PUBLIC HEALTH PROGRAMME GUIDANCE
PREVENTING OBESITY: WHOLE SYSTEM APPROACHES

Consultation on the Draft Scope from 15 January - 12 February 2010

Please note that any attached papers and footnotes have been removed from the table of comments below.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Aga Khan Health Board UK (AKHB)		General point 1	The AKHB sees this initiative on guidance as a 'global' approach to maintaining healthy weight and preventing obesity as an excellent way to tackle a multi-factorial problem and would be willing to fully support NICE	Thank you.
Aga Khan Health Board UK (AKHB)		General point 2	Given the breadth of the scope, AKHB feel it is critical that NICE collaborate with a variety of stakeholders including communities with diverse ethnic and religous backgrounds such as ourselves, in developing this guidance and through to putting it into practice. These aspects will have to be carefully addressed	Thank you. NICE would welcome working with a broad range of stakeholders on this work and acknowledges the importance of obtaining the views of those from a diverse range of backgrounds. NICE encourage AKHB to fully participate in the guidance development process.
Aga Khan Health Board UK (AKHB)		General point 3	One difficulty that may arise from a whole-system approach is in effectively auditing different aspects/ level of guidance once established. The guidance should be structured so that it is possible to study individual interventions. This might help identify key areas of impact from this guidance.	Thank you for this comment.
Aga Khan Health Board UK (AKHB)		2b	Large scale community caterers should also be considered as they are a source of regular food supply/ distribution	Thank you for this comment. Large scale community caterers will be considered, depending on the evidence available.

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Aga Khan Health Board UK (AKHB)		3b and c	Ideally all or the majority of ethinic groups need to be included in this and partnerships with other communities will be beneficial for this. In our community the mean percent mortality in the UK over the last 3 years from cardiac disease is 32%. Furthermore, patterns of obesity may vary between ethnicity and gender. For instance central obesity that presents with increased waist size is a marker for increased visceral fat and linked to Type II diabetes. This may also need to be considered in the scope of the guidance and given appropriate emphasis rather than attributed to excess body fat.	Thank you for this comment. The scope covers the whole population.
Aga Khan Health Board UK (AKHB)		3e	Cultural aspects, diet, cooking practices, foods also need consideration.	Noted
Aga Khan Health Board UK (AKHB)		4.2.1	Many different outcomes could be used to measure, and the scope and choice of outcomes will strongly influence the evidence available. Whilst there are many outcome measures to choose from to measure the risk of obesity and to bring about population-wide behaviour change, it is important that a wide range are used to fit with the wide range of interventions.	Thank you. A broad range of outcomes will be considered, as appropriate. A note to this effect has been added to section 4.3 of the draft scope.
Aga Khan Health Board UK (AKHB)		Question 7 to be considered	The document does not question specifically the intended decision-making process for recommended deployment of limited government resources, once effective strategies have been identified. Cost-effectiveness, cost-consequence and cost-benefit analyses have been mentioned. However, the scope does not specifically mention whether NICE intends to consider a risk-based approach to tackling this issue (i.e. focusing resources first on individuals with the highest risk of developing obesity)? Whilst AKHB appreciate this is a sensitive topic, perhaps it should be debated/discussed and recommendations considered as part of the scope of this document	Thank you for this comment. How resources are allocated is partly a technical question and partly a question of equity. This issue will almost certainly be discussed by the PDG and is too detailed to be part of the scope.

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Association for Family Therapy and Systemic Practice (AFT)		General	AFT membership includes professionals from different disciplines and a range of services in the NHS, Social Care and third sectors, who work systemically with whole families, their networks, parents, couples and individuals. Members have different levels of systemic family therapy training, and use systemic approaches and family therapy within their roles. Some are employed as UKCP registered family psychotherapists. Further information and publications can be found on the website: www.aft.org.uk, including *Current practice, future possibilities* and *Evidence Base for Family Therapy*	Noted.
Association for Family Therapy and Systemic Practice (AFT)		2.e	There is evidence (from Sweden) that Family Therapy for young children with obesity provides a way to prevent them from having more severe obesity as teenagers. The systemic models include methods that are often provided within UK family therapy training. Flodmark, Ohlsson, Ryden & Sveger : Prevention of progression to severe obesity in a group of obese schoolchildren treated with family therapy. Flodmark & Ohlsson (2008): Childhood obesity: from nutrition to behaviour. Proceedings of the Nutrition Society. 67.4.356-362.	Thank you for providing this reference.
Association for Family Therapy and Systemic Practice (AFT)		4.2.1.	AFT has proposed some relevant training for groups who will be working with families in different ways: *Family Friendly UK: making it happen. A proposal for developing family sensitive trainings and services to support the UK's most valuable resource – its people.* Details can be access on the AFT website www.aft.org.uk	Thank you for providing this reference.
Association for Family Therapy and Systemic Practice (AFT)		Appendix B Potential considerations	*Critical elements: status and characteristics of the person delivering packages of interventions.* One feature of a 'whole system' approach is the importance of acknowledging that obesity may be just one of the problems in some families. This has implications for the levels of basic levels of training needed for staff who work with families, as well as when to recognise the need for further help.	Thank you for raising this issue.

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Association for Family Therapy and Systemic Practice (AFT)		Appendix B Potential considerations	*Factors that prevent – or support effective implementation* A whole system approach for obesity will benefit from structures that provide access to systemic therapy with families, eg University College London Hospital has a programme HELP –Healthy Eating Lifestyle Programme, which is informed by systemic, narrative and solution focused approaches. Training is provided for staff at different levels in the NHS. SLAM is developing evidence for working with families and obesity. The strong evidence base for the Maudsley model for family therapy with anorexia nervosa has led to the appointment of family therapists in many eating disorder services, some of whom cover obesity.	Thank you for providing this information.

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Baby Milk Action		General	The comments relating to infant and young child feeding are submitted on behalf of Baby Milk Action, the Baby Feeding Law Group,[1] and the Breastfeeding Manifesto Coalition .[2] Other more general comments relating to older children and education are from Baby Milk Action alone. In 2008 the UK was called to answer questions from the UN Committee on the Rights of the Child (CRC) - 5 years after being told by the Committee to implement the Code. The Committee was unimpressed by the Government's submission which claimed it had implemented the International Code. *"The CRC Committee, while appreciating the progress made in recent years in the promotion and support of breastfeeding in the State party...is concerned that implementation of the International Code of Marketing of Breastmilk Substitutes continues to be inadequate and that aggressive promotion of breastmilk substitutes remains common.... The Committee recommends that the State party implement fully the International Code of Marketing of Breastmilk Substitutes.*	Noted.

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Baby Milk Action			References: [1] The Baby Feeding law Group is a coalition of 23 leading health professional and lay organisations working to bring UK and EU legislation into line with International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly Resolutions. 2 The Breastfeeding Manifesto Coalition has 33 member organizations and calls for action in 7 areas to protect, promote and support breastfeeding. http://www.breastfeedingmanifesto.org.uk BFLG Member organisations: Association of Breastfeeding Mothers - Association for Improvements in the Maternity Services - Association of Radical Midwives - Baby Milk Action - Best Beginnings – Breastfeeding Community - Breastfeeding Network - Caroline Walker Trust - Community Practitioners and Health Visitors' Association - Food Commission - Lactation Consultants of Great Britain - La Leche League (GB) - Little Angels - Midwives Information and Resource Service - National Childbirth Trust - Royal College of Midwives - Royal College of Nursing - Royal College of Paediatrics and Child Health - The Baby Café - UK Association for Milk Banking - Unicef UK Baby Friendly Initiative - UNISON - Women's Environmental Network.	Noted.

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Baby Milk Action		General	The importance of regulating the baby food market Many of the following comments focus on the importance of regulating food marketing rather than on strategies which focus on lifestyle and individual choice. The importance of this strategy is shown in the latest Euromonitor International analysis of the global baby food market, *Global Packaged Food: Market Opportunities for Baby Food to 2013,* which states: *"Government Regulation a Growing Constraint….There are significant international variations in the regulations governing the marketing of milk formula, which are reflected in sales differences across countries."* This is a clear indication that restricting marketing protects breastfeeding, so limiting market growth. *"The industry is fighting a rearguard action against regulation on a country-by-country basis,"* In industrialised countries the industry focus is on increasing value growth as well as volumes, through the promotion of added ingredients such as DHA and ARA (Long Chain Polyunsaturated Fatty Acids) and 'probiotics'. Promotion of breastfeeding is a concern to the industry, even in the US where formula advertising is unregulated: *"The rising popularity of breast feeding and a low birth rate will combine to drag North American retail value growth down by a percentage point in 2008, to 5.9%."*	Thank you for raising this issue.

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Baby Milk Action		General	Organic baby foods are seen as a significant marketing strategy, but Euromonitor acknowledges: *"In Western Europe, most parents are unaware that, as a result of stringent EU regulations on permitted levels of pesticide residues in baby food, there is very little difference between regular and organic baby food."* The internet is portrayed as a major marketing opportunity and also promoting 'good night milks': *"With an increasing number of mothers returning to work after giving birth, products that help babies sleep better could have a wide appeal."* The Euromonitor report *Global Packaged Food: Market Opportunities for Baby Food to 2013* is available at: **euromonitor.com** Another report, Datamonitor's *Babies and Toddlers: Emerging Opportunities*, shows the importance of Build brand loyalty early *"Mothers are returning to a more traditional parenting technique of breastfeeding their children. This presents problems for the baby drinks industry, with the growth of formulas stunted as a consequence. Manufacturers must find ways of creating appeal without positioning drinks as a direct alternative, which creates ill-feeling among mothers. "Marketers are becoming more aware of the need to target parents as early as possible. Brand relationships and trust bonds can be formed during pregnancy when the child is not yet even born. This lifestage targeting will becoming increasingly important going forwards."* datamonitor.com	Thank you for providing this information. However, please note that specific issues relating to infant feeding are covered by existing NICE guidance on maternal and child nutrition (2008).

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Baby Milk Action		Question 1	**Question 1:** What are the key societal, environmental and organisational factors operating at the local level that can lead to obesity? How do these factors interact with each other? Do they reflect social integration and connection with local or broader community and cultural institutions? The contribution of high fat, high sugar, high calorie foods alongside reduced levels of physical exercise to rising levels of obesity is well established and acknowledged. The role of optimal infant and young child feeding (exclusive breastfeeding for six months, followed by continued breastfeeding alongside appropriate complementary foods) is less well acknowledged. When considering ways to tackle this problem its important that the focus is moved away from individual 'choice' to providing an environment that supports good healthy decision making. Schemes that seek promote breastfeeding but fail to ensure that women receive adequate and consistent and objective support and advice at the time they need it and allow conflicting commercial messages to continue, are likely to back fire and create hostility.	Thank you for this comment. As noted in section 2b of the draft scope, taking a whole systems approach to obesity will mean shifting attention away from individual risk factors or isolated interventions and considering may influences simultaneously. However, please note that specific issues relating to infant feeding are covered by existing NICE guidance on maternal and child nutrition (2008).

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Baby Milk Action		Question 1 continued	See Protecting breastfeeding -*Protecting babies fed on formula Why the UK government should fulfil its obligation to implement the International Code of Marketing of Breastmilk Substitutes* and other papers*:* *http://www.babymilkaction.org/shop/publications01.html#bflgsubmission* *http://www.babyfeedinglawgroup.org.uk/monitoring.html* *http://www.babymilkaction.org/policy/policyindex.html*	Thank you for providing this information.

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Baby Milk Action		Question 1 continued	Although the vast majority of women in the UK want to breastfeed, most are failed by the system and stop breastfeeding long before they wanted to because of problems that could have been avoided with proper support and care. Most give up long before they have to return to work. Indeed the UK has one of the lowest breastfeeding rates in Europe – with less than 1 per cent of mothers in the UK exclusively breastfeeding at six months. The UK infant feeding survey 2005 (Bolling et al. 2007) showed that 78% of women in England breastfed their babies after birth but, by 6 weeks, the number had dropped to 50%. Only 26% of babies were breastfed at 6 months. Exclusive breastfeeding was practised by only 45% of women one week after birth and 21% at 6 weeks (Bolling et al. 2007). As new formulas are promoted with lower protein levels, it is important to recognize that rapid early weight gain and later obesity is not only the result of the extra calories in formulas and baby foods. Breastfeeding and baby-led feeding is likely to influence the development of a taste receptors, fostering a preference for lower energy diets later on in life, and may help in developing appetite control mechanisms.	Thank you for raising this issue.

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Baby Milk Action		Question 1 continued	**Evidence regarding breastfeeding** Epidemiological evidence strongly suggests that breastfeeding represents an ideal window of opportunity for obesity prevention. Systematic reviews on the association between breastfeeding and obesity show that breastfeeding acts as a protective factor in a dose-dependent and causal fashion Scientific research shows that many biological factors associated with obesity and chronic diseases may be programmed very early in life or even during pregnancy. Once a child becomes obese, it is quite likely that s/he will remain obese as an adult.	Thank you for raising this issue.

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Baby Milk Action		Question 1 continued	The report of the BMA Board of Science on *Early life nutrition and lifelong health*, February 2009 states that: *"Breastfed infants have more control over the flow of milk than bottle-fed infants. Breastfeeding is therefore often described as an ideal 'supply and demand' regulation system. The feeding behaviour of the baby and the quality of the breast milk change with time in a way that may prevent overfeeding, teach the infant how to recognise satiety signals, and regulate energy intake differently from formula-fed infants. The role of leptin in breast milk may be of particular importance in the early development of both adipose tissue and appetite regulatory systems in the infant, and ultimately on propensity to obesity in later life. A recent study showed that administration of physiological levels of leptin to suckling rats caused a significantly lower body weight in adulthood.[129] Observational studies have shown that breastfeeding is associated with lower rates of childhood obesity.[130] Bearing in mind the absence of leptin in formula milk, this may have important implications for the prevention of obesity in children and in adults."* The USA Centre for Disease Control and Prevention (CDC) considers that there are only two potential, cost-effective interventions that can be put into place immediately to deal with the childhood obesity epidemic: decreased television viewing and breastfeeding promotion. (Dietz WH. *Breastfeeding may help prevent childhood overweight*. JAMA. 2001; 285:2506	Thank you for providing this information.

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Baby Milk Action		Question 1 continued	**References:** When the US Department of Health (HSS) broadcast advertisements promoting breastfeeding in the period 2003-5, the industry brought in powerful lobbyists who succeeded in getting the ads toned down. At the same time, the industry substantially increased its own advertising as soon as the Government campaign was launched. According to a 2006 report by the Government Accountability Office, formula companies spent about $30 million in 2000 to advertise their products. In 2003 and 2004, when the campaign was underway, infant formula advertising increased to nearly $50 million.: The result was a fall in breastfeeding rates: *"the proportion of mothers who breast-fed in the hospital after their babies were born dropped from 70 percent in 2002 to 63.6 percent in 2006, according to statistics collected in Abbott Nutrition's Ross Mothers Survey, an industry-backed effort that has been measuring breast-feeding rates for more than 30 years."* [2] Kalies H, Heinrich J, Borte N, et al and LISA Study Group. *The effect of breastfeeding on weight gain in infants: results of a birth cohort study*. Eur J Med Res, January 28, 2005; 10(1): 36-42. In this prospective cohort study healthy term neonates were followed up to age 2 years in Germany. Duration of exclusive breastfeeding was inversely associated with the risk of elevated weight gain in a strongly duration-dependent way.	Thank you for providing this information.

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Baby Milk Action		Question 1 continued	Akobeng AK, Heller RF. *Assessing the population impact of low rates of breast feeding on asthma, coeliac disease and obesity: the use of a new statistical method*. Archives of Disease in Childhood 2007;92:483-485. In the population of the 596,122 babies born in England and Wales in 2002, the number of cases of asthma, coeliac disease and obesity that could be prevented over 7–9 years if all babies were breastfed was 33 100 (95% CI 17 710 to 47 543), 2655 (95% CI 1937 to 3343) and 13639 (95% CI 7838 to 19308), respectively. [Further supporting references on obesity:] Bergmann KE, Bergmann RL, Von Kries R, Böhm O, Richter R, Dudenhausen JW, Wahn U. Early determinants of childhood overweight and adiposity in a birth cohort study: role of breast-feeding. Int J Obes Relat Metab Disord. 2003 Feb;27(2):162-72. Gillman MW, Rifas-Shiman SL, Berkey CS, et al. *Breast-feeding and overweight in adolescence: within-family analysis* [corrected] Epidemiology. 2006 Jan;17(1):112-4. Gillman MW, Rifas-Shiman SL, Camargo CA Jr, Berkey C, Frazier AL, Rockett HRH, et al. *Risk of overweight among adolescents who had been breast fed as infants.* JAMA 2001;285:2461–7. Hediger ML, Overpeck MD, Kuczmarski RJ, Ruan WJ. *Association between infant breastfeeding and overweight in young children*. JAMA 2001;285:2453–60.	Thank you for providing these references.

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Baby Milk Action		Question 1 continued	von Kries R, Koletzko B, Sauerwald T, Von Mutius E, Barnert D, Grunert V, et al. *Breast feeding and obesity: cross sectional study.* BMJ 1999;319:147–50. Toschke AM, Vignerova J, Lhotska L, Osancova K, Koletzko B, von Kries R. *Overweight and obesity in 6- to 14-year-old Czech children in 1991: protective effect of breast-feeding*. J Pediatr 2002;141:764–9.	Thank you for providing these references.

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Baby Milk Action		Question 1 continued	Excerpts from: **Recommended Community Strategies and Measurements to Prevent Obesity in the United States Morbidity and Mortality Weekly Report** **www.cdc.gov/mmwr July 24, 2009 / Vol. 58 / No. RR-7** *This report describes the expert panel process that was used to identify 24 recommended strategies for obesity prevention and a suggested measurement for each strategy that communities can use to assess performance and track progress over time. The 24 strategies are divided into six categories including strategies to promote the availability of affordable healthy food and beverages; to support healthy food and beverage choices, and to encourage breastfeeding,* **Strategy to Encourage Breastfeeding** Breastfeeding has been linked to decreased risk of pediatric overweight in multiple epidemiologic studies. Despite this evidence, many mothers never initiate breastfeeding and others discontinue breastfeeding earlier than needed. The following strategy aims to increase overall support for breastfeeding so that mothers are able to initiate and continue optimal breastfeeding practices. systematic reviews of epidemiologic studies indicate that breastfeeding helps prevent pediatric obesity: breastfed infants were 13%–22% less likely to be obese than formula-fed infants (*77,78*), and each additional month of breastfeeding was associated with a 4% decrease in the risk of obesity (*79*). Furthermore, one study demonstrated that infants fed with low (<20% of feedings from breastmilk) and medium (20%–80% of feedings from breastmilk) breastfeeding intensity were at least twice as likely to have excess weight from 6 to 12 months of infancy compared with infants who were breastfed at high intensity (>80% of feedings from breastmilk) (*80*).	Thank you for highlighting this report.

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Baby Milk Action		Question 1 continued	Systematic reviews indicate that support programs in health-care settings are effective in increasing rates of breastfeeding initiation and in preventing early cessation of breastfeeding. Training medical personnel and lay volunteers to promote breastfeeding decreases the risk for early cessation of breastfeeding by 10% (*81*) and that education programs increase the likelihood of the initiation of breastfeeding among low-income women in the United States by approximately twofold (*75*).	Thank you for providing this information.

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Baby Milk Action		Question 1 continued	**Age of introduction of complementary foods and drinks** Many baby foods and drinks in the UK are promoted as suitable from 4-months – (some even younger). This encourages the introduction of solid foods before the vast majority of babies are developmentally ready to eat family foods, and conflicts with the UK Government and WHO recommendations: Practices encouraging puree as first weaning foods also encourage parents to overfeed infants at too early an age. *WHA Resolution 54.2, adopted in 2001 URGES Member State: to improve complementary foods and feeding practices by ensuring sound and culture-specific nutrition counselling to mothers of young children, recommending the widest possible use of indigenous nutrient-rich foodstuffs.* *It requests the Director-General to provide support to Member States in the identification, implementation and evaluation of innovative approaches to improving infant and young child feeding, emphasizing exclusive breastfeeding for six months as a global public health recommendation, taking into account the findings of the WHO expert consultation on optimal duration of exclusive breastfeeding (note 1), the provision of safe and appropriate complementary foods, with continued breastfeeding up to two years of age or beyond, and community-based and cross-sector activities.*[1]	Thank you for providing this information. However, as previously noted, specific issues relating to infant feeding are covered by existing NICE guidance on maternal and child nutrition (2008).

