slimmingworld.com/alcohol)
1.1	Diabetes UK	Adults having their NHS Health Check are given brief advice about	Obesity is the most significant risk factor for Type 2 diabetes. It accounts for 80-85% of the overall risk of developing Type 2 diabetes. Diabetes	This is a key area for quality improvement as almost two in every three people in the UK are overweight or obese and approximately 11.5 million people in	1 Hauner H (2010). Obesity and diabetes, in Holt RIG, Cockram CS, Flyvbjerg A et al (ed.) Textbook of diabetes, 4th edition. Oxford: Wiley-Blackwell

		<p>how to reduce their weight (if necessary) and referred to weight-management programmes if appropriate to do so.</p>	<p>can cause serious complications and early death. Diabetes is responsible for more than 100 amputations each week; is the leading cause of preventable sight loss in people of working age; and is a major contributor to kidney failure, heart attack and stroke². Each year in the UK, 20,000 people die early from diabetes³.</p>	<p>the UK are at risk of getting Type 2 diabetes⁵. Every effort must be made to ensure that health professionals provide advice and, if appropriate referrals, to their patients who are either overweight or obese. Diabetes UK notes that currently some opportunities to provide brief advice are missed. Individuals who are at risk of developing Type 2 diabetes must be supported to eat healthier and engage in more regular physical activity and maintain a healthy weight. As a result of taking these measures, individuals will have the opportunity to lead healthier lives and experience fewer adverse health outcomes.</p>	<p>2 State of the Nation 2014, Diabetes UK 3 HSCIC: National Diabetes Audit 2011/2012: Report 2: Complications and Mortality 4 World Health Organisation (2005). What is the scale of the obesity problem in your country? http://bit.ly/whoBMI 5 Mainous III AG, Tanner RJ, Baker R, et al. Prevalence of prediabetes in England from 2003 to 2011: population-based, cross-sectional study. <i>BMJ Open</i> 2014;4:e005002. doi:10.1136/bmjopen-2014-005002</p>
1.1	SCM – Kate Jolly	<p>For the general population provide a clear and consistent message about the most effective ways to maintain a healthy weight and prevent weight gain, e.g. reducing sugary drinks and replacing with water, reducing portion sizes,</p>	<p>The general public often cite the inconsistency of public health messages as a reason for inaction.</p>	<p>Evidence is now available suggesting consistent associations between various dietary habits and other health behaviours and weight gain.</p>	<p>Increase in portion sizes since 1993 identified in research by British Heart Foundation: https://www.bhf.org.uk/publications/policy-documents/portion-distortion-report-2013 Comprehensive report from Benson at University of Durham: http://dro.dur.ac.uk/8041/ Physical activity recorded in Health Survey for England. 66% of men and 55% women self-report meeting UK guidelines for physical activity. But, this is likely to be a huge over-estimate</p>

		limiting alcohol consumption, replacing refined carbohydrates with wholegrains, moderate physical activity in line with government recommendations, self-monitoring or weight and physical activity and reducing screen time.			given that in 2008 when they used objective measurement of physical activity only 5% of men met the UK guidelines.
1.1	SCM – Samantha Scholtz	Increased emphasis on weight maintenance and healthy behaviour regardless of weight	Whilst it is not in doubt that even 10% weight loss will reduce many obesity-related comorbidities, the reality is that even the best weight management programmes do not result in more than 5-10% long term weight loss for most patients, and that that return to baseline weight occurs in is as high as 80% of patients, particularly once the support is discontinued. For many very obese patients, weight loss programmes do not result in any weight loss. This should be borne in mind when seeing overweight and obese patients. Seeing obesity as a	The focus of consultations with obese patients tends to be on encouraging weight loss toward a “normal” BMI of 25kg/m ² as a measure of success. However for most patients, based on the evidence available, a far more modest goal of 5-10% weight loss is a more realistic goal. Weight maintenance, improvement in diet, exercise and lifestyle choices are more achievable successes that will empower patients in the long term. Encouraging weight maintenance and healthy lifestyle choices, and addressing comorbidities of obesity early on will improve quality of life	Wadden TA, Webb VL, Moran CH, Bailer BA. Lifestyle Modification for Obesity : New Developments in Diet, Physical Activity, and Behavior Therapy. Circulation. 2012;125:1157-1170 NICE guidelines Obesity: identification, assessment and management of overweight and obese people NICE guidelines: Managing overweight and obesity in adults – lifestyle weight management services: Recommendation 7 Address the expectations and information needs of adults

			preventable condition in those of healthy weight or overweight, and as a potentially healthy state in those who are obese if lifestyle is improved and comorbidities are addressed should be a goal of treatment in patients who do not wish to pursue bariatric surgery.	irrespective of weight loss, empower patients to make healthy choices, give patients appropriate goals and a focus for targeted individualised interventions and empower clinicians to feel more effective. An honest appraisal of the success of lifestyle interventions may also allow patients to progress on to bariatric surgery where appropriate.	thinking about joining a lifestyle weight management programme Bacon L. Aphramor L. Weight science: evaluating the evidence for a paradigm shift
1.1	SCM – Samantha Scholtz	Pre-emptive weight control	The DOH recommends that every opportunity should be used as a life course approach to obesity treatment and its’ prevention: every contact with every patient should be seen as an opportunity to prevent obesity and its comorbidities. Given the epidemic proportion of adults with obesity in the UK, prevention of obesity should extend to all patients presenting to any healthcare setting. In line with the Marmott review and the epidemic scale of obesity in the UK, every consultation should be an opportunity for obesity prevention. By extending screening and weight monitoring to <i>all</i> patients, rather than just those who look overweight, stigma is reduced and healthy ideals are promoted nationally.	In a of 91,000 GP consultations, 90% of overweight patients and 59% of patients with morbid obesity did not have any record of receiving weight management in primary care. In CMACE Maternal Obesity in the UK report, only 6% of obstetric units gave preconception advice to obese women, only one fifth of obese women were given information about the risks associated with obesity during pregnancy,	DOH: Healthy Lives, Healthy People A call to action on obesity in England Booth HP, Prevost AT, Gulliford MC. Access to weight reduction interventions for overweight and obese patients in UK primary care: population- based cohort study. BMJ Open 2015;5:e006642. doi:10.1136/bmjopen-2014-006642 Centre for Maternal and Child Enquiries (CMACE). Maternal obesity in the UK: Findings from a national project. London: CMACE, 2010
1.2	SCM – Sarah West-	1. Raising awareness of local lifestyle	To enable potential service users to take responsibility for their own health and have an increased awareness of	Raising awareness with potential service users could also make it easier for them to approach a health	

