Public Health Guidance

Overweight and obese children and young people - lifestyle weight management services - Consultation on the Draft Guidance from 19 April 2013 - 18 June 2013

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African Health Policy Network	General		African children and young people face the highest obesity risks of all ethnic groups. Targeted information and support to this group (compared with more general resources) can disproportionately reduce the problem. Strategies to manage overweight and obesity should take BME and African people into account predominantly.	Thank you for your comments on the draft guidance. In the final guidance, Recommendation 2 highlights the need to commission lifestyle weight management services which meet the needs of local children and young people according to various factors, including different cultural backgrounds. It also recommends that any groups at particular risk that should be particularly targeted, are specified in contracts and includes children and young people from black and minority ethnic groups as an example. Recommendation 3 lists cultural background and ethnicity among the factors to be taken into account when tailoring programmes for individuals.

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African Health Policy Network	General		African children and young people as a whole fail to meet Dept of Health exercise requirements; participation in exercise is 21% below the national average. Priority should be given to helping these young people in particular overcome barriers and engage in healthy activity.	This particular guidance focuses specifically on lifestyle weight management services. However NICE guidance PH17 Promoting physical activity for children and young people. makes recommendations regarding the promotion of physical activity to children and young people and in the final guidance we cross refer to those recommendations.
African Health Policy Network	1 (recommendation 4)	11	Agree dietary changes with community/ethnic group's attitudes toward food to ensure that the advice and support being given is acceptable and culturally competent	Recommendation 4 recognises the importance of agreeing dietary changes with children, young people and their families, that are culturally acceptable. In the final guidance, recommendation 2 includes the use of community engagement techniques with families to ensure any barriers or facilitators to engagement and

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				completion of programmes are identified. Recommendations 11 and 12 highlight the importance of ensuring that programme staff and health professionals referring participants to programmes, are aware of the issues they may need to consider to ensure activities are culturally acceptable.
African Health Policy Network	1 (recommendation 4)	11	Explore food options in the local area for tailored guidance	Please see above
African Health Policy Network	1 (recommendation 4)	11	Explore opportunities for physical activity in the local area for tailored guidance, considering barriers to uptake of activity and how best to overcome social obstacles	In the final guidance, signposting to local services and activities that can help support children and young people in managing their weight, is covered by recommendation 10 .
African Health Policy Network	1 (recommendation 4)	11	Explore family/community attitudes towards weight and body image (is obesity seen as a sign of wealth and success?) to give information and advice that will be most acceptable	Noted, thank you. In the final guidance, please see recommendation 4 which includes exploration of the family's attitudes towards food, physical activity

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				and whether or not they recognise that their child is overweight and the benefits of managing their weight. Recommendations 11 and 13 also highlight the importance of ensuring that programme staff and health professional referring participants to programmes , are aware of the way in which obesity is viewed by different communities.
African Health Policy Network	1 (recommendation 12)	19	Train staff in culturally competent communication, understanding the way some communities view weight/obesity, so that they can connect with targeted people	Please see above.
African Health Policy Network	1 (recommendation 13)	19-20	Ensure staff are aware of which children are most at risk, given demographic/geographic information, and how to best prepare for their needs	Recommendation 4 focuses on tailoring programmes appropriately and Recommendation 11 includes training in using a locally approved co-morbidities assessment tool.
African Health Policy Network	2	24	Add information about who is most at risk for childhood obesity—risks are higher in Black Africans than any other demographic	Please see paragraph 2 in the section on public health need and practice.
African Health Policy Network	3	26	Include evidence of higher baseline risk in certain (BME) people	Please see

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				Consideration 3.15. The PDG were aware that there is evidence that adults from black and minority ethnic groups are at risk of obesity associated co-morbidities at a lower BMI than the white European population, however it was beyond the remit of this guidance to assess if the same applies to children and young people.
African Health Policy Network	4	37	Include studies of who is most at risk and why	As this guidance focuses specifically on research recommendations for lifestyle weight management services, this is beyond the remit. However the recommendations in the recently published NICE guidance PH46 Assessing body mass index and waist circumference thresholds for black, Asian and other minority ethnic groups may be of interest.

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African Health Policy Network	4	37	Stratify data by ethnicity to enable targeted understanding and interventions	Please see above.
African Health Policy Network	4	39	Study barriers and angles for reaching people from BME communities, particularly what is the best way to design services so these groups can be impacted	Please see the first bullet point of Research Recommendation 3 in the final guidance
Association for Improvements in the Maternity Services (AIMS)	General: ethnicity		There is surprisingly little about tailoring services to needs of different ethnic groups – presumably because again, there is little on this subject in the papers located in the reviews. This is important in view of the higher rate of problems in Asian, black and mixed community children, which may be the largest group in particular areas. (p. 22 Facilitators & Barriers) However, there is also one reference to ethnicity of professionals Involved, and since being treated by psychiatrists of similar ethnicity has shown benefits, we suggest this should be explored. The range of fruits, vegetables and other goods sold in shops serving ethnic communities in this country is different to that in supermarkets; it offers different opportunities and different risks, as do cultural patterns of eating. We therefore suggest that problems and solutions should be explored by communities from the bottom up, in conjunction with professionals of similar background where they are available. There is also the well-known problem of added health risks (eg breast cancer, obesity) in migrants from Asia and Africa to Western countries when they adopt a diet to which they are not adapted. This should be seen within a larger context that mere "child/family/behaviour solutions.	Thank you for your comments on the draft guidance. Various amendments have been made and in the final guidance: Recommendation 2 highlights the need to commission lifestyle weight management services which meet the needs of local children and young people according to various factors, including different cultural backgrounds. It also recommends that any groups at particular risk that should be particularly targeted, are specified in contracts

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				and includes children and young people from black and minority ethnic groups as an example. In addition, Recommendation 2 includes the use of community engagement techniques with families to ensure any barriers or facilitators to engagement and completion of programmes are identified . Recommendation 3 lists cultural background and ethnicity among the factors to be taken into account when tailoring programmes for individuals. Recommendation 4 recognises the importance of agreeing dietary changes with children, young people and their families that are culturally acceptable.

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				Recommendations 11 and 12 highlight the importance of ensuring that programme staff and health professionals referring participants to programmes, are aware of the issues they may need to consider to ensure activities are culturally acceptable.
Association for Improvements in the Maternity Services (AIMS)	General Social Influences		As the Facilitators and Barriers paper points out (p.41) the evidence quoted does not consider the issue "within the broader context of lifestyle and behaviour change". And it is this broader context of the society people live in that we hear about on the help-line every day, and try to link with relevant research. e.g. the connection between child obesity and mother's employment. Any maternal employment after a child's birth was associated with early childhood overweight, after adjustment for confounding factors, and weight increased as mother's hours of work rose. And this did not seem to be in the poorest families. The researchers concluded "long hours of maternal employment rather than lack of money may impede young children's access to health foods and physical exercise. *(1)* The difficulties here need to be acknowledged and possible solutions explored. *(1) S. S. Hawkins et al (2008) Maternal employment and early childhood overweight finding in the UK Millenium Cohort Study.* *Int. Journ. Obesity*	Noted , thank you. This guidance focuses specifically on lifestyle weight management services but does acknowledge some of the very practical issues that may impact on attendance . For example, Recommendation 5 refers to offering programmes at times convenient for working parents and notes the need for families to accommodate other commitments alongside attendance. NICE guidance PH 42

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				Obesity: working with local com munities takes a broader perspective and may be of interest.
Association for Improvements in the Maternity Services (AIMS)	General: low income groups		In all health advances (weight reduction, exercise, smoking avoidance) it is the more affluent, better educated, and healthier groups who adopt changes first. Unfortunately little was available in the evidence on very low income groups. We know that disrespectful and controlling treatment in the past contributes to their avoidance of health care *(1)*(. Also, transport problems, fear of social groups and going out of area may contribute to failure to participate in programmes. We would like to see work tailored to their needs, based on empowerment (which has been shown to work in Sure Start centres in improving parenting) rather than control and surveillance. Above all, use of child protection powers or threats to refer, or actual referral to social services, in families with obese children, as reported by our clients,and in the media, would be disastrous, and invariably causes avoidance of contact with services in future. Also nothing has been said about the rise of food insecurity and its effects - Most of the literature on this seems to be from the USA, despite the increase in food banks here. Yet food insecurity can have complex effects on obesity .e.g.*(2)* When families need the cheapest, filling foods, and "comfort" foods, there is little point in preaching more fruit and veg. *(1) K. Canvin (2007) Can I risk using public services? Perceived consequences of seeking help and health care among poor households. Journ Epidem Community Health* *(2) M.M.Martin & Adam Lippert(2012) Feeding her family but risking her health: the intersection of gender, household food insecurity and obesity. Soc. Sci. Med 74 (1754-1764)*	Noted, thank you. In the final guidance : Recommendation 2 notes the need to specify particularly at risk groups which may be being targeted, in programme specifications and contracts. Low income families and neighbourhoods have been given as an example. Recommendation 3 includes cultural background, economic and family circumstances in the list of factors that a tailored programme plan needs to take account of. Also, 'on a budget' has been added to 'how to modify culturally appropriate recipes' In Recommendation 4 re developing a tailored programme plan, 'affordable' has been added to dietary changes.

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Association for Improvements in the Maternity Services (AIMS)			*Among poor households. Jourj. Epidm. Comm Health 61 (11) 984-989* *(2) M. A. Martin & Adam Lippert (2012) Feeding her family & risking her health: the interaction of gender, household food insecurity and obesity. Soc Sci Med 74. 1754-1764)*	Noted, thank you.
Association for Improvements in the Maternity Services (AIMS)		16	POSSIBLE ADVERSE EFFECTS This assumes that children suffering from psychological distress, bulimia or self-harm as a result of stress from the programme will be identified. The very nature of these problems means that they are likely to be concealed. In a number of studies quoted in the evidence, staff have expressed their feelings of inadequacy of training on behavioural and mental health issues. We feel this phrasing is too sanguine.	The aim of this recommendation is to ensure children suffering from psychological distress are identified in order that they may be referred on for specialist support from Child and Adolescent Mental Health Services . Recommendation 11 notes the need for staff to be trained to identify any concerns about mental wellbeing and how to refer children on for specialist support. However the guidance does not recommend that these issues are addressed by programme staff themselves. The final guidance also

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				notes that obesity may be either a cause or symptom of mental wellbeing issues and stresses the importance of identifying this in either case.
Association for Improvements in the Maternity Services (AIMS)		17	PSYCHO SOCIAL OUTCOMES the research papers show benefits from increased self-esteem and confidence, which are valued by parents and children alike, even when weight is not reduced. However, this may also be brought about by reduction in depression from changes in nutrition which may have taken place, and this should be added to the list of future research needed, and borne in mind by personnel currently involved in treatment *(1)* As we have mentioned before, in our submissions on pregnancy, we are concerned not just that our clients are overweight, but that they are mal-nourished. No concern is shown here for their children who happen to be thin, but we are concerned that they too, lack many important nutrients in their diet, and would also benefit from improvements. From observation in clients' homes we have many concerns. It is not just lack of money, but lack of time and energy, especially in parents who are depressed. Depression rates increase with poverty. If poor diet contributes to depression and hinders recovery, we have a continual problem. Why don't we stop saying to people "Stop being fat" and start saying "We want you to feel better and enjoy life more."? These are parents who care deeply about their children. If messages imply that they love their kids less than richer, skinny folk, this is harmful and causes them to withdraw.	This guidance focuses specifically on lifestyle weight management services for children who are overweight or obese. Children who are underweight are therefore outside the scope of this particular guidance. NICE guidance PH 11 Maternal and child nutrition focuses in particular on low income households and may be of interest.