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Baby Milk Action		Question 1 continued	According to the 2009 BMA Board of Science report, Early life nutrition and lifelong health, "*The influence of the timing and nutritional content of complementary feeding and the specific effects of variations in quality of complementary feeding on current and later health in countries such as the UK are still to be determined. There are wide variations in infant size, weight gain, linear growth and body composition. There is increasing evidence that these influence the risk of developing obesity, diabetes, cardiovascular disease and other health outcomes in later life. The optimal pattern(s) of infant growth to minimise the risk of obesity, cardiovascular disease and diabetes need(s) to be determined…* Nutrition during infancy also determines later risk of obesity. Rates of overweight and obesity are lower in people who were breastfed, although there is debate as to whether this is a causal relationship. Rapid weight gain in infancy also predicts an increased risk of obesity. According to a study in the *American Journal of Clinical Nutrition*, the age at which parents introduce foods to infants may influence his/her body mass indexes (BMI) in adulthood. Babies who are breastfed for longer seem to have lower BMIs in adulthood, and delaying the introduction of complementary foods reduces the risk of becoming overweight in the long run by 5 to 10 percent.	Thank you for providing this information.

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Baby Milk Action		Question 1 continued	According to the **UK *Infant feeding survey 2005*** the quality of the weaning diet for UK infants is strongly influenced by the socio-economic status and educational attainment of the mother. Early introduction of solid foods was more common in younger mothers, and among mothers of lower socio-economic status and lower educational attainment. Although very few women (2%) delayed weaning onto solid foods until six months, the adoption of by the UK of the WHO recommendation (which was arrived at after a systematic review of over 3000 studies) did lead to an important behavioural shift in public health terms. The proportion of mothers introducing solid foods by 4 months fell from 85% in 2000 to 51% in 2005. The proportion introducing by 3 months halved in that five years, from about 23% to 10%.(6) Of concern to the BFLG is a new opinion of the European Food Safety Authority (EFSA) which is at variance with the WHO recommendation and reintroduces the concept of complementary feeding from 4-6month. If the EFSA opinion is used to inform EU and UK policy one can expect a reversal of this positive trend and an undermining of the UK Government's efforts to protect and support optimum infant feeding practices Baby Milk Action has issued a comment on the recommendation, questioning the independence of some of the members of the EFSA Working Group. http://www.babymilkaction.org/press/press23dec09.html	Thank you for providing this information.

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Baby Milk Action		Question 1 continued	**High levels of sugar in baby foods** Another important factor could be the high levels of sugar in baby foods permitted by current EU legislation and Codex Standards. The way this issue was discussed and handled at the Codex meeting in 2006 illustrates how global political forces and industry influence can impact directly on child health at local level. Codex standards have assumed greater importance since the formation of the World Trade Organisation, since they can be used as benchmarks in trade disputes.	Thank you for raising this issue.

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Baby Milk Action		Question 1 continued	Thailand presented an outline of the problem and an analysis of the sugar content of baby foods on its market. It proposed that the permitted maximum levels of sugar in the standard are reduced from 30% to 10% of calories. Thailand stated that *"foods for infants and young children are very crucial contributing to their immediate and long term health. Since, a high intake of sugars enhances the development of sweet taste preference and dental caries in children, and provides excessive energy intake which may contribute to childhood obesity, therefore, the sugars intake in cereal-based foods should be limited."* Thailand was supported by Norway, Indonesia the International Baby Food Action Network (IBFAN), the International Lactation Consultants Association (ILCA) and the International Association of Consumer Food Organisations (IACFO). However, the US and the European Commission succeeded with the help of the German Chair, in blocking the lowering of the sugar level, maintaining the high levels permitted by current EU legislation. There were over 100 food industry delegates at the meeting, half of them on Government delegations. Nine of the 11-member Chinese delegation were industry, one of the two Belgian, one of the 2 for Switzerland and 2 of the 3 for the Netherlands were from industry. http://www.ibfan.org/news-2006-eu_us.html	Thank you for providing this information.

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Baby Milk Action		Question 1 continued	**Bottle versus cup feeding** The Infant Feeding Survey found that children being fed milk in a bottle consumed greater volumes when compared with children given milk in a cup; this was particularly marked for the children only fed by bottle. A wide variety of drinks were given at this age, including low calorie squashes (48%), tea and coffee (17%), and fizzy drinks (7%). Maternal education was the most important factor associated with the types of drinks consumed at this age – more highly educated mothers gave their children fruit juices more often, whereas women with low levels of educational attainment were more likely to give their children tea, coffee and soft drinks. Seventeen per cent of children whose mothers had Certificate of Secondary Education (CSE) qualifications or less were given fizzy drinks over a 24-hour period.	Thank you for providing this information.

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Baby Milk Action		Question 1 continued	**Goodnight Milks** *"With an increasing number of mothers returning to work after giving birth, products that help babies sleep better could have a wide appeal."* *Global Packaged Food: Market Opportunities for Baby Food to 2013Euromonitor International* In November 2008 The Scientific Advisory Committee on Nutrition (SACN) Subgroup on Maternal and Child Nutrition (SMCN) was asked by the Department of Health to advise on the risks associated with the use of "Good Night" milk products for infants six months of age and above. It concluded: *15. The Committee has not identified published evidence that the use of any follow-on formula offers any nutritional or health advantage over the use of infant formula among infants artificially fed. Moreover it has not identified any scientific evidence that either "Good Night" milk product offers advantage over the use of currently available follow-on formula or infant formula. Specifically the Committee are unaware of published scientific evidence to support the statements made about "settling the baby for the night", or being "gentler on the baby's tummy".* *16. The Committee is concerned that such statements encourage parents to believe that it is desirable for a baby to sleep longer at an age when healthy infants show considerable variation in normal sleeping behaviour. There is also a risk that mothers may consider the product suitable for "settling" their infant more than once a day and use these products on occasions additional to bedtime, or even use them to "settle" infants younger than six months. With regard to HiPP Organic's product, such unintended use would be contrary to advice that gluten-containing products should not be given to infants under six months of age.*	Thank you for raising this issue. However, as previously noted specific issues relating to infant feeding are covered by existing NICE guidance on maternal and child nutrition (2008).

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Baby Milk Action		Question 1 continued	*21. The Committee is concerned that the claims made could undermine breastfeeding, as either product could replace or displace the night-time breastfeed. In light of the current recommendations to continue breastfeeding beyond six months, the Committee considers both products to be breastmilk substitutes, which should be labelled and marketed appropriately.* *22. The Committee was unable to identify any published scientific evidence to support a claim that "Good Night" milks offer nutritional or other health advantage over the use of infant formula or follow-on formula.* *23. The Committee is concerned that the use of these products to "settle" babies at night could promote poor dental hygiene.* *24. The Committee does not agree with HiPP Organic's statement that its product is suitable for young children as an alternative to the evening meal.*	As above.

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Baby Milk Action		Question 1 continued	The following factors undermine breastfeeding and good complementary feeding and so lead to obesity: • Lack of full implementation of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA Resolutions, and subsequent promotion of follow-on formulas, bottles, teats and related equipment. • Lack of clear leadership at local regional and national level to performance manage improvements in health care. • Lack of adequate, support for breastfeeding and consistent objective information on infant and young child feeding for parents • Food industry influence on the media • Lack of adequate maternity legislation and protection • Policies which promote Public Private Partnerships • Lack of controls on the marketing of high fat, high salt, high fat and calorie dense foods aimed at and for children and teenagers. • Lack of Baby Friendly Hospitals and Communities.	Thank you for providing this information.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Baby Milk Action		Question 2	**Question 2**: How does national policy impact on the effectiveness, cost effectiveness and sustainability of local action to prevent or manage obesity? Are there any unintentional consequences? While strong clear and guidance on best practice are important, unless it is backed up with robust legislation and cross cutting policies across all relevant Government Departments (health, education, culture, media, sport, energy and climate change, transport, business and innovation) the effectiveness of local action is likely to be undermined. At EU, UK and global level, governments have a duty and responsibility to enact policies that foster a healthy environment and control inappropriate marketing. It is in the interests of the food industry to advocate self-regulation rather than regulation and to place emphasis on education, personal decision-making and 'lifestyle.' (see the predominance of 'lifestyle' commitments submitted to the EU Commission Platform for Action on Diet and Physical Activity. Strategies to address current concerns about the financial crisis, jobs and growth through 'innovation and competition' must not undermine the adoption of legislation which protects public health. National policies must first and foremost create environments which support healthy behaviour and respect children's rights to protection against exploitation.	Thank you for raising these issues.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Baby Milk Action		Q2 cont	**Health and Nutrition claims.** The lack of regulation, monitoring and accountability on health and nutrition claims on foods has had a profound damaging impact on public understanding and knowledge of nutrition. Few people are aware that the majority of the claims used on packaging and promotion – indeed ALL the claims on foods for infants and young children – are not only unfounded but are deceptive and misleading. The companies continue to use these claims because they believe that they will not be prosecuted. The Government's Scientific Advisory Committee on Nutrition (SACN) made a clear statement about claims in a submission to the Government during the consultation on the UK formula marketing Regulations in 2007. *"There is no case for allowing the 'advertising' of follow-on formula... there is no scientific evidence demonstrating nutritional advantage of this product over infant formula...[both these] are breast milk substitutes as defined by the Code (which sets no upper infant age limit on this term)...We find the case for labelling infant formula or follow on formula with health or nutrition claims entirely unsupportable. If an ingredient is unequivocally beneficial as demonstrated by independent review of scientific data it would be unethical to withhold it for commercial reasons. Rather it should be made a required ingredient of infant formula in order to reduce existing risks associated with artificial feeding. To do otherwise is not in the best interests of children, and fails to recognise the crucial distinction between these products and other foods."*	Thank you for raising this issue.

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Baby Milk Action		Q2 cont	**Product Reformulations – intense sugars** Much attention is paid to the need for Product Reformulation to reduce levels of fat, salt and sugar in foods. However little attention is paid to the impact on taste profiles of intense sugars and the risks of the novel ingredients used. The safety and nutritional value of intense and novel processes are controversial. These ingredients also maintain preferences for sweet foods and highly processed foods rather than fresh fruits and vegetables. The use of health and nutrition claims further exacerbates this problem, as does the food industry's insistence that novel ingredients are safe and well researched. If children's rights to truly objective information on this tricky subject are to be protected, the food industry should be excluded from providing nutrition education materials and services. (see below)	Thank you for raising this issue.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Baby Milk Action		Q2 cont	**Inappropriate Partnerships** Policies that encourage Public Private Partnerships and collaborations with the private sector create opportunities for undue corporate influence on policy setting and practice. Rigorous safeguards must be applied to address conflicts of interest and governance. If inappropriate 'partners' are used for example in the running of Children's Centres, unintended consequences can occur which can undermine the efforts of all those working to improve public health and effect behaviour change. In addition to these risks, corporations can use such partnerships as evidence of Corporate Social Responsibility and to build trust. While the UK is seen as a leader in the field of PPPs some believe that public-private partnerships (PPPs) ultimately cost more and deliver worse outcomes. The report of the United Nations Research Institute for Social Development (UNRISD) *Beyond Pragmatism: Appraising UN-Business Partnerships* identifies a clear need for more critical thinking in relation to PPPs and UN-Business Partnerships to ensure that they are compatable with the mandate of the UN and do not legitimise corporate power - acting as a broker for foreign investors in developing countries. www.unrisd.org An example of an innovative partnership which is not inappropriate is Brazil's Breastfeeding Friendly Postman Program, where 17,000 trained mail carriers deliver infant feeding information in addition to the mail (IMPACT 2001; Ministério da Saude 2003b) http://findarticles.com/p/articles/mi_qa3800/is_200410/ai_n9419340/	Thank you for raising this issue.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Baby Milk Action		Q2 cont	**Self regulation vs Regulation** Baby Milk Action represents IBFAN on the **Platform for Action on Diet, Physical Activity and Health** - the European Commission's experiment to see if the food industry can make voluntary commitments that will reverse the rise in obesity and food related diseases. While the NGOs call for more regulation of junk food marketing, the food industry argues that trust and self regulation is the best way forward, while the large majority of its Platform commitments are in the area of 'lifestyle' and education. At the February 2007 Platform meeting Corinna Hawkes of the International Food Policy Research Institute in Washington. Corinna gave a presentation that looked at the global growth of self-regulation and showed that it does not wark as a way to limit the extent and impact of marketing. Instead, self-regulatory systems promote trust in advertising among consumers and governments, undermining their resolve to bring in the legislation that is needed to protect health. Under these systems the volume of advertising increases.	Thank you for raising this issue.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Baby Milk Action		Q2 cont	**The risks of commercial sponsorship of education** As pressure builds to stop junk food advertising to children, many companies are turning their attention to nutrition education. Indeed the majority of commitments for action made by the food industry members of the European Commission's Platform for Action on Diet and Physical Activity are for 'lifestyle' education activities rather than for labeling, reformulation or advertising. By sponsoring education and media literacy companies seek to build public trust and establish themselves as producers of healthy food and portals of sound advice, while diverting attention from activities anti-social and which harm sustainable development, the environment (and for the global corporations - human survival.) Commercially - funded education materials and facilities – like product placement - present an even more complex problem than straightforward advertising because they blur the boundaries between advertising, marketing and education, and can easily mislead and undermine public health messages. Companies use their sponsorship of education as evidence of Corporate Social Responsibility (CSR) For example: Nestlé's *'Programme about Correct Nutrition - working notebook for school children"* has been used in thousands of schools in Russia. Page 55 shows a mother telling her child that eating chocolate rather than a sandwich before an exam will help her manage the difficult excercises. The message is that the more chocolate you eat the cleverer you will be.	Thank you for raising this issue.

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Baby Milk Action		Q2 cont	A teaching site for Primary schools, sponsored by Northern Foods and Nestlé. Phunky Foods claims to be a "*comprehensive programme to teach primary school children health eating and physical activity messages through art, drama, music, play and hands on food experience."* Its powerpoint presentation for teachers has a Nestlé, Cargill and Northern Foods logo alongside the Government's 'Curriculum on Line' logo on every page.(www.phunkyfoods.co.uk/) And in this way can use education facilities as a channel for commercial propaganda and distort the curriculum in favour of business interests - promoting a self regulation and partnership approach to marketing rather than regulation.	As above

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Baby Milk Action		Q2 cont	**Media Literacy** Concern about the impact of the commercial world on children has led some to recommend the use of media literacy programmes as a solution. However there is little evidence that these programmes are as effective as they claim, especially when they are funded by the food and toy industry.. Some, such as Media Smart, may do harm. Media Smart claims to provide 6-11 year-olds with the "tools to help them interpret, understand and use information provided in adverts to their benefit." yet it subtly undermines the health messages teachers are trying to convey and suggests. For example, many of its excercises and games reward children directly in proportion to the amount of television they watch. The child cannot move on to the next page until they give the right answer. In another game, called Product Match, children are asked to match reasons why they might buy certain products. A chocolate bar must be matched with "Tastes great!" and a tawdry comic with" A great read!" (www.mediasmart.org.uk) For more information and examples of misleading education materials see: Baby Milk Action response to CDSF consultation on the Impact of the Commercial World on Children; Baby Milk Action Briefing, *Tackling Obesity, how Companies use education to build Trust and* www.babymilkaction.org/spin, www.babymilkaction.org/obesity. *Through the Back Door, An exposé of educational material produced by the food industry.* The Children's Food Campaign. December 2008 www.childrensfoodcampaign.org.uk	As above.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Baby Milk Action		Question 3	**Question 3:** What 'packages' of actions and strategies may be effective and cost effective in bringing about population-wide improvements in weight management within a given community? How does effectiveness vary between different communities or population groups? **At the very minimum the Government should:** Advocate the strengthening of EU legislation to incorporate all the recommendations of the Global Strategy on Infant and Young Child Feeding, the *International Code of Marketing of Breast-milk Substitutes* and subsequent relevant World Health Assembly Resolutions, the *Blueprint for Action on the Promotion, Protection and support of breastfeeding.* the *Global Strategy on Diet, Physical Activity and Health* and the *Convention of the Rights of the Child.* Specifically this means: • ban on the promotion of breastmilk substitutes (BMS) (including follow-on formula and specialised formulas) • prohibit baby feeding companies from seeking direct or indirect contact with pregnant women, mothers, carers of infants and young children and other members of the public (including a clear ban on company 'carelines', pamphlets, mailshots, emails and promotional websites);	Thank you for raising this issue. However, as previously noted specific issues relating to infant feeding are covered by existing NICE guidance on maternal and child nutrition (2008).

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Baby Milk Action		Q3 cont	• prohibit baby feeding companies from offering sales incentives and bonuses or setting sales quotas linked to BMS for employees; • prohibit idealising text and images on BMS; • prohibit company-produced or sponsored materials on pregnancy, maternity, infant feeding or care (the Government must provide accurate, objective information, avoiding conflicts of interest in funding infant feeding programmes); • advocate at EU level for the prohibition of health and nutrition claims on foods for infants and young children. Require claims that must be permitted (because of the EU Directive) to be placed at the back of the package near the nutrition panel; • prohibit the promotion of names associated with BMS and their use on other products; • restrict information for health professionals to scientific and factual matters with no idealising text or images; • prohibit promotion in healthcare facilities and gifts to health workers (allowing only single samples for evaluation); • prohibit promotion of all baby foods for babies under 6 months (marketing of complementary foods should not undermine breastfeeding); • Require all public facilities to respect women's right to breastfeed in public.	As above

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Baby Milk Action		Q3 cont	• Require all health care and community facilities dealing with infants and young children, to be in compliance with the Baby Friendly Initiative best practice recommendations. http://www.babyfriendly.org.uk/ • Call for the scrapping of the EU Framework Directive PARNUTS and require a pre-authorisation procedure for all new ingredients and require all authorised ingredients to be added to the annex of EU Directive 2006/141; • Introduce regulations in line with the International Code on the marketing of feeding bottles, teats, dummies etc. • Empower the public at local level to monitor and report on the implementation of regulations (with free phone lines, publicized weblinks etc) • Institute meaningful sanctions for violations of the above. • Routinely monitor the ingredients used in baby milks and foods. • Require workplaces to provide breastfeeding breaks • Improve maternity provision., with full 52 weeks maternity leave and pay. Unpaid leave is not an option for many families. Increase the rate of Statutory Maternity Pay and Maternity Allowance. Increase the statutory minimum pay. • Advocate at EU level for changes in the EU Directives on baby milks and foods – for a lowering of the permitted sugar levels.	As above

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Baby Milk Action		Q3 cont	**Marketing of foods and beverages** • Call for an International Code of Marketing on foods and beverages for children – at the World Health Assembly and take the lead in implementing it. • Ban the use of health and nutrition claims on 'children's foods' and encourage instead consumption of home prepared fresh fruits and vegetables. • Advocate legislative rather than self-regulatory approach to the marketing of foods. There is no evidence that Self-regulation is an adequate way to limit the extent and impact of harmful marketing. The public and health planners need a common benchmark on which to judge effectiveness of measures. Voluntary codes drawn up by companies are also usually narrow, full of loopholes, entirely dependent on industry's goodwill and consequently difficult to monitor. Companies work to their own codes of practice which can vary over time and from country to country and shop to shop. If companies choose not to behave, very little can be done.. • create a junk food tax - or better still call it a 'user fee' (using that particular food profile) • Require Traffic Light Labelling	Thank you for raising these issues.
Baby Milk Action		Q3 cont	One way to raise funds for health programmes is through taxation of alcohol or junk foods. In the US a 1penny per ounce tax on sodas would raise about $150 bn and save health costs of at least $50 bn over a decade. The Thai Sin Tax on alcohol and tobacco already raises $100m per year for ThaiHealth Promotion. latimes.com/news/opinion/la-oe-brownell6-2009oct06,0,4876212.story. http://en.thaihealth.or.th	Thank you for providing this information.

PUBLIC HEALTH PROGRAMME GUIDANCE
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Consultation on the Draft Scope from 15 January - 12 February 2010

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Baby Milk Action		Q3 cont	**OTHER RECOMMENDAYIONS** • Encourage and facilitate safe cycling and walking (cycle paths, safer pavements and roads etc) • give cyclists greater legal protection (as in the NL and Denmark) • Provide free access to swimming pools and tuition – with incentives to cycle or walk to the pool (free breakfast etc`) • Take steps to reduce paranoia so carers trust and encourage children to play and walk more. Children move around much more when playing and walking unaccompanied. • Place less emphasis on competitive sports and more on regular exercise which can continue throughout life. • Provide subsidies to disco owners to encourage dancing. • Provide free school fruit schemes. • Encourage employers to provide free fruit on a regular basis to employees • Encourage schemes for growing foods in cities • Require planners to make the stairs the most attractive option in new building, with the lifts tucked away. • Ban all product placement – not just of certain foods but all products. http://info.babymilkaction.org/pressrelease/pressrelease09feb10	Thank you for these suggestions.