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	Sadler	weight management (LWM) groups amongst the local population (Rec 5: PH 53)	services that might be able to help them manage their weight.	care professional and reduce some of the anxiety that might be associated with their G.P. or health worker raising the issue of their weight.	
1.2	SCM – Sarah West-Sadler	3.Raise awareness of LWM services amongst healthcare professionals (Rec4: PH 53)	It is essential that those approaching the issue of weight have a clear pathway of options to advise to patients.	Having awareness of the types of LWM groups that are available locally can ensure that the healthcare professional refers the patient onto a service that is suitable for them, rather than a one-size-fits-all, approach.	
1.2	Weight Watchers	Publication of locally available services and ability to self refer	<p>Awareness among potential obesity management service users, and thus those most in need, is often very low.</p> <p>It is recommended that Local Authorities, in partnership with Clinical Commissioning Groups, publish their care pathways for weight management services across all tiers, enabling signposting across public health, primary and secondary care touch points and professionals and promote self-referral access routes into tier 2. This would enable the many people who are overweight or obese and highly motivated to lose weight to identify for themselves what is available and how it can be accessed. Improving access for all is a key area for quality improvement.</p>	<p>It would enable health professionals to signpost effectively to local services. It would also ensure public accountability for engagement in their own health and services, ultimately improving equality of access for people.</p> <p>Engaging ‘hard to reach’ overweight/obese families, particularly those from the most deprived communities is challenging. Numerous reports have identified primary care as the key NHS setting for screening, management and prevention of obesity in families (National Audit Office, 2001, Royal College of Physicians, 2013, Academy of Medical Royal Colleges, 2013). On an individual basis 90% of NHS contact is with primary care. Signposting and referrals from</p>	<p>National Audit Office (2001) Tackling Obesity in England, The Stationery Office, London.</p> <p>Royal College of Physicians (2013) Action on Obesity: Comprehensive care for all, London, RCP</p> <p>Dixon K, Shcherba S, and Kipping R. Weight Loss from Three Commercial Providers of NHS Primary Care Slimming on Referral in North Somerset: Service Evaluation. J Public Health. 2012 May 18.</p> <p>Lloyd A and Khan R (2011) Evaluation of Healthy Choices: a commercial weight loss programme commissioned by the NHS, Perspect. Public</p>

				<p>primary care is essential.</p> <p>It is becoming increasingly prevalent, but not yet best practice, to enable self-referrals into tier 2 services. Self-referrals are screened by providers to ensure eligibility under locally agreed terms, but vastly facilitates engagement and uptake from service users and minimises burden on NHS and Local Authorities. Promoting and enabling self-referral pathways has the potential to improve access and ultimately the quality of care received by the service user.</p>	<p>Health, 131, 177-83.</p> <p>Wrieden W.I Et al (2012) NHS referral to a commercial, community-based lifestyle modification programme. Does area of deprivation make a difference? Proceedings of the Nutrition Society (2013); 72 / Issue OCE2</p>
2	Royal College of Physicians of Edinburgh	Primary care has referral pathways for healthy lifestyle/weight management.	Opportunity to offer support in primary care.	There may be inconsistent access to support at present in primary care.	<p>Access to weight reduction interventions for overweight and obese patients in UK primary care: population-based cohort study</p> <p>BMJ Open 2015</p> <p>http://bmjopen.bmj.com/content/5/1/e006642.full</p>
2.1	College of Occupational Therapists	Guidance about the need to tackle stigma and discrimination among health and care	Literature indicates a high level of stigma and discrimination towards people who are obese. This limits their ability to lead full and valued lives and for example, inhibits people engaging in employment or leisure outside of the home environment.	Occupational therapists have done some work towards addressing this within the profession but this area needs a larger targeted campaign based on identification as a key area for quality improvement.	Vroman K, Cote S (2011) Prejudicial attitudes towards clients who are obese: Measuring implicit attitudes of occupational therapy students. <i>Occupational Therapy in Healthcare</i> , 25(1), 77-90.

		professionals and the general public.			<p>Forhan M, Law M (2009) An evaluation of a workshop about obesity designed for occupational therapists, <i>Canadian Journal of Occupational 89Therapy</i>, 76 (5), 351-358.</p> <p>Lang J, James C, Ashby S, Plotnikoff R, Guest M, Kable A, Collins C, Snodgrass S (2013) The provision of weight management advice: An investigation into occupational therapy practice. <i>Australian Journal of Occupational Therapy</i>, 60, 387-394.</p>
2.1	SCM – Samantha Scholtz	Stigmatisation of obese patients in healthcare settings.	<p>Every patient with obesity should be treated with empathy and respect and their dignity preserved in all public and healthcare settings.</p> <p>Perceived stigmatisation by health professionals is a major barrier in obese patients accessing or utilising treatments. Open, matter of fact, non-judgmental discussion of weight, the stigma associated with obesity, and barriers to healthy lifestyle choices is needed to engage patients. Additional sensitivity to the health inequalities compounded by obesity in patients</p>	<p>Healthcare professionals are misinformed about the causes of obesity, and of the potential for treatments to reduce weight long term. This results in either failure of health professionals to broach the subject for fear of causing offence, or due to therapeutic nihilism. When the subject is broached, the perception by patients that they are being judged and criticised for having become obese or for failing to have lost weight with the recommended lifestyle interventions is a barrier to accepting treatment.</p>	<p>Mold F, Forbes A. Patients and professionals experiences and perspectives of obesity in health-care settings: a synthesis of current research <i>Health Expectations</i>, 16, pp.119–142 Obesity Learning Centre; Stigmatisation and obesity: Literature update February 2015 https://www.noo.org.uk http://www.obesitylearningcentre.org.uk DOH: Healthy Lives, Healthy People A call to action on obesity in England</p>

			<p>from lower socioeconomic groups, people with learning difficulties and those with mental health issues, who suffer additional stigma is important. Using appropriate language with compassion and empathy, and using appropriate adjunct information should be a part of every consultation with every patient. Clinicians should be supported by provision of accurate information about obesity its causes, realistic goals of treatment and obesity care pathways (e.g. NICE toolkit 1 for obesity, information from http://www.obesitylearningcentre.org.uk, and information on National Obesity Observatory).</p>	<p>This reinforces the stigmatising beliefs that obese people are lazy or greedy. Lack of provision of appropriate equipment of weighing and measuring obese patients in primary and secondary healthcare settings further intensifies feelings of shame and humiliation, which are barriers to accepting treatment. In CMACE Maternal Obesity in the UK report, only two thirds of maternity settings did not have appropriate equipment to manage obese expectant mothers. See also NICE guidelines for obesity recommendation 1.1 for general principles of care and recommendation 2: Ensure services cause no harm</p>	<p>Fair Society, Healthy Lives Marmott review executive summary Centre for Maternal and Child Enquiries (CMACE). Maternal obesity in the UK: Findings from a national project. London: CMACE, 2010 NICE guidelines Obesity: identification, assessment and management of overweight and obese people NICE guidelines: Managing overweight and obesity in adults – lifestyle weight management services</p>
2.2	SCM – Sarah West-Sadler	2.Equip healthcare professionals with the right skills to approach weight (Rec2: PH 53)	<p>People can often feel very anxious about visiting their doctor for fear that they will be told they have to lose weight.</p>	<p>Enabling healthcare professionals to approach weight carefully and sensitively might increase uptake of LWM services</p>	
2.2	Slimming World	Training for all health professionals to ensure confidence in raising the issue of weight with patients in a sensitive and	<p>We feel that there should be consistent training for health professionals to help them to sensitively raise the issue of weight with patients, to recognise the need for compassion and care when supporting people in weight management and to ensure they are familiar with options for</p>	<p>A key recommendation in the NICE guideline (PH53) is that health professionals should be aware of the stigma adults who are overweight or obese may feel or experience, and should ensure that the tone and content of all communications is respectful and non-judgemental. In line with this we would suggest that</p>	<p>Research has shown that making people feel bad about their weight is counterproductive and is more likely to cause people to gain weight than lose it (Jackson et al, 2014. Obesity). Therefore if initial conversations are not handled in a supportive manner it may hinder</p>