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			(1) Almudena Sanchez-Villegas & Miguel A. Martinez-Gonzalez (2013) Diet, a new target to prevent depression? BMC Medicine 11.3.	
Association for Improvements in the Maternity Services (AIMS)			*(1) Almudena Sanchez-Villegas & Miguel A. Martinez-Gonzalez (2013) Diet, a new target to prevent depression? BMC Medicine 11.3.*	Noted, thank you.
Association for Improvements in the Maternity Services (AIMS)		p. 16	MENTAL HEALTH NEEDS "refer to child & adolescent health services". This assumes that the services will be there and accessible reasonably quickly. However, evidence from the Royal College of Psychiatrists suggests this may not be so *(1)* Their report points out that demand greatly exceeds capacity, and that many are struggling to reach targets and waiting times. They also pointed out that black and minority clients had difficulty in gaining access, and that there were problems with parents who did not speak English. As money gets tighter, the situation is hardly likely to improve. We know from some of our clients, that weight issues (too much or too little) can also mask serious underlying problems of previous sexual abuse, sexual assault, and so on, in both adults and children. Sadly, they do not feel they can talk about these to professionals nowadays, since such information is widely shared with other agencies. *(1) Royal College of Psychiatrists (2006) Building and sustaining child and adolescent mental health services. Council Report CR137, RCP, London.*	The PDG were aware of capacity issues, but felt that referral to their GP for onward referral to CAMHS, is the most appropriate course of action where there are concerns about a child or young person's mental wellbeing. Noted thank you. Recommendation 4 in the final guidance, recognises that obesity can be either a cause or a symptom of mental wellbeing issues and stresses the importance of identifying this and referring on for specialist support in either case.
Association for Improvements in the Maternity Services (AIMS)	General		APPROACHES MISSED OUT	
Association for Improvements in the Maternity Services (AIMS)	Area & Community		Many areas have a high percentage of obese adults and children, The approaches suggested of offering programmes to those individuals willing to	The remit of this guidance is specifically

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			participate, will be expensive, will reach comparatively small numbers, and will not reach those at the bottom end of the scale. We are surprised that WHOLE COMMUNITY or SCHOOLS Strategies were not covered more, as illustrated in Leeds, where the importance of different micro-areas was emphasised, which needed different strategies *(1)* We also need to learn from, and copy, school strategies which have proved effective elsewhere *(2)* The success of the Annapolis Valley schools in Canada, and the clear explanations on how this was achieved, are impressive and helpful*(3)* *(1) K.L. Edwards et al (2010) The neighbourhood matters: studying exposures relevant to childhood obesity & the policy implications in Leeds, UK. Journ. Epidem Com. Healt h64: 194-201* (2) *P. Veugelers & A. Fitzgerald (2005) Effectiveness of school programs in preventing child obesity: a multilevel comparison. Am J. Pub Health* (3) *Annapolis Valley Health Promoting schools. Making the healthy choice the easy choice http://www.avrsb.ca/sites/default/files/forms/avhpsp.pdf* (4)	about lifestyle weight management services. However this guidance is complemented by a range of other NICE guidance which does focus on working in schools, communities and other settings. See NICE guidance PH 42 Obesity: working with local com munities, NICE guidance PH17 Promoting physical activity for children and young people. and NICE guidance CG43 Obesity which may be of interest.
Association for Improvements in the Maternity Services (AIMS)			http://www.avrsb.ca/sites/default/files/forms/avhpsp.pdf	
Association for Improvements in the Maternity Services (AIMS)	Family approaches		PARENTS There are many references to parents, and what they can and should be educated and trained to do. There seems to be no information from the literature on how many family attendances involved both parents, and how much it was only mother attending, and how far fathers were also involved. This is, in fact, important, both for health of fathers, and for family education. Mention was made of other family members (?doting grannies) sabotaging healthy eating programmes. However, consideration should be given to many varying family structures – with separated parents, one of whom maybe has	Noted, thank you. In the final guidance Recommendation 3 acknowledges that not all family members may be able to attend the programme and

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			overnight visits, where we see competition for child's approval and different approaches to parenting (on which we gave evidence to Ministry of Justice consultation), There are also households with step-parents trying to establish bonds, step and half-siblings, and so on. Not to mention the many single mothers, who are often in dire poverty. All these make "family" interventions much more complex.	recommends that they be provided with information that explains the aims of the programme and how they can support the child or young person. In addition, Consideration 3.11 gives examples of family members who may not attend the programme itself, including non-resident parents, grandparents and step parents.
Association for the Study of Obesity	1	4 and 5	The use of BMI centiles for clinical assessment and z-scores for monitoring and research is agreed.	Thank you for your comments on the draft guidance. Noted, thank you.
Association for the Study of Obesity	1	6	The allocation of long term resources (> 5 years) to research and monitoring is strongly endorsed, as medical research in obesity interventions has been almost entirely short term, which is why we know so little about long term outcomes and durability of interventions.	Noted, thank you. However, since the consultation period on the draft guidance, there have been changes in funding arrangements for public health and it is not within NICE's remit to make recommendations regarding local government's funding decisions. This

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				recommendation has therefore been revised in the final guidance.
Association for the Study of Obesity	1	7	ASO generally agrees with all of the recommendations: Recommendation 2: The ASO strongly endorses the need for appropriately trained staff for programmes, and for the training and up-skilling of professionals to undertake these specialised roles. The current lack of trained personnel and funding are obstacles to the development of programmes in many areas.	Noted, thank you. Please see Recommendations 11, 12, 13 and 14 in the final guidance.
Association for the Study of Obesity	1	8	Recommendation 3: It is observed that the draft suggestions focus entirely on individual and family management, whereas there is very clearly strong linkage with a range of other external considerations including food and drink marketing and sales, the build environment and planning, commercial factors, and potentially factors at school. While these may not be the focus of the current guidance, it is plausible that these factors might actually be more important to control at population level in young children than the individual and family factors and personal choices. This links to the need for research and continued examination of other factors and different types of public health interventions	As you note, these factors are beyond the remit of this particular guidance but are addressed in other NICE guidance, all of which include recommendations for research. These include NICE guidance PH 42 Obesity: working with local com munities, NICE guidance PH17 Promoting physical activity for children and young people. NICE guidance CG43 Obesity NICE guidance PH25 Prevention of cardiovascular disease ,

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				all of which may be of interest.
Association for the Study of Obesity	1	9	The ASO strongly endorses the application of the evidence-based approach to weight control interventions taken here.	Noted, thank you.
Association for the Study of Obesity	1	18/19	Recommendations 12/13: The need for appropriate staff training is strongly endorsed. Recommendation 16: The ASO strongly endorses this recommendation. Given the lack of long term evidence about the relative effectiveness and importance of different components of personal weight control programmes in childhood, and the possibility that environmental factors beyond these programmes might be equally, if not more important for weight control, formal monitoring and long term evaluation is essential. The ASO also considers that the whole evidence base should be considered, and not restricted to the limited available RCTs. The complexity of the field and the evidence is such that commissioners may find it beneficial to work with local, or other national academic experts with knowledge of this field as partners.	Noted, thank you. Please see Recommendations 11, 12, 13 and 14 in the final guidance. Noted, thank you. Noted thank you. This guidance is based on a range of study types, including ,but not limited, to RCTs. Recommendation 15 in the final guidance cross refers to NICE guidance PH 42 Obesity: working with local com munities which recommends that academic health networks and institutions establish links with local

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				practitioners to assist with planning, collecting and analysing data.
Association for the Study of Obesity	2	24	This section would benefit from substantial amplification and reordering. The principal importance of overweight and obesity in childhood (at a public health level) is that this feeds through into adult life, where it is associated with increased risks of the chronic diseases that account for most mortality (CHD, Stroke, Cancer, diabetes). At present this key point is relegated below the lesser issues of asthma and sleep disordered breathing, which while significant issues, miss the main point. The financial consequences of childhood obesity are reaped entirely as the result of these same chronic disease in adults. This is one of the fundamental reasons for understanding and tackling childhood obesity. There are also mounting concerns about obesity-related type 2 diabetes in children, not least because of the long term difficulty in controlling this condition effectively. Diabetes is a major health concern. There is scope to build on the current text and amplify the importance of early prevention of diabetes, both as an objective of intervention and as a research need.	Noted, thank you. These issues have been addressed in the final guidance.
Association for the Study of Obesity	3.6	26	ASO endorses the need for further understanding of the barriers that prevent people from accessing existing programmes. Are there hard to reach groups that require different approaches?	Noted, thank you. Research recommendation 3 in the final guidance relates to this point.
Association for the Study of Obesity	3.11 and 3.12	29	It was suggested that this section could be stronger.	Noted, thank you. However as this

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			GPs and HVs are generally not equipped with training to identify at-risk children. Furthermore, we are not aware that there are good tools that can be used to identify this group, and it was suggested by members that this would benefit from specific research.	guidance is specifically focused on lifestyle weight management services for children who are overweight or obese, children at risk of obesity are outside of the scope. The PDG were therefore unable to make a research recommendation in this area.
Association for the Study of Obesity	3.25	34	ASO strongly endorses the need for continuing research on monitoring, evaluation and establishing outcome measures to assess the long term impact of weight control programmes It was noted by Dr Maria Bryant that The Childhood obesity Outcomes Review (CoOR) has contributed to this guidance and provides recommendations for primary and secondary outcome measurements. It was observed by a member of ASO that the reference group might not have seen a preliminary report from the Trim Tots healthy lifestyle programme showing early promise of an intervention for the 1-5 age group. Lanigan J et al. Prevention of Obesity in Preschool children. Obesity vol 18; supplement 2: 2012 261P	Noted, thank you. Noted, thank you.
Association for the Study of Obesity	4	37	There is a need for ongoing research, but not only on new types of interventions. There is a need to understand a range of basic issues about childhood	The focus of this particular guidance is on lifestyle weight management services

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			obesity and weight control, including the critical window and factors for its establishment and subsequent opportunities for remodelling. There appears to be an early life window of risk (age< 5), suggesting that the most impact might be achieved by focusing attention on early childhood and parenting, but weight can also be modified strongly at later ages by environmental and biological factors. The mechanisms responsible are not well defined and deserve further research. While not denying that a continuous range of interventions across childhood might be appropriate in the face of a continuous environmental challenge, valuable resources could be misdirected if they are not aimed at such critical windows. Recommendations for outcome measures should also ensure that measures match the intended populations (or sufficiently similar). Timelines for follow up measures should also be based on distance from baseline.	for children and young people up to the age of 18. As there was a dearth of evidence for programmes for children under the age of 6, the PDG were unable to make age specific recommendations. They have however, made research recommendations which focus on children of this age – see Research Recommendations 3 and 4 in the final guidance. Noted, thank you
Association for the Study of Obesity	4	37	Research also sometimes challenges orthodox opinions about factors that influence weight (eg Metcalf B, Henley W, Wilkin T. Effectiveness of intervention on physical activity of children: systematic review and meta-analysis of controlled trials with objectively measured outcomes (EarlyBird 54). BMJ. 2012 Sep 27;345:e5888. doi: 10.1136/bmj.e5888).	Noted, thank you.
Association for the Study of Obesity	4	38	The ASO considers that a range of evaluative methodologies is appropriate.. RCTs and other designs answer different questions. Phase III RCTs of effectiveness represent a gold standard and are expensive. These should form a fundamental part of the evidence base, but should also demonstrate value for money. In contrast, RCTs are not appropriate for assessing community evaluations by PDGs,	Research recommendation 1 in the final guidance notes that alternative research designs should be considered where RCTs

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			and audit data also provide valuable insights.	are not possible. NICE considers a range of evidence in developing it's guidance including RCTs and data from a range of other study types.
Association for the Study of Obesity	4	38	It is agreed that a commitment to long term, 5-10 year studies are needed to understand the long term implications of childhood obesity interventions into adult life.	Noted, thank you.
Association for the Study of Obesity	4	40	Recommendation 4: It is agreed that research on the components of interventions that are most effective is important, including family and parent involvement. Research is also needed on environmental and public health factors beyond the individual and his or her family that influence body weight.	Noted, thank you. The focus of this particular guidance is on lifestyle weight management services but other NICE guidance has made research recommendations on broader issues e.g. NICE guidance PH 42 Obesity: working with local com munities, NICE guidance CG43 Obesity and NICE guidance PH25 Prevention of cardiovascular disease , all of which may be of interest.
Association for the Study of Obesity	3.29-3.44	35	Economic evaluations do not currently consider quality of life (likely due to lack of valid utlity measures). The text in this section does not	The economic evaluation fully considers the quality-of-life of children,