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Baby Milk Action		Question 4	**Facilitators:** BFHI, health professionals, Counsellors, workplace facilities, Maternity protection legislation **Barriers:** Health professionals, industry (marketing practices such as health and nutrition claims, advertising other promotion and misleading information materials), media, workplace facilities, Maternity protection legislation In its expose of myths surrounding breastfeeding, the Department of Health identified that parents make decisions about how they feed their infants on the basis of many things – their social situation, the information they have received (and believed), on the availability and affordability of products, out of habit and sometimes out of preference for certain flavours. The whole environment into which women become pregnant and give birth, must use an integrated approach that reaches beyond the health care system into the community, the education system, to policy makers, local authorities, social services, voluntary agencies and to the legal system. . Baby Milk Action takes the view that all parents want to do the best for their children, but many are thwarted in their efforts. In addition to looking at what support systems are needed to support breastfeeding, attention must be paid to the obstacles. The extent to which parents are bombarded with commercial messages, either directly via idealised packaging (health and nutrition claims), advertising and information materials or indirectly through the educators and health professionals, is too often overlooked. The fact that commercial promotion is rarely cited as a reason for unhealthy 'choices' does not mean that it has not had an impact.	Thank you for raising these issues.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Baby Milk Action		Question 5	Respect for Child and Human rights and robust legislative framework. To protect public health. Parents and children must be assured objective and sound information from independent sources. If this is to be consistent it follows that commercial information must be banned. The UK Government must recognise its moral and legal obligations under the many Resolutions on Infant feeding passed at the World Health Assembly and the Convention on the Rights of the Child.. **Resolution WHA58.32** Urges Member States: *"to ensure that financial support and other incentives for programmes and health professionals working in infant and young child health do not create conflicts of interest".* **Essential Partners.** See answer to Question 1 regarding partnerships. While innovative measures and collaborations can be useful – innovation always involves risk. It is important that care is taken to avoid undue corporate influence on policy setting and practice, especially in the provision of infant and young child feeding information. Rigorous safeguards and risk management procedures must be applied to address conflicts of interest and governance issues before Public Private Partnerships and collaborations are considered. The involvement of inappropriate 'partners' can create unintended consequences which can undermine the efforts of all those working to improve public health and effect behaviour change. Corporations use such partnerships as evidence of CSR and encourage reliance on self-regulation rather than essential legislation.	Thank you for raising these issues.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Baby Milk Action		Q5 cont	**Clear leadership** There needs to be clear leadership at local regional and national level to performance manage improvements in health care. Having policies is one thing but without managers to drive it forward and prevent commercial companies from getting a foothold, any progress will grind to a halt.	Thank you for raising this issue.
Baby Milk Action		Question 6	**Question 6:** How can political, social, economic and environmental factors be tackled simultaneously as part of a whole-system approach to preventing obesity? What factors need to be considered to ensure the programme is robust and sustainable (for example, is public opinion important, is the sequence, phasing and timing of actions and strategies important)? The impact of the European Union policies on health and the above recommendations for the UK cannot be underestimated. The draft of the proposed EU Strategy for 2020 sent out for consultation is extremely disappointing in that it stressing only the financial crisis and the need for innovation while ignoring the importance of public health. The EU has an obligation to ensure a high level of human health and environmental protection in all Community policies and activities. But at EU level, lack of policy and programme coherence on marketing and conflicts of interest, creates opportunities for commercial practices which undermine health. The focus on innovation in the Strategy is disturbing. Unlike the food industry, human beings do not need 'novel' foods to be healthy! Children should not be subjected to mass uncontrolled trials of new foods. Transparency, accountability and regulation to protect the most vulnerable in Europe (whilst encouraging an appropriate influence globally) are essential.	Thank you for raising these issues.

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Baby Milk Action		Q6 cont	Specifically at EU level this requires: • policy coherence between the EU and UN recommendations (specifically but not exclusively on infant and young child feeding and marketing to children.) • greater transparency and accountability of the EU policy making process and its Expert Committee meetings. (In particular the Framework Directive PARNUTS should be scrapped in favour of a more accountable and transparent system for creating legislation on dietetic foods.) • official logs of the meetings between EU officials and industry, allow for some transparency in the balance of exposure to different stakeholder views. • Discourage rather than promote PPPs. The term *Public Private Partnership*, could often be more appropriately be replaced with *"Interactions with the Private Sector'* (See minutes of the HLG meeting on Governance of PPPs, Oct 2008.)	Thank you for raising these issues.

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Big Brother Watch		GENERAL	It is the firm view of Big Brother Watch that the vast majority of this document represents a wholly unwarranted nanny-state approach to decisions that ought to be left up to individuals and families. Children should certainly be encouraged in school to eat healthily but beyond that, the choices we make about what we eat are up to us as individuals – as adults and autonomous individuals, particularly – and we should not be bullied via the media or any other source into eating whatever is currently in dietary vogue. Outside of narrow guidance for schools (if even that's really necessary, given the existence of documents to this end already), Big Brother Watch's position as a stakeholder in this consultation process is that there should be no guidance at all.	Noted.
Big Brother Watch		2(d)	The existence of a remarkable number of documents encouraging people to eat in a particular way already, as set out in this section, might properly be thought to demonstrate the pointlessness of this exercise.	Noted

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Breastfeeding Network		Q5 - P8	**Question 5:** What are the essential elements of a robust, community-based, whole-system approach to preventing obesity? Who are the essential partners (formal and informal)? How does such an approach avoid being dependent on highly motivated individuals? This question needs to include consideration of national and regional structures to achieve strategic leadership. We need to develop a clearer understanding of what is required to deliver strong strategic leadership in order to provide a whole-systems approach to prevent obesity. With the impending financial climate these strategic posts are at risk. Evidence of the effectiveness of their role in underpinning a systematic, whole-system approach is critical. Leadership models would also be useful.	Thank you for raising this issue. The wording of this question has been amended.
Breastfeeding Network		Q6 - P8	**Question 6:** How can political, social, economic and environmental factors be tackled simultaneously as part of a whole-system approach to preventing obesity? We think this is the section that could highlight the need to anticipate and prevent conflicting policies being developed which give mixed messages – as an illustration the recent publication on the commercial influences on children was unduly positive and the recent move to allow product placement on TV is likely to be a retrograde step, exposing more of us to less healthy food choices.	Thank you for this comment. A reference to conflicting policies has been added to a question in the draft scope.

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Cambridge Weight Plan		General	Cambridge Weight Plan (CWP) welcomes the development of this guidance as a useful contribution to efforts to halt the nation's increasing obesity problem, by focusing on the whole systems approach at a local and community level.	Thank you.
Cambridge Weight Plan		General	Further to the comments made at the stakeholder meeting, CWP would like NICE to clarify if secondary prevention will be included in the scope, and also how this will be defined. For example will it include the management of overweight people to prevent them gaining further weight, and will it also include the management of obese people to preventing them progressing through the different stages of obesity until they reach morbid obesity?	Thank you for this comment. The scope addresses population prevention in the broadest sense and, as such no BMI cut off has been set. Secondary prevention is not explicitly excluded from the scope as it stands and there is nothing to preclude the PDG considering issues around secondary prevention depending on the focus of their discussions and the evidence available. Clinical management is outside the remit of this scope and the guidance will not re-consider specific issues already covered by the existing NICE guidance on obesity.

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Cambridge Weight Plan		General	NICE guidance 43 *Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children* recommends that people should only aim to lose 5-10% of body weight, with a maximum weekly weight loss of 0.5-1kg. For some people with very large amounts of weight to lose, such as the morbidly obese, this is not enough to make sure they achieve a good level of health and fitness. Furthermore, this recommendation is in place despite the fact that interventions do exist which enable people who need to lose a larger amount of weight to do so safely.As you are no doubt aware, the amount of weight lost on a particular programme is determined by the energy deficit and one kg per week is achieved by about a 1000kcal daily deficit. Greater weight losses are sometimes needed and a typical loss on a CWP programme is 11.4kg in 8 weeks [1.4kg per week]. Additionally, such programmes can also have other benefits, such as helping to maintain weight loss in the longer term.	Thank you for this comment. However, this issue is outside the remit of this scope and falls under the remit of CG43.

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Cambridge Weight Plan		4.2.1	The QOF could be used to provide better incentives to GPs to help obese patients to lose weight. For example, at the moment GPs are given QOF points for keeping a register of obese patients in their practice, but not for taking any practical steps to help them achieve a healthy weight, such as offering them advice or referring to them to weight management services. However, for this to work, it is important that GPs are fully informed about all the options available to people looking to lose weight, so that they can offer appropriate advice to patients. There is a need to recognise the contribution that private sector weight management programmes can make, as currently the NHS does not have the resources to help all patients who need to lose weight to do so; the private sector can provide capacity in this area.	Thank you for raising this issue. As you may be aware, NICE now has responsibility for QOF. At the QOF June 2009 meeting it was agreed that obesity and QOF would be reviewed given a suitable stakeholder submission on weight management. Submissions were received in Autumn 2009 and these are currently being reviewed. For more information about QOF see http://www.nice.org.uk/aboutnice/qof/qof.jsp As I'm sure you are aware, existing NICE guidance on obesity (CG43) includes recommendations about management of obesity in self help, commercial and community settings.

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Child Growth Foundation		2d	The Wanless Report [2004] famously included the phrase that " interventions should be evidence-based, though the lack of conclusive evidence should not, where there is a serious risk to the nation's health, block action proportionate to that risk ". The Child Growth Foundation has identified yearly Body Mass Index [BMI] of children as being proportionate to the crisis we face. It will be a means of identifying the earliest signs of unhealthy weight gain before it becomes a problem, the trigger to act on the information and, thereby, prevent subsequent obesity. CGF insist that NICE, in view of childhood obesity being a serious to the nation's health, drops its mantra [?] that recommendations must be underpinned by RCTs . The PDG must no longer accept the current medical view that "screening for obesity " is a non-starter in the absence of available interventions. That has been outdated since CMO penned in 2003 that " health professionals - including general practitioners, school nurses, practice nurses and health visitors – should identify early signs of obesity in children and offer interventions at an early stage ". If a more recent example of action-without-evidence were needed, the anti-obesity campaign in the USA – launched by Michelle Obama in early February - should provide it. The US plan will include a yearly BMI calculation [weight ÷ height m^2] for every child. This action has been endorsed by both the US Academy of Paediatrics and the US Preventive Services Task Force . Furthermore, a consortium of Canadian medical bodies [including the Canadian Paediatric Society] has just issued the same recommendation.	Thank you for this comment. The draft scope acknowledges that the existing evidence base for this area is limited. Therefore, section 4.3 of the draft scope highlights that a broad range of literature will be considered in the development of this guidance. You may be interested to read the methods manual for the development of public health guidance which stresses that evidence and knowledge from a broad spectrum of sources are used in the development of guidance (for example, see section 1.5, page 15 http://www.nice.org.uk/media/2FB/53/PHMethodsManual110509.pdf) Screening may be considered as an element within the whole system, screening per se is outside the remit of this work.

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Child Growth Foundation			The UK has no proper growth monitoring protocol whatsoever and will continue to miss the early signs of " obesity " whilst that persists. The Department of Health's [DH] *Healthy Child Programme* [HCP] is a million miles away from laying down a protocol that would allow health professionals to achieve th CMO's wish. Though the HCP does require a single weight/height measurement session at school entry, a single measure is quite insufficient for diagnosis. At every other time when a child is being seen by a health professional, HCP suggests merely taking a measurement " if there is parental or professional concern about a growth or risk to normal growth [including obesity]". This qualification is crass since it is well documented that both parents and health professionals frequently fail to recognise poor growth/fatness in the children in their care. The lack of any official UK growth protocol has also allowed others to " invent " their own. The Royal College of Paediatrics & Child Health [RCPCH], for instance, features a weight monitoring protocol in the user instructions for the UK-WHO growth charts which is quite different to anything the HCP suggests. The CGF has a protocol, too - and would be happy to explain it to PDG if considered appropriate. **The PDG should recommend yearly BMI screening as a means towards identifying the early signs of childhood obesity as recommended by the CMO**	Thank you for raising this issue.

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Child Growth Foundation		3f	If the " whole system approach "is to be accomplished, the PDG must focus on life events that precede the " downstream " improvement of children's diet and physical activity levels – even if " upstream " events might already have been earmarked for other NICE piece-meal guidance. The UK needs to see this PDG take a comprehensive look at the development of overall childhood obesity which means, according to current literature, examining its roots not only in pregnancy and the very early years but even prior to that. In the CGF's opinion it is in the pre-conceptual months and even schools years that the " vicious circle " of obesity must be broken. School would be the place/time where the most effective/cost-effective breaks could be made. Until the UK makes it possible for its children seriously to learn about healthy lifestyles, cooking and parenthood, the country will continue to wallow in the epidemic that unhealthy children are spawning. John Reid, when Minister for Health, talked about getting to grips with childhood obesity at the earliest opportunity with almost religious fervour. He quoted the Society of Jesus' mission statement " Catch 'em young: keep 'em for life " and applied it to the prevention of unhealthy lifestyles. **PDG should be recommending, particularly, adjustments to the National Curriculum which will take teach children about the need to prepare for parenthood and future living as well as the need to see if two plus two makes four. It is disgraceful that our schools churn out children who think that breasts are sex toys and can't recognise potatoes.**	Thank you for raising this issue. As stressed in section 4.1.1 of the draft guidance, the focus of this work is everyone except those under-going clinical management. Therefore, action aimed at children or adults of any age or life stage that meets the inclusion criteria for this work will be considered.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Child Growth Foundation		4.2.1	To " minimise the risk of obesity " PDG must not only recommend screening as a means to catch the early signs of unhealthy weight gain but must also recommend the measures which will may have a real chance of preventing children getting fat in the first place. Key to this will be the provision of front-line staff and PDG should endorse the provision of midwives, health visitors, school nurses and other professionals [dieticians/nutritionists etc]. Each discipline has specific tasks in helping ensure that families in general raise their children healthily - and " at risk " families in particular. The additional establishment called for by their respective trade associations is as follows:- Midwives 5,000 Health Visitors 4,000 School Nurses 2,000 One specific task of the midwife should be to turn around the lamentable state of UK breastfeeding. UK levels are so low that it will take more than a few Government leaflets/DVDs to bring about the sea change required to establish breastfeeding as the nutritional norm for Birth – 6 months.	Thank you for raising this issue. The PDG may wish to consider staffing issues in relation to delivery systems , implementation of strategies and initiatives and training (as section 4.2.1 of the draft guidance). You may also be interested in existing NICE guidance on maternal and child nutrition (2008).

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Child Growth Foundation			The ideal time to accomplish the work will be in the first two trimesters of pregnancy and not close to/at the time of birth as is often the case to-day! The additional establishment will allow the midwife enough time to " sell " breastfeeding and train expectant mothers in its art before delivery rather than addressing it during the chaos of the event. In addition, the average midwife would have more time to coax would-be mothers who are increasingly overweight/obese at the time of conception to slim down by delivery. CGF is adamant that the UK also needs a proper pregnancy screening policy whereby, when required, BMI is tracked on a " once per trimester " basis to ensure that expectant mums are not piling on pounds inappropriately. The lack of any UK guidelines for weight gain in pregnancy is also an issue that PDG should address.	Thank you for raising this issue. You will be aware that NICE is currently developing guidance on weight management during pregnancy and after childbirth (see http://guidance.nice.org.uk/PHG/Wave18/3).

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Child Growth Foundation			Midwives could share the additional breastfeeding tasks with an increased health visitor work force - both during the months of in pregnancy and the critical first days/weeks following EDD. Health visitors' specific tasks will then encompass taking up the educational battle to improve the state of UK weaning. Unfortunately it is not uncommon for infants to be " force-fed " food at Week 12 – or earlier! CGF fully recognises the difficulties that mothers have in to delaying weaning even to Week 17 but it is of paramount importance that the NHS provides enough support to ensure that weaning is optimised and inappropriate early weaning is consigned to history. With an enhanced workforce, the additional pre-school specific task of BMI assessment aqlso could be addressed. School nurses levels are in an even more parlous state than health visitors'. The school nursing service has struggled to achieve the hugely important National Child Measurement Programme [NCMP] measuring sessions at Reception YR and Yr 6 but would collapse if the frequency increased without further nurses being employed. PDG should recognise their success so far and call for enough staff properly to service UK's 25,000 schools and annual BMI calculation. . The UK currently has absolutely no idea of the specific age[s] that overweight/obesity grips its youngsters but, with their special tasks, each of the above will allow that error to be righted. 25% of pre-schoolers put on unhealthy weight but exactly at which age[s]: primary school children are twice as obese at Yr 6 than at Reception Year but at what age[s]?	Thank you for raising these issues. You may also be interested in existing NICE guidance on the maternal and child nutrition (2008) which addresses some of the issues you raise.

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Child Growth Foundation			In addition to midwives, health visitors and school nurses PDG should also address the paucity of dietitians and physical activity specialists etc whose expertise is essential if the general ignorance of food, food selection and recognition of the need to exercise is to be improved in a substantial number of UK children.	Thank you for this comment.
Child Growth Foundation		4.3 Question 2	PDG must remind the Government that national policy should now include the use of Qualiity Outcome Frameworks [QOF] payments to prevent obesity in children. Currently GPs – still the principal health care provider in the eyes of the family – are " disinterested " in childhood obesity because they don't get paid to be involved. A sweeping statement perhaps, but true. Contrasting with the numerous family doctors whose " interest " transcends the fact that they have no QOF payment for their work, the GPs who prefer to absolve themselves from any intervention - and blame the obesity on the parents – appear legion. Were it otherwise, why does the UK have so many fat children who frequent are dragged through through surgery doors yet still end up having BMIs greater than obese adults? Alan Johnson, when Minister for Health, is on record as stating that the use of QOFs would be " crucial " in the DH's strategy to combat obesity. Unfortunately, he moved to the Home Office before his idea got debated and, under new ownership, the DH appears quite to have forgotten Mr Johnson's intention. It has no provision for new QOFs either for adults or children.	Thank you for raising this issue. The PDG may wish to consider QOF in relation to the public health system as a whole. For information, NICE now has responsibility for QOF. At the QOF June 2009 meeting it was agreed that obesity and QOF would be reviewed given a suitable stakeholder submission on weight management. Submissions were received in Autumn 2009 and these are currently being reviewed. For more information about QOF see http://www.nice.org.uk/aboutnice/qof/qof.jsp

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Child Growth Foundation			There should be one or two QOFs around a GP's service for children in order to cover identification and intervention. They should further provide the guarantee that obesity would be prevented. The PDG should address the exact age[s] at which the QOFs might kick but they should certainly be in the pre-school years. The RCPCH's current policy states that children displaying " severe or progressive obesity " should be in the hands of a paediatrician before age 2. This presupposes that QOFs must be atttuned to come on line sometime earlier.	Please see above.
Child Growth Foundation		General	This submission has been written by Tam Fry, Honorary Chairman of the Child Growth Foundation. He is also spokesperson for the National Obesity Forum [NOF] Board has not formally endorsed the submission as written, the basis for the above has been run past the Board informally. Tam Fry has a matter-of-fact style of writing which is not universally acceptable!	Noted.
Department of Health		General	Apart from concerns for the significant need to acknowledge obesity in pregnancy, we are content that the scope is comprehensive, and in line with Departmental policy.	Noted.
Department of Health		General	We welcome the emphasis on a "whole system", sustainable approach, involving wide-ranging local action by a range of organisations on the influences on obesity.	Thank you for this comment.

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Department of Health		General	Could you please give consideration to the following issues: • the (minimum) set of intervention elements for a successful whole-system, community-level approach to tackling obesity and overweight; • the implications for how, when and in what order interventions should be introduced; • the sustainability of the impact and implementation of different interventions; • barriers to implementation and effectiveness; • critical success factors for implementation and effectiveness; • implications for the priority given to different interventions and the balance between targeted and more universal approaches. Could you please clarify whether the evidence suggests that it is possible to prioritise some interventions (or sets of interventions) over others; implications for surveillance activities in communities.	Thank you for raising these issues. The issues would be covered by the key questions outlined in section 4.3 of the draft scope. The implications for monitoring and evaluation have been added to the key questions.
Department of Health		General	We support this guidance and its inclusion of children and young people. We welcome its intention to consider all the settings where children and young people might be reached with messages and/or interventions promoting healthy weight (such as education, health, voluntary sector, leisure and community services).	Thank you for this comment.

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Department of Health		General	Could you please consider making reference to the new *'Healthy Child Programme: from 5 - 19 years old'* as we feel that this provides an integrated framework for delivery of both universal and progressive health and wellbeing support/services for children and young people (building on 'Healthy Child Programme: Pregnancy and the first five years of life').	Thank you for highlighting this programme. The final scope will include a reference to this programme in section 2d.
Department of Health		General	Could you please give consideration to the Healthy School Programme, and the contribution it makes to encourage whole school approaches to healthy eating and physical activity, with a specific focus on building partnerships with wider community supports/services.	Thank you for this comment. Any evidence available on the healthy school programme which meets the inclusion criteria for this work may be considered.
Department of Health		2d	In addition to the publications listed, we consider that the guidance will also support the work set out in "Health Inequalities: Progress & Next Steps" (June 2008), and the final report of "the Strategic Review of Health Inequalities in England Post 2010" (the Marmot Review) which will be published on 11 February 2010.	Thank you for highlighting these publications. A reference to these will be included in section 2d in the final scope.
Department of Health		2e	We welcome the intention to produce recommendations for "good practice, based on the best available evidence of effectiveness and cost effectiveness". In our view, this supports one of the key recommendations made by the Health Select Committee in its report on health inequalities (published in March 2009).	Thank you for this comment.