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		supportive manner	signposting/referring people to.	all professionals who interact with people who are overweight or obese receive training to equip them with the skills to sensitively and confidently raise the issue of weight with patients.	someone's weight loss attempts rather than improve them. Talking to health professionals on a regular basis this is an area which many feel uncomfortable working in due to a lack of training/perceived skill in raising the issue.
2.2	SCM – Carol Weir	Increased awareness and understanding of obesity evidence base inc: prevalence, consequences, causation, effective interventions for loss and maintenance etc for commissioners and health and wellbeing boards and clarity over their roles and responsibility in relation to this	There is a current focus on local responsibilities. Therefore, local authorities/councils, Clinical Commissioning Groups, Hospital Trusts and equivalent partners on health and wellbeing boards which includes among them areas such as education and social care are all important actors in tackling obesity. However, evidence shows that many professionals responsible for this area of work (be that commissioning or provision) have limited understanding of the complexity, skills, knowledge, training, autonomy and influence to clearly and effectively impact on the local obesity strategies/action plans.	NICE found that since 2011 Liberating the NHS the system for obesity pathways is fragmented with responsibility and roles unclear in some areas. The recommendation is an integrated pathway locally. Clarity over roles and responsibilities wrt obesity and the consequences of acting/not acting would help to achieve this.	Obesity NST (2011) Strategic High Impact Changes, Childhood Obesity National Support Team, Department of Health. Although this was highlighted for childhood obesity by the NST it is also a key recommendation in the NICE PH guidance 27 for adult obesity published May 2014. HOOP Report 2014
2.3	SCM – Sarah West-Sadler	4.The importance of addressing expectations of adults entering a	It is essential that healthcare professionals discuss with the patient the effort required to lose weight and that there is no quick and easy option but also that they have empathy for the	This might help to inform the type of LWM service that is suitable and also identify if the patient is ready for change.	

		LWM programme (Rec 7: PH 53)	effort required.		
3.1	The National Obesity Forum	The identification and engagement with obese individuals by GPs	<p>The identification and engagement with obese individuals by GPs – regardless of their presenting complaint - is an essential initial step in assisting such individuals with addressing their weight and therefore in preventing them from developing secondary illnesses associated with being obese.</p> <p>Engagement by GPs, particularly in the form of advice to obese individuals about the existing weight loss support they can access, can significantly aid them with efforts to lose weight and this, ultimately, will help curtail the increasing prevalence of obesity across the nation.</p> <p>Recommendations 14 and 1 of NICE guidance PH53 support this view in setting out that GPs should identify and refer obese patients to weight management services. Yet evidence shows that discussions about weight management and referrals to such services are happening infrequently, indicating that more needs to be done.</p>	<p>The latest statistics from the Health and Social Care Information Centre (HSCIC) reveal that obesity has increased drastically from 13.2 per cent in men and 16.4 per cent in women in 1993 to 26.0 per cent for men and 23.8 per cent for women in 2013.</p> <p>Although the current QOF obesity indicator requires that GPs establish and maintain a register of patients aged 18 years or over with a BMI ≥ 30, the continued steady rise in levels of obesity since 1993 shows this clearly has not helped with addressing the nation’s obesity problem.</p> <p>Evidence has shown that, in incentivising GPs to simply record the BMI of overweight patients, the current approach means that many GPs – who are already thinly stretched – do no more than meet this bare minimum requirement.</p> <p>Again, the latest statistics from the HSCIC on obesity rates show that this manner of identification alone is insufficient. Having GPs engage meaningfully with obese patients –</p>	<p>The following studies and statistics support the points made in the previous columns:</p> <p>http://www.thelancet.com/journal/s/lancet/article/PIIS0140-6736(11)61344-5/abstract</p> <p>http://www.hscic.gov.uk/catalogue/PUB16988/obes-phys-acti-diet-eng-2015.pdf</p> <p>http://bmjopen.bmj.com/content/5/1/e006642.full#ref-4</p>

				<p>whatever their presenting complaint – is essential if any real progress is to be made in tackling obesity. Moreover, as GPs are often the first health professional that overweight and obese individuals will encounter, they are in a unique position to not only identify such individuals but also to help them take the first crucial steps needed to lose or manage their weight.</p>	
3.1	Diabetes UK	<p>A wide-range of health professionals can ensure that overweight and obese people at risk are identified and referred to appropriate weight-management services.</p>	<p>When an individual consults their GP, or other health professional, it is essential that the patient is made aware of local weight management programmes which are available to them. This is in line with Recommendation 6 in the NICE Public Health Guidance 53 (PH53)⁶. Furthermore, Recommendation 14 of PH53 notes the need for continuing professional development for health and social care professionals regarding lifestyle weight management. Diabetes UK also supports health professionals ‘Making Every Contact Count’ to improve patient health and wellbeing. Every consultation with a GP or other health professional is an opportunity to promote healthy lifestyle choices and encourage behavioural change, if necessary.</p>	<p>As aforementioned, 11.5 million people in the UK are at risk of developing Type 2 diabetes, however up to 80% of cases of Type 2 diabetes could be prevented or delayed⁷. By ensuring that patients are provided accurate information about the risk factors for developing Type 2 diabetes when visiting their local GP or health professional, they can take simple steps to reduce their risk, such as eating healthily and increasing their levels of physical activity. Diabetes UK notes that consideration of recommendations 13 ‘Weight management advice’ and 14 ‘Dietary advice’ of PH388 will similarly lead to improved quality of care. In particular, action should be taken by providers of intensive lifestyle-change programmes and primary healthcare teams to advise</p>	<p>6 http://www.nice.org.uk/guidance/ph53 7 WHO. (2005). Preventing Chronic Diseases: A vital investment 8 https://www.nice.org.uk/guidance/ph38</p>