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			appear to consider this although there is some mention of self-esteem, which may or may not contribute to QALYs. Some of the text is somewhat arbitrary here. E.g. what is a 'small reduction' in BMI?	and continues to consider the quality-of-life as the children grow into adults, for the whole of their lives. A 'small reduction' in BMI in this context may be as low as 0.5kg.
British Heart Foundation	General comments	x	The British Heart Foundation (BHF) is the nation's leading heart charity. Our vision is of a world in which no one dies prematurely of heart disease. There are over 2.3 million people in the UK living with coronary heart disease.[1] The BHF warmly welcomes the opportunity to respond to this consultation and to help develop NICE guidance in this area. The BHF is committed to improving heart health and tackling childhood obesity is a key part of this. Approximately one third of children and young people aged 2-15 years in the UK are now classed as overweight or obese.[2] Obese children are more likely to become obese adults, and this in turn is linked to an increased risk of serious health problems, including heart disease. We raise awareness of the benefits of a healthy lifestyle, advocate for the right environment to make the healthy choice, the easy choice and provide information and support for people at risk of living with heart disease. If you have any queries about this response or would like more information please contact Amy Smullen, Policy Researcher smullena@bhf.org.uk	Thank you for your comments on the draft guidance.
British Heart Foundation	General recommendation	x	The BHF recommends that the guidance could be more explicit that the evidence is absent for those aged five years and under, which has meant that	Please see page 6 of the final guidance and

[1] BHF Coronary Heart Disease Statistics 2012 http://www.bhf.org.uk/plugins/PublicationsSearchResults/DownloadFile.aspx?docid=e3b705eb-ceb3-42e2-937d-45ec48f6a797&version=-1&title=England+CHD+Statistics+Factsheet+2012&resource=FactsheetEngland

[2] British Heart Foundation (2009) *Couch Kids: The nation's future*

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	1		there is no consensus statement of evidence-based approaches. Addressing this evidence gap should be a priority of research arising from this consultation.	Research recommendations 3 and 4.
British Heart Foundation	General recommendation 2	x	The guidance lacked mention of the role that schools, through physical education, both in the curriculum and through after school activity could play in weight management programmes. As the majority of children and young people's time is spent within the school environment it is vital that the key messages promoted at weight management programmes are mirrored in schools.	The focus of this particular guidance is on lifestyle weight management services. It does not make recommendations about physical activity in schools as this area is already addressed in complementary NICE guidance CG43 Obesity and NICE guidance PH25 Prevention of cardiovascular disease , which may be of interest.
British Heart Foundation	General recommendation 3	x	The guidance could be strengthened by placing more emphasis on the inequalities in the prevalence and incidence of overweight and obese children tailoring the weight management programmes provided in local areas accordingly.	Noted thank you, In the final guidance: Recommendation 2 highlights the need to commission lifestyle weight management services which meet the needs of local children and young people according to various factors, including

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				different cultural backgrounds. It also recommends that any groups at particular risk that should be particularly targeted, are specified in contracts and includes children and young people from black and minority ethnic groups and those from low income families or neighbourhoods as examples. Recommendation 3 lists factors to be taken into account when tailoring programmes for individuals, including age, gender, ethnicity, cultural background and economic and family circumstances. Recommendation 15 also highlights the need to monitor any variation in outcomes and the numbers recruited and retained by the programme according to

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				socio-economic group. See also Research recommendations 3 and 4
British Heart Foundation	General recommendation 4	x	Similarly, the guidance does not take into consideration differences in Black and Minority Ethnic and white communities' body weight and body mass index. Taking this into consideration will ensure services and interventions are tailored to individual needs.	Please see the response above which highlights recommendations within the guidance which are intended to help address the needs of children from black and minority ethnic groups. Regarding differences in body composition, the PDG were aware that there is evidence that adults from black and minority ethnic groups are at risk of obesity associated co-morbidities at a lower BMI than the white European population, however it was beyond the remit of this guidance to assess if the same applies to children and young people. Please

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				see Consideration 3.15.
British Heart Foundation	General recommendation 5	x	In addition, it is also important for healthcare practitioners to better detect potential co-morbidities of those children that have been identified as overweight or obese – for example, diabetes.	Noted, thank you. In the final guidance, the PDG has recommended that each child or young person is assessed for co-morbidities using a locally approved co-morbidities assessment tool, where available. See Recommendation 4 and Consideration 3.16.
British Heart Foundation	Recommendation 1	5-6	Greater detail in the definitions of 'overweight' and 'obesity' is needed to include socio-economic and cultural differences to help with the identification of children and young people who would benefit from intervention.	The PDG were aware that there is evidence that adults from black and minority ethnic groups are at risk of obesity associated co-morbidities at a lower BMI than the white European population, however it was beyond the remit of this guidance to assess if the same applies to children and young people.
			The current rates of childhood obesity present a huge undertaking for services at a local level. To ensure success and effective services, commissioners need to consider appropriate levels of staffing and ensure on-going training	Noted. The guidance will be accompanied by a costing report and

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			and support for staff. The overall costs of running the programmes, including staff costs, must also be considered – and must take into account the level of on-going support for those participants who have completed the programmes that the guidance proposes.	template that addresses these issues in detail.
British Heart Foundation	Recommendation 2	6-8	Many children's dietetic outpatient referrals from general practice will currently be treated in hospital-based dietetic services. Therefore providers of obesity services in acute settings should also be included in commissioning services. Public health teams should consider this and use their expertise and experience in making decisions about new services in the community to make sure that the two complement each other in terms of what is offered and to whom. The BHF strongly supports the commitment to 5 year dedicated funding and inclusion of criteria to ensure that interventions are properly implemented and evaluations are sustained. The BHF also strongly supports the guidance's inclusion that weight management programmes will only occur where it is demonstrated to be safe, effective, acceptable to children and families, facilities and value for money. The BHF recommends that weight management services share their findings of evaluation through peer-reviewed processes such as NHS QI, PHE or NICE.	Recommendation 1 in the final guidance highlights the importance of lifestyle weight management services being provided as part of a locally agreed obesity care or weight management pathway. It recognises that these are just one part of a comprehensive approach to preventing and treating obesity. Noted, thank you. However, since the consultation period on the draft guidance , there have been changes in funding arrangements for public health and it is not within NICE's remit to make recommendations regarding local government's funding

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				decisions. This recommendation has therefore been revised in the final guidance.
British Heart Foundation	Recommendation 3	8-9	The BHF strongly welcomes Recommendation 3 and agrees that an important part of tackling childhood obesity is promoting healthier lifestyles within the family setting, equipping families with the tools, skill, knowledge and confidence to ensure long term sustainable behaviour change. There is also an important opportunity available for the use of local case studies of those who have successfully used weight management services to make real behaviour change to incentivise and promote the programmes with potential participants.	Noted, thank you.
British Heart Foundation	Recommendation 4	9-11	To ensure greater effectiveness and success among participants the guidance should ensure that weight management programmes include goals and activities that can occur between appointments. This would help two fold; first, by sustaining motivation of participant, encouraging them to see the behavioural changes as permanent. Secondly, it would also increase the confidence of participants in the management of their weight by letting them take control of their programme from the start, outside of a health care setting. As a result, this would instil confidence to continue their behaviour change once the programme has ended. The guidance does not include the psychological consequences of being overweight. This should not be overlooked as the impact can be significant both for the wellbeing of the child of young person and also for the success for weight management programmes. Psychological consequences should be considered at the early stages of intervention and should shape the tailoring of services offered to a child or young person.	The focus of the guidance is very much on making changes which are sustained outside of the programme sessions. For example, see the second bullet point of Recommendation 3 in the final guidance which focuses on strategies to help the family identify how changes can be implemented and sustained at home.

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British Heart Foundation	Recommendation 5	11-13	When setting weight management programmes there needs to be consideration of how much prior knowledge the children and young people and families have of weight management and healthy living. This would distinguish between cases of knowledge but no action and cases of no knowledge at all. This would enable more targeted identification of barriers to participation and provide a tailored service on an individual basis according to need and preference.	Noted, thank you. In the final guidance, this in included in Recommendation 4.
British Heart Foundation	Recommendation 6	13	The BHF agrees that an up-to-date list of local weight management programmes is imperative to offering the best possible service. This list must be kept up to date and an online database would be the best choice to ensure updates are captured easily. The BHF recommends that an appointed staff member is responsible for the compilation and maintenance of the list.	Noted, thank you.
British Heart Foundation	Recommendation 7	14	The information provided to parents or carers by health professionals at the point of intervention should include a summary of benefits, time commitment, payable fees and activities included. The up-to-date list outlined in Recommendation 6 should also be included.	Noted, thank you
British Heart Foundation	Recommendation 8	14-15	The BHF supports the promotion of consistent messaging across other professionals and voluntary organisations. Further clarification of how consistent messaging from clinical to wider local settings would occur is required. The BHF also recommends that there is a great opportunity for previous users of weight management services to be linked with those commencing weight management services – offering guidance, motivation and further support.	Noted, thank you. No studies were identified on the use of peer support approaches and so specific recommendations have not been made in this area.

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British Heart Foundation	Recommendation 9	15-16	Promoting the potential benefits that weight management services offer should be the focus point for all communications with those families at the point of intervention, not exclusively for those families not ready to attend a programme. The BHF also has a wealth of resources targeted for both parents and carers and children and young people to encourage greater participation in physical activity and also improving eating habits. These would complement the weight management services and resources referenced in the guidelines. Resources include; '*Kids on the go'* resource for parents of 7-11 year old to help them ensure their children are physical active. 'Let's get active' pocket planner aimed at 7-11 years old to record your physical activity *'Artie beat likes to play'* reading book aimed at under 7s to promote physical activity *'Artie beat picnic'* reading book aimed at under 7s to promote concept of healthy eating '*Healthy living kit'* aimed at 11-13s to encourage making school days healthy through activity and diet.	Recommendation 8 in the final guidance addresses this point. Noted, thank you.
British Heart Foundation	Recommendation 11	18	The BHF believes that offering on-going support to all participants is ideal but also a huge undertaking and adds pressure on services. Consideration of comments made under Recommendation 1 of staff time, staffing and resource costings will be key to ensuring on-going support. It will also ensure that on-going support is sustainable to be offered to all participants. The BHF recommends that greater clarification is required on the correct referral process of those participants who fail to maintain or reduce their BMI whilst receiving on-going support.	Noted, thank you.

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British Heart Foundation	Recommendation 12	18-19	Staff training outlined within the guidance would benefit from learning from past participants, finding out what worked well for them and what could have been improved and taking this forward to influence future training. The guidance should note that an important part of training should be measuring impact of intervention both qualitatively and quantitatively.	See Recommendation 15 in the final guidance which includes the collection of views of participants including what was found to be helpful and how the programme could be improved. It is recommended that commissioners use the findings from monitoring and evaluation to improve the service. In addition, Recommendation 2 requires commissioners to ensure the programme content is regularly reviewed and updated by the multi-disciplinary team and Recommendation 11 that staff training is developed and regularly reviewed by the multi-disciplinary team.
British Heart Foundation	Recommendation 13	19-20	In order to provide the best programmes, professional boundaries must be overcome to promote integrated working, moving away from working in silos towards partnership working. This will ensure the holistic approach as outlined in the guidelines approaching weight management through wider behaviour	Noted, thank you.