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Department of Health		3, Page 4	Could you please consider making reference to the risks of obesity in pregnancy in the "need for guidance" section. Could you please also consider inserting wording, such as the following (taken from Page 3, Section 3 of the *"weight management in pregnancy"* guideline): a) 50% of women of childbearing age are either overweight (that is, they have a body mass index [BMI] of 25.0 – 29.9kg/m2) or obese (that is, they have a BMI equal to [or greater than] 30.0kg/m2). At the start of the pregnancy, 18% of women are obese (the information centre 2008). Maternal obesity is related to socioeconomic deprivation and other inequalities within minority ethnic groups (Heslehurst et al 2007). b) Pregnant women who are overweight or obese and their babies face an increased risk of complications during pregnancy and childbirth. For the mother, these include impaired glucose tolerance and gestational diabetes, miscarriage, pre-eclampsia, thromboembolism and death. In addition, the mother is more likely to have an instrumental delivery or caesarean section. The baby faces a higher risk of macrosomia, congenital anomaly, obesity (in later life) and fatal death (Ramachenderan et al 2008).	Thank you for raising this issue. Pregnancy will not be specifically excluded from this guidance. However, space limitations in the guidance template mean that there is no detail on a range of stages in the lifecourse where the risk of obesity or weight gain is increased. You will be aware that NICE is due to publish guidance on weight management during pregnancy and after childbirth in July 2010.

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Department of Health			c) A major report found that over half of mothers who died during pregnancy, childbirth, or within 42 days of childbirth, were either overweight or obese. It concluded that pregnant women with a BMI of greater than 30.0kg/m2 are more likely to die than those with a BMI of less than 30.0kg/m2. (confidential enquiry into maternal and child health 2007).	As above
Department of Health		4.2.1	Could you please consider adding the Third Sector (and community and faith groups) to the existing examples of organisations, involved in partnership working at local level. We feel that this will help to re-enforce action by these organisations in communities with higher prevalence (such as Pakistani and Bangladeshi communities).	Thank you for this comment. The third bullet point in section 4.2.1 has been amended to include community organisations.
Department of Health		4.3 (Question 3)	Could you please consider adding the following text to the last sentence: *"How does effectiveness vary between different communities or population groups, including disadvantaged groups."*, to reflect the earlier reference (in paragraph 3b) to the relationship between obesity and social disadvantage among adults and children.	Thank you. The scope has been amended as suggested.
Department of Health		Appendix B	We support the intention of the PDG's to consider the relative effectiveness of a population-based approach, compared to targeted action among vulnerable groups.	Noted.

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Diabetes UK		4.2.1	It could also be useful to consider nutritional and food manufacturing policies as was considered by the Draft NICE public health guidance on CVD prevention. The FSA for example has developed guidelines on food labelling: http://www.food.gov.uk/foodlabelling/	Thank you for this comment. "Food systems" has been added to the list of elements in 4.2.1
Diabetes UK		4.2.2	Whereas this guidance will not consider assessment of the definitions of "overweight" and "obese" it would be useful for these definitions to be incorporated into the guidance as information for readers to be able to refer to.	Thank you for this comment. The definition of obesity is given in section 3a of the draft scope. The definitions of obesity and overweight will be as recommended in existing NICE guidance on the prevention and management of obesity (2006, CG43).

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Fitness Industry Association Ltd		General	The FIA welcomes this opportunity to respond to the *NICE Preventing obesity: a whole system approach consultation.* The FIA is committed to promoting the use of exercise in the prevention and management of long term chronic conditions. It is widely acknowledged that increasing levels of physical activity contributes to achieving reductions in the risk of CHD, Obesity, Hypertension, Cancer, Osteoporosis and Depression. The FIA is actively attempting to tackle the rising tide of obesity and has worked with weight management specialists & behavior change specialists, MEND, to develop the MoreActive Health kit. The facilitated self help guide is the first of its kind to receive Department of Health Approval. The lifestyle guide addresses complex issues including, behaviour change, physical activity and nutrition to how to sustain lifestyle change. It encourages readers to undertake 10 healthy lifestyle habits over a six week period by helping them to set themselves simple, achievable goals, record their success in prepared documentation. The health and fitness sector is a significant resource for local communities in encouraging exercise and providing expert advice to members of those communities on healthy, active living. A key plank in a whole system approach is the formation of partnerships locally between health commissioners and providers and their local clubs. Leisure facilities could potentially become the centres from which a range of healthy lifestyle activities, such as walking clubs can centre.	Noted.

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Fitness Industry Association Ltd		General	The FIA is pleased to see the inclusion of industry in the whole system approach for preventing obesity. Time constraints caused by employment is a significant barrier to physical activity, the FIA is actively encouraging employees to take a greater role in promoting greater workplace health and offer employees healthy lifestyle opportunities. Inactive and sedentary lifestyles are significant risk factors for obesity and given the large proportion of time spent in employment this guidance must encourage incorporating physical activity into workplace health. The FIA is aware that the direct cost of absenteeism caused by ill health is £13.2 billion whilst the indirect cost of this absenteeism is £19.9 billion, therefore increasing physical activity levels amongst large employers would represent a significant saving for the economy. The FIA is working with employers across the country to ensure that employees have access to health and fitness facilities to empower them to take responsibility for their health by reducing overweight through physical activity and improving health through increasing fitness levels. The FIA is a partner in a scheme to improve the physical activity levels of employees at a hospital in London. As well as offering free and reduced rate membership the scheme will involve physical activity classes taking place in the workplace to reduce time pressures on participants. In summary polices and practice in local communities should be geared to: • Increasing levels of physical activity • Improving workplace health • Ensuring that the environment encourages increased levels of physical activity	Noted.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Food and Drink Federation		General	Thank you for inviting us to attend the workshop on 27 January in London to discuss the NICE draft scope for recommendations on guidance for the prevention of obesity and for asking us to make a submission. In summary we believe: • This guidance should focus on the practical interventions that can be made at a local level by PCTs, local authorities and others to help those living in local communities maintain a healthy weight. • Consistency of approach is important in encouraging behaviour changes – so local activities should seek to amplify the national Change4Life obesity campaign. • Local partnership with industry is important and food and drink manufacturers should be viewed as a key [n important] stakeholder for PCTs, local authorities and others. • Public Health Guidance 13 (2008) should be extended to include workplace wellbeing within the scope of this guidance. • We believe that there is much to be learnt from industry's positive work in local communities – particularly around food, diet and healthy lifestyles – and we would be pleased to facilitate any detailed conversations with exemplars in this area.	Thank you for these comments. Please note that local businesses are included in this guidance in relation to their role in the whole public health system influencing obesity (see 4.2.1 of the draft scope). "Food systems" has been added to the list of elements in section 4.2.1 in the updated scope.

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Food and Drink Federation		General	**DETAIL** The Food and Drink Federation (FDF) represents the interests of the UK's largest manufacturing sector. There are 7,000 food and drink manufacturers in the UK, employing around 440,000 people and generating annual turnover of £73bn. Our industry has a strong track record of responding to societal concerns about the health of the nation and our members have been showing real leadership over many years through voluntary action in areas such as reformulation, innovations on healthier products, nutrition labelling, responsible marketing and workplace wellbeing. Here are some examples of our sector's work in this area: • **Continually reformulating our products**: one of our sector's priorities is finding new ways to lower the salt, fat or sugar content of our products to help consumers make healthier choices. Between January 2008 and June 2009, more than 700 reformulated food and drinks products were launched in the UK; more than a third of these were in meals, processed meat, fish and side dishes; 14% were in sauces and seasonings; 11% in bakery and 11% in non-alcoholic drinks (Mintel 2009) • **Developing healthier choices**: sometimes reformulation is not enough – or technically difficult to achieve. In that case, members are also looking to develop 'better for you' alternatives to popular brands, or develop a range of appropriate portion sizes, as another way of helping consumers choose the products best suited to their consumption needs	Noted.

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Food and Drink Federation		General	• **Empowering the consumer**: we recognise the importance of providing clear nutrition information and support the use of Guideline Daily Amount labelling on the front of our packs, believing that this is an important tool in helping boost the food literacy of consumers. Many of our members are also actively supporting the Department of Health's Change4Life campaign at both a national and local level.	Noted.
Food and Drink Federation		General	We were pleased to attend the workshop on 27 January in London to discuss the NICE draft scope for recommendations on guidance for the prevention of obesity and look forward to actively collaborate and contribute to the development of the document. In particular, we agree that this guidance should focus solely on the practical interventions that can be made at a local level by PCTs, local authorities and others to help those living in local communities maintain a healthy weight.	Thank you for this comment. As key question 2 (section 4.3) of the draft scope, the PDG will also consider the impact of national policy and actions on the effectiveness of local action.
Food and Drink Federation		General	Wherever possible, local activities to tackle obesity should reflect the national Change4Life obesity campaign – and should seek to amplify the campaign, thus creating a consistency that will ensure the key healthy weigh messages genuinely resonate among citizens.	Thank you for this comment. As noted in section 4.3 of the draft scope, a broad range of literature will be considered in the development of this guidance.
Food and Drink Federation		General	We would also urge you to consider the role of the food and drink manufacturing industry as an important local partner for PCTs and local authorities. Given its status as a major national employer, employing 440,000 people across the UK, we feel our industry can play an active part in developing any 'packages of interventions' aimed at reducing the risk of obesity and can help consumers make more informed choices.	Thank you for this comment. "Food systems" has been added to the list of elements in section 4.2.1 in the updated scope.

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Food and Drink Federation		General	For instance, our members are pioneers in the development of **workplace wellbeing schemes** that go beyond the traditional health and safety agenda to focus on initiatives that will help employees lead healthier lives. While we appreciate you do not to cover such activities directly, we do think these schemes are having a major impact and can provide valuable learnings to underpin your new guidance – particularly around partnership working. We would be happy to share our insights and experiences with NICE, and would urge you to build on Public Health Guidance 13 (2008). We believe strategies for developing partnerships with employers to improve weight management and health through workplace initiatives will be important because of the number of people that can be reached and the ability to flex such an approach to meet local needs. The Department of Health Change4Life obesity campaign has recently started to focus on the importance of the workplace in reaching 'at risk' adults.	Thank you for providing this information.
Food and Drink Federation		General	Partnership working is vital for the success of the **wide variety of local community activities** already supported by companies in our sector (such as sports competitions, healthy eating projects and partnerships with local schools). Despite the economic slowdown, companies have continued to see the importance of investing their time, money and effort in this area. Again, we feel there is much to learn from this positive work. We showcase many of the ongoing projects through our annual 'Community Partnership Awards' – http://www.fdf.org.uk/cpa2009_winners.aspx – and can provide you with additional information on the partnership activities now underway in communities across the UK.	Thank you for providing this information.
Food and Drink Federation		General	FDF will follow with interest the development of the NICE guidance and would be keen to participate fully in future consultations.	Thank you.

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Heart of Mersey		General	Heart of Mersey (HoM) is a cardiovascular disease (CVD) prevention charity primarily funded by the Primary Care Trusts and Local Authorities across Greater Merseyside and Western Cheshire. HoM aims to co-ordinate a strategic approach to preventing the high rates of cardiovascular disease and associated inequalities in our region.	Noted.
Heart of Mersey		3 (b) & (c)	HoM is in strong support for the development of guidance that uses a whole systems approach in preventing obesity. As the draft scope document states almost a quarter of heart disease is attributable to excess body fat. Cardiovascular disease (CVD) is the greatest contributor to both male and female reduced life expectancy in North West England compared to the England and Wales average and thus is also the greatest contributor to continuing health inequalities[1]. Greater Merseyside suffers disproportionately from health inequalities with deaths from CVD around 25% higher than the average figure in England.	Noted.

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Heart of Mersey		3 (f) and (g) 4.3 (question 2)	HoM supports that an upstream population-based approach [2] is the most cost-effective for addressing and reducing CVD prevalence and health inequalities and the benefits of a population based approach to obesity would have similar significant benefits. Evidence indicates that whilst the downstream medical approach is beneficial and effective for patients with recognised CVD, it is responsible for a surprisingly small reduction in the proportion of CVD deaths that occur in the total population [3]. Large reductions in CVD prevalence can be achieved only by a reduction in the population levels of multiple risk factors and this requires a "population-based approach". However, in order to provide "communities" with the opportunity to make changes in their lifestyle to reduce risk factors, it is necessary to have a supportive environment and public policies (both directly related to health affecting the wider determinants) to enable the "healthy choice to become the easy choice" [4].	Noted.
Heart of Mersey		3 (g)	The HoM CVD programme is based on a population based approach developed in North Karelia, Finland originating in the 1970's. A collaboration with the government and WHO led to the development of a programme to target smoking, control blood pressure and reduce cholesterol, amongst the population and this included development of comprehensive strategies to change dietary habits. As a result of the programme and an integrated approach to food policy; cholesterol levels and CHD decreased[5]. A population based approach can change everyone's exposure to risk within a population and may have significant benefits. Upstream population based approaches are however difficult to evaluate.	Noted.

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Heart of Mersey		4.2.1	HoM feels strongly that the guidance should include the impact of national policy including fiscal or regulatory change. Evidence shows that that reliance on voluntary behaviour change can be a limitation when considering interventions and socio-economic activity and alternatively strategies that use regulation may have beneficial effects[6.]	Thank you for this comment. We have clarified the focus of the guidance in the draft scope. It was noted at the stakeholders meeting that NICE have had a post referral clarification meeting with DH . NICE received a strong steer to primarily focus on the impact of national policy on effectiveness of local action rather than focusing on national policy per se. There are already many good examples of guidance on obesity prevention at a national level and it is clear what the main policy levers are. However translating these into meaningful action down the delivery chain at local level has proved challenging. The purpose of the approach adopted in this guidance is to unlock capacity in the system at local delivery level to bring about change. The decisions relating to implementation and to delivery are made at the community and local level in the system and that is where guidance is needed. This guidance will support the decision makers at that level. The delivery chain is long. Our focus is on the point of delivery. The nuances of what exactly will and will not be covered are difficult to specify at this stage and are likely to depend on the evidence available and the direction of the PDG discussions. Depending on the evidence available, the PDG may wish to consider national policy action per se; the current scope does not preclude this.

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Heart of Mersey		4.2.1	HoM is also supportive of regulatory change or policy at local level in reducing the prevalence of obesity such as improving public sector food procurement, economic regeneration policy, reinforcing local authority planning procedures to reduce the density of fast food outlets and local transport policies to promote cycling and walking. Greater reference should be made to the concept of public health, planning and the built environment. This should be included and explored within the scope of the guidance.	Thank you for this comment. The built environment and transport systems are included in possible elements t o be considered in section 4.2.1. The updated scope also includes a reference to food systems.
Heart of Mersey		4.2.1	HoM strongly believes the guidance should also consider wider influences such as the media, particularly if we are to protect the health and wellbeing of children and young people. Children's food promotion is known to be dominated by television and does have an influence over children's food preferences and their purchasing behaviour. The majority of the promotions are unhealthy foods, known as the 'big five' e.g. pre-sugared breakfast cereals, soft drinks, confectionary, savoury snacks and fast food outlets[7]. If the UK is to tackle the current obesity epidemic and improve the health and well being of children, wider influences such as the media must be considered, including the opportunity for presenting positive messages.	Thank you for this comment. Wider influences such as the media are included in possible elements to be considered in section 4.2.1.

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Heart of Mersey		4.3 (Question 2 &3) And General.	Heart of Mersey believes that all sections of society should be engaged in addressing health inequalities. A population-based approach to prevention is more effective than focusing on a number of individuals at high risk of poor health. The role of government in tackling health inequalities is critical as appropriate legislation is essential to support the development of healthier environments where healthier lifestyle choices are made easier. Marketing campaigns which focus on changing the lifestyles of individuals in isolation are likely to increase health inequalities as a consequence. It is important to maintain an all-inclusive strategy to tackle health inequalities, which includes health behaviour determinants as well as social. More evaluations of upstream interventions also need to be conducted and funded and future evaluations of public health interventions should incorporate a health inequalities dimension and therefore be considered within the scope of the guidance.	Noted.
Heart of Mersey		References		
Heart of Mersey		1.	Hennell T. *Where are we now and where are we heading? – understanding the gap and forecasting trends.* Presentation at DH Health Inequalities conference, Manchester, 2009.	Thank you for this reference
Heart of Mersey		2.	McKinlay JB. Paradigmatic obstacles to improving the health of populations: implications for health policy. *Salud pública Méx*. [online]. 1998, vol. 40, no. 4 [cited 2007-01-17], pp. 369-379. Available from: http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0036-36341998000400010&lng=en&nrm=iso>.ISSN 0036-3634	Thank you for this reference

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Heart of Mersey		3.	Unal B, Critchley JA, Capewell S. Modelling the decline in coronary heart disease deaths in England and Wales, 1981-2000: comparing contributions from primary prevention and secondary prevention. *BMJ.* 2005; 331(7517):614.	Thank you for this reference
Heart of Mersey		4.	Lewis B and Rose G. Prevention of coronary heart disease: putting theory into practice. *J R Coll Physicians London*. 1991. Jan:25(1):21-6	Thank you for this reference
Heart of Mersey		5.	The Strategy Unit. *Food Matters Towards a Strategy for the 21st Century.* 2008.	Thank you for this reference
Heart of Mersey		6.	White, M.,Adams, J., Heywood, P. *How and why do interventions that increase health overall widen inequalities within populations?* In Baboness (Ed.). Health, Inequality and Society. Bristol: Policy Press. 2009	Thank you for this reference
Heart of Mersey		7.	Review on research of the effects of food promotion to children, final report, prepared on behalf of the food standards agency 2003. http://www.food.gov.uk/multimedia/pdfs/foodpromotiontochildren1.pdf	Thank you for this reference

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Imperative Health Ltd		4.1.1	Groups excluded on the basis of undergoing "clinical treatment for obesity" need to be better defined as CG43 covers all adults and children that are overweight or obese. If the exclusion is purely for surgical patients, a discussion may be required around why this group is exempt from locally implemented programmes, strategies and interventions.	Thank you for this comment. The scope addresses population prevention in the broadest sense and, as such no BMI cut off has been set. Secondary prevention is not explicitly excluded from the scope as it stands and there is nothing to preclude the PDG considering issues around secondary prevention depending on the focus of their discussions and the evidence available. Clinical management is outside the remit of this scope and the guidance will not re-consider specific issues already covered by the existing NICE guidance on obesity.
Imperative Health Ltd		4.2.1	Consider an integrated approach with CG43 to assess and recommend programmes, strategies and interventions for the wide spectrum of individuals requiring weight management support, including those meeting the "clinical treatment" criteria.	Please see above. The clinical management of obesity is outside the remit of this scope.
Imperative Health Ltd		4.2.1	The internet should also be considered as both an influence and a delivery route for programmes and interventions.	The internet may be considered as a wider influence, depending on the evidence available.
Imperative Health Ltd		4.2.1	Consider patient centred and / or initiated programmes or interventions and patient focus groups.	Please see previous response. The clinical management of obesity is outside the remit of this scope.

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Imperative Health Ltd		Section 4.3 Question 5	The question "How does such an approach avoid being dependent on highly motivated individuals?" assumes that the presence of highly motivated individuals is a negative characteristic of programmes or interventions. This question should be rephrased as "Is such an approach dependent on highly motivated individuals?" and the outcome reviewed in the cost benefit analysis of the specific programme or intervention. There is a growing body of literature on the cost effectiveness of changing health professional's behaviour in addition to the work examining common bias of health professionals in the treatment of patients with obesity. If the presence of highly motivated individuals proves to be a cost effective method of achieving the required outcomes, the questions should then be "How can more health professionals be supported to enable and promote higher levels of motivation?".	Thank you for your comment. This question has been re-worded.
LighterLife		General	During the stakeholder meeting it was mentioned that the guidance would cover secondary prevention. However this was not clear from the draft scope. Could NICE please clarify if secondary prevention will be included and what exactly is understood under secondary prevention? For example, is it just the prevention of overweight people becoming bigger or does it also include obese people moving through the different levels of obesity (stage 1, 2 and morbidly obese).	Thank you for this comment. The scope addresses population prevention in the broadest sense and, as such no BMI cut off has been set. Secondary prevention is not explicitly excluded from the scope as it stands and there is nothing to preclude the PDG considering issues around secondary prevention depending on the focus of their discussions and the evidence available. Clinical management is outside the remit of this scope and the guidance will not re-consider specific issues already covered by the existing NICE guidance on obesity.