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				overweight and obese individuals to make changes which will reduce their risk of developing Type 2 diabetes.	
3.1	Dietitians in Obesity Management UK (domUK)	Regular measurement & recording of WC in adults.	Distribution of body fat, in addition to total body fat, is a key aspect of risk. Although different cut-off points have not been recommended for different ethnic groups due to lack of evidence, differential risk at lower waist circumference cut off points for some ethnic groups is recognised.	Waist circumference is not routinely measured and therefore key opportunities to identify high risk individuals are being missed.	Waist circumference is not routinely measured (http://www.noo.org.uk/data_sources/adult/health_survey_for_england and http://www.nice.org.uk/guidance/ph46/resources/guidance-assessing-body-mass-index-and-waist-circumference-thresholds-for-intervening-to-prevent-ill-health-and-premature-death-among-adults-from-black-asian-and-other-minority-ethnic-groups-in-the-uk-pdf).
3.1	Royal College of Physicians	1	Early identification of overweight and obesity in primary care is poor and means that opportunities for early intervention are missed.	Much evidence points to the benefits of early intervention for overweight.	NICE NG7
3.2	SCM – Kate Jolly	People should NOT be referred to an exercise referral service (ERS) for the primary objective of weight loss unless that are also receiving dietary	Exercise alone is less effective for weight loss than exercise and dietary advice and behavioural change components. (PH53)	Local service data shows 27% of ERS referrals are for obesity.	

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		advice/support alongside or the ERS is part of a weight loss maintenance programme.			
3.2	Dietitians in Obesity Management UK (domUK)	Referrals to lifestyle weight management services are considered at lower BMI and/or WC cut-off points in Asian populations.	Asian (South Asian and Chinese) populations are at increased risk of ill-health at lower levels of body fat than Caucasians. Type 2 diabetes and cardiovascular disease are more prevalent at BMI <25kg/m ² in these groups. However due to the heterogeneity of these groups, specific cut-off points for overweight and obesity have not been identified. However given their increased risks, a pragmatic approach is to use the WHO cut-off points for populations as a trigger for referral of individuals to lifestyle weight management services (23 kg/m ² for increased risk and 27.5 kg/m ² high risk).	Commonly used cut-off points for diagnosis of overweight (BMI≥25kg/m ²) and obesity (BMI≥30kg/m ²) are likely to underestimate risks of ill-health in these populations.	Regular recording of BMI is not always optimal and healthcare practitioners may not be aware of differential risk for different ethnic groups http://www.nice.org.uk/guidance/ph46/resources/guidance-assessing-body-mass-index-and-waist-circumference-thresholds-for-intervening-to-prevent-ill-health-and-premature-death-among-adults-from-black-asian-and-other-minority-ethnic-groups-in-the-uk-pdf .
3.2	Diabetes UK	Adults having their NHS Health Check who are identified as being at increased risk of Type 2 diabetes are referred to	Diabetes UK is working with NHS England and Public Health England in developing the National Diabetes Prevention Programme (NDPP). The NDPP aims to reduce the prevalence of Type 2 diabetes and will provide an evidence-based intervention to reduce the individual's risk of developing the condition.	The implementation of the NDPP and the continued roll-out of the NHS Health Check are important measures to reduce the prevalence of Type 2 diabetes in the community. This is a key area for quality improvement as by identifying individuals that are at risk of developing Type 2 diabetes, and by	

		the National Diabetes Prevention Programme.		ensuring that they receive evidence-based interventions and effective support, millions of people across the UK who are at risk of developing Type 2 diabetes can improve their health and wellbeing. Feedback received by Diabetes UK suggests that there are currently people that are at high risk of developing Type 2 diabetes who are not being referred to intensive lifestyle intervention programmes. When the NDPP is established in 2016/17 it will be important to ensure that referrals to the programme are maximised.	
3.2	SCM – Kate Jolly	Weight management programmes and services need to be acceptable and accessible to all people including men, people from minority ethnic groups, people with disabilities and people with other 'protected characteristics'. Data needs to be available to monitor access	<p>This is an issue of equity.</p> <p>Men are at a higher risk of overweight and obesity than women. The proportion of men who are overweight or obese increases from 54% of 25-34 year olds, to 72% of 35-44 year olds and reaches a peak of 81% of men aged 45-54 years.[HSE 2012]</p> <p>Inequalities are evident with a higher proportion of men in the lowest income quintile having a raised waist circumference (>102cm) (36% vs 31% in highest income quintile)[NOO 2011].</p> <p>Compared to white Europeans, people of South Asian ethnicity living in England tend to have a higher percentage of body fat at the same</p>	Robertson et al identified a paucity of weight management studies in men or that reported the outcomes separately for men. The qualitative research in the qualitative systematic review in Robertson et al, identified programme characteristics liked by men, that differ from those of most commercial and generic weight loss programmes.	<p>Robertson C, Archibald D, et al. Systematic reviews of and integrated report on the qualitative, qualitative and economic evidence base for the management of obesity in men. HTA 2014;18:35.</p> <p>Health Survey for England 2012: Adult anthropometric measures, overweight and obesity. Available at: http://www.hscic.gov.uk/catalogue/PUB13218/HSE2012-Ch10-Adult-BMI.pdf</p> <p>National Obesity Observatory. Obesity and ethnicity, January 2011.</p>

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		by all groups.	BMI and more features of the metabolic syndrome at the same waist circumference.[NICE PH46] Men of South Asian ethnicity also have higher waist-to-hip ratios compared to men from other ethnic groups.[NOO 2011]		http://www.noo.org.uk/uploads/doc/vid_9851_Obesity_ethnicity.pdf Only 10-11% of referrals from NHS to Weight Watchers and Slimming World were male. (Ahern A. BMC 2011;11:43 Stubbs RJ. Obesity facts 2011;4(2):113-20.)
4	Royal College of Physicians of Edinburgh	Community health improvement programmes are funded specifically to improve diet and physical activity levels.	Community health improvement programmes promote healthy lifestyles and carry out vital prevention work.	Lack of funding for prevention programmes would impede prevention work.	BMJ: Raiding the public health budget 27 March 2014 BMJ 2014;348:g2274 http://www.bmj.com/content/348/bmj.g2274 NHS England: Get serious about obesity or bankrupt the NHS https://www.england.nhs.uk/2014/09/17/serious-about-obesity/
4	SCM – Carol Weir	Commissioning of obesity services locally	Experiences of overweight and obese people support the Royal College of Physician’s Report (2013), which outlined weight management services in England as “patchy”. The HOOP Report 2014 supports this with evidence from La regarding commissioning of services. Without action to address both	The HOOP Report indicated that of the 109 local authorities that responded to their freedom of information request: <ul style="list-style-type: none"> • On average 2.5% of the public health allocation was spent on weight management services. • On average 0.9% of the allocation was spent on children and young 	HOOP Report 2014 RCP Report 2013 Report of the working group into: Joined up clinical pathways for obesity, 2014