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			change.	
British Heart Foundation	Recommendation 14	20-21	The BHF supports the guidance that all health professionals must have the necessary knowledge and skills to assess whether referral to a lifestyle weight management programme is appropriate. It is also salient that the health professionals have confidence in their approach and referral. To support this there must be awareness of available channels for health professionals to find out more information on programmes, both for their own reference and to signpost others. An up-to-date list of weight management programmes discussed in Recommendation 6 is salient resource in enabling health professionals to do this.	Noted, thank you.
British Heart Foundation	Recommendation 15	21	There is an important need to prepare staff to be able to answer questions and discuss their own experience confidently with parents and carers and with children and young people. Managers should also be trained to raise the issue of obesity sensitively and confidently before they raise this issue with their teams.	In Recommendation 14 in the final guidance, it has been clarified that if staff identify the reason for their lack of confidence is a result of being overweight or obese themselves, they should be offered access to a weight management programme.
British Heart Foundation	Recommendation 16	22-23	As outlined above under Recommendation 12 learning's from past participants should be key to the evaluation process and dependant on findings programmes should be modified accordingly. Evaluations should take into consideration differences between those who were referred, who attended, who dropped out and the number that completed the programme.	This point is addressed in Recommendation 15 in the final guidance. See earlier response.
British Heart Foundation	3. Considerations;	32	At the BHF we have found that evaluation is essential in assessing the benefit of a particular programme locally. Standard approaches and evaluation across	Noted. Please see Research

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	The evidence		different areas can increase the confidence on the finding, and can improve learning and the potential to sustain and disseminate the models of lifestyle intervention to other areas.	Recommendation 1.
British Heart Foundation	Further research:	34- 37	The BHF agrees strongly that there is a need for more emphasis on what works for participants from different ethnic and socio-economic backgrounds, as well as different genders and ages. This would help towards reducing rather than widening inequalities in health. Further research is also required to assess if children and young people from different sub-groups respond to different types of intervention differently.	Noted, thank you.
British Psychological Society	General		The Society welcomes public health guidance in this important area and is encouraged that the guidance contains many important points regarding planning, delivering, monitoring and evaluating childhood obesity services. We particularly welcome the importance accorded to family interventions and the awareness that children have developmentally different needs and cognitive abilities, within the recommendations and considerations. The Society believes that it is essential that weight management services do not become 'scaled-down' versions of adult weight management services. Children have a fundamentally different context and power to act than adults, as well as there being developmental cognitive differences. It is important to both engage meaningfully with other family members and to engage with the child at a developmentally-appropriate level so that the child can meaningfully engage, in contrast to acquiescence to keep others happy.	Thank you for your comments on the draft guidance.
British Psychological Society	General		The Society notes that there is a strong focus on Cognitive Behaviour Therapy, even though it is stated that "current evidence does not allow conclusions to be drawn on its effectiveness" (page 31). Other approaches to behaviour change, such as Motivational Interviewing, solution-focused brief therapy and systemic approaches are also likely to be useful in this context.	Thank you for highlighting this. In the final guidance, Recommendation 12 (Recommendation 11 in the draft guidance) refers to training in 'behaviour

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				change techniques and psychological approaches (for example motivational interviewing)'' as opposed to 'cognitive and behaviour change strategies'
British Psychological Society	General		Parents are often anxious about the potential for accusations of being "bad parents". We believe that it is important that this is addressed, as it is likely to act as a barrier to service uptake. We suggest that positive, non-blaming approaches will need to be developed in referrers and programme staff, and this may have training implications.	Noted, thank you. The PDG were very concerned that staff and health professionals treated all children, young people, and their families with empathy and sensitivity. This is reflected in Recommendations 11, 12 and 13 which focus on staff and referrer training .
British Psychological Society	General		The Society is concerned about the absence of recommendations regarding programme duration. Obesity is unlikely to be something that can be solved in 9-12 weeks, which is how long most programmes seem to be. If there is not yet enough evidence to make a suggestion, this need to be stated.	Noted, thank you. Please see Consideration 3.30 in the final guidance.
British Psychological Society	General		The guidelines make clear the focus is on change achieved via lifestyle management/ education rather than tackling wider structural determinants. In light of evidence on the extent to which families' experiences of attending programmes and maintaining change afterwards are grounded in their wider circumstances (see for example expert paper 5, qual section), could more be made of the useful points on p6 and p33 that programmes are commissioned	Noted thank you. In the final guidance it has been emphasised that lifestyle weight management services should be provided as

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			as part of a wider, more sustainable approach to preventing and treating obesity'. There should be scope to highlight this more strongly by having a separate section within 'Considerations' on structural/environment change and more explicitly advising how Department of Public Health and Local Authority commissioners could integrate provision of weight education/management programmes with this. This is closely bound up with some of the 'very practical issues' which providers are encouraged to grapple with on p 30 and seems important in light of what we know about the impact of lifestyle management/education only approaches on health inequalities - see Expert paper 5.	part of a locally agreed obesity care or weight management pathway and this hyperlinks to a detailed definition of this in the glossary. The focus of this guidance is specifically on lifestyle weight management services but the PDG have cross referred wherever possible to other relevant NICE guidance, in particular to NICE guidance PH 42 Obesity: working with local com munities which focuses specifically on the issues you describe. Once published, this guidance will also form part of an overall 'Obesity pathway' which will be available on-line and which will show clearly how this guidance interfaces with other NICE guidance which focuses on the

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				prevention and treatment of obesity.
British Psychological Society	General		The Society believes that referral to weight management programmes could also come from teachers and thus teachers should be added to the list of referrers. Appropriate support and training for teachers on raising the issue of weight management and dealing with any internal conflict regarding their own lifestyle behaviours should be addressed.	The PDG discussed the role of teachers in detail, however while they felt it would be appropriate for school nurses or school health teams to make formal referrals to programmes and provide ongoing support (see Recommendations 8,9 and 13) they did not feel this would be an appropriate role for teachers. The evidence indicates that health professionals sometimes lack the confidence to raise the issue of obesity with parents, yet it is part of health professionals' role to point out the health implications of being obese. The PDG did not feel it was appropriate for teachers to be expected to do this, or that they or parents would necessarily see it as part of their role. In addition it was queried if

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				they would be in a position to provide the ongoing monitoring and support that the school nurse or school health care team could provide (see Recommendation 9 in the final guidance). Finally they were aware that some children and young people fear being bullied by their peers. For example, the report commissioned by the PDG into the practical and process issues of delivering weight management interventions, shows that in some cases children and young people may not be willing to attend a programme delivered on school premises for fear of being bullied.
British Psychological Society	General & Recommendations	4-24	The Society believes that a distinction between overweight and obese children is needed within the recommendations. It is likely that they have different barriers and needs, motivation and health risks that services should consider.	Please see Recommendations 3 and 4 and Consideration 3.14 in the final guidance, which highlights the importance of an

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				individually tailored plan which takes account of how overweight or obese a child or young person is and the need to set appropriate goals.
British Psychological Society	Draft recommendations 1	4	The Society agrees with the comment about paucity of evidence for interventions in children under six years of age and suggests that this is better highlighted.	This issue is highlighted in the background section, and Consideration 3.4 of the final guidance. The PDG has also made two recommendations for further research – please see Research Recommendations 3 and 4.
British Psychological Society	Draft recommendations 1	5	The Society is concerned that BMI does not necessarily reflect important factors such as body fat or body composition and particularly variation in these resulting from ethnicity. There may be groups more vulnerable to the consequences of adiposity at relatively lower BMI levels.	Please see Consideration 3.15 in the final guidance. The PDG was aware that there is evidence that adults from black and minority ethnic groups are at risk of obesity associated co-morbidities at a lower BMI than the white European population, however it was beyond the remit of this guidance to assess if the same applies to children and

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				young people.
British Psychological Society	Recommendation 2	7	The Society welcomes the recommendations that promote the inclusion of a behaviour change specialist- particularly the expertise from practitioner psychologists on the multi-disciplinary team. However, the skill set, expertise, competencies and knowledge that are specific to these listed staff members (Health Psychologist, exercise psychologist, child psychologist and health promotion specialist) vary considerably. They are not interchangeable roles. There is not a clear, widely used definition of the term "Health promotion specialist" and this may therefore be used by individuals with a range of backgrounds and would not be interchangeable with practitioner psychologists who have doctoral level training in a specific domain of applied psychology. A child psychologist is also not one of the HCPC protected / defined titles in psychology practice. Therefore we suggest that this section should be re-worded as: *"A Practitioner Psychologist such as a Health or Clinical Psychologist, with expertise in obesity management and childhood healthcare. For support specific to the physical activity behaviour changes a sports and exercise psychologist may be appropriate."*	Thank you for highlighting this. This section has been clarified in the final guidance.
British Psychological Society	Recommendation 2	7	Whilst the last bullet point refers to completion of the programme, there is no recommendation for what this completion timescale should be.	The PDG did not make recommendations regarding the optimal length of programmes. Please see Consideration 3.30 in the final guidance.

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British Psychological Society	Recommendation 2	8	"Ensure any barriers to facilitating the uptake of programme is managed…" The Society is concerned that the barriers considered and reflected in this document as practical/ physical barriers such as time/ location of the programme etc. However programmes should be aware of the need, and have the skills, to support families regarding the psychological conflicts that influence attendance and acceptance of a programme (such as social-family influence/ personal identity/ stigma attached to acceptance of obesity as a label) See Newson, Povey, Casson, Grogan (2013) for example.	Noted thank you. The PDG recognised the importance of these issues and have reflected them in Recommendation 8 in the final guidance.
British Psychological Society	Recommendation 2	8	The Society also welcomes the recommendation that BMI Z score is recorded one year after post-intervention. Following a recent systematic review (Chater et al., 2011) many studies were excluded due to a lack of a 6 month or longer follow-up.	Noted, thank you.
British Psychological Society	Recommendation 3	9	The Society would encourage the addition of action planning to 'goal setting, monitoring and feedback'. As planning how to achieve a goal is an important next step to attainment.	This is implicit within Recommendation 4 which provides the detail on developing and implementing an individually tailored plan.
British Psychological Society	Recommendation 3	9	The Society suggests core components also include understanding obesity assessment (i.e. BMI and percentiles) and how to identify obesity (i.e. in contrast to popular belief, obesity is not always visibly obvious).	Recommendations 4 and 8 and Consideration 3.21 in the final guidance, highlight the importance of families recognising whether the child and young person are overweight or obese. Recommendations 11 and 13 focus on training programme staff and

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				health professionals to accurately weigh and measure children to determine if they are overweight or obese. In addition they focus on helping families to recognise this and to understand the benefits of addressing the child or young person's weight.
British Psychological Society	Recommendation 3	9	The Society agrees that positive parenting skills training can be extremely important in this group. It will be important therefore to ensure that there is access to this from staff who are appropriately trained. The input of a clinical psychologists specialising in children and families would be useful in addressing this.	Noted, thank you. In the final guidance, Recommendation 12 highlights the need to have access to staff who are able to provide this training.
British Psychological Society	Recommendation 3	9	The inclusion of information for the wider family is welcomed in order to enable influence members of the family system who do not attend the programme. Also although on-going support is recommended within this section, no indication is given of the recommended timescales, or whether this is intended to continue indefinitely. Clarification would be useful for commissioners and providers.	Recommendation 3 is intended to provide an overview of the core components of the programme. Further detail regarding ongoing support is provided in Recommendation 10 in the final guidance. This recommends that ongoing support is provided for at least the first year following completion of the

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				programme, and longer if possible, depending on the family's needs.
British Psychological Society	Recommendation 4	9-10	We believe that family context is also important to take into account, as different family members may view their child's weight issue differently and thus feel more/less motivated towards behaviour change. An example of this is Jain et al (2001), who found that extended family members may undermine parents in helping their child be healthy. For example, the parents limited the child's sweet intake to then have the grandparents giving the child unlimited amounts of sweets. Clearly showing that some family members believe weight management is more important than others.	Noted, thank you. The evidence reviews identified such issues. The PDG recommended that programmes provide information for family members who may not attend the programme itself to explain the aims and objectives and how they can provide support. Please see Recommendation 3 and Consideration 3.11in the final guidance.
			It is also important to take account of the child or young person's wider emotional and psychological context (e.g. caring responsibilities, experience of looked after system, sleep routine and quality, any health, loss bereavement issues, etc.)	Noted, thank you. Please see Recommendation 4 in the revised guidance which recognises that a child or young person's weight may be a consequence of circumstances that have affected their well-being.
British Psychological Society	Recommendation 4	10	The Society suggests that the current wording could be interpreted as suggesting an "all or nothing" approach to the use of the age of 12 years to	Noted, thank you. This has been revised in the

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			begin self-monitoring and can reliably monitor their food intake, (Domel, S.B et all (1994)). Younger children are capable of engaging in age-appropriate forms of self-monitoring and this is often helpful. We would suggest adopting at a continuum approach between parental led-monitoring at an earlier age (e.g. star charts, etc), moving over time to the child becoming more involved, according to their developmental stage. With older children parent / carer involvement is still important in terms of praise and encouragement reinforcing behaviour.	final guidance. Please see Recommendation 4.
British Psychological Society	Recommendation 4	11	The Society believes that the recommendation regarding goal setting would be strengthened by recognition that the family is not a single unit. Different members even within the immediate 'family' may have different, conflicting priorities which wider social/economic circumstances may make more or less easy to reconcile - again see for example, qual section of Expert paper 5s. It is important to acknowledge that for children and parents, these goals may not be weight or physical health related, however may be psychological (confidence) or social (more friends).	Noted thank you. The PDG was very aware of these issues, hence the emphasis in Recommendation 4 on mutually agreeing goals with the child or young person and their family and ensuring that these relate to factors that they value and that motivate them to attend.
British Psychological Society	Recommendation 4	11	We suggest that the order of the two sentences in the 2nd bullet point on pg11 be reversed i.e."*Goals should be mutually agreed….*" since the current wording could be interpreted to imply that the health professional sets goals first and then they are agreed rather than being co-constructed which is more appropriate and effective.	Noted, thank you. This has been amended in the final guidance.
nBritish Psychological Society	Recommendation 4	11	The Society would encourage that the recommendation should not just be to praise progress, but to encourage "to self-praise of progress". Otherwise, when the programme ends and the positive reinforcement (praise) is removed, the behaviour may not be sustained as it is no longer being rewarded. Moreover in order for praise / self-sustaining reward to be effective it would	Thank you for suggesting this, but as the PDG did not review any specific evidence on the concept of self-