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LighterLife		General	Currently, certain obesity interventions for the overweight and obese in weight management groups are subject to VAT. This is counterproductive in tackling obesity as it makes safe and effective programmes more expensive, which in turn can form a barrier for participation for some people. Would NICE consider making recommendations to Ministers in this area, for example that proven effective programmes should no longer be subject to VAT?	Thank you for raising this issue.
LighterLife		General	NICE guidance 43 *Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children* is also limited in this regard, as it recommends that people should only aim to lose 5-10% of body weight. For some morbidly obese people, this will not be enough to ensure good health. Interventions do exist which can help those who need to lose a significant amount of weight to do so. These programmes also help people to maintain their weight loss at an appropriate and individual target.	Thank you for raising this issue, however it is outside the remit of this work.
LighterLife		4.2.1.	In terms of actions at local level, it may be appropriate to recommend that GPs receive more individual responsibility to tackle obesity in a more tailored approach which fits with their local area needs, and that they should receive appropriate funding to do so. In addition, the public sector approach to tackling obesity is not always appropriate, for example there is little care and support available outside of normal working hours. GPs should therefore also be given the opportunity to make referrals to private sector weight management services, if this can offer a more flexible and accessible service.	Thank you for these comment. Primary care will be considered as one of many elements in the whole system influencing the prevention of obesity. However, specific issues relating to individual care of patients is outside the remit of this work. As I'm sure you are aware, existing NICE guidance on obesity (CG43) includes recommendations about management of obesity in self help, commercial and community settings.

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LighterLife		4.2.1	PCT commissioning is often not realistic about what can be achieved; patients are often only set targets of losing a small amount of weight, which is not always sufficient to achieve a healthy body weight and BMI. Programmes do exist which can help people lose a significant amount of weight, if this is an appropriate target to achieve a healthy lifestyle, and help keep it off in the long term, including programmes such as ours which combine a very low calorie diet with long term support.	Noted. As previously stated, the management of overweight and obese individuals is outside the remit of this work.
LighterLife		4.2.1	The QOF should be updated to better incentivise preventative measures for GPs- this is an example of where a national policy change could have real effects on improving preventative care. At the moment, GPs are able to gain points for making a register of obese patients in their practice, but are not offered extra points for offering advice to patients on how they can lose weight or preventing overweight patients from becoming obese.	Thank you for raising this issue. As you may be aware, NICE now has responsibility for QOF. At the QOF June 2009 meeting it was agreed that obesity and QOF would be reviewed given a suitable stakeholder submission on weight management. Submissions were received in Autumn 2009 and these are currently being reviewed. For more information about QOF see http://www.nice.org.uk/aboutnice/qof/qof.jsp
LighterLife		4.2.2	Could NICE please define clinical management, for example do weight loss groups fall under clinical management if they are delivered under clinical supervision, or is clinical management to be understood as a doctor dispensing drugs or care in secondary care environment?	Thank you for this comment. The focus for this work is at the population level. Clinical management is outside the remit of this scope and the guidance will not re-consider specific issues already covered by the existing NICE guidance on obesity.

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LighterLife		4.2.2	Does the fact that certain interventions, such as very low calorie diets included as an option in NICE guidance 43 Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children, mean that they will not be considered as part of this piece of guidance?	Interventions aimed specifically at managing overweight and obesity in individuals under supervision from a health professional, such as VLCDs, are excluded from this work and fall under the remit of CG43.

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Liverpool John Moores University		General & Appendix A (page 12)	There seems to be some confusion about the target audience for this scope. Guidance on a "whole systems approach" is of little use for people who do not have the power to implement such guidance. As such, the proposed guidance should be aimed at national and local policy makers, and not at local organisations as DH propose - guidance specific to individual areas already exists. Page 2 states the guidance will involve **"shifting attention away from individual risk factors or isolated interventions"**, and must involve **"action by central and local government, industry, communities, families and society as a whole."** Yet this is very poorly reflected in the rest of the document. Even the title itself (page 2) refers to **"local and community levels"**. And pages 5 & 6 give the impression the guidance is focussing on yet more community scale initiatives. This is really failing to grasp a) the scale of the obesity problem and b) its complexity in terms of the very deep seated causes in fundamental ways that 'society' works eg. car dependence and power of the car lobby and the time it will take to change things at a population level.	Thank you for your comments. The title and focus of the guidance reflect the referral received by NICE. The key questions in section 4.3 focus on more than individual, small scale community interventions. In light of your comments "policy makers" has been added to 3e of the draft scope. We have clarified the focus of the guidance in the draft scope. It was noted at the stakeholders meeting that NICE have had a post referral clarification meeting with DH . NICE received a strong steer to primarily focus on the impact of national policy on effectiveness of local action rather than focusing on national policy per se. There are already many good examples of guidance on obesity prevention at a national level and it is clear what the main policy levers are. However translating these into meaningful action down the delivery chain at local level has proved challenging. The purpose of the approach adopted in this guidance is to unlock capacity in the system at local delivery level to bring about change. The decisions relating to implementation and to delivery are made at the community and local level in the system and that is where guidance is needed. This guidance will support the decision makers at that level. The delivery chain is long. Our focus is on the point of delivery. The nuances of what exactly will and will not be covered are difficult to specify at this stage and are likely to depend on the evidence available and the direction of the PDG discussions. Depending on the evidence available, the PDG may wish to consider national policy action per se; the current scope does not preclude this.

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Liverpool John Moores University		General & Appendix A (page 12)	Essentially, a whole systems approach to obesity prevention requires significant cultural change supported by policy at a national level. Yet the Department of Health's referral seems to absolve all responsibility in this issue, asking NICE to produce PH guidance for **"PCTs, local authorities, primary care, sports recreational services, food retailers and the voluntary sector".** The document is correct in acknowledging a **"downstream"** approach has been adopted in the past (3 (f), page 5), but it does not really identify the "upstream" approach that is required. At present it lacks scope / vision and commitment to trying to make the deep seated and fundamental changes which are required. The guidance is relevant in identifying the importance of a "whole systems approach" but if it is to have any impact it needs to recognise obesity as the political issue it is and acknowledge the role of societal and cultural change in tackling this issue.	Please see previous response.
Liverpool John Moores University		3 (e) (page 5)	Refers to "food production"- why blame the farmers? Obesity is far more a food manufacturing / retailing problem.	Noted. Section 3e reflects the referral received by NICE. Please note that "food systems" has been added to the list of elements in section 4.2.1

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Liverpool John Moores University		4.2.1 (page 6 to 7)	• How about tackling the 'food industry'? • How about improving health literacy (ie consumer empowerment)? • The impact of social norms and underlying beliefs / values needs to be considered. • The impact of economic factors on obesity urgently need reviewing eg price elasticity etc.	Thank you for your comments. These issues may be considered depending on the evidence available. Please note that "food systems" has been added to the list of elements in section 4.2.1.
Medical Research Council, Social and Public Health Sciences Unit		General	We are pleased to see that population diversity, especially in terms of ethnicity and socio-economic status, are among the potential considerations of the "critical elements" of the approach to preventing obesity. Novel processes addressing these issues should be a key aspect of the guidance. We have just completed an exploratory study with ethnic minority children, examining whether the interface between places of worship and ethnic minority families could offer opportunities for supporting an obesity prevention program. Our findings indicate the importance of a combined intervention approach to support culturally distinct frameworks (Maynard et al 2009). Schools provide access to children and opportunities for a generic format of an intervention via the curriculum. Places of worship, however, provide opportunities for ethnic specific support via endorsement from trusted and respected community leaders in the congregation, access to extended families, culturally specific support networks and also via active partnerships with local community groups. Places of worship are integral to the fabric of family life of Black Caribbeans, Black Africans and South Asians, not just in terms of religious observance but also of common identities, values and histories. The inclusion and further exploration of this type of approach is welcome.	Thank you for providing this information.

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MEND		General	MEND welcomes this timely forthcoming guidance and we are aware of a clear demand for it from many of our PCTs. We believe the resultant guidance would be a positive step towards achieving the vision of reducing obesity through a systems approach, as alluded to by Foresight.	Noted.
MEND		General	The scope of this subject is extremely broad, so it is important that helpful elements are not missed by narrowing down the evidence that will be looked at.	Noted.
MEND		General	In order to capture the broad influences on a whole systems approach to preventing obesity, the scope needs to be defined more precisely, as does the meaning of a 'whole systems approach'. This will also allow those submitting evidence to be able to submit helpful and relevant documentation.	Thank you for this comment. We are aware that the scope only includes a brief definition of whole systems approach. However, we assume that the definition of the approach will be a fundamental issue for the PDG and will be finalised over the course of the guidance development.
MEND		2b	Food industry is not mentioned here in the list of organisations that affect a local system. MEND believes that the influence of the food industry will need to be considered, for example how the labelling of food or levels of fat and sugar in food affects a system. The food industry was represented at the scoping meeting and said that they would be responding and feeding in evidence to the consultation.	Thank you for this comment. Section 2b of the draft scope reflects the original referral from NICE. However, the wording has now been amended to include "food industry".
MEND		2e	The results of an obesity prevention guidance such as this should also be shared with national policy makers. NICE should take the opportunity to share this with such policymakers, even though it has said it cannot influence policy directly.	Thank you for your comments. "Policy makers" have been added to this list.

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MEND		3e	Under the determinants of obesity, NICE should mention that there are vulnerable periods in life where obesity is more likely to occur. The Foresight report refers to these periods as 'critical opportunities for intervention' in the life course and identifies these various stages from preconception through to 60+ (ageing). Nice CG43 also refers to 'interventions at specific times when weight gain is more likely e.g. women during and after pregnancy or the menopause. At the scoping meeting NICE agreed that it would be looking at systems that influence weight gain at these vulnerable times.	Thank you. In light of your comments a brief mention of key stages in the lifecourse has been added to the considerations section of the draft scope (appendix B).
MEND		3g	As mentioned in the scoping meeting, NICE should explicitly state that as there may be very little evidence regarding a whole system approach that has influenced obesity, it should therefore draw on evidence where such an approach has worked to influence other areas such as smoking and road traffic accidents.	Thank you. Section 4.3 has been amended to reflect your comments.
MEND		4.1.1	As was made clearer in the scoping meeting, the guidance should state that the scope includes preventing lean people becoming overweight or obese, and also preventing individuals of any weight from gaining further weight. It should also make clear that it includes preventing those individuals who have lost weight to not regain that weight. Currently the scope does not make this explicit.	Thank you for this comment. The scope addresses population prevention in the broadest sense and, as such no BMI cut off has been set. Secondary prevention is not explicitly excluded from the scope as it stands and there is nothing to preclude the PDG considering issues around secondary prevention depending on the focus of their discussions and the evidence available. Clinical management is outside the remit of this scope and the guidance will not re-consider specific issues already covered by the existing NICE guidance on obesity.

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MEND		4.2.1	NICE have asked for evidence on the impact of national policy but also stated that the evidence should be about preventing obesity in a locality. At the scoping meeting there was quite a lot of confusion about what national evidence could be included and what couldn't. This needs to be spelt out further, for example national considerations would include the impact of the recession.	Thank you for this comment. We have clarified the focus of the guidance in the draft scope. It was noted at the stakeholders meeting that NICE have had a post referral clarification meeting with DH . NICE received a strong steer to primarily focus on the impact of national policy on effectiveness of local action rather than focusing on national policy per se. There are already many good examples of guidance on obesity prevention at a national level and it is clear what the main policy levers are. However translating these into meaningful action down the delivery chain at local level has proved challenging. The purpose of the approach adopted in this guidance is to unlock capacity in the system at local delivery level to bring about change. The decisions relating to implementation and to delivery are made at the community and local level in the system and that is where guidance is needed. This guidance will support the decision makers at that level. The delivery chain is long. Our focus is on the point of delivery. The nuances of what exactly will and will not be covered are difficult to specify at this stage and are likely to depend on the evidence available and the direction of the PDG discussions. Depending on the evidence available, the PDG may wish to consider national policy action per se; the current scope does not preclude this.

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MEND		4.2.2	MEND questions why 'discrete interventions in a particular location, such as schools or workplaces' will not be looked at as part of a whole system approach to preventing obesity. These approaches may have been covered in other NICE guidance, but the emphasis of these other guidance was different. MEND believe they should be looked at again from this new whole systems perspective of obesity prevention.	Thank you for this comment. The focus of this guidance is the whole system. Individual locations such as schools or workplaces are included as part of the system. Existing NICE guidance shows what works in terms of discrete interventions in these locations. The focus of this guidance is how a range of interventions can be implemented simultaneously, what are the key elements of the system, what are the key partnerships etc (as key questions outlined in section 4.3 of the draft scope).
MEND		Appendix: the DH referral	DH asked NICE to look at 'effective community based approaches to maintaining a healthy weight and prevention of obesity'. MEND questions whether maintaining a healthy weight is in fact the same as prevention of obesity. If they are not, the scope only seems to focus on the latter and evidence for the former should therefore also be sought.	Thank you for raising this issue.
MEND		Appendix B: Potential considerations	This section appears to be an add-on to the main scoping document. It does seek to explain further what the scope is to include or exclude and therefore should form part of the main document.	Thank you for this comment. The scope follows a standard template.

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MEND		Appendix B: Potential considerations	The eighth bullet point is confusing as it states that 'issues relating to the identification, treatment and referral of individuals will not be considered'. MEND questions why such 'issues' are excluded as a local policy which has put into place a way of say identifying at risk individuals who may become obese, such as children with obese parents, would surely need to be included as a systems approach?	Thank you for this comment. The focus of this work is the whole population and takes a population based approach. The identification and treatment of individuals is covered by existing NICE guidance on obesity (2006, CG43). However, as noted the start of the draft scoping document, this work is one a suite with a focus on obesity. Two other pieces of guidance to be developed will focus on overweight and obesity in children.
National Heart Forum		Key questions section	Need to include how to tackle inequalities in obesity	Thank you for this comment. Question 3 in section 4.3 of the draft scope has been amended to "How does effectiveness vary between different communities or population groups, including disadvantaged groups?"
National Heart Forum		General	Need to include a consideration of the wider social benefits of obesity prevention for climate change and sustainable development	Thank you for raising this issue.
National Heart Forum		General	Need to consider the integration of obesity prevention with other chronic disease and public health and related social policies and programs	Noted.
National Heart Forum		General	What support is needed to enhance leadership, strategic planning and professional development	Thank you for raising this issue.
National Heart Forum		D	Need to refer to the new Department of health strategy on promoting physical activity-"Be Active: Be healthy" a plan for getting the nation moving (2009)	Thank you for highlighting these documents; they have been included in section 2d of the draft scope.

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National Heart Forum		General	Need to refer to DEFRA food strategy (2010) and Cabinet Office Food Matters review (2009)	Thank you for highlighting these documents; the former has been included in section 2d of the draft scope, the latter has not been included (the list is not intended to be exhaustive).
National Heart Forum		General	The NHF is very supportive of the review and agrees with the scope with the addition of the above comments	Noted.

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National Obesity Observatory		4.2.1	The scope is slightly unclear about whether national-level policy interventions – including fiscal or regulatory change - will be included. It mentions national policy that has local implementation, but to our mind that is contrary to the 'whole systems' theme of the scope. This implies an 'upstream' approach that influences people's opportunities to be active and to eat more healthily. Some of these may be direct influences on behaviour, without the need for any local implementation. Examples might be a 'fat tax'; VAT or other taxation changes; or road pricing. We feel this sort of approach should be included	Thank you for this comment. We have clarified the focus of the guidance in the draft scope. It was noted at the stakeholders meeting that NICE have had a post referral clarification meeting with DH . NICE received a strong steer to primarily focus on the impact of national policy on effectiveness of local action rather than focusing on national policy per se. There are already many good examples of guidance on obesity prevention at a national level and it is clear what the main policy levers are. However translating these into meaningful action down the delivery chain at local level has proved challenging. The purpose of the approach adopted in this guidance is to unlock capacity in the system at local delivery level to bring about change. The decisions relating to implementation and to delivery are made at the community and local level in the system and that is where guidance is needed. This guidance will support the decision makers at that level. The delivery chain is long. Our focus is on the point of delivery. The nuances of what exactly will and will not be covered are difficult to specify at this stage and are likely to depend on the evidence available and the direction of the PDG discussions. Depending on the evidence available, the PDG may wish to consider national policy action per se; the current scope does not preclude this.

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National Obesity Observatory		Question 2 page 8	Again, why local action?	As above
Natural England		2d	Need to include "Be Active Be healthy"	Thank you. The scope has been amended to reflect your comments.
Natural England		4.2.1	The Natural Environment needs to be specifically mentioned in addition to the Built Environment. This will include access to beaches, rivers, lakes, woodland, rights of way, parks and any other green space . The evidence from Bell demonstrates that after 2 years children living near green space put on significantly less weight (6kg) compared to those living away from green space. (Bell et al Neighbourhood Greenness and 2-Year Changes in Body Mass Index of Children and Youth. Am J Prev Med 2008;35(6):547–553) Other study by Ellaway from the MRC epidemiology unit BMJ 2005;331:611-612 found that greenery was important in preventing obesity and increasing physical activity.	Thank you; the scope has been amended to reflect your comments.
NHS Alliance		General	Would be good to have some background evidence and recommendations about the theoretical under-pinning and the strengths and weaknesses of local whole systems approaches.	Thank you for this comment. The theory of taking a whole systems report comes from the Foresight report (as referenced in the draft scope). T he evidence base, strengths and weakness of such an approach will most likely be the focus of one of the evidence reviews undertaken for the development of this guidance.
NHS Alliance		2 (b)	It would be helpful if "sports and recreational services" could be amended to "sports, physical activity and recreational services". The aim of physical activity services is to increase levels of physical activity in everyday life.	Thank you, the text has been amended as suggested.

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NHS Alliance		4.2.1	One of the gaps in existing systems is effective approaches to maintenance of weight loss. The guidance should not cover clinical treatment but whole systems should have in place a local step-down approach to long term maintenance of weight loss.	Thank you for this comment. The scope addresses population prevention in the broadest sense and, as such no BMI cut off has been set. Secondary prevention is not explicitly excluded from the scope as it stands and there is nothing to preclude the PDG considering issues around secondary prevention depending on the focus of their discussions and the evidence available. Clinical management is outside the remit of this scope and the guidance will not re-consider specific issues already covered by the existing NICE guidance on obesity.
NHS Alliance		4.2.1	Consideration will need to be given to clarifying the meaning of locally and of community. Locally is often shorthand for local strategic partnership at local authority level. This is the appropriate level for agreeing strategy but ownership of actions and delivery needs to happen within geographical communities and communities of interest below this level.	Thank you for this comment. A more detailed definition of local and community is likely to emerge during the development of the guidance and may depend on the evidence available.
NHS Alliance		4.2.1	The bullet point at the top of p7 on partnership working needs to include “third sector and social enterprises such as healthy living centres”.	Thank you; the bullet has been amended to include “local community organisations”.
NHS Alliance		4.2.1	Might be helpful if the bullet point on “wider influences, such as media” was changed to “wider influences, such as local and national media”. The role and influence of local and national media is very different.	Thank you, the bullet has been amended as suggested.

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NHS Alliance		4.2.1	Might be helpful to have an additional bullet point about the role of health trainer services. Much of their focus is on obesity and there is a growing national database of outcomes from health trainer services. In the context of whole systems and obesity prevention it would also be worth exploring the evidence for "support from next door, rather than advice from on high"	Thank you for this comment. The text has not been amended as we would envisage this issue to be covered by the current bullet on training and development.
NHS Alliance		4.3	Suspect most areas now have strategies. The key question is why strategies don't get translated into effective action? Agree this will probably be picked up by the questions as they exist but it might be helpful if this was an explicit question linked to the role of NHS and local authority commissioners.	Thank you; the wording of question 4 in the draft scope has been amended in light of your comments.
NHS Highland		4.2.1	Spirituality should be included, as beliefs of individuals, from the evidence rating to spirituality and health play a mayor role. In the context of this report would recommend the definition of spirituality to be all-inclusive and as such: Spiritual Health is not merely the absence spiritual disease or weakness but a state of spiritual wellbeing. Spiritual wellbeing is constituted from the following interrelated and interactive aspects of spirituality: Relationships Belief, Meaningful and Purposeful living Transcendence Empowerment Discourse Experiential	Thank you for raising this issue. The wording has not been amended as we would envisage "spirituality" being covered by "wider influences".