			<p>prevention and treatment how can we expect to see a change in obesity levels?</p>	<p>people’s weight management services.</p> <ul style="list-style-type: none"> • These allocations are extremely low when compared to: Substance misuse (29%), Sexual health (21%) and smoking (5%). • This disparity is more problematic when the direct and indirect costs of each public health issue are considered: Obesity (£6.1bn (direct) & £27bn (indirect)); Drugs misuse (£488 m & £14.9bn); Alcohol misuse (£3.5bn & £21bn) and, sexual health (£1.5bn & £14.1bn) respectively. • A major concern was that two thirds of local authorities were not able to respond to our request. • The majority of the investment in obesity (84% children and young people and 73% adults) was in tier 2 services. These services tend to be brief interventions most often run by non-clinical staff, and there was no clarity on the degree to which these services are NICE guidance compliant or effective. 	
4	SCM – Kate Jolly	Commission programmes that include core components to prevent weight regain, such as	There is good evidence that a high proportion of people who attend a weight loss programme regain the weight. Strategies for weight loss maintenance and maintaining behavioural change are recommended	Weight regain is common. Most evidence comes from cohort studies. Wing and Phelan estimate that approx. 20% of overweight individuals are successful weight losers.	The Diabetes Prevention Programme illustrates the gradual weight regain following a weight loss programme.

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		encouraging feedback and monitoring, action plans for coping with challenging situations, social support, restructuring the environment and establishing new healthy routines.	within NICE PH49 and PH53	Wing RR, Phelan S. Am J Clin Nutr 2005;82:2225-55.	
4	SCM – Sarah West-Sadler	5. Commissioners should commission a range of LWM services (Rec 9: PH 53)	To ensure that there are groups available to best suit the needs of the individual rather than a one-size-fits-all approach, such as men only groups.	This might help to increase effectiveness of weight management.	
4	Weight Watchers	Commissioning of proven, NICE compliant lifestyle weight management programmes for adults, using best practice guidance on developing service specifications	Different weight management interventions and services have different approaches and different outcomes. The level of evidence underpinning different interventions also varies. Some services (such as Weight Watchers) has good quality efficacy data from randomised controlled trials published in high impact peer reviewed journals, in addition to real world evaluative data. Others have little or no evidence. Commissioners should prioritise	There is now good evidence that for overweight and obese patients who present in primary care, referral to a provider such as Weight Watchers is more effective and costs the taxpayer less (Jolly et al, 2011; Jebb et al, 2011; Fuller et al, 2012) than the usual care that GP practices are able to provide. Yet few commissioners seem to refer to this evidence and commission on this basis. Services for individuals provided by health professionals or by providers with little or no evidence	NICE Public Health Guideline 53, 'Managing overweight and obesity in adults – lifestyle weight management services' May 2014 Comparison of Range of Commercial or Primary Care Led Weight Reduction Programmes with Minimal Intervention Control for Weight Loss in Obesity: Lighten Up Randomized Controlled Trial. K Jolly, A Lewis J Beach, J

			<p>commissioning services which are known to work with proven outcomes. Out of small pilot or evaluative work on emerging innovations, commissioned services should have already been proven to work.</p>	<p>of efficacy (simply claiming their services or programmes are 'evidence based') remain a popular option. However, there is often little evidence for either the rationale for these interventions, or any clinical outcomes, at best evaluation usually consists of self-reported data/anecdotal responses.</p> <p>There is huge variability across the country in terms of the type, duration, level of quality and provider of services commissioned to manage obesity in adults; local nuances, innovation and choice are vital to provide high quality care to the public. However, it is not acceptable to commission services that are not yet proven to be effective or indeed have been proven to be ineffective.</p> <p>Service specifications such as the publication by the Department of Health (now Public Health England) 'Development of a specification for lifestyle weight management services: Best practice guidance for tier 2 services.' have an essential role to play in quality commissioning processes.</p> <p>They are a key tool that enables a commissioning organisation to set</p>	<p>Denley, P Adab, JJ Deeks, A Daley, P Aveyard. http://www.ncbi.nlm.nih.gov/pubmed/22053315 - # BMJ 2011; Nov 3; 343.</p> <p>Primary Care Referral to a Commercial Provider for Weight Loss Treatment versus Standard Care: a Randomised Controlled Trial SA Jebb, AL Ahern, AD Olson, LM Aston, C Holzapfel, J Stoll, U Amann-Gassner, AE Simpson, N Fuller, S Pearson, NS Lau, AP Mander, H Hauner, I Caterson. Lancet. 2011. September 7.</p> <p>Weight Loss from Three Commercial Providers of NHS Primary Care Slimming on Referral in North Somerset: Service Evaluation. K Dixon, S Shcherba, and R Kipping. J Public Health. 2012 May 18. [Epub ahead of print]</p> <p>Weight Watchers on Prescription: An Observational Study of Weight Change among Adults Referred to Weight Watchers by the NHS. AL Ahern, AD Olson, LM Aston, SA Jebb. BMC Public Health 2011; 11:434.</p>
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				<p>out the need, expectations of service quality, outputs and outcomes of the service being sought. They are the key source of information from which a service provider will shape the design and delivery model for the service that they are proposing. Producing a good quality service specification is crucial in securing market interest during the tendering process and in helping to secure an intervention that is fit for purpose.</p>	<p>Developing a specification for lifestyle weight management services. Department of Health, Obesity and Food Policy Branch, PHD. March 2013</p>
4	Weight Watchers	Encourage the commissioning of longer term open services	<p>Currently predominantly commissioned services are of standard term at only 12 weeks. This general commissioning practise is largely driven by cost requirements and restraints. However, new emergent models of longer term services should be explored due to the developing evidence base to support their role in weight management. We believe that a change in commissioning practices can have a positive impact on longer term outcomes. Obesity interventions for adults at a tier 2 level should be of longer term.</p>	<p>Qualitative, unpublished insights from a cohort of severely obese patients, with complex social and medical problems, who were referred by GP practices in Worcester for a year-long Weight Watchers intervention suggested that many reported tangible medical benefits such as: Ceasing blood pressure medication, a reduction in HbA1c from 8.6% to 6.2% in a patient with type II diabetes, increased level of stamina/energy, reduction in back and joint pain, a reduction in medication to control blood glucose. Additionally, a randomised controlled trial carried out in 2003 evaluated two weight loss methods; Weight Watchers and self-help. After 1 and 2 years, body weight, BMI and waist circumference were more</p>	<p>Heshka S, Anderson JW, Atkinson RL. et al. Weight loss with self-help compared with a structured commercial program: a randomized trial. JAMA. 2003;289:1792-1798</p>