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			need to be embedded in the family context, i.e." facilitating the child / young person AND their families to develop skills in using positive feedback and praise, aimed at the behaviour changes and effort NOT solely dependent on weight change.	praise, they were unable to make recommendations in this area.
British Psychological Society	Recommendation 4	11	The Society believes that reflection on what has been learnt from not meeting goals should be encouraged. For instance through the use of positively framing goals not met as learning opportunities or feedback for instance that perhaps the size of change attempted was too large for the stage of change	Recommendation 4 highlights the need to discuss the possible causes for not meeting goals and modifying goals if necessary.
British Psychological Society	Recommendation 5	12	'Rolling programmes' benefit from flexibility and reducing waiting time to join. However, this is at the expense of continuity of participant group and potentially also of staff involved. It is recommended that the potential benefits of peer support from a consistent group be weighed against flexibility. This may be addressed, for instance, by establishing fixed entry/exit points at intervals through the programme.	Noted, thank you. Rolling programmes have been more clearly defined in the final guidance. Please see Recommendation 5 and the glossary definition.
British Psychological Society	Recommendation 7&8	14-15	The Society believes that health professionals need to be able to explain the child's weight measurement to the families and justifying why they need support. Often parents do not realise that their child is overweight as to them they don't "look overweight." Therefore, health professionals need to be able to explain that children are overweight using other means than vision. Jones et al (2011), shows quite clearly that parents rely on visual assessment of childhood obesity. They also highlight that parents are bad at identifying childhood obesity; 69.3% of parents of overweight or obese children identified their child as being of 'normal' weight. Professionals who discussing h a child or young person's weight with them and their families would benefit from training on how to address these issues in a positive, sensitive and non-blaming way. This could be achieved by commissioning this element from within weight management programmes.	Noted, thank you. The PDG was very aware of this issue. Recommendations 4 and 8 and Consideration 3.21 in the final guidance, highlight the importance of families recognising whether the child and young person are overweight or obese. Recommendations 11 and 13 focus on training programme staff and

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				health professionals to help families to recognise this and to understand the benefits of addressing the child or young person's weight.
British Psychological Society	Recommendation 7&8	14-15	Health professionals also need to be aware of parent's barriers to taking up support and how to talk about these sensitively and in a non-blaming way in other to help parents and carers engage in programmes and facilitate the involvement of the child / young person.	Noted thank you. Please see Recommendation 8 in the final guidance which provides detail regarding the approach health professionals should take in raising this issue and Recommendation 13 regarding training health professionals.
British Psychological Society	Recommendation 9	16	The Society recommends the addition of another bullet point: • Assess families' expectations of the programme. Address any expectations or beliefs that are incorrect or inconsistent.	This is addressed in Recommendation 8 of the final guidance.
British Psychological Society	Recommendation 9	16	It is not clear in recommending that referrers assess psychosocial distress and refer to CAMHS, whether this precludes referral to the Weight Management programme. Expert evidence 3 links overweight and obesity with psychological distress – it is therefore important that children and young people who are experiencing psycho-social distress are not excluded from programmes. It may be ideal to develop a route for CAMHS referral into programmes where this is appropriate, or developing effective liaison with CAMHS. Some of this may be facilitated if the WM team contains some staff with experience of working in CAMHS.	This would need to be assessed on an individual basis by the CAMHS specialist.
British Psychological Society	Recommendation 10	17	The Society believe that In providing ongoing support, it is critical to continue to manage the child's and family's / carer's expectations and focus on	Noted, thank you. this point is captured by this

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			successes in change in behavioural factors such as diet and exercise, and general healthiness, rather than weight change. Improvements in psycho-social outcomes are also important for the child's parents.	recommendation.
British Psychological Society	Recommendation 10	17	The recommendation that healthcare professionals acknowledge the positive health effects of changing eating and activity behaviours and psychosocial benefits, independent of effect on weight or BMI is welcomed. We recommend that after completion follow-up monitoring should be done by a health professional – we would welcome guidance on what happens post 1 year follow-up.	Noted, thank you. The guidance does recommend that ongoing support is provided by programmes and by the referring health professional. Ongoing support needs after 1 year would need to be assessed on an individual basis .
British Psychological Society	Recommendation 12	18-19	Health professionals also need to be able to understand obesity and behaviour change in overweight/obese children and how to discuss weight in a sensitive way with families and their children. The recommendation that staff are able to communicate effectively with 'the family' needs to include specific skills for working with young children and families (qual section of Expert paper 5)	Noted, this is captured by Recommendation 12 in the final guidance.
British Psychological Society	Recommendation 13	20	The Society recommends the addition of 'assist the participants and their families to' identify possible reasons for relapse. It would be best to make these guidelines as client-centred as possible.	Noted, this is captured by Recommendation 12 in the final guidance.
British Psychological Society	Recommendatio	22-23	We believe that it is important to ensure other measured outcomes relate to	Improvements in self

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	n 16		the programme's main objective which is to support or contribute towards reductions in BMI Z score. The Society suggests adding: "improvements in self-esteem **and body confidence**".	esteem are included in this recommendation (Recommendation 15 in the final guidance). The PDG were unable to provide an exhaustive list of all the outcome measures that could be collected but have provided a link to the Standard Evaluation Framework that provides further examples.
British Psychological Society	Recommendation 16	23	The Society recommends the addition of: • Collect data on factors influencing families' decisions not to attend a programme, families' decisions not to continue on a programme.	This recommendation (Recommendation 15 in the final guidance) includes the views of those who do not complete the programme. However it may not be feasible to identify and follow up those who decline to be referred.
British Psychological Society	Recommendation 16	23	The Society suggests collecting data from families that decline weight management programmes, as according to Taveras, E. M et al (2011), this can be very helpful in terms of programme improvement.	Please see above.
British Psychological Society	Recommendation 16*	23	The call for longer-term evaluation is welcomed, especially in light of evidence of non-monetary costs to families of programme attendance. The statements about effectiveness are strong. There should be scope to include greater clarity about the maximum time frame we currently have for evidence of	These issues cannot be addressed within the Recommendations, but are addressed in the

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			impact at follow up and include some acknowledgement about the lack of evaluation and /or effectiveness of most of the programmes attended by UK families.	Considerations. Please see Considerations 3.3 and 3.30 in the final guidance.
British Psychological Society	3.16	31	A recent coding exercise of childhood obesity interventions using the CALO-RE behaviour change technique taxonomy (Michie et al., 2011) has found that the most commonly used behavioural change techniques are goal setting and self-monitoring of behaviour (Chater et al., 2011). Expert evidence 3 described different theoretical approaches to behaviour change which are not captured in 3.16. The use of 'behavioural therapy' would only relate to Dr Hill's 'learning theory' approaches and which does not relate to the subsequent examples which would come within self-regulation theory. We would suggest that either each be identified, or if a generic term is preferred that this be "behaviour change techniques"	Noted, thank you. This has been amended in the final guidance. Please see Consideration 3.23.
British Psychological Society	3.17		Whilst CBT has been recommended, motivational interviewing (MI) has not. A recent report by the Royal College of Physicians (2013) has recommended that all those working in weight management should be trained in MI (see pg 16). Other approaches such as family and systemic approaches are also relevant in this context.	As noted in response to your earlier comment, In the final guidance, Recommendation 12 refers to training in 'behaviour change techniques and psychological approaches (for example motivational interviewing)'' as opposed to 'cognitive and behaviour change strategies' .
British Psychological Society	3.18		Emotional/comfort eating should also be highlighted alongside binge eating, as they are two distinct eating patterns that contribute to weight gain.	This consideration is a summary of the issues

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				the PDG considered from Expert Testimony. As this issue was not discussed, it has not been included here.
British Psychological Society	Recommendation 1	37	When discussing standardised time points - the recommendations states 2 years from baseline, but this will not be helpful if the intervention is 2 years long. The Society believes that it also be measured as 2 years from the end of the intervention. Longer term follow up data (e.g. 5-10 years) would also be important in my view. The Society also recommends that authors are clear about what they are referring to when they use the term 'follow-up'. There are some papers in the literature that refer to follow-up as from baseline rather than from end of intervention, which can complicate sustainability analysis (Martin, J. et al 2013)	Noted, thank you. This has been revised in the final guidance. Please see Research Recommendation 1.
British Psychological Society	Recommendation 3	39	The recommendations for research into barriers and facilitators specifically mention skills/expertise of staff, quality/convenience of venues and timing, exploration of non-monetary costs of attendance and maintaining recommended behaviours afterwards. The Society questions whether this should be included given the prominence of these issues in the implementation literature (see qual section, Expert paper 5)	Recommendations for practice have been made regarding these factors. The Research recommendations do not focus on these points but on the gaps in the evidence including: how barriers and facilitators vary according to sub-population group, how the families of children aged under 6 can be encouraged to participate in

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				programmes; and the barriers and facilitators relating to children with special needs.
British Psychological Society			The Society fully supports the recommendation that details of intervention components should be included. This should be linked to BCT taxonomy for replicability and analysis of effective component techniques. However it should also be acknowledged that sometimes the effectiveness of a programme may more closely related to the philosophy and process of the programme, rather than specific techniques. This is harder to measure and so is likely to be neglected. In highlighting issues of family involvement, peer groups, and developing programme staff and health professionals' empathy skills, the recommendations allude to this dimension.	Noted, thank you. NICE guidance PH6 Behaviour change is currently being updated and is due to be published early in 2014.
British Psychological Society	Recommendation 3	39	Any variation in the barriers to and facilitators for participating in lifestyle weight management services needs to be determined The Society suggests Including: - Ethnicity and cultural aspects - Socioeconomic group - Gender (boys in particular) - Age **Beliefs (about obesity)**	This has been added in the final guidance.
British Psychological Society		40	It is not clear what behavioural therapy 'packages' are or what they include. We believe that "behaviour change techniques" would be a more accurate description here as it includes techniques outside of learning theory. The effectiveness of other approaches should be investigated as well as CBT including motivational interviewing, solution-focused brief therapy and systemic approaches.	Noted, thank you.
British Psychological Society			**References**	Noted, thank you .

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			British Psychological Society (2011) *Obesity in the UK: A Psychological Perspective.* Report of a Working Party, Leicester, BPS Chater, A., Martin, J., Smith, L. & Lorencatto, F. *Behaviour change techniques used in randomised controlled trials with children to prevent and treat obesity: A systematic review.* BPS Division of Health Psychology Annual Conference (Southampton, September, 2011) Michie, S., Ashford, S., Sniehotta, F. F., Dombrowski, S. U., Bishop, A., & French, D. P. (2011). A refined taxonomy of behaviour change techniques to help people change their physical activity and healthy eating behaviours: The CALO-RE taxonomy. *Psychology & Health, **26*****(11)**, 1479-1498. Royal College of Physicians. (2013). Action on Obesity: Comprehensive Care for All. Report of a Working Party. London: RCP.	
British Psychological Society			Newson, L., Povey, R., Casson, A., & Grogan, S. (2013)*The experiences and understandings of obesity: Families' decisions to attend a childhood obesity intervention.* Psychology and Health. ISSN 0887-04.) DOI: 10.1080/08870446.2013.803106 Jain, A., Sherman, S. N., Chamberlin, D., A., L., Carter, Y., Powers, S. W., & Whitaker, R. C. (2001). Why Don't Low-Income Mothers Worry About Their Preschoolers Being Overweight? *Pediatrics, **107*****(5)**, 1138-1146. doi: 10.1542/peds.107.5.1138 Jones, A. R., Parkinson, K. N., Drewett, R. F., Hyland, R. M., Pearce, M. S., & Adamson, A. J. (2011). Parental perceptions of weight status in children: the Gateshead Millennium Study. *Int J Obes, **35*****(7)**, 953-962. Taveras, E. M., Hohman, K. H., Price, S. N., Rifas-Shiman, S. L., Mitchell, K.,	Noted, thank you.