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NHS North Staffordshire		Q 1	Low breastfeeding rates, lack of knowledge about baby led weaning. Lack of knowledge about normal baby development – lack of understanding re feeding ques. Unrealistic expectations about baby behaviour i.e. moving onto hungry baby formula or early weaning to encourage babies to sleep longer, or go longer in between feeds.	Thank you for raising these issues. You may also be interested in existing NICE guidance on maternal and child nutrition (2008).
NHS North Staffordshire		Q2	Full implementation of the WHO code of marketing of breastmilk substitutes needed. Advertising and marketing of breastmilk substitutes – sleep through the night milks and toddler milks and weaning foods marketed from 4 months are all confusing parents and contributing to later obesity.	As above.
NHS North Staffordshire		Q 4	Short term funding one off projects – mainstream funding needed to develop and sustain programmes	Thank you for raising this issue.
NHS North Staffordshire		Q 6	As answer to Q 4	As above
NHS North West		General	Delighted to see this overarching approach which will be very helpful in partnership working, supporting improvement and working with the media.	Noted.
NHS North West		General	We would like to see the phrase families and children throughout the scoping guidance as well as populations	Thank you for raising this issue. The scope has not been amended as we would envisage families and children being covered by the population approach.
NHS North West		2e	Although this is a document produced by NICE (hence an NHS audience is its most obvious audience), the current phrasing at 2e potentially allows the reader to assume its primary audience is NHS. In keeping with its whole systems approach, 2e could be better phrased by perhaps stating as the following “It is aimed at leaders, practitioners, planners, managers and commissioners working within the wider public, community, voluntary and private sectors”	Thank you for this comment. We are of the view that the draft scope as it stands makes it clear that the primary audience of the guidance is more than just the NHS.

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NHS North West		4.2.1	Wider influences need to include food industry, food retailers, leisure industry – this is primarily on a local and regional level.	Thank you for this comment. "Food systems" has been added to this list.
NHS North West		4.3 Question 2	We would like to see linkage to the emerging findings of Obesity NST process here -i.e. forthcoming high impact changes recommendations.	Noted.
NHS North West		4.3 Question 6	A societal perspective must be included in the economic analysis, as it is likely that obesity can cause societal disadvantage as well as being linked to it. Links to wider societal behaviours and values could be included showing links to psychological wellbeing, for example the lifetime cost of bullying at school leading to lower attainment, leaving school early and the loss in earning potential for the individual and next generation.	Noted.

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Novo Nordisk Ltd		General (Section 3 and 4.2.1)	As outlined in the draft scope (section 3) the determinants of obesity are complex. Factors contributing to obesity include genetic disposition, individual lifestyle, the physical environment, food production and consumption, education and the influence of the media. A whole system approach to the prevention of obesity is critical, however the anticipated recommendations for this guidance are expected to extend beyond the healthcare sector, thus in order to support the successful implementation of such recommendations this would require collaboration with other government sectors to influence policy. In its current form the scope does not outline how these key stakeholders will be engaged and how the recommendations of the report will be successfully implemented in order to ensure a 'whole system' approach to the prevention of obesity.	Thank you for these comments. NICE public health guidance has a history of making recommendations beyond the NHS and health sectors. NICE has already flagged the consultation on the draft scope to a broad range of stakeholders (and many are registered, as you will see from the NICE website http://guidance.nice.org.uk/PHG/Wave20/53). The membership of the PDG will also reflect the proposed direction of this work. You may wish to read more about CPHE methods (see http://www.nice.org.uk/aboutnice/howwework/developingnicepublichealthguidance/developing_nice_public_health_guidance.jsp) and implementation of NICE guidance (see http://www.nice.org.uk/usingguidance/niceimplementationprogramme/nice_implementation_programme.jsp).

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Novo Nordisk Ltd		Section 3 and 4.2.2	The scope suggests that around 58% of type 2 diabetes is attributable to excess body fat, however section 4.2.2 suggests that the prevention and management of medical conditions associated with being overweight or obese will not be covered by this guidance. We would suggest that this guidance gives due consideration to obesity related conditions in order to ensure the prevention of morbidity and mortality associated with obesity complications is adequately addressed.	Thank you for these comments. It is vital that the scope for this work is achievable according to the time and resources available. Furthermore, it important that it doesn't waste resources by re-appraising areas already covered by existing or forthcoming NICE guidance. You may be aware that there is forthcoming NICE public health guidance on the prevention of CVD (due April 2010), prevention of pre-diabetes (due June 2011) and the prevention of the progression of pre-diabetes (May 2012).

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Royal College of Paediatrics and Child Health		General	We note that the scope's focus is on local systems with 'national policy' limited to the impact of national policy on local systems. We believe this is a false dichotomy because local systems operate as part of national and international systems. Some of the greatest public health gains have been through national legislation and taxing (e.g. smoking). Therefore, we recommend the scope be expanded to include national and international systems, including the opportunity to make suggestions or recommendations to the Government/Ministers as part of the guideline. *Reference* McKee M, Hogan H, Gilmore A. Why we need to ban smoking in public places now. J Public Health 2004. 26: 325-326. Sargent RP, Shepard RM, Glantz SA. Reduced incidence of admissions for myocardial infarction associated with public smoking ban: before and after study. BMJ 2004. 328: 977-980.	Thank you for raising this issue and for the references provided. We have clarified the focus of the guidance in the draft scope. It was noted at the stakeholders meeting that NICE have had a post referral clarification meeting with DH . NICE received a strong steer to primarily focus on the impact of national policy on effectiveness of local action rather than focusing on national policy per se. There are already many good examples of guidance on obesity prevention at a national level and it is clear what the main policy levers are. However translating these into meaningful action down the delivery chain at local level has proved challenging. The purpose of the approach adopted in this guidance is to unlock capacity in the system at local delivery level to bring about change. The decisions relating to implementation and to delivery are made at the community and local level in the system and that is where guidance is needed. This guidance will support the decision makers at that level. The delivery chain is long. Our focus is on the point of delivery. The nuances of what exactly will and will not be covered are difficult to specify at this stage and are likely to depend on the evidence available and the direction of the PDG discussions. Depending on the evidence available, the PDG may wish to consider national policy action per se; the current scope does not preclude this.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Royal College of Paediatrics and Child Health		General	We think that the term "prevention" would benefit from further definition. We would hope it would include primary and secondary prevention, i.e. preventing those who are overweight getting unwell as well as prevention of further progression The College sent a representative to the stakeholder meeting on 27 January, who reported that NICE said the scope covers both primary and secondary prevention; however, we note this is not clear in the scope. It currently appears to be primary prevention only because of the exclusion of people receiving clinical treatment (4.1.1). We think it is appropriate to draw the distinction that it is not about management of obesity.	Thank you for this comment. The scope addresses population prevention in the broadest sense and, as such no BMI cut off has been set. Secondary prevention is not explicitly excluded from the scope as it stands and there is nothing to preclude the PDG considering issues around secondary prevention depending on the focus of their discussions and the evidence available. Clinical management is outside the remit of this scope and the guidance will not re-consider specific issues already covered by the existing NICE guidance on obesity.
Royal College of Paediatrics and Child Health		General	We think it may be more helpful to make clear that the whole-system approach is not aimed primarily at those who are obese already but that any recommended approaches should help (or at least not make it harder) for those who need to take action to control their weight as well as make it more likely that they will be able to so. We suggest that the impacts of any interventions need to be considered with respect to the whole population, including people of all ages, including infants, pregnant mothers, the elderly and those at all levels of weight (underweight, normal, overweight or obese – even those also having clinical treatment) to minimise the chances of unwanted effects.	As above Noted.
Royal College of Paediatrics and Child Health		General	The College thinks it would be helpful to reference the role of hospitals in preventing obesity.	Thank you for this comment. The second bullet of 4.2.1 has been changed from "primary care" to "NHS".

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Royal College of Paediatrics and Child Health		General	The College notes there is no explicit mention or exclusion of pregnant women and babies. We recommend this be made clear, and hope they will be included.	Thank you for raising this issue. Pregnancy will not be specifically excluded from this guidance. However, space limitations in the guidance template mean that there is no detail on a range of stages in the lifecourse where the risk of obesity or weight gain is increased. You will be aware that NICE is due to publish guidance on weight management during pregnancy and after childbirth in July 2010.
Royal College of Paediatrics and Child Health		General	The College thinks that, overall, the draft scope is comprehensive. However, we are concerned that there is no highlighting of babyhood and toddlerhood as key periods where obesity prevention has the potential to be effective. We think it is very important to address obesity prevention during babyhood and the pre-school years.	Thank you for raising this issue. Babyhood and toddlerhood are not specifically excluded from this guidance. However, space limitations in the guidance template mean that there is no detail on a range of stages in the lifecourse where the risk of obesity or weight gain is increased. You will be aware that NICE has already published guidance on maternal and child nutrition (2008).
Royal College of Paediatrics and Child Health		General	Although NICE is not including screening *per se* as an aspect of obesity prevention, the College believes it may be relevant to look at processes that predict young children's risks as these have potential for intervention. (A College member has received a grant from the Department of Health to consider whether this information is helpful to professionals and parents.)	Noted

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Royal College of Paediatrics and Child Health		General	The College is working with e-Learning for Healthcare to develop an e-learning resource for the 'Healthy Child Programme' (see http://www.e-lfh.org.uk/projects/healthychild/index.html). We feel it is important to consider the role of Health Visitor teams delivering the Healthy Child Programme as prevention in the early years is key.	Noted
Royal College of Paediatrics and Child Health		General	We recommend NICE consult with Professor Boyd Swinburn at WHO Collaborating Centre for Obesity Prevention at Deakin University in Australia.	Noted
Royal College of Paediatrics and Child Health		2 b	We think that education or schools need to be explicitly included because they are a key setting for involving children and families. *Reference:* Brown T, Summerbell C. Systematic review of school-based interventions that focus on changing dietary intake and physical activity levels to prevent childhood obesity: an update to the obesity guidance produced by the National Institute for Health and Clinical Excellence. *Obesity Reviews* 2009.10:110-141.	Thank you for this comment. Education systems are included in section 4.2.1.
Royal College of Paediatrics and Child Health		2 f	We think that the link / cross reference to obesity guidance needs to be more explicit. We would like clarification on whether this guidance will supersede the public health sections of the clinical guideline or build on them.	Thank you for this comment. The guidance will complement the existing guidance rather than superseding it.

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Royal College of Paediatrics and Child Health		3	We are surprised to see that no reference was made to the considerable evidence relating perinatal risk factors to later obesity. These include parental BMI, gestational diabetes, weight gain in pregnancy, smoking in pregnancy, birth weight, bottle feeding, age at weaning, etc., along with socio-economic status and ethnicity. As some of these are modifiable there is significant potential for prevention of obesity. *References*: Rudolf, M. Framework for Action: Tackling obesity through the Healthy Child Programme: a framework for action. *National Obesity Observatory* www.noo.org.uk Whitaker RC, et al. Predicting obesity in young adulthood from childhood and parental obesity. *N Engl J Med.* Sep 25 1997;337(13):869-873. Baird J et al. Being big or growing fast: systematic review of size and growth in infancy and later obesity. *BMJ.* 2005;331:29.	Thank you for raising this issue and for providing these references. This section is not intended to be exhaustive and the amount of information provided reflects the space limitations in the standard scope template.

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Royal College of Paediatrics and Child Health		3	The College notes there are a number of other major areas that are relevant, such as parenting (both in terms of parenting styles and modelling), early eating behaviour and sleep, which are linked to the development of obesity later in childhood. We believe it is important that the consultation have a focus on these factors in the early years, too. *References:* Benton D. Role of parents in the determination of the food preferences of children and the development of obesity. *Int J Obes Relat Metab Disord.* 2004;28:858-869. Rudolf, M. Framework for Action: Tackling obesity through the Healthy Child Programme: a framework for action. *National Obesity Observatory* www.noo.org.uk	Thank you for raising this issue and for providing these references. This section is not intended to be exhaustive and the amount of information provided reflects the space limitations in the standard scope template.
Royal College of Paediatrics and Child Health		3 a	We recommend the projected prevalence of obesity for children in 2050 be updated with the revised National Heart Forum projections for 2020 as the previous 2050 projections are no longer valid. *Reference* McPherson K, Brown M, Marsh T et al. Obesity: recent trends in children aged 2–11y and 12–19y. Analysis from the health survey for England 1993–2007. 2009. London: National Heart Forum.	Thank you. The draft scope already states that "While there is some suggestion that it may be starting to level off among children in England (McPherson et al. 2009), prevalence remains very high among this group. "

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Royal College of Paediatrics and Child Health		4.1.2	We note that the exclusion of those who are undergoing 'clinical treatment' for obesity seems sensible in principle, but may be difficult to define. Are community interventions to control or reduce weight gain 'clinical treatment'? Does it mean undergoing treatment by health professionals (which is often an arbitrary fact in intervention programmes)?	Thank you for this comment. The scope addresses population prevention in the broadest sense and, as such no BMI cut off has been set. Secondary prevention is not explicitly excluded from the scope as it stands and there is nothing to preclude the PDG considering issues around secondary prevention depending on the focus of their discussions and the evidence available. Clinical management is outside the remit of this scope and the guidance will not re-consider specific issues already covered by the existing NICE guidance on obesity.

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Royal College of Paediatrics and Child Health		4.2.1	We support the emphasis on training and development for those involved in local efforts to prevent obesity. There is a body of research that shows that health professionals can be unhelpful in the area of healthy lifestyle promotion. Other research shows that they lack self-efficacy. There is evidence that methods such as motivational interviewing and the those approaches such as the RCPCH-led HENRY (Health Exercise Nutrition for the Really Young – see http://www.henry.org.uk/) approach may promote motivational enhancement. *References*: Schwartz RP, et al. Office-based motivational interviewing to prevent childhood obesity: a feasibility study. *Arch Pediatr Adolesc Med.* 2007;161(5):495-501. Edmunds L. The primary prevention of obesity: the developmental research to support the pilot study of an intervention in infancy. A report undertaken for the Royal College of Paediatrics and Child Health. 2006. Rudolf M, Hunt C et al. HENRY: development, pilot and long term evaluation of a programme to help practitioners work more effectively with parents of babies and preschool children to prevent childhood obesity. 2010 (*In preparation)*	Thank you for raising this issue and providing these references.
Royal College of Paediatrics and Child Health		4.2.1	We think that some inclusion of food-related issues is needed, for example, food availability, supply, and local and national marketing.	Thank you for this comment. “Food systems” has been added to this list.
Royal College of Paediatrics and Child Health		4.2.1	In the list of elements to be considered, we recommend adding primary care trusts to the examples listed in ‘partnership working’ (first bullet point on page 7).	Thank you for this comment. The text has not been amended as we would envisage primary care covering primary care trusts.

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Royal College of Paediatrics and Child Health		4.2.2	We agree with these exclusions. We would suggest adding 'screening'.	Thank you for this comment. Screening may be considered as an element within the whole system, screening per se is outside the remit of this work.
Royal College of Paediatrics and Child Health		4.2.2	We agree that the exclusion of discrete interventions in a particular location seems reasonable; however, we are concerned that Sure Start Children's Centres and other day care settings are not included in other aspects of the guidance. We think it is important that interventions in these settings, provided they engage parents, be an essential aspect of obesity prevention.	Noted.
Royal College of Paediatrics and Child Health		4.3	We note the questions are admirable aspirations but note they are very broad and question whether the process will be able to answer them. It would be helpful if they were refined and separated into discrete questions (similar to the scope for NICE Physical activity and the environment).	Thank you for this comment. More detailed questions will be drawn up as part of protocols for each evidence review undertaken during the development of the guidance.
Royal College of Paediatrics and Child Health		4.3 Question 1	We note this set of questions is similar to those posed at Foresight Tackling Obesities: Future Choices Project (see http://www.foresight.gov.uk/OurWork/ActiveProjects/Obesity/Obesity.asp). We suggest the guidance describe how it will use / build on Foresight rather than cover similar ground.	Thank you for this comment. We have clarified the focus and purpose of the guidance in the updated scope.
Royal College of Paediatrics and Child Health		4.3 Question 2	Although we agree that we need to look at the implication of national policies such as transport, we should also look at international (EU in particular) policies such as farming subsidies, which may have a major impact on the success (or otherwise) of national and local approaches.	Thank you for this comment. International policies, actions and interventions may be considered.
Royal College of Paediatrics and Child Health		4.3 Question 2	We recommend removing "manage" obesity, as this is too broad.	Thank you, the scope as been amended as suggested.
Royal College of Paediatrics and Child Health		4.3 Question 3	We recommend removing "weight management" and changing to "obesity prevention".	Thank you for this comment. However, the scope has not been amended

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Royal College of Paediatrics and Child Health		4.3 Questions 3, 4, and 5	We think that a definition of 'community' may be helpful. There appears to be a great deal of emphasis on 'local community', but think that the regional / national picture needs to be covered too.	Thank you for this comment.
Royal College of Paediatrics and Child Health		Appendix B	We are pleased to see the explicit intention to make use of international experience and research, as well as the need to look for unintended effects.	Noted.
Royal Society for Public Health (RSPH)		General	The RSPH is pleased that the scope for the guidance is taking into account the Foresight report which highlighted the wide number and complexity of influences of obesity.	Noted.
Royal Society for Public Health (RSPH)		4.2.1	We would like the activities to include those that do not necessarily have as their prime aim to reduce obesity but that will undoubtedly have an impact e.g. cooking classes, green gyms and similar initiatives. We realise this may be problematic if appropriate evaluation methodologies where not put in place to measure impacts on health.	Thank you for these comments. The type of activities you suggest may be considered, depending on the evidence available.
Royal Society for Public Health (RSPH)		4.2.1.	The partnerships examined should also look at partnerships with and between voluntary sector organisations.	Thank you for this comment. Partnerships with and between voluntary organisations may be considered depending on the evidence available. "Local community organisations" has been added to the 3rd bullet of 4.2.1.
Royal Society for Public Health (RSPH)		4.3	One of the key questions is more then just sustainability but about how programmes or projects can be effective in addressing obesity (long-term solutions required) when they are so frequently funded in such short-term funding regimes e.g. maximum of three years agreed funding.	Thank you for raising this issue.

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Slimming World		2 Background b)	Commercial slimming organisations generally adopt a family approach to supporting individual's weight management and thus should also be included as part of the 'local systems' approach to preventing obesity. (ref; Pallister, C. et al 2009 'Influence of Slimming World's lifestyle programme on diet, activity behaviour and health of participants and their families' JHND 24(4) pp 351- 358)	Noted.
Slimming World		2 Background a)	There needs to be some consideration as to what is meant by 'maintaining a healthy weight and preventing obesity'. A 'healthy weight' is very individual and may not be in the desirable BMI range of 18.5 – 24.9. Does there need to be some mention of preventing weight regain as this is an important component of preventing obesity which is often overlooked?	Thank you for this comment. The scope addresses population prevention in the broadest sense and, as such no BMI cut off has been set. That said, the BMI criteria as recommended in existing NICE guidance on the prevention and management of obesity (2006, CG43) will be used. Secondary prevention is not explicitly excluded from the scope as it stands and there is nothing to preclude the PDG considering issues around secondary prevention depending on the focus of their discussions and the evidence available. Clinical management is outside the remit of this scope and the guidance will not re-consider specific issues already covered by the existing NICE guidance on obesity.
Slimming World		2 Background d)	Related policy documents not included; 'Healthy Schools', Food 2030'. The latter is particularly relevant given the emerging relationship between the rising prevalence of obesity and global issues including food security/sustainability	Thank you for highlighting these documents. The list in 2d is not intended to be exhaustive and is space limited.

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Slimming World		4.1.1/2	Are people who have been discharged from/completed a clinical treatment for obesity going to be included? Prevention of weight regain may be considered an important component of preventing obesity.	Please see previous response re secondary prevention.
Slimming World		4.2.1	Again we would urge that commercial slimming organisations should be considered as part of the community based services which have an important role in preventing obesity. People currently involved in weight management can influence their whole family, particularly their children, in healthy lifestyle behaviours. There is the opportunity for current healthcare systems to work in partnership with the commercial slimming sector.	Noted. Community and commercial sectors are referenced in the scope.
Slimming World		4.2.2	We would suggest that 'discrete intervention in a particular location' could be quite valuable to include. For example a number of 'whole school' approaches to healthier behaviours are likely to have an impact on the wider family	Thank you for this comment. The focus of this guidance is the whole system. Individual locations such as schools or workplaces are included as part of the system. Existing NICE guidance shows what works in terms of discrete interventions in these locations. The focus of this guidance is how a range of interventions can be implemented simultaneously, what are the key elements of the system, what are the key partnerships etc (as key questions outlined in section 4.3 of the draft scope).
Slimming World		4.3	A general comment with reference to all of the questions is that there is a need to be reasonably clear as to what outcome measures will be used – it is currently quite difficult to see what outcome measures will be considered.	Thank you for this comment. A note has been added to this section that a broad range of outcomes will be considered.