				significantly decreased in participants assigned to the Weight Watchers group. Regular meeting attendance was significantly correlated with both weight loss and weight loss maintenance (Heshka et al 2003).	
4.1	Royal College of Physicians of Edinburgh	Access schemes for leisure activities available for low income or vulnerable groups such as elderly, pregnant women, physical and learning disability.	Cost or type of leisure activities may be a barrier for becoming more physically active for different groups.	Improving access to active leisure pursuits for low income or vulnerable groups would help reduce inequalities.	<p>Sport England: Economic conditions and key influences https://www.sportengland.org/research/encouraging-take-up/key-influences/economic-conditions/</p> <p>https://www.sportengland.org/research/encouraging-take-up/key-influences/</p> <p>Examples of access schemes include:</p> <p>http://www.poole.gov.uk/leisure-and-culture/sports-clubs-fitness/access-to-leisure/</p> <p>http://www.wrexham.gov.uk/english/leisure_tourism/sports_development/disability/dash_card.htm</p>
4.1	SCM – Samantha Scholtz	Access to multi-disciplinary teams across an integrated treatment pathway for	An integrated pathway for the treatment of obesity using a multi-disciplinary (MDT) model has been shown to be effective and is recommended by the Royal College of Physicians in their “Action on obesity, comprehensive care for	Despite these recommendations, implementation of and access to MDT support for obesity is patchy and in many areas Tier 3 services are non-existent. Psychology, dietetic and physical therapy input into Tier 3 and 4 services in	NICE guidelines: Managing overweight and obesity in adults – lifestyle weight management services: Recommendation 1 Adopt an integrated approach to preventing and managing obesity

		<p>obesity</p>	<p>all” and is recommended by NICE guidelines. The NHS Commissioning Board Clinical Commissioning Policy: Complex and Specialised Obesity Surgery in April 2013 recommended that all patients considered eligible for bariatric surgery should be referred for Tier 3 (specialist MDT) management of their obesity.</p> <p>Psychiatric comorbidity is high in obese patients, and causation is likely to be bidirectional. Acknowledgement and assessment of the mental health issues associated with obesity, such as depression, the effects of early trauma, and the iatrogenic obesogenic potential of many commonly prescribed psychotropic drugs is likely to improve patients’ ability to use weight management interventions, including bariatric surgery. Improved access to multidisciplinary treatments would be aided by integrated pathways of care, and a centralised system for accessing weight management in the community as recommended in NICE guidelines, at Tier 1 and 2 level, with onward referral to Tier 3 considered for all patients not benefiting from these interventions (see NICE guidelines recommendation 1.3.7 for appropriate</p>	<p>particular is underfunded.</p>	<p>Royal College of Physicians in their “Action on obesity, comprehensive care for all” The NHS Commissioning Board Clinical Commissioning Policy: Complex and Specialised Obesity Surgery Ratcliffe et al. Bariatric psychology in the UK National Health Service: input across the patient pathway BMC Obesity 2014, 1:20</p>
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			referral to Tier 3.		
4.1	Slimming World	Equal access to effective and evidence based weight management services for adults should be available across the country.	Services (provided through the NHS or local authorities) are currently not consistent across the country meaning that some adults have access to evidence based weight management services while others have no/much fewer options.	Currently there are health inequalities across the UK for both adults and children in terms of the provision of services for weight management.	For example, at present, if you live within the Nottingham City Council area and have a BMI>30 and would like support with weight management then you can be referred to attend a local, evidence based, weight management group free of charge for 12 weeks. Yet if you live in the neighbouring council area and you have a BMI>30 this is not an option.
4.1	Weight Watchers	Equality of access and availability of obesity management for adults	<p>There is currently a postcode lottery for access to obesity treatment and for quality standards of obesity treatment, with disjointed commissioning of the stepped care model. Lifestyle weight management services (tier 2) currently sit within the remit of Public Health, where clinically led services sit is with CCGs, (tier 3 and tier 4).</p> <p>Numerous reports (HOOP and RCP) illustrate the lack of access to quality local services; describing access as “patchy”. It is thought that very little is invested in weight management services in comparison to other public health issues, disproportionately when impact on health and social care and wellbeing is considered.</p> <p>Greater emphasis should be placed on</p>	<p>At present obesity services throughout the public system, are restricted and do not meet volume needs.</p> <p>In 2013, the American Medical Association (AMA) reclassified obesity as a disease, to enable improvements in treatment planning, access and outcomes. Whilst it is consensus that obesity is complex and requires multilevel actions, improving access and quality standards for treatment across tiers 2-4 would play one part in offering significant benefits.</p> <p>The Darzi Review recommended that ‘systematic and industrial scale’ interventions are needed to make any meaningful impact on obesity and the resultant long term conditions like type 2 diabetes and</p>	<p>Darzi A (2008) High Quality Care for All: NHS Next Stage Review (Final Report). Department of Health London.</p> <p>HOOP (Helping Overcome Obesity Problems) (2014) Tackling obesity: all talk, no action</p> <p>Royal College of Physicians. Action on obesity: comprehensive care for all. Report of a working party. London: RCP, 2013.</p>

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			commissioning tier 2 lifestyle weight management services on a scale that meets demand, in order to reduce the need for progression into more costly and higher risk tiers of treatment and potentially more invasive surgical procedures and in order to enhance the entire care pathway.	coronary heart disease.	
4.1	SCM – Carol Weir	Local Health and wellbeing boards to develop obesity strategies with a clear vision and action plan owned across the partnership.	NICE PH 27 recommended integrated pathways. Local (unpublished) results from obesity providers, and commissioners, recognise that where resources and pathways are integrated better outcomes and experience measures are achieved. Since the transition of PH into LA the number of obesity strategies and action plans has reduced with pathways confused and fragmented and investment stalled (Report of the working group into: Joined up clinical pathways for obesity, 2014)	This standard would focus attention on this issue, foster partnership working and support integrated pathways across commissioners and providers locally to offer services and where these are now available, a seamless transition through and between wider environmental approaches and weight management services rather than a fragmented and incomplete offer	Report of the working group into: Joined up clinical pathways for obesity 2014 HOOP Report 2014
5	Slimming World	Services should encourage a family approach in both the prevention and management of obesity.	It is vital that services supporting adults encourage and adopt a family approach in terms of dietary and physical activity support which will positively benefit the wider family.	A family based approach is vital due to the continuing evidence base of an association between overweight and obesity in children and parental overweight and obesity.	Scottish Intercollegiate Guidelines Network. (2010) Report No.115: Management of Obesity: A National Clinical Guideline. Available at: http://www.sign.ac.uk .
6	Dietitians in Obesity	Outcome data from weight	Optimal strategies for weight management need to be identified and	Sharing of outcome data is not widespread, with the risk that less	The importance of evaluating and reporting outcome data for