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			Gortmaker, S. L., & Gillman, M. W. (2011). Correlates of Participation in a Pediatric Primary Care-Based Obesity Prevention Intervention. *Obesity,* ***19*****(2)**, 449-452.	
British Psychological Society			Domel, S.B., Baranowski, T., Leonard, S.B., Davis, H., Riley, P.& Baranowski, J. (1994a) Accuracy of fourth- and fifth-grade students' food records compared with school-lunch observations.Am. J. Clin. Nutr. **59**, 218S–220S. Martin, J., Chater, A. & Lorencatto, F. *(under review after invited resubmission - International Journal of Obesity).* Effective behaviour change techniques in the prevention and management of childhood obesity.	Noted, thank you.
Children's Food Trust	3	8	Core components should also include the skills families need to shop and budget for, prepare and cook healthier food from scratch	Thank you for your comments on the draft guidance. Recommendation 3 in the final guidance highlights the need for programmes to provide information and help to master skills in modifying culturally appropriate recipes on a budget.
Children's Food Trust	5	12	Ensure staff delivering lifestyle weight management programmes have the skills to promote and share healthier cooking techniques, along with strategies for shopping and budgeting for healthier food	Noted, thank you. In the final guidance Recommendation 12 notes the need to ensure there are staff trained in practical food preparation.
Children's Food Trust	13	19	Skills to teach and demonstrate practical cooking and recipe modification, and to promote advice on shopping and budgeting for healthier food should be	Please see above.

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			among the skills which providers offer	
Children's Food Trust	General		Sustaining the impact of lifestyle weight management programmes relies on giving participants the knowledge and confidence to maintain new behaviours well beyond the completion of the programme. Practical skills for preparing, cooking, shopping and budgeting for healthier foods are among the essential skills participants will need to continue and sustain their healthier lifestyles after completing the programme.	Noted, thank you. This is reflected in the two recommendations outlined above. In addition Recommendation 3 highlights the need for programmes to include strategies to help families identify changes which can be implemented and sustained at home.
Department of Health	General		**I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.**	Noted. Thank you for confirming this.
Diabetes Management and Education Group	General		Overall we feel that the guidance is very comprehensive and we are generally in agreement with it . However there are some points that we feel are worth considering further or need clarification.	Thank you for your comments on the draft guidance.
Diabetes Management and Education Group	General		The majority of the comments made are considered under two of the consultation response headings – points not covered and practicalities . Further consideration is given to the equality issue.	Noted, thank you.
Diabetes Management and Education Group	General		Group sessions or programmes not always appropriate for all patients and guidelines need to be able to be used in an individual setting	Noted, thank you. The PDG was aware of this and have addressed this point in Recommendation 5 and Consideration 3.22 of the final guidance.
Diabetes Management and	General		**Format of the document -** It is quite repetitive in style and could be improved	NICE guidance has to

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Education Group			with some tables/summarising	follow a particular format and template.
Diabetes Management and Education Group		Page 1	Clarification of what does 'overweight issues' mean. The guidance needs to be clear who it is aimed at – is it all children who are defined as overweight or obese, the term 'overweight issues' is confusing The guidance doesn't cover prevention but it does need to acknowledge that environmental, legislative, preventive actions need to be in place to ensure there is a healthy environment which can support maintenance of healthy lifestyles after intervention . It should also strongly indicate the need for such interventions to be part of other wider community initiatives for sustainability and support.	Noted, thank you. This has been addressed in the final guidance. Noted thank you. In the final guidance it has been emphasised that lifestyle weight management services should be provided as part of a locally agreed obesity care or weight management pathway. The focus of this guidance is specifically on lifestyle weight management services, but the PDG have cross referred wherever possible to other relevant NICE guidance, in particular to NICE guidance PH 42 Obesity: working with local com munities which focuses specifically on the issues you describe. Once published, this

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				guidance will also form part of an overall 'Obesity pathway' which will be available on-line and which will show clearly how this guidance interfaces with other NICE guidance which focuses on the prevention and treatment of obesity.
Diabetes Management and Education Group		Page 4	Although the guidance acknowledges the lack of evidence for under 6 year olds it may be useful to consider a consensus of what should be in place for the younger age groups . Minimum levels of service are not indicated - it states '*Ensure services are available* ' This is vague and doesn't put any onus on minimum levels or meeting needs – there should be some guidance in terms of amount of services per 100,000 population or per rates of childhood obesity?	Please see Consideration 3.13 in the final guidance which explains that the PDG were unable to make age- specific recommendations due to a lack of evidence, but notes that they stressed the importance of tailoring programmes according to age and stage of development. The final guidance will be accompanied by a costing report and template which may be helpful in relation to this issue.
Diabetes Management and		Recommendati	Family therapy approaches, cognitive behaviour therapy and motivational	Behaviour change

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Education Group		on 2, page 6	interviewing can be added in to the approach	techniques are included among the core components of programmes in Recommendation 3 of the final guidance.
Diabetes Management and Education Group		Page 6	Welcome action which states dedicated long term funding is needed of at least 5 years duration to support process i.e. development through to monitoring/ evaluation and exploration of outcomes- feel governmental bodies need to fully appreciate this.	Noted, thank you. However, since the consultation period on the draft guidance , there have been changes in funding arrangements for public health and it is not within NICE's remit to make recommendations regarding local government's funding decisions. This recommendation has therefore been revised in the final guidance.
Diabetes Management and Education Group		Page 7	Refers to the need for Registered Dietitians input to programme design. Ongoing support from RD's would also be needed in terms of monitoring and adapting the programme or training for staff as required. It refers to providers being 'appropriately trained to deliver specific programmes. But there should be more detail re what would constitute appropriate training and appropriate and adequate quality assurance processes in place to monitor standards of implementation. Appropriate training should have minimum criteria and or levels of competency or skill and strategic buy in.	Noted, thank you. This has been captured in Recommendations 2 and 11 in the final guidance. Further detail on the training requirements for staff are outlined in Recommendations 11 and 12 of the final

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			It is good to see action requires defining funding of 10% for monitoring and evaluation. It should read as minimum of 10% of budget and that evaluation is planned from the outset to ensure good project management.	guidance. Noted, thank you. Please see the response to the above comment re funding.
Diabetes Management and Education Group		Page 7	Specify what appropriate training is	Please see above.
Diabetes Management and Education Group		Page 8	Recommendation 6 could also be referred to from NICE PH 42 – involving the community i.e. target audience is consulted and needs and motivations are determined.	NICE PH 42 underpins this guidance generally and in the pathway will directly link to this guidance.
Diabetes Management and Education Group		Page 9	Should acknowledge needs will be identified prior to programme design to ensure recipients are involved in whole process. Potential for more emphasis on Motivational Interviewing (MI) consistent approaches.	This is addressed in Recommendation 2 of the final guidance. Recommendation 3 is intended to provide an overview of the core components of programmes and therefore more detail on each aspect is given in later recommendations.
Diabetes Management and Education Group		Page 9	Specify what ongoing support would be. I.e. phone calls, visits, frequency	Please see above.
Diabetes Management and Education Group		Page 10	Give example of moderate to vigorous activity, specify intensity of 60 min to several hours per day	This level of detail is provided in the hyperlink to the UK physical

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				activity guidelines.
Diabetes Management and Education Group		Page 12	Agree with the need for a flexible approach e.g. rolling programme. Although this can be challenging to evaluate. Also agree that consideration should be given to the degree of age ranges considered where practically it may be difficult to engage a wide range from e.g 7-13 in the same group, due to different points of learning/ comprehension/ development. This can contribute to early disengagement of some participants. Regarding maintaining regular contact with participants it may be worth proposing the importance of initial contacts prior to commencing programme e.g. phone call prior to first session to alleviate any potential anxieties/ provide reassurance	Noted, thank you.
Diabetes Management and Education Group		Page 13	**Equality issues -** refers to whether people should pay or not – if this is an NHS service should it not be free at point of entry ? Particularly regarding the higher childhood obesity rates in areas of deprivation and reducing inequalities .We have concerns regarding information on prices for participants being made available by Public Health teams in terms of their role and the impact on recruitment . This type of service has the potential to increase inequities if more affluent families are more able to access the service through better education, awareness, transport etc or if not free at the point of service. If it is going to make a difference to inequalities then all these have to be considered when setting up programmes .	Noted, thank you
Diabetes Management and Education Group		Page 13	**Equality issues cont -** All programmes should seek to be inclusive on the basis of gender, religion, belief, socio economic status . Age – the age range covered needs to take into account different stages of development. General weight management group interventions may not be appropriate for some children with learning disability or physical disability but attempts must be made to be inclusive, or needs assessment undertaken in order to provide alternative provision to meet specific requirements	Noted thank you. Please see Recommendation 2 and Considerations 3.18 and 3.19 in the final guidance.

Public Health Guidance
Overweight and obese children and young people - lifestyle weight management services - Consultation on the Draft Guidance from 19 April 2013 - 18 June 2013

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Diabetes Management and Education Group		Page 13	Agree that it helps to have the same staff throughout each cycle of the programme - staff changes have led to increased attrition in local examples . Children & families more likely to respond and share information once they get to know the programme leader. Although there are practical difficulties in achieving this and attention needs to be paid to long term funding to aid this so that services are incorporated into job descriptions and integration of the service so it is not seen as a stand alone or add on.	Noted, thank you.
Diabetes Management and Education Group		Page 14	Raising awareness – it is not just about those who have been formally identified but raising issues around concern about being above a healthy weight so people can self refer	Noted thank you. Recommendations 6, 7 and 8 in the final guidance are intended to increase both self-referrals by raising awareness of the availability of programmes and to increase referrals by health professionals.
Diabetes Management and Education Group		Page 15	Agree this should link to MECC and training HCP's and other frontline workers to raise the issue of weight.	Noted, thank you.
Diabetes Management and Education Group		Page 15	final bullet where refers to non judgemental manner- this links with application of MI techniques as in earlier point so it would be worth the document referring to MI	Motivational interviewing is given as an example of a technique which may be used in Recommendation 12.
Diabetes Management and Education Group		Page 16	should 'tell them how' be rephrased to 'provide information about'	Noted, thank you.
Diabetes Management and		Page 17- final	re follow up- in agreement with this as best practice but this has to be	Noted, thank you. No

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Education Group		bullet	balanced with capacity and what provision there is within teams/ health boards. This also relies on robust communication measures between both HP and provider (if they are different) in order to ensure it takes place and that individuals participating in programmes are not lost to follow up. Could it not consider trained peers, community lay support, support workers to provide support.	evidence was identified on the effectiveness of peer supporters in relation to this. However the PDG noted concerns re loss to follow-up and in the revised guidance, it is recommended that monitoring takes place at 6 months and 1 year.
Diabetes Management and Education Group		Page 18	Is 6 month follow up regular enough- i.e. just one follow up in 12 month period.	This has been clarified in the final guidance. On-going support should be provided for at least the first year and longer if possible, depending on the family's needs. Please see Recommendation 10 in the final guidance.
Diabetes Management and Education Group		Page 18	The Guidance refers to alternative lifestyle weight management programmes- are there likely to be more than one – some areas do not have Level 3 for children and in most areas all services for childhood obesity are limited	Noted, thank you. In the final guidance, re-referral to the original provider or an alternative programme may be considered. The PDG were aware that specialist obesity services are not available in all areas and has noted that if not available, referral to a

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				paediatrician might be considered. Please see Recommendation 9 in the final guidance.
Diabetes Management and Education Group		Page 19	Ensure staff can and are able ....how ? this needs to be more explicit re demonstrating competency and skills	Noted, thank you. Your comment has been passed to our Implementation team
Diabetes Management and Education Group		Page 19	the session in training staff- should also include MI training	Recommendation 12 in the final guidance gives motivational interviewing as an example of a behaviour change technique or psychological approach which may be taken.
Diabetes Management and Education Group		Page 20	Recommendation 14- this does not really need to be a separate recommendation – could be built into another – possibly combine 14 + 15 and rename as something that covers the referring process(es)?	Recommendation 15 in the draft guidance concerned both health professionals and programme staff. Recommendation 14 was specifically for health professionals, therefore they do need to be separate. In the final guidance, these appear as Recommendations 13 and 14.
Diabetes Management and Education Group		Page 20	could include learning outcomes for training programmes i.e. what systems will be in place to ensure staff are trained to a level that they feel confident to raise complex issue and deliver CWM programmes. Often lay people will be	Recommendation 2 and 11 in the final guidance state that the multi-