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Slimming World		general	Please refer to the following links to further support the role of commercial slimming organisations in providing a robust, community-based, whole system approach to preventing obesity P:\W&HNow Spring10 2.pdf(2)	Thank you for providing this link.
Tailored Learning Resources Ltd (NutriSkill)		4.3 Q1	Among the key societal factors operating at local level is the ease of access by secondary school pupils, and society generally, to exciting looking unhealthy food in off-school-site surroundings, in which they feel comfortable with their friends, vs the difficulty accessing interesting healthy options along these lines and the general lack of public knowledge of how to balance a diet for good health.	Thank you for raising this issue.

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Tailored Learning Resources Ltd (NutriSkill)		Q3	• Businesses, using legislation and incentives such as tax breaks and reduced rates, should be encouraged to open only sites which offer healthy options at reasonable prices and the menus could include information to educate customers. • Planning applications for unhealthy food sites should be declined, particularly if they are in walking distance of schools. • Supermarkets etc should have to provide clear store mapping and nutrition information to help people shop – not one brand over another, but foods in categories according to benefits or food grouping. • Technology could be used on receipts to help customers gain knowledge of what they are buying, perhaps with suggestions for improvement etc. • National policy on school meals does not address Q1 above, as for many the desire to go off-site will remain more appealing than the school canteen, regardless how much effort is put into improving this experience. • Incentives could be offered to local businesses to open premises near secondary schools, with comfy seats and food that meets the nutritional standards. • GPs, schools, shops, churches and other community settings are well placed to supply healthy eating and healthy lifestyle information to the local people, and if the information is available everywhere in a locality, and coming from the people themselves rather than carrying any government branding, it may gradually push its way into people's lives.	Thank you for raising these issues.

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The British Dietetic Association		General	The BDA welcomes this guidance, as a positive step towards achieving the vision of reducing obesity through a systems approach, as described by Foresight.	Noted.
The British Dietetic Association		General	The focus of this guidance is broad, therefore it's target audience is broad. The BDA recommend that NICE collaborate with other stakeholders in developing this guidance, from the start, to ensure implementation is effective, and across the whole system.	Noted.
The British Dietetic Association		General	A whole systems approach to obesity is by its nature wide in scope. In terms of changing behaviours, interventions and/or policies that seek to enable individuals to adopt more healthful behaviours, associated with maintaining and reducing body weight, should also be considered, (such as becoming less sedentary, improving access to fruit and vegetables and so on). Potential differences in response between different population subgroups should also be investigated.	Noted.
The British Dietetic Association		General	This guidance (when published) should aim to encourage local and national bodies to develop strategies aimed at preventing obesity. However, we feel it is important that built in to these guidelines is an obligation for local authorities etc to seriously consider implementing the guidelines (perhaps a directive from government tied in with financial incentives?). We are concerned that unless this happens, the guidelines will be useful in theory but never implemented in practice.	Noted.

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The British Dietetic Association		2b	The system, as described here appears to comprise of at least 2 levels: the local system, and the national. This guidance focuses on the local system, but recognises the impact of the national system. Therefore 2 questions need to be considered, 1. What impact does national policy (or lack of policy) have on local systems? 2.. What local factors facilitate or inhibit the local system to function well? Both of these components must be addressed to understand the local system.	Thank you for raising this issue. The key questions have been amended to reflect your comments.
The British Dietetic Association		2b	This section should include the food industry (which includes food retailers). Food industries exist at a local level as well as national e.g. community food projects, local food producers, including public sector etc. Many food suppliers will make decisions at a national level that will impact locally.	Thank you; the wording of this section has been amended to include "food industry".
The British Dietetic Association		2b	We feel it is important that when the group considers the effectiveness of various local schemes and interventions that the sole outcome measure is not weight reduction (or obesity prevention) alone. We feel that any change toward a healthier lifestyle should be considered a positive end point. This may include increase in activity, reduction in consumption of high sugar, high fat foods etc	Thank you for this comment. For information, section 4.3 has been amended to include a note that a broad range of outcomes will be considered.
The British Dietetic Association		2b	This section should include the local education system, transport and business.	Thank you for this comment. These sectors are included in the list of elements in section 4.2.1.
The British Dietetic Association		2b	The scope should also consider media (and advertising) and the impact this has on food choice and public perception.	Thank you for this comment. These sectors are included in the list of elements in section 4.2.1.

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The British Dietetic Association		2	A new subsection should be added to highlight this guidance focuses on the linkages between policies. This concept is not immediately obvious from the guidance as it stands. However, it should also highlight that it may be useful to study individual interventions, carried out in isolation. This might help identify the difference that working across the system brings, and what value linking across the system brings.	Thank you for this comment. Section 4.2.1 lists the range of elements that may be considered and notes that how they interact may also be important.
The British Dietetic Association		2e	This guidance may also find evidence that will be useful for national policymakers. Therefore national and regional Government should be included in the target audience if this guidance is to be implemented effectively.	Thank you; policy makers have been added to 2e.
The British Dietetic Association		3g	As the scope states, no country has managed to reverse the rising obesity trend. Therefore the guidance will need to look beyond obesity policy, at other areas where systems have brought about change e.g. tobacco, climate change, road traffic accidents etc. The scope should state this.	Thank you for this comment. Section 4.3 has been amended to note that where evidence is lacking, reviews may look beyond obesity into other public health areas.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
The British Dietetic Association		4.1.1	Maintaining a healthy weight and preventing obesity requires both a primary and secondary prevention focus, i.e. should prevent people who are not overweight or obese becoming obese (primary prevention), but should also stop those that are overweight becoming obese, and those that have lost weight (irrespective of their current weight status) becoming, or increasing their overweight/ obesity. The guidance should include both primary and secondary prevention and the scope should make this explicit.	Thank you for this comment. The scope addresses population prevention in the broadest sense and, as such no BMI cut off has been set. Secondary prevention is not explicitly excluded from the scope as it stands and there is nothing to preclude the PDG considering issues around secondary prevention depending on the focus of their discussions and the evidence available. Clinical management is outside the remit of this scope and the guidance will not re-consider specific issues already covered by the existing NICE guidance on obesity.
The British Dietetic Association		Section 4.1.1	While the focus will be "everyone except those undergoing clinical treatment for obesity", the nutritional needs of specific groupings may warrant specific guidance e.g. children and older people. We consider that the document should take account of this.	As above. Furthermore, the needs of specific groups are to some extent covered by existing or forthcoming NICE guidance (such as forthcoming guidance on obesity in children and existing NICE guidance on maternal and child nutrition (2008)).
The British Dietetic Association		4.2.1	The scope states that the guidance will look how interventions will interact to 'minimise the risk of obesity and to bring about population-wide changes in behaviour'. Many different outcomes could be used to measure this risk of obesity and behaviour change, and the scope and choice of outcomes will strongly influence the evidence available. The BDA recommends that a wide range of outcomes are included and that these are as flexible as possible.	Thank you for this comment. Section 4.3 has been amended to include a note that a broad range of outcomes will be considered.

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The British Dietetic Association		4.2.1	NICE has stated that there will be a call for evidence for this guidance. However, stakeholders may need a significant amount of support to identify what evidence they have. The call for evidence needs to be very explicit, spelling out what a local system might include; a range of outcomes; and also what is meant by local evidence.	Thank you for raising this issue.

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The British Dietetic Association		4.2.1	National policy should be included as a bullet point. It's effect on local systems is important and should be stated here explicitly. In addition, changes at a national level that are unplanned but may affect behaviours (e.g. recession) should be considered.	Thank you for this comment. We have clarified the focus of the guidance in the draft scope. It was noted at the stakeholders meeting that NICE have had a post referral clarification meeting with DH . NICE received a strong steer to primarily focus on the impact of national policy on effectiveness of local action rather than focusing on national policy per se. There are already many good examples of guidance on obesity prevention at a national level and it is clear what the main policy levers are. However translating these into meaningful action down the delivery chain at local level has proved challenging. The purpose of the approach adopted in this guidance is to unlock capacity in the system at local delivery level to bring about change. The decisions relating to implementation and to delivery are made at the community and local level in the system and that is where guidance is needed. This guidance will support the decision makers at that level. The delivery chain is long. Our focus is on the point of delivery. The nuances of what exactly will and will not be covered are difficult to specify at this stage and are likely to depend on the evidence available and the direction of the PDG discussions. Depending on the evidence available, the PDG may wish to consider national policy action per se; the current scope does not preclude this.

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The British Dietetic Association		Section 4.3, question 5	We particularly welcome that the approach being taken takes account of the fact that not all people are highly motivated to change. Having a good infrastructure for obesity prevention in places people work and relax will assist societal obesity prevention.	Noted.
The British Dietetic Association		4.3 question 6	This should state that international literature, including grey literature will be included.	Thank you for this comment. Section 4.3 notes that a broad range of literature will be considered.
The British Nutrition Foundation		general	The British Nutrition Foundation shares the concern about the escalating problems associated with overweight and obesity in the UK. We welcome the planned public health guidance on preventing obesity.	Noted.
The British Nutrition Foundation		general	More clarification of what is meant by a 'system'. The scope explains that a 'whole-system' sustainable approach to obesity involves a broad set of integrated policies combined with population-wide and targeted measures. However it would be useful if the scope could also clarify what is meant by a system. The Foresight report defines a system as 'a structured set of objects and/or attributes together with the relationships between them'. The constitutive elements of a system are therefore (1) its elements; (2) the relationship between these elements; and (3) the system boundary that distinguishes between what does and does not belong to the set (Foresight, 2007).	Thank you for this comment. We have added some additional information to the updated draft scope. We are aware that the scope only includes a brief definition of whole systems approach. However, we assume that the definition of the approach will be a fundamental issue for the PDG and will be finalised over the course of the guidance development.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
The British Nutrition Foundation		1	The guidance title should include reference to both the primary prevention (prevention of healthy weight individuals becoming overweight or obese) and also the secondary prevention of obesity (preventing overweight or obese individuals gaining more weight), as both are equally important.	Thank you for this comment. The scope addresses population prevention in the broadest sense and, as such no BMI cut off has been set. Secondary prevention is not explicitly excluded from the scope as it stands and there is nothing to preclude the PDG considering issues around secondary prevention depending on the focus of their discussions and the evidence available. Clinical management is outside the remit of this scope and the guidance will not re-consider specific issues already covered by the existing NICE guidance on obesity.
The British Nutrition Foundation		1	Further clarification within the scope of what is meant by 'community level' in the title, as the size of communities can vary from communities at local levels to communities at a national level. If possible, it would be useful if the scope could cover all sizes of community.	Thank you for this comment. A more detailed definition of local and community is likely to emerge during the development of the guidance and may depend on the evidence available.
The British Nutrition Foundation		2b	The sentence "This includes action by central and local government, industry, communities, families and society as a whole" should also include "educators" as they play an important part in obesity prevention.	Thank you for this comment. Education is one of the elements listed in section 4.2.1.
The British Nutrition Foundation		general	The British Nutrition Foundation shares the concern about the escalating problems associated with overweight and obesity in the UK. We welcome the planned public health guidance on preventing obesity.	Noted.

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The British Nutrition Foundation		4.3	In **Question 1** the first question to fall under this should consider cultural factors along side societal factors and therefore should be - "What are the key *sociocultural*, environmental, organisational and *media* factors at the local level that can lead to obesity? Cultural differences are important to consider when preventing obesity. Some cultures consider overweight or obesity as acceptable, or even desirable, whereas other cultures have strong prejudice against overweight people, which may affect both children and adults. Also, not all cultures support physical activity of children in the same way, especially for girls. (See WHO, 2007 "The challenges of obesity in the WHO European Region and the strategies for response" Copenhagen: WHO.	Thank you for highlighting this information.
The British Nutrition Foundation		4.3	In **Question 6** the scope states that a framework which is consistent with the whole-system approach will be used to consider action at the societal level (Kelly et al 2009). We would suggest that the ANGELO framework (Analysis grid for elements linked to obesity) may provide a useful framework for structuring the review of evidence. See: WHO 2007 "*The challenge of obesity in the WHO European Region and the strategies for response*" Copenhagen: WHO, p218-9.	Thank you for providing this information.
The British Nutrition Foundation		4.3	In **Question 6** an additional question that could be addressed here is "what can be learnt from an effective whole-system approach aimed at other public health issues such as smoking or binge drinking?"	Thank you for this comment. Section 4.3 has been amended to highlight that where evidence on obesity is lacking other public health areas, such as smoking or alcohol may be considered.
The Royal College of Nursing		General	The Royal College of Nursing welcomes proposals to develop this guidance. It is timely. The scoping document is comprehensive.	Noted.

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The Royal College of Nursing		4.3	Question 1 Access to affordable options is very important. One needs to avoid the trap of a middle class approach which does not impact on the lower income families. One would also need to consider peer pressure on children, which makes healthy eating choices difficult.	Thank you for raising this issue.
The Royal College of Nursing		4.3	Question 2 There needs to be ease of access to ring fenced funding. We need to consider the professional skill mix to facilitate and cascade activities and competence to families and communities.	Thank you for raising this issue.
The Royal College of Nursing		4.3	Question 3 Nurses, especially School Nurses and Health Visitors along with Midwives have a key role to play here. Also, working with community dieticians and "food workers" is key to the effective implementation of this guidance.	Thank you for raising this issue.
The Royal College of Nursing		4.3	Question 4 There is no quick fix as "buy in" and societal and cultural change is inter-generational, therefore sustainability of approach is important.	Thank you for raising this issue.
The Royal College of Nursing		4.3	Question 5 Integrated approaches, pricing policies, ease of access to healthy choices, acceptability of healthy choices and likability are all essential elements to take into consideration in preventing obesity.	Thank you for raising this issue.

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The Royal College of Nursing		General	Finally, more use of social marketing where healthy choices are seen, as "sexy" not "nerdy" is essential. We consider that the move for the exception to the normal when making healthy choices is key.	Thank you for raising this issue.
The British Psychological Society		3a	Whilst the measurement issue of obesity in comparison to other countries is acknowledged, I wonder if NICE have considered looking at more accurate measures of obesity than the BMI? For example, at the University of Kent in Medway research has been proposed in order to examine prevalence of obesity using air displacement technology, which will offer more accurate measures of obesity, which will lead to more accurate interventions, which will cut funding.	Thank you for raising this issue. The measurement of body fatness and obesity is considered by existing NICE guidance on the prevention and management of obesity (2006, CG43).
The British Psychological Society		3e and General	The Foresight (2007) report raised some important issues, including those mentioned in this section. However, the Draft Scope omits to mention psychological aspects of diet and exercise as part of the complexities of the determinants of obesity and this is an important omission. Factors should include individual psychological difference and inter-generational family and patterns.	Thank you for raising this issue. A reference to psychological issues has been added to section 3e of the draft scope.
The British Psychological Society		3g	This section suggests a whole-system approach is critical but does not mention within that approach the role of psychological support. It is important to highlight that psychologists from several domains can offer support in the area of obesity. For example, Sport and Exercise Psychologists can advise on behavioural change, particularly with regard to increasing exercise and physical activity; Counselling Psychologists can assist in better understanding eating patterns; Educational Psychologists can assist in children's knowledge of healthy lifestyles.	The scope as it stands does not preclude the consideration of psychological support. However, some of the issues you mention refer to an individual rather than population approach, which fall under the remit of existing NICE guidance on the prevention and management of obesity (2006, CG43).

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The British Psychological Society		Question 2.	NICE/Government would be well advised to look at the adolescent health choice literature which highlights the aversion of young people, especially, to 'top-down' governmental directives on lifestyle. Perhaps there should be a question relating to how this can be managed/mediated?	Thank you for raising this issue.
The British Psychological Society		Appendix B	The third bullet point highlights the need to consider which institutions and individuals are key players in a whole systems approach, which illustrates the importance of including psychological support.	Thank you for raising this issue.
The British Psychological Society		General	The British Psychological Society's Obesity Working Group is developing a Professional Position Paper for practicing psychologists working as key players within teams tackling obesity issues in PCTs. This paper is due for dissemination this year (Summer 2010). The Working Group would be pleased to share its developments with interested parties.	Thank you for highlighting this work.
The British Psychological Society		General	The whole document seems to reiterate the dichotomy of individual level issues and organisation, societal level issues. We think this is not helpful and that in seeking to improve the whole system, repeated patterns across large groups of individual data are necessary, i.e. repeated case study material is likely to provide indicators of useful strategies/arrangements, which can be rolled out nationally and/or in local contexts.	Thank you for raising this issue.
The British Psychological Society		General	There should be a reference to community psychology, i.e. the need for theorised and skilled practitioner input from this field.	Thank you for raising this issue.
The Royal College of Midwives		General	The Royal College of Midwives welcomes the opportunity to comment on the scope of this very important guideline.	Noted.

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The Royal College of Midwives		General	We are pleased to see that the scope going into such depth about the problem. It will be a big piece of work, but very necessary	Noted.
The Royal College of Midwives		3 b	We found it helpful to look at the evidence already discussed as in the link to ethnicity and geographical areas, and the recognition that the determinants of obesity are complex.	Noted.
The Royal College of Midwives		4	We are pleased to see the activities targeted at population-wide changes – with the focus on locally implemented strategies	Noted.
The Royal College of Midwives		4.2.2	We were disappointed to see that complementary therapies were not to be covered - as these have a significant attraction for a large proportion of the population.	Noted.
The Royal College of Midwives		4.3	We were pleased to see the very broad range of literature that is going to be considered.	Noted.

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The Royal College of Physicians		General	The Royal College of Physicians is grateful for the opportunity to comment on this draft scope. We welcome the intent of NICE to take a broad view of what is meant by 'evidence' in this non-clinical context, and the recognition of a 'whole system' approach. We suggest that other stakeholders could include non-health related groups that nevertheless have a role to play in delivering public health in this case such as architects, planners, teachers and other professionals. The Programme Development Group will need to bring order to a very diverse body of evidence. We would recommend that they follow well recognised scientific protocol and start with a broad conceptual approach or 'hypothesis' that can then be tested against the evidence that emerges from the reviews. The Foresight map, or the WCRF report (WCRF/AICR. *Policy and Action for Cancer Prevention. Food, Nutrition, and Physical Activity: a Global Perspective*. Washington DC: AICR, 2009) both provide versions of this.	Noted. Thank you for this comment. NICE have contacted a diverse range of stakeholders about his work and you will see from the NICE website that a range are already registered (see http://guidance.nice.org.uk/PHG/Wave20/53). Thank you for suggesting this approach.

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The Royal College of Physicians		4.3	**Question 1:** What are the key societal, environmental and organisational factors operating at the local level that can lead to obesity? How do these factors interact with each other? Do they reflect social integration and connection with local or broader community and cultural institutions? Preventing obesity: a whole-system approach draft scope for consultation 15 January to 12 February 2010 The 2009 report from the World Cancer Research Fund *Policy and Action for Cancer Prevention* (WCRF/AICR. *Policy and Action for Cancer Prevention. Food, Nutrition, and Physical Activity: a Global Perspective*. Washington DC: AICR, 2009) performed a systematic review of cancer prevention policy and action which included prevention of obesity. This could be a useful resource.	Thank you for providing this information.

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The Royal College of Physicians		4.3	**Question 2**: How does national policy impact on the effectiveness, cost effectiveness and sustainability of local action to prevent or manage obesity? Are there any unintentional consequences? In addressing this, the College welcomes NICE's whole system approach. However the narrow remit relating to national impact and the exclusive focus on local actions is inherently at odds with this approach, as higher level factors such as national legislation are an integral part of the whole system. The College urges NICE to take a broad view of interpreting the impact of national level factors both in terms of the impact of existing legislation or guidance, as well as the impact of the absence of such factors.	Thank you for this comment. We have clarified the focus of the guidance in the draft scope. It was noted at the stakeholders meeting that NICE have had a post referral clarification meeting with DH . NICE received a strong steer to primarily focus on the impact of national policy on effectiveness of local action rather than focusing on national policy per se. There are already many good examples of guidance on obesity prevention at a national level and it is clear what the main policy levers are. However translating these into meaningful action down the delivery chain at local level has proved challenging. The purpose of the approach adopted in this guidance is to unlock capacity in the system at local delivery level to bring about change. The decisions relating to implementation and to delivery are made at the community and local level in the system and that is where guidance is needed. This guidance will support the decision makers at that level. The delivery chain is long. Our focus is on the point of delivery. The nuances of what exactly will and will not be covered are difficult to specify at this stage and are likely to depend on the evidence available and the direction of the PDG discussions. Depending on the evidence available, the PDG may wish to consider national policy action per se; the current scope does not preclude this.

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The Royal College of Physicians		4.3	**Question 3:** What 'packages' of actions and strategies may be effective and cost effective in bringing about population-wide improvements in weight management within a given community? How does effectiveness vary between different communities or population groups? In terms of the whole system approach, a major problem is the general one of identifying factors that make systems work coherently as opposed to what works for disparate individual factors. This general issue may be informed by research which is not aimed at obesity prevention but may involve quite different outcomes (e.g. smoking or even non health related outcomes). NICE should ensure that the evidence reviews are not limited by a narrow view of what evidence might inform this aspect.	Thank you for this comment. Section 4.3 has been amended to note that where evidence on obesity is limited, evidence from other public health areas such as smoking or alcohol, may be considered.

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The Royal College of Physicians		4.3	**Question 4**: What barriers and facilitators may influence the effectiveness of these 'packages' of actions and strategies among a given community? (This should include any barriers and facilitators for specific groups). In addition to identifying barriers to specific outcomes e.g. weight maintenance, the evidence reviews should focus on the broader issue of the barriers to engendering coherent systems – such as divergent objectives between different players. For instance, while local authorities, education authorities and health authorities might agree that obesity prevention is a good thing, their short and medium term objectives may diverge considerably. This may depend considerably on the national context and leadership (see question 2. above)	Thank you for raising this issue.
The Royal College of Physicians		4.3	**Question 5:** What are the essential elements of a robust, community-based, whole-system approach to preventing obesity? Who are the essential partners (formal and informal)? How does such an approach avoid being dependent on highly motivated individuals? Again the national context is an inherent player in the overall functioning of local systems and should be included broadly. It should be considered in the interpretation of the effectiveness or otherwise of individual actions that have been taken in specific local settings e.g. schools or workplaces. This means that the exclusion of these from the scope as currently proposed should be reviewed.	See previous response re national policy.

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The Royal College of Physicians		4.3	**Question 6:** How can political, social, economic and environmental factors be tackled simultaneously as part of a whole-system approach to preventing obesity? What factors need to be considered to ensure the programme is robust and sustainable (for example, is public opinion important, is the sequence, phasing and timing of actions and strategies important)? As with the WCRF Report (see 1. above), it is important to evaluate the actions reviewed or recommended in terms of various factors such as the political or general feasibility or the transferability. Without consideration of the role of national leadership, whether political or professional, any assessment of the impact of local actions will be incomplete and potentially misleading. The key issue is to identify critical factors for effective functioning of the whole system, and for creating synergy between different players.	Thank you for raising this issue.
The Swimming Teachers Association		General	As an Organisation we can assist through our Swimming and Aquacise programmes in the prevention of obesity. Along with this we can offer anti-natal and post-natal programmes. By introducing exercise in the water this helps with the weight control, is non-weight bearing on joints, improves flexibility, co- ordination, stamina, confidence and an overall improvement in sense of well-being.	Noted

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UK Public Health Association		General	The UK Public Health Association (UKPHA) is an independent voluntary organisation that brings together individuals and organisations from all sectors, who share a common commitment to promoting people's health and wellbeing. The work of the organisation focuses particularly on three key priorities: eliminating health inequalities, combating anti-health forces and promoting sustainable development.	Noted
UK Public Health Association		General	The topic of this consultation and its approach is welcomed by the UKPHA because it is one of the Association's aims to promote people's health and wellbeing through primary prevention and promotion of healthy environments. The UKPHA has consulted all of its Special Interest Groups (SIGs) and the Food SIG collated the comments and co-ordinated the response. The comments below therefore represent the balance of opinion of the responses received.	Noted

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
UK Public Health Association		General	The UKPHA welcomes the approach taken by NICE with regard to this consultation. However, the UKPHA questions the necessity of another consultation on obesity prevention. The need for 'a whole system approach' has already been discussed and recognised in previous documents and the need for guidance is not very robust, especially following the Foresight Report (2007) and all the stream of work since then. The UKPHA queries why the Foresight report was not used as a platform to initiate some action. Collecting an evidence-base is a dynamic process and should be ongoing rather than being a barrier to implement action plans.	Thank you for these comments. This work aims to take forward the issues raised by Foresight. Our rationale in relation to the Foresight work is best summarised by section 3g in the draft scope: "The Foresight report (2007) argued that policies and small-scale interventions aimed at individuals are inadequate and that a whole-system approach is critical. However, it remains unclear how a broad range of partners can best develop and implement consistent, cost-effective, community-wide approaches to tackling the determinants of obesity. Such programmes are notoriously difficult to evaluate and do not lend themselves to traditional research designs. Foresight (2007) noted that the evidence base will need to develop in tandem with novel interventions which are informed by the available evidence and strengthened by expert advice." The consultation process is a standard part of NICE methods allowing stakeholders an opportunity to feed into the guidance development process.
UK Public Health Association		General	NICE claims that the novelty of this consultation is about how different sectors can 'work in partnership' at local level and how they can communicate with each other (Stakeholder meeting, London 27th January, 2010). It is surprising therefore, that there is no mention in the entire document of the existence of Local Area Agreements, which have been in place now for some years.	Thank you for raising this issue.

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UK Public Health Association		General	Whilst it is recognised that obesity is a major health problem in the UK (as it is in many other parts of the world), focussing on this condition alone is a narrowing approach that could divert the attention from the broader problem. There is evidence that obesity is linked to social and economic inequalities, but the same can be said about many other chronic diseases, some of which linked to obesity itself (e.g. some cancers and heart disease). This fragmented approach leading to different consultations for different conditions is not very effective. It would be much more effective to improve the wellbeing of the population through primary prevention actions that cover the whole health spectrum.	Thank you for these comments. The scope for this work is intended to ensure that the work is manageable in the time and resources available. NICE develops guidance on a broad spectrum of public health issues and aims to ensure that the work of different pieces of guidance are complementary. For more information on the work of the CPHE at NICE see http://guidance.nice.org.uk/PHG/InDevelopment).
UK Public Health Association		General	In the consultation there is no clear definition of the workforce involved with the delivery of the proposed recommendations	Thank you for raising this issue.
UK Public Health Association		General	The UKPHA believes that we should utilise our experience and evidence-base regulatory policies on alcohol and smoking when dealing with obesity.	Thank you for this comment. Section 4.3 of the draft scope has been amended to note that where the evidence on obesity is limited evidence from other public health areas, such as smoking or alcohol, may be considered.

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UK Public Health Association		General	The UKPHA believes that, as part of a whole system approach, GPs should be trained and motivated to address obesity prevention. Obesity will not become a priority for GPs and practice managers unless it receives equal QOF points like diabetes and other chronic diseases.	Thank you for raising this issue. For information, NICE now has responsibility for QOF. At the QOF June 2009 meeting it was agreed that obesity and QOF would be reviewed given a suitable stakeholder submission on weight management. Submissions were received in Autumn 2009 and these are currently being reviewed. For more information about QOF see http://www.nice.org.uk/aboutnice/qof/qof.jsp
UK Public Health Association		General	At the stakeholder meeting it was surprising to see no representation from the transport sector in the consultation panel, when there is evidence for a link between sedentary life, increase dependence on motorized transport and rates of obesity.	Thank you for raising this issue. A broad range of stakeholders have registered for this work but not all were able to attend this SH meeting. An individual with expertise in transport may be invited to be a member or co-opted member of the PDG.
UK Public Health Association		General	As well as having regulatory policies, it is necessary to forge working partnerships between stakeholders from different sectors, including commercial organizations, supermarkets, food industries, alcohol and tobacco industries. For example, integrated advice and policies are necessary when people stop smoking or give up alcohol and have a higher risk of overweight/obesity by becoming dependent on comfort foods.	Thank you for raising this issue.

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UK Public Health Association		General	The focus of the consultation appears to be mainly on children. However, research clearly links obesity to familial behaviours. There is evidence that children have a strong influence on their own diet in many households- the emphasis therefore needs to be on the whole family rather than the child alone. A 'whole system' approach means accepting the impact and potential influence of the family as a system in its own right, certainly in terms of lifestyles.	Thank you for raising this issue. The population approach being taken will focus on both children and adults.
UK Public Health Association		General	Research indicates that all our efforts to reduce obesity at present are misplaced. By the age of 5, obesity has already 'set in'. There should be more focus on early years and make sure that children "stay on track" i.e. continue on the centile track that they were born to. We should have more broad based approaches to tackle childhood obesity, which in turn could reduce the rates of obesity in adults as well.	Thank you for raising this issue.
UK Public Health Association		General	The consultation does not seem to include any mention of 'culture' and the role it plays in obesity. Research suggests that public health nutrition professionals should develop interventions and policies that take into account the different cultural contexts of the current obesity epidemic. Stereotypes and strong cultural influences on people's food choice may contribute to the obesity epidemic.	Thank you for raising this issue. A reference to culture has been added to section 3e of the draft scope.

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UK Public Health Association		2 (b) page 2	Both national and local policies have an impact on obesity. Although at local level retailers can have an impact on many communities, national policies are essential to define issues such as food labeling or reduction of salt and fat contents. The UKPHA is therefore concerned that the food industry has received little or no mention in the consultation.	Thank you for raising this issue. Section 2b of the draft scope has been amended to include the food industry. We have clarified the focus of the guidance in the draft scope. It was noted at the stakeholders meeting that NICE have had a post referral clarification meeting with DH . NICE received a strong steer to primarily focus on the impact of national policy on effectiveness of local action rather than focusing on national policy per se. There are already many good examples of guidance on obesity prevention at a national level and it is clear what the main policy levers are. However translating these into meaningful action down the delivery chain at local level has proved challenging. The purpose of the approach adopted in this guidance is to unlock capacity in the system at local delivery level to bring about change. The decisions relating to implementation and to delivery are made at the community and local level in the system and that is where guidance is needed. This guidance will support the decision makers at that level. The delivery chain is long. Our focus is on the point of delivery. The nuances of what exactly will and will not be covered are difficult to specify at this stage and are likely to depend on the evidence available and the direction of the PDG discussions. Depending on the evidence available, the PDG may wish to consider national policy action per se; the current scope does not preclude this.

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UK Public Health Association		2(c) on page 3	Recent guidance on CVD and the guidance planned for early type 2 diabetes and the existing NSF frameworks should have been linked to the current consultation, rather than been just mentioned.	Noted.
UK Public Health Association		2(e) on page 3	There is a need to include Healthy Child and Healthy Schools Programmes and education in 21st century under the supporting guidance documents.	Thank you for highlighting these documents. The list in 2e is not intended to be exhaustive.
UK Public Health Association		2(f) on page 4	Section 6 refers to a list of published or yet to be published literature. There needs to be more clarity, however, on how this community engagement is planned.	Thank you for raising this issue.
UK Public Health Association		3(a) page 4	There are still some unresolved problems concerning the measurement and classification of obesity. NCMP [National Child Measurement Programme] measurements should become more standardised, and a decision should be made whether to use UK90, the IOTF classification or the new centile charts adopted for the UK by the Royal College of Paediatrics and Child Health. This is particularly important in view of the fact that the UK population has become more diverse over the years. Ethnicity has been recognized as an important factor in BMI measurements of adults and children and this factor will be incorporated by the South Asian Health Foundation in the guidance for Asians. The UKPHA believes that agreement is urgently needed for all stakeholders to be able to address the issue. Without the correct parameters, obesity rate estimates will be unreliable, thus affecting the whole preventative exercise.	Thank you for raising this issue. However, issues around the identification and measurement of obesity fall under the remit of existing NICE guidance on the prevention and management of obesity (2006, CG43), the recommendations of which still stand.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
UK Public Health Association		3(b) page 4	There is now evidence that obesity is linked to social disadvantage, especially as far as children are concerned. It should now be recognized by social services on the same level as severe undernutrition as a sign of parental neglect. PCTs are currently making considerable financial investments on "failure to thrive" babies, but next to nothing on babies that go "off track" in the obesity direction.	Thank you for raising this issue.
UK Public Health Association		3(f) page 5	This is an important area to focus on for the NICE panel as well as the policy makers at national level. For example an unintended regulation on the on salt content in food could increase the fat content instead or vice versa, which could have an important impact on obesity. In the same way the policy or lack of policy on transport, leisure/sport/recreation will have a major impact on obesity. The Foresight Report has presented sufficient evidence to suggest that all these wider determinants have a major role to play, so rather than call them unintentional, they should all be linked together.	Thank you for raising this issue.
UK Public Health Association		3(g) para 1 page 5	Childhood obesity [NI55 and NI56] is usually a Local Area Agreement target and comes under LAA streams of work with no consistent funding and no credibility. The prevention of childhood obesity should be led by the heads of children's services and be part of Local Strategic Partnership stream of work. At the same time it should be an integral part of local policy initiatives such as healthy town planning, involving transport, leisure, schools, fast food outlets and green spaces.	Thank you for raising this issue. Local Area Agreements have been added as an example to the elements listed in section 4.2.1

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UK Public Health Association		3 (g) page 5	At the stakeholder meeting (London, January 27th, 2010) NICE stressed that all recommendations will be evidence based. This approach could slow down the process, considering that there is still a debate on how to evaluate the effectiveness of all the strategies implemented so far, an issue also recognised here by NICE itself.	Thank you for this comment. Section 4.3 of the draft scope highlights that a broad range of literature will be considered to address the key questions.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
UK Public Health Association		4.2.1 page 6	More clarity is required to define what is meant by national policy, for example some of the fiscal and regulatory changes should be listed and explained more extensively. There are instances of population wide approaches on taxing trans fats, salt and unhealthy foods, but rarely it is linked to subsidies on fruits and vegetables. Examples come from Finland, Sweden, some parts of the USA and very recently from Romania. Fiscal policies should be applied also to alcohol, an important source of excess calories that too often is not recognized in the obesity debate. The consultation should also be more explicit on what is meant by "local efforts"	Thank you for this comment. We have clarified the focus of the guidance in the draft scope. It was noted at the stakeholders meeting that NICE have had a post referral clarification meeting with DH . NICE received a strong steer to primarily focus on the impact of national policy on effectiveness of local action rather than focusing on national policy per se. There are already many good examples of guidance on obesity prevention at a national level and it is clear what the main policy levers are. However translating these into meaningful action down the delivery chain at local level has proved challenging. The purpose of the approach adopted in this guidance is to unlock capacity in the system at local delivery level to bring about change. The decisions relating to implementation and to delivery are made at the community and local level in the system and that is where guidance is needed. This guidance will support the decision makers at that level. The delivery chain is long. Our focus is on the point of delivery. The nuances of what exactly will and will not be covered are difficult to specify at this stage and are likely to depend on the evidence available and the direction of the PDG discussions. Depending on the evidence available, the PDG may wish to consider national policy action per se; the current scope does not preclude this.

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UK Public Health Association		4.2.2 page 7	If the recommendations resulting from this consultation have to be based on a 'whole system' approach, the UKPHA is questioning the exclusion of schools and workplace. Although it is stressed that these locations are covered by an existing NICE guidance, they are an integral and crucial component of the 'whole system' and cannot and should not be treated as a separate issue. PSHE and citizenship lessons, matched by good practice can play a very important role.	Thank you for this comment. The focus of this guidance is the whole system. Individual locations such as schools or workplaces are included as part of the system. Existing NICE guidance shows what works in terms of discrete interventions in these locations. The focus of this guidance is how a range of interventions can be implemented simultaneously, what are the key elements of the system, what are the key partnerships etc (as key questions outlined in section 4.3 of the draft scope).
UK Public Health Association		Appendix B page 14 last point	It is not very clear what is meant by 'adverse effects'. Surely sound, integrated policies and recommendations can only have positive effects?	Thank you for this comment. Evidence / information for potential barriers or adverse effects will come from existing experience / action.
Unite the Union			Unite/CPHVA strongly supports a whole system approach to tackling obesity.	Noted.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Unite the Union		4.1.1 ands 4.1.2	We do not see the need for those who have sought help for obesity to be excluded from the scope; after all they live and work in the real world and are also exposed to the 'obesogenic environment'. Clinical treatment for obesity is of a temporary nature; they will spend most of their lives *not* undergoing treatment.	Thank you for this comment. The scope addresses population prevention in the broadest sense and, as such no BMI cut off has been set. Secondary prevention is not explicitly excluded from the scope as it stands and there is nothing to preclude the PDG considering issues around secondary prevention depending on the focus of their discussions and the evidence available. Clinical management is outside the remit of this scope and the guidance will not re-consider specific issues already covered by the existing NICE guidance on obesity.
Unite the Union		4.2.1	Would the guidance cover stigmatisation of larger than average people? The danger is that groups of thin people tell groups of fat people what to do, and inevitably those fat people will 'turn off'. In USA they have a saying; 'we're fat; that's that'.	Thank you for this comment. Stigmatisation of groups may be included within the whole system approach, depending on the evidence available
Unite the Union		4.3	One approach which does not seem to be under consideration is 'what are the views of fat people?' Very little research into the opinions (and possible solutions) to the problem of overweight and obese teenagers, young adults, middle-aged and older adult's views has been undertaken, but we urge NICE to find it.	Thank you for raising this issue.

Stakeholder Organisation	Evidence submitted	Section	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Very Low Calorie Diet (VLCD) Industry Group		General	Could NICE please clarify if secondary prevention will be included and what exactly is understood under secondary prevention? This was something which was not clear in the draft scope, but was mentioned at the stakeholder meeting. Does secondary prevention include management of obese people to prevent them moving through the different levels of obesity, or is it only the prevention of overweight people becoming bigger?	Thank you for this comment. The scope addresses population prevention in the broadest sense and, as such no BMI cut off has been set. Secondary prevention is not explicitly excluded from the scope as it stands and there is nothing to preclude the PDG considering issues around secondary prevention depending on the focus of their discussions and the evidence available. Clinical management is outside the remit of this scope and the guidance will not re-consider specific issues already covered by the existing NICE guidance on obesity.
Very Low Calorie Diet (VLCD) Industry Group		General	VAT is currently payable on certain (safe and effective) obesity interventions for the overweight and obese in weight management groups. This make such programmes more expensive, and so acts as a disincentive to people looking to lose weight. Perhaps NICE could consider making recommendations to Ministers in this area.	Thank you for raising this issue.
Very Low Calorie Diet (VLCD) Industry Group		General	NICE guidance 43 *Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children* recommends that people should only aim to lose 5-10% of body weight. For some people with very large amounts of weight to lose, such as the morbidly obese, this is not enough to make sure they achieve a good level of health and fitness. Furthermore, this recommendation is in place despite the fact that interventions do exist which enable people who need to lose a larger amount of weight to do so safely. Such programmes can also have other benefits, such as helping to maintain weight loss in the longer term	Thank you for this comment. This issue is outside the remit of this scope.

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Very Low Calorie Diet (VLCD) Industry Group		4.2.1	Better use could be made of the QOF in providing incentives for GPs to help obese patients achieve a healthy weight, for example if GPs were able to gain points for offering advice to obese patients on how to lose weight, or on preventing overweight patients from putting on further weight and becoming obese, rather than just making a register of obese patients.	Thank you for raising this issue. For information, NICE now has responsibility for QOF. At the QOF June 2009 meeting it was agreed that obesity and QOF would be reviewed given a suitable stakeholder submission on weight management. Submissions were received in Autumn 2009 and these are currently being reviewed. For more information about QOF see http://www.nice.org.uk/aboutnice/qof/qof.jsp
Very Low Calorie Diet (VLCD) Industry Group		4.2.2	Will interventions already considered as an option in NICE guidance 43 Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children, such as very low calorie diets, not be considered as part of this piece of guidance?	Thank you for this comment. This guidance will complement the existing NICE guidance on the prevention and management of obesity (2006, CG43); it will not repeat the work.
World Cancer Research Fund		2 (b)	Suggest making importance of working with third sector explicit in partnership approach as well as the importance of many actor groups working together towards a common perspective, as outlined in *Policy and Action for Cancer Prevention'* World Cancer Research Fund (2009)	Thank you for this comment. "Local community organisations" has been added to the third bullet of section 4.2.1 of the draft scope.
World Cancer Research Fund		2 (b)	Suggest attention should also focus on ensuring individuals have control over their lives so they can choose healthy living behaviours as highlighted in the World Cancer Research Fund's *Nutrition, Physical Activity and the Prevention of Cancer: A Global Perspective (2007) and 'Policy and Action for Cancer Prevention (2009);* and policy objectives in the *Fair Society, Healthy Lives* Marmot Review (2010)	Thank you for raising this issue. The Marmot review has been added to section 2d of the draft scope.

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World Cancer Research Fund		2 (b)	Suggest importance of involving local communities in order to execute policies is made explicit, as highlighted in Marmot Review (2010)	Thank you for raising this issue. "Local community organisations" has been added to the third bullet of section 4.2.1 of the draft scope.
World Cancer Research Fund		3 (c)	Recent UK specific estimates for percentages of oesophageal, pancreatic, gallbladder, colorectal, breast, endometrial and kidney cancer that are attributable to excess body fat are available in *'Policy and Action for Cancer Prevention (2009);*	Thank you for providing this information.
World Cancer Research Fund		3 (d)	Suggest guidance will also support Marmot Review (2010)	Thank you for highlighting this report. The Marmot review has been added to section 2d of the draft scope.
World Cancer Research Fund		4.2.1	'Following elements – and how they interact – may be considered:' – suggest strategies to promote early years development and family/community involvement in education should be included as recommended in Marmot Review (2010)	Thank you for raising this issue.