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	Management UK (domUK)	management interventions is collated and shared.	shared so that best practice is adopted and rolled out. Although there is clear guidance on what lifestyle weight management interventions should include, a pathway for sharing robust outcome data is not in place.	helpful strategies may continue to be utilised. In order to develop a robust evidence base, outcome data sharing is necessary.	weight management is recognised and a standard evaluation framework has been developed (http://www.noo.org.uk/uploads/doc721_2_noo_SEF%20FINAL300309.pdf). An evaluation data collection tool exists on the National Obesity Observatory website (https://www.noo.org.uk/core), but the data it contains is in many cases incomplete and patchy
6	SCM – Carol Weir	Obesity weight loss and maintenance KPIs are evidence based both in % weight loss and time to achieve both loss and maintenance, and adequately resourced	Service specifications published for obesity services vary greatly and are not in line with the DH guidance for commissioning lifestyle weight management services 2013.	The key performance indicators in specs are often not evidence based eg 100% achieving 5% weight loss at 3 months, and services are 'set up to fail'. The amount of resource to achieve weight loss and more importantly longer term maintenance are also inadequate. The amount and length of investment does not often support weight maintenance and hence evidence in this area is lacking, as identified by NICE.	DH guidance for commissioning lifestyle weight management services 2013 NICE PH 27 2014 Service specifications for obesity services.
6	Weight Watchers	Weight loss to be a key modifiable outcome for the prevention of disease development	The Darzi Review recommended that 'systematic and industrial scale' interventions are needed to make any meaningful impact on obesity and the resultant long term conditions like type 2 diabetes and coronary heart disease (Darzi, 2008). To that end, we recommend that when weight	Not all interventions centred upon reducing the incidence of certain diseases focus on weight as an outcome. This is in spite of evidence to support the key role of weight reduction in disease prevention. It is important that disease prevention programmes are supported by good	Darzi A (2008) High Quality Care for All: NHS Next Stage Review (Final Report). Department of Health London. NICE Public Health Guidance 38 (July 2012). Preventing Type 2 Diabetes: Risk Identification

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			reduction has been identified as a key modifiable outcome for preventing disease development, (Type 2 diabetes for example), it is suggested that this should be the primary outcome that is targeted in any intervention.	quality evidence to demonstrate significant and meaningful reductions in weight.	and Interventions for Individuals at High Risk
6.1	SCM – Carol Weir	Investment in evaluation to enable Sharing of services provided in detail and what they can achieve with what resource	Professional practice and personal research has lead me to understand that as investment is reduced evaluation is one element that is dropped. There is little published evidence that is clear about what real weight loss programmes can and do achieve as this is now a commercial environment and therefore publication of trials etc is available but not actual programme data to allow realistic evaluation	NICE struggled with the evidence for the programmes that are being delivered. There is evidence of some of the commercial programmes but not a great deal that can be compared due to either lack of data, lack of information about the programme or that these are trials not real programmes	NICE PH 27
6.1	SCM – Kate Jolly	Data on characteristics of weight management service users and their attendance rates and outcomes need to be collated on a local basis and available in an anonymised format for	We cannot compare services for weight management or outcomes for particular population groups or determine equity of provision without available data.	Information about equity of service provision is largely determined by trial results	The National Obesity Observatory has links to survey data from Health Survey for England, the Active People survey and QOF. http://www.noo.org.uk/data_sources/adult None of these provides information on outcomes of services.

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		national comparison and monitoring, by Public Health England for example.			
7	College of Occupational Therapists	Occupational therapy for the prevention and management of obesity in adults	Occupational therapists in addition to all the allied health professionals have approximately four million client contacts every week (RSPH 2015). This workforce if harnessed correctly could improve both the prevention and management of obesity in adults.	A recent literature review reveals that occupational therapists can use the power of occupation to address the overall lifestyle changes required to target obesity. They can deliver health promotion and prevention interventions, can increase physical activity participation, modify dietary intake and reduce the impact of obesity in self-care, work and leisure activities.	Haracz K, Ryan S, Hazelton M, James C (2013) Occupational therapy and obesity: an integrative literature review. <i>Australian Occupational Therapy Journal</i> , 60(5), 356-365. Royal Society of Public Health (2015) Healthy conversations and the allied health professions. Available at: http://www.rsph.org.uk/filemanager/root/site_assets/our_work/reports_and_publications/2015/ahp/final_for_website.pdf
7	Royal College of Physicians	Additional developmental areas of emergent practice	Development of both physicians specialising in obesity and hospital-wide ‘champions’ to ensure patients with obesity get appropriate care.	Most (or a substantial minority of) patients admitted to hospital are overweight or obese and the most severely obese need specialised care	RCP report
8	Sustrans	Environmental determinants of behaviour	Many of the behavioural choices contributing to weight gain and obesity, at individual or population level, are heavily influenced by the environment	NICE has down the years produced much excellent guidance addressing environmental determinants of behaviour. There is also a mass of policy,	We were a bit surprised not to see PH8 mentioned in the topic overview. This and the implementation materials surrounding it could be

				<p>expert guidance and technical recommendation from government, professional bodies and other experts in various sectors – not just in healthcare or public health, but also for example in planning or transport.</p> <p>But implementation of this expert advice is often patchy, particularly where NICE is inviting actors outside the health sector to do something differently. NICE is well aware of this and has taken steps to increase the likelihood that, for example, local authority planning or transport teams would implement PH8 and PH41.</p> <p>The new QS could be an opportunity to revisit that promotional effort, particularly now that local Directors of Public Health are based within local government, and should be able to speak peer-to-peer to their colleagues in other disciplines, and advocate for better implementation</p>	<p>incorporated.</p> <p>That would allow local Public Health teams to encourage their colleagues in other sectors to implement the relevant NICE recommendations, which are sufficiently detailed for the purpose.</p>
8	College of Occupational Therapists	Guidance about the need for built environments to support those with obesity problems	Occupational therapists report to COT that they are increasingly being asked to facilitate the movement and participation of people with obesity both inside and outside their homes as the built environment is too small or unsafe.	The UK has the smallest domestic space standards in Europe based on retrospective data when the population was smaller. Added to this are difficulties with the small size of seats in trains, planes and cars, and seats in public facilities such as cinema and restaurants. Both	Grisbrooke J, Bracher M, Archibold P (2014) <i>Implications of design and availability of space at home for safe handling of plus size people</i> . Presentation at COT conference 2014, Brighton.