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			delivering programmes and e.g. leisure centre staff whilst confident to undertake PA sessions with Children and young people, they are not always confident to cascade evidence based nutrition messages to parents without adequate training and ongoing professional support e.g. from Registered Dietitians.	disciplinary team is responsible for designing and reviewing programme content and training and that staff training needs are regularly reviewed by the multi-disciplinary team.
Diabetes Management and Education Group		Page 21	mentions about staff being overweight – what if underweight ?. Should there be screening of staff involved in delivery re any personal food or weight issues that may impact on their delivery, also with regard to having positive attitudes and being non judgemental, show empathy and being able to raise the issue of weight sensitively .	The PDG made a recommendation regarding this issue as there is evidence from the Childhood Obesity National Support Team's findings that a lack of confidence to deliver weight management interventions was in some cases related to staff being overweight themselves. The PDG did not review any evidence on the other issues you suggest and therefore have not made recommendations regarding this.
Diabetes Management and Education Group		Page 22-23	Monitoring, BMI etc. there is no mention of Waist Circumference – it would be helpful to cross reference this across to NICE 2006 guidance which doesn't appear to advocate for routine WC measurements, however this is a measure that some programmes use, so requires specific guidance	NICE guidance CG43 Obesity does not recommend the use of waist circumference in children and young

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				people and as above, the PDG did not review the evidence in this area. Therefore they have not made recommendations on the use of waist circumference as an outcome measure.
Diabetes Management and Education Group		Page 30	The PDG noted that programmes were commissioned and bought in and rarely tailored to meet local needs – this needs to be balanced against cost of developing own programmes , and the reduced ability to compare outcomes if tailored or altered too much .	The guidance makes recommendations for all programmes, regardless of whether they are 'bought in' or developed 'in house'. In either case, the PDG wanted to ensure that they were tailored to address local needs.
Diabetes Management and Education Group		Page 30	re encouraging adherence to programmes and tailoring to local needs, it is critical as part of supporting families in the longer term that any lifestyle/ weight management programme that is commissioned is integrated with other services and programmes (especially preventative services working within settings such as Eearky years, schools, youth sector and leisure services). Along with this key messages about lifestyle- food & PA need to be consistent across the board (Change4life helps with this). Any potential 'provider' should be required to clearly demonstrate the links between their programme and existing services such as these. Actually this is highlighted too within point 3.24	Noted, thank you.
Diabetes Management and Education Group		Page 31	Agree range of approaches needed i.e. 1:1 and group, but again expectation and capacity needs to be considered from a practical perspective	Noted, thank you. In the final guidance Recommendation 5 has

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				been amended to address stakeholders concerns about capacity.
Diabetes Management and Education Group		Page 32	**I**ncreasing uptake – recognition of low rates of referral and lack of awareness of programmes by health professionals – this also needs to highlight the lack of awareness of parents of their child's weight	Noted, thank you. In the final guidance, the issue of parental recognition of whether a child is overweight or obese has been addressed in Recommendations 4 and 8 and Consideration 3.21. Recommendations 11 and 13 focus on training programme staff and health professionals to help families to recognise this and to understand the benefits of addressing the child or young person's weight.
Diabetes Management and Education Group		Page 32 (bottom)	again would mention MI training – this could include group based MI to support those working with children, young people and families- engaging people in change talk etc.	Recommendation 12 in the final guidance gives motivational interviewing as an example of a behaviour change technique or psychological approach which may be taken.
Diabetes Management and Education Group		Page 33	Agree with acknowledgement and link to wider PH agenda and importance of creating supportive environments and developing personal skills and self efficacy of staff and health professionals.	Noted, thank you.

Public Health Guidance

Overweight and obese children and young people - lifestyle weight management services - Consultation on the Draft Guidance from 19 April 2013 - 18 June 2013

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Diabetes Management and Education Group		Page 34	Need a consistent approach to gathering evidence of what works for future. Can NOO Standard Evaluation Framework be referred to as an example.	In the final guidance, the NOO Standard Evaluation Framework is referred to from Recommendation 15, which focuses on monitoring and evaluation.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	General		We welcome this comprehensive and timely guidance on an important aspect of public health.	Thank you for your comments on the draft guidance.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	1 Draft recommendations	4	We would like to see a statement about the lack of evidence for interventions for children with disabilities made. This group are more likely to be overweight in the longer-term, however there is currently a lack of appropriate intervention models.	Noted, thank you. Please see Recommendation 2, Considerations 3.18 and 3.19 and Research Recommendation 3 in the final guidance.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 1: Planning lifestyle weight management services for children & young people. What action should they take?	6	We agree that data from the NCMP & JSNA should be used to inform service need. However we would like the following point added: 'Consideration of differential effects of BMI within different specific ethnic groups & potential for ill health should be given., so that in areas with a high proportion of south Asians for example, needs for such services may be higher than in other areas, even if prevalence of overweight and obesity does not appear to be high'. We recognise that this may be contentious, and that NICE is currently examining whether waist circumference and BMI cut-off points should be lower in specific ethnic groups. However even if that recommendation is not made, we would like this opportunity taken to underline that fact that health risks related to body fat are not the same for all population subgroups. We would welcome your consideration of this point.	Noted, thank you. The PDG carefully considered this point but were unable to make any recommendations. While they were aware that there is evidence that adults from black and minority ethnic groups are at risk of obesity associated co-morbidities at a lower BMI than the white European population, it

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				was beyond the remit of this guidance to assess if the same applies to children and young people. Please see Consideration 3.15 in the final guidance.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 2 Commissioning lifestyle weight management programmes for children and young people. What action should they take?	7	BMI for age and gender (BMI z score) is recorded… **if over 2 years of age.** Guidance about measuring progress in the under 2s is required	This point is addressed in Recommendation 8 in the final guidance. This hyperlinks to the Standard Evaluation Framework for practical advice on weighing and measuring children of different ages.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 2: Commissioning lifestyle weight management programmes for children & young people. What action should they take?	7	We would like the following added to the first point: 'commission services offering **multi-component** programmes to meet local needs. **Multi-component means diet, physical activity, behaviour change within the family setting & encouragement of adoption & maintenance of healthy habits'**.	These issues are addressed in Recommendation 3, which provides detail on the type of programmes to be commissioned and their core components.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 2: Commissioning lifestyle weight	7	Under programme objectives, outputs, outcomes & monitoring we would like to see the following points added: Key considerations include monitoring of recruitment & retention, particularly	Please see Recommendation 2 in the final guidance which addresses some of these

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	management programmes for children & young people. What action should they take?		of target groups. Where specific population subgroups (eg age/gender/ethnicity) are being targeted, consider building this into the contract to incentivise recruitment & retention from these potentially hard-to-engage groups. Clear definitions of recruitment & retention must be agreed, and the contract should stipulate that feedback to referring agents occurs regularly.	points.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 2: Commissioning lifestyle weight management programmes for children & young people. What action should they take?	8	We agree that recording outcomes at 1 year post programme is ideal. However it may not, for a variety of reasons, be possible. For this reason we would like to see the following amendment made: **6 months and ideally** 1 year post-completion of the programme.	Noted, thank you. In the final guidance, it is recommended that data are collected at both 6 months and 1 year post-completion of the programme.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 3: Lifestyle weight management programmes: core components. What action should they take?	8	To the points upon which to focus we would like the following addition: **Participation of parent or carer either directly (younger children) or indirectly (adolescents) in the programme.** We recognise that for adolescents attendance of a parent or carer may be neither desirable nor beneficial but for younger children active involvement of a parent or carer is essential. For adolescents and young adults, the involvement of a parent or carer may be less direct depending on the needs of the young person. In addition, the point about physical activity should be split into two points since it is now recognised that that sedentary behaviour is a risk factor in its own right.	The PDG was very aware that a flexible approach would need to be taken regarding parental involvement, This is recognised in Recommendation 5 and Consideration 3.9 of the final guidance. Noted, thank you. this has been addressed in the final guidance.
Dietitians in Obesity Management (domUK), a	Recommendation 3: Lifestyle	9	To the core components we would like to see the following addition: Comprehensive baseline assessment of the child or young person. This	These issues are addressed in

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specialist group of the BDA	weight management programmes: core components. What action should they take?		should include but not be limited to diet, activity levels, sedentary behaviours, weight management strategies, weight and dieting history, self esteem, medical and medication history.	Recommendation 4, which focuses in more detail on the steps taken to developing an individually tailored programme plan.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 3: Lifestyle weight management programmes: core components. What action should they take?	9	To goal-setting, monitoring & feedback we would like to see 'rewards' added.	As no evidence was found in relation to the effectiveness of offering rewards, the PDG were unable to make any recommendations in this area.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 3: Lifestyle weight management programmes: core components. What action should they take?	9	To the final point about ongoing support and follow-up, we would like added: 'including signposting to existing local activities & resources both throughout and post-programme'	This point has been addressed in Recommendation 10 in the final guidance as this focuses in more detail on the ongoing support programmes can offer.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 4: Developing a tailored programme plan	10	We would like the following addition made: 'Offer to weigh, measure determine **and record** the BMI of ....'	This has been added in the final guidance.

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	to meet individual needs. What action should they take?			
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 4: Developing a tailored programme plan to meet individual needs. What action should they take?	10	To the point about physical activity, whilst we recognise the importance of achieving 60 mins of moderate to vigorous intensity activity a day, we feel that as an initial recommendation it may prove counter-productive to those children and young people who are currently very sedentary, have had poor previous experience of physical activity and/or who are very obese. We would rather see an initial assessment of current activity and sedentary behaviours with a tailored plan for each child starting from there they are, aiming to build up to 60 mins a day and ultimately several hours. To this point we would also like to add the importance of signposting to local activities.	This is the approach that is taken in Recommendation 4, beginning with monitoring by the child or their parents (depending on age, stage of development and ability) to identify opportunities to become less sedentary and more active, followed by an emphasis on gradually increasing activity towards the UK physical activity guidelines.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 4: Developing a tailored programme plan to meet individual needs. What action should they take?	10	To the point about dietary changes we would like to see consideration of appropriate portion sizes added.	This point already makes reference to appropriate amounts of foods from each of the food groups.
Dietitians in Obesity Management (domUK), a	Recommendation 5:	11	To the first point we would like the addition of 'or combination' to the group or individual basis, since there may be a preference for a mixture of group and	Noted thank you. In the final guidance

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specialist group of the BDA	Encouraging adherence to lifestyle weight management programmes. What action should they take?		individual sessions either from commissioners, providers and/or users.	Recommendation 5 has been amended to address concerns raised by stakeholders about capacity. It is noted that some families may prefer to attend individual sessions initially and group sessions as their confidence and self-esteem grows.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 6: Raising awareness of lifestyle weight management programmes: commissioners and programme providers. What action should they take?	13	We agree with the first point with relation to public health teams. We would like to see the following additions made to this point: Public health teams should maintain an up to date list of weight management programmes and others relevant to energy intake or expenditure, including (but not limited to) leisure opportunities, access to green spaces, cook and eat sessions, supermarket tours, parenting classes etc. Public health teams should not just hold this information but regularly update and disseminate it including among local authority partners, who can cascade it to education, leisure, planning and other appropriate departments. Information should also include referral criteria, mechanisms for accessing programmes or resources and contact details for further information.	Recommendation 6 in the final guidance has been amended to address these points.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 7: Raising awareness of lifestyle weight management programmes: health professionals.	14	We would like to see dietitians added to 'health professionals in particular general practitioners'.	Noted, thank you. Dietitians have been added as actors to this recommendation in the final guidance.

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	Who should take action?			
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 8: Raising awareness of lifestyle weight management programmes: other professionals and voluntary organisations. Who should take action?	14	We would like to see nurseries added to schools and children's centres.	Early years organisations have been added as actors to this recommendation in the final guidance (see Recommendation 7).
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 9: Formal referrals to lifestyle weight management programmes. What action should they take?	15	We agree that weighing should take place on regularly calibrated scales, but would like it specified that these should be Class III scales.	The PDG have recommended that clinically approved scales are used, in the final guidance.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 9: Formal referrals to lifestyle weight management programmes. What action should they take?	15	To the second point, we would like ethnicity added to the factors which should be taken into account given that there may be differential health effects of body fat even below the current cut-off points for overweight and obesity.	Noted, thank you. Family history and comorbidities are listed among these factors. However, while the PDG were aware that there is evidence that adults from black and minority ethnic groups are at risk of

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				obesity associated co-morbidities at a lower BMI than the white European population, it was beyond the remit of this guidance to assess if the same applies to children and young people. Please see Consideration 3.15 in the final guidance.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 9: Formal referrals to lifestyle weight management programmes. What action should they take?	15	'If the family is not ready to attend…' Should include a statement about following safe guarding procedures as appropriate	All health professionals have a duty to comply with statutory requirements and local policies relating to safeguarding.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 9: Formal referrals to lifestyle weight management programmes. What action should they take?	16	We would like the following point added: 'Explain that the involvement of a parent or carer increases the chances that health habits will be adopted and maintained by children, as well as benefitting the whole family'. AND 'Either complete or refer for a co-morbidity screen (see OCSA guidance)'	These issues are addressed in Recommendation 4 in the final guidance. In recommendation 8 in the final guidance, referring health professionals are expected to take account of co-morbidities.
Dietitians in Obesity	Recommendatio	17	Point 2 should include a statement such as **any improvement in BMI centile**	Noted, thank you.

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Management (domUK), a specialist group of the BDA	n 10: Providing ongoing support: health professionals. What action should they take?		**should be recognised as being positive**	
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 10: Providing ongoing support: health professionals. What action should they take?	17	After the programme has been completed, we would like to see the following point added: Health professionals should signpost to local opportunities to be active or gain appropriate skills (such as walking for health, green spaces, swimming, cook & eat sessions, supermarket tours, parenting skills and so on).	This point has been addressed in Recommendation 10 of the final guidance.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 12: Programme staff: training. What action should they take?	19	In addition to the important overall point about treating children and families with empathy we would like the following point added: By training them in: Appropriate wording to introduce and discuss the topic of weight management	This level of detail cannot be provided by the guidance itself but it will be accompanied by implementation tools which will provide links to such resources.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 13: Programme staff: knowledge and skills. What action should they take?	19	To the first point we would like added: 'as well as current information about resources and opportunities available'.	Noted, thank you.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 14. Training in how to make	20	To the final sentence of the first point we would like added: 'using appropriate wording'.	Please see the response to the earlier point on this matter.

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	programme referrals. What action should they take?			
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 16. Monitoring and evaluating programmes. What action should they take?	22	We make the following observation, that both recruitment and completion need to be clearly defined and agreed as part of the contract. In a multi-session programme does completion mean attendance at 100%, 90%, 80% of sessions? In a rolling programme with multiple sessions what % of sessions need to be attended within a given period of time to constitute completion? Is recruitment attendance at the first session, or more?	Noted, thank you. Recommendation 2 in the final guidance highlights the need for commissioners and providers to agree how 'completion' of a programme will be defined. 'Rolling programmes' are also further clarified in the final guidance. Please see Recommendation 5 and the glossary definition.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Recommendation 16. Monitoring and evaluating programmes. What action should they take?	22	With regard to recruitment and retention we make the additional observation that if specific population subgroups are being targeted, data on recruitment and retention of these subgroups will need to be separately reported especially where the contract differentially rewards this.	Noted, thank you. Please see Recommendation 15 in the final guidance.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	2: Public Health Needs and Practice: Childhood obesity and	24	Reference should be made to non-alcoholic fatty liver disease as a risk.	Noted, thank you. This has been added to this section in the final guidance.

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	health			
Dietitians in Obesity Management (domUK), a specialist group of the BDA	2: Public Health Needs and Practice: Financial consequences	26	Again non-alcoholic fatty liver disease should be specifically mentioned as obesity is becoming the main cause of liver disease now in the UK. Also it should be recognised that many of these co-morbidities may also be present and require management in childhood and adolescence.	Please see above.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	Monitoring evaluation… 3.26	34	Consideration should be given to improving BMI centile, as this is more achievable in the short-term.	As outlined in the 'Principles of weight management' section, in this guidance, BMI centile is used in relation to recommendations focusing on individuals. BMI z score is used in relation to monitoring and research.
Dietitians in Obesity Management (domUK), a specialist group of the BDA	4. Recommendations for research	37	The beginning of the document states that there is insufficient evidence for those 6 years and under – we would like to see this included in this section. In addition, we would like to see consideration of the specific or differing requirements of a programme for children with disabilities included in this section.	Noted, thank you. Both of these issues have been added to Research Recommendation 4 in the final guidance.
Durham County Council	1. Recommendation 2- what action should they	7	Suggest include BMI review at 6 months be included. Most programmes run for 8 to 10 weeks and waiting till 1 year before another review may be rather late to reinforce initial behavioural change that was achieved at the time of involvement with the programme. This is in line with recommendation for the Standard evaluation framework for weight management interventions[3] by the national obesity observatory.	Thank you for your comments on the draft guidance. Noted, thank you. In the final guidance it is recommended that data

[3] National Obesity Observatory, standard evaluation framework for weight management interventions, http://www.noo.org.uk/uploads/doc721_2_noo_SEF%20FINAL300309.pdf, accessed 22/5/13

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	take?			are collected at both 6 months and 1 year post-completion of the programme.
Durham County Council	1. Recommendation 3- who should take action	8	Suggest include public health teams working on obesity and child health and wellbeing	In the final guidance, a link to recommendations primarily for providers is given from recommendation 2, in which public health teams working on obesity and child health and wellbeing and commissioners are actors. This links to recommendations, 3, 5, 10 and 14.
Durham County Council	1. Recommendation 5- who should take action	11	Suggest include public health teams working on obesity and child health and wellbeing	Please see above.
Durham County Council	1. Recommendation 11- who should take action	18	Suggest delete 'Directors of public health and their teams, Local authority commissioners and NHS commissioners' as they are not involved with direct delivery to Children and Young People and their families. The role to ensure on-going support for service users by the commissioners is covered in recommendation 3.	Noted, thank you. Please see the response to the earlier point.
Durham County Council	1. Recom	21	Suggest include Director of public health and public health teams working on	Please see the response

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	mendation 15- who should take action		obesity and child health and wellbeing	to the earlier point.
Hartlepool Borough Council – Healthy Weight, Healthy Lives Group	5 Related NICE Guidance	41	We believe it is important that the NICE Guidance '*Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation*' (PH41) is included in the list of related NICE guidance	Thank you for your comments on the draft guidance.
Hartlepool Borough Council – Healthy Weight, Healthy Lives Group	*Recommendation 4 Developing a tailored programme plan to meet individual needs*	9	We would like this section to include a reference to opportunities to prevent children and young people reaching the stage of requiring lifestyle weight management services. In particular through specific reference to behaviour change interventions such as Walk to School. We would recommend looking at recommendation 8 of the NICE Guidance '*Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation*' (PH41) which recommends to schools '*activities, such as 'Walk once a week' projects, which support and encourage walking and cycling to school*'.	Noted, thank you. Recommendation 4 in the final guidance includes reference to the need to build activity into daily life, including through active play and walking and cycling.
Hartlepool Borough Council – Healthy Weight, Healthy Lives Group	General		The guidance as it currently stands makes very little reference to tackling the issue of childhood obesity by preventing children and young people from reaching the stage of requiring lifestyle weight management services. Recommendation 4 notes **'***For children and young people aged 5–18, aim to gradually increase the amount of moderate to vigorous-intensity physical activity they do every day*'. Programmes such as Living Streets Walk to School programme can help achieve this by encouraging more children and young people to walk to school.	This particular guidance focuses specifically on lifestyle weight management services. However NICE guidance PH17 Promoting physical activity for children and young people. makes recommendations

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				regarding the promotion of physical activity to children and young people and in the final guidance we cross refer to those recommendations.
			Walk to School (WtS) is a national campaign which has existed since 1995 and aims to encourage all parents and children to make walking to school part of their daily routine, emphasising the benefits to physical and mental health and wellbeing, the social aspects and the potential to address congestion, improve air quality and reduce carbon emissions. WtS reaches over 1.9 million children throughout the UK……..cont.…	Noted, thank you.
Hartlepool Borough Council – Healthy Weight, Healthy Lives Group			The best known element of the campaign, and the element around which much of Living Streets' evidence gathering has focused, is the Walk Once a Week (WoW) programme, which over 300,000 children now take part across the UK. WoW sees children record how they travel to school, on a class wall chart or individual postcards. If they walk at least four times a month, they receive a collectable badge for that month, designed in a national art competition which receives thousands of entries from children across the UK each year. These resources are obtained either by the local authority or directly by the school. The health benefits of walking to school are a key driver for the project: for example, children who travel by walking use twice as many calories as those who travel by car. The Walk to School outreach project began as a pilot project funded by the Department for Transport which saw partnership working with Hertfordshire County Council to work intensively with a cluster of schools. This work	Noted, thank you.

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			included using incentive schemes, promotional events, and working with parents and schools to identify and tackle local barriers to more walking….cont…..	
Hartlepool Borough Council – Healthy Weight, Healthy Lives Group			At the end of the project, walking to school had increased from 46% to 53%. Park and Stride (where parents drop off their children at a designated point within walking distance of the school) increased from 8% to 18%, and driving rates decreased from 36% to 19%. **This is one of the most effective interventions we have seen in terms of shifting the mode of travel to school - in the UK and internationally**. As a result of our focus on breaking down behavioural barriers with parents, we saw a 33% reduction in the number of children who perceived school being too far to walk and a 44% reduction in the number who perceived that it took too long to walk to school. The Walk once a Week (WoW) extension project for the Department of Health saw us working with 736 schools and over 118,000 children in order to increase walking levels in schools across England. 61,567 children and 6,515 parents took part in surveys which revealed a 25% increase in numbers of children walking to school (during the project lifetime) and a 35% decrease in car use….cont…..	Noted, thank you.
Hartlepool Borough Council – Healthy Weight, Healthy Lives Group			Before the WoW intervention, schools had a 43% walking proportion, and following the WoW interventions schools reached a peak of 59% walking in 2011, levelling at 54% in 2012 (the final year). In 2012, Living Streets - in partnership with Durham County Council - secured funding through the Government's Local Sustainable Transport Fund to roll out the outreach project in 11 local authority areas. The project targets to convert 4.2 million school journeys from car to walking and a further 2.8 million	Noted, thank you.

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			to Park and Stride, saving an estimated 3.59 thousand tonnes of CO2. In the first year alone we have launched Walk Once a Week (WoW) in 210 primary schools, reaching over 50,000 more children. We have also worked with 42 secondary schools and invested £70,000 in capital improvements to help remove environmental barriers to walking, which has leveraged in further match funding. By the end of the project in 2015 we will have collectively engaged over 1,000 schools (854 primary and 182 secondary). **Early results replicate the success of the pilot project, with walking rates at participating primary schools increasing from 53% to 68%.**	
Hartlepool Borough Council – Healthy Weight, Healthy Lives Group	General		This document is very much welcomed by the Healthy Weight, Healthy Lives Steering Group, particularly as it reflects many of the ideas and plans we have already identified in our own action plan. We agree that a family approach is necessary to implement change in children's dietary and activity levels to sustain results. We are pleased to see that a multi-agency approach is suggested which will only work with full engagement by all partners. To get buy in from everyone proves difficult without contracts being very explicit. We endorse the short term aim of maintaining a child's existing weight as they grow taller – allowing them to 'grow into their weight' resulting in an improved BMI centile over time. Due recognition given to the emotional aspect of being an overweight young person identifying issues of low self esteem and lack of confidence. We endorse firmly the emphasis on evaluation – 10% of overall budget – to ensure good practice is identified allowing an evidence base to be built up.	Noted, thank you for your comments.

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Kent Community Health NHS Trust	Recommendation 4	10	Whilst there is agreement that mental wellbeing needs to be addressed this also needs to be a recommendation for commissioners as well as providers. This is a more specialist role and requires appropriate training and supervision.	Noted, thank you. The guidance recommends that programme staff are trained to identify any concerns regarding a child or young persons mental wellbeing and refer them to their GP for assessment and treatment, and if appropriate, for onward referral to CAMHS. It is not expected that programme staff themselves will address these issues.
Kent Community Health NHS Trust	Recommendation 5	12	There is some conflict in the provision of lifestyle weight management for children and the recommendation that this could be on an individual basis. This role is for specialists such as dietitians. Community programmes will find it extremely difficult to provide a cost effective 1 to 1 delivery.	There is evidence that effective programmes can be delivered on a one to one basis and this may be a preferred option for some families. However in the final guidance, Recommendation 5 has been amended to address stakeholders concerns about capacity.
Kent Community Health NHS	Recommendatio	15	It will be very welcome for there to be guidance for other partners to take	Noted, thank you.

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Trust	n 9		responsibility for raising the issue of weight and referring to community programmes. This can be a very real barrier and requires action.	
Kent Community Health NHS Trust	General		This guidance is urgently required to engage all partners in the healthy weight agenda.	Noted, thank you for your comments.
Ki Performance Lifestyle Ltd.	Recommendation