				domestic and public spaces are increasingly posing barriers to participation for those with obesity which perpetuates exclusion.	
8	College of Occupational Therapists	Clear guidance about the need to address the personal care issues of those with obesity problems	Occupational therapy literature from America and Canada indicates that people with obesity problems are usually left to struggle to manage their personal care without any input from occupational therapists or others.	The literature indicates that people with obesity problems spend three times as much time in self-care activities than the general population which limits their energy and time to spend in other activities such as employment or leisure.	Forhan M, Law M, Vrkljan BH, Taylor VH (2011) Participation profile of adults with class three obesity. <i>Occupational Therapy Journal of Research</i> , 31, 135-142. Forhan M, Gill S (2013) Cross border contributions to obesity research and interventions: a review of Canadian and American occupational therapy contributions. <i>Occupational Therapy in Healthcare</i> , 27(2), 129-141
8	College of Occupational Therapists	Clear guidance about correct bariatric equipment, its cost, and the need to include carer assessment in its correct and safe use	In 2014 occupational therapists from around the UK indicated to COT that over the past five years they have seen a large increase in referrals for specialist bariatric equipment both in hospital and home settings. They report difficulties with: lack of clear guidance about which equipment to use; problems accessing the equipment due to its higher cost than standard equipment and lack of attention to carers who frequently also have problems with obesity and are expected to use the equipment.	Occupational therapists report that because of a lack of clear guidance and increased costs of bariatric equipment, it is more difficult to meet the needs of people with obesity problems than those without. This is resulting in further exclusion of this client group from occupational participation.	Heslop J (2008) <i>A critical review of the role of occupational therapy in promoting quality of life for people with bariatric needs</i> . York St John University. BSc(Hons) thesis – COT Library. Grisbrooke J, Bracher M, Archibold P (2014) <i>Implications of design and availability of space at home for safe handling of plus size people</i> . Presentation at COT

					conference 2014, Brighton.
8	Dietitians in Obesity Management UK (domUK)	Reduce unintended purchases of high fat, salt and sugar containing foods and drinks at the till by ensuring that food retailers adopt a national 'healthy till' approach.	High intake of dietary fat, salt and sugar-containing foods and drinks are recognised modifiable risk factors for ill-health, including weight management and associated conditions such as cardiovascular disease. Dietary survey data recognises some improvements in national diet compared with recommendations; however intakes of sugar, salt and (in some population groups) dietary fat are still higher than recommended.	Unintended purchases of these foods and drinks, particularly by parents under pressure from children, may be a contributory factor. In addition prominent product placement of unhealthy foods and drinks normalises them, and children may be particularly vulnerable to this. Environment is recognised as a critical factor which can help or hinder efforts at weight management.	The role of the environment in weight management is recognised, and there is acceptance that maintaining a healthy weight is difficult within the current obesogenic environment www.foresight.gov.uk , http://www.nice.org.uk/guidance/cg43/chapter/guidance#public-health-recommendations and https://www.nice.org.uk/guidance/ng7 Parents have identified a need for healthier checkouts and a national campaign set up to remove unhealthy foods and drinks from the tills has resulted in some high profile retailers pledging to remove junk, including Lidl, Aldi and Tesco (http://domuk.org/viewpage.php?cat=8&page=48).
8	Dietitians in Obesity Management UK (domUK)	Participation in the Public Health Responsibility Deal for food reformulation needs to become	Participation in the Public Health Responsibility Deal is currently optional. Reformulation of foods to achieve lower salt, fat and sugar content is an important step to help achieve dietary change by altering the food environment.	Key health advocates have expressed concern over the voluntary nature of the Public Health Responsibility Deal. Although beneficial changes to food formulation have occurred both as part of this Deal and outside it, mandatory participation with	Concern over the voluntary nature of engagement and lack of accountability if outcomes are not achieved has been expressed https://www.rcplondon.ac.uk/policy/responding-nhs-reform/public-health-

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		mandatory and outcomes measurable.		measureable outcomes to improve national dietary intakes is likely to speed up the rate of change.	responsibility-deal and http://www.fph.org.uk/search/responsibility+deal).
8	Royal College of Physicians	2	Appropriate use of pharmacotherapy of obesity	Orlistat is both misused and underused.	NICE CG 189 Br J Clin Pharmacol . 2009 Dec;68(6):844-51. doi: 10.1111/j.1365-2125.2009.03528.x. Viner RM1 , Hsia Y , Neubert A , Wong IC . Br J Clin Pharmacol . 2014 Dec 31. doi: 10.1111/bcp.12578. [Epub ahead of print]. Douglas IJ1 , Bhaskaran K , Batterham RL , Smeeth L .
8	Royal College of Physicians	3	Development and provision of Tier 3 services	Central to overarching obesity strategy, yet most CCGs fail to commission.	RCP Survey
8	Royal College of Physicians	4	Bariatric surgery is under-provided and under-delivered by current guidelines and in particular not ‘routinely’ considered as an option in patients with T2DM. At the same time the lessons of the NCEPOD report ‘Too Lean a Service’ are not implemented.	Bariatric surgery can offer optimal care for obesity especially in those with T2D and be economically dominant within several years. Weight management strategies that are not fully implementing this approach are of sub-optimal quality.	NICE CG189
8	Royal College of Physicians of Edinburgh	Workplaces including NHS offer lifestyle support to maintain healthy weight.	Working age population influenced by peers and spends significant amount of time in work.	Support may be inconsistent at present. There would also be positive benefits for employers to reduce sickness in longer term.	NHS Employers: Health and Wellbeing http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing BHF: Health at work: Promoting

					<p>workplace health and wellbeing https://www.bhf.org.uk/health-at-work</p> <p>UK Government: Health, work and wellbeing https://www.gov.uk/government/policies/helping-people-to-find-and-stay-in-work/supporting-pages/co-ordinating-the-health-work-and-wellbeing-initiative</p>
8	SCM – Samantha Scholtz	Earlier referral and adequate access to bariatric surgery	Fertility problems, type 2 diabetes, heart disease, sleep apnoea, and joint disease are some conditions in which earlier referral is likely to improve outcomes for bariatric surgery. NICE has recently updated guidelines to emphasise the need for early referral for bariatric surgery for type 2 diabetes.	<p>Applying the NICE algorithm to 2011 census statistics indicates that there is a potential cohort of patients who may be eligible for bariatric surgery of approximately 257,000 people. However less than 9,000 patients were admitted for bariatric surgery in 2010/2011.</p> <p>This shortfall is unlikely to be explained solely by patients not wishing to have or not being suitable for bariatric surgery. Furthermore there is wide variation in availability of bariatric surgery and the variation of provision is aligned with other factors influencing health inequality such as socioeconomic status. NICE guidelines recommend that obese patients should not be discriminated against when requesting treatment for their obesity-related comorbidities. Equally ignoring the issue of weight when considering</p>	<p>The NHS Commissioning Board Clinical Commissioning Policy: Complex and Specialised Obesity Surgery Owen-Smith Amanda, Kipping Ruth, Donovan Jenny, Hine Christine, Maslen Christina, Coast Joanna et al. A NICE example? Variation in provision of bariatric surgery in England BMJ 2013; 346 :f2453 https://www.nice.org.uk/news/article/offer-weight-loss-surgery-to-diabetics</p>

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				comorbidities of obesity can delay appropriate referral for treatment of obesity.	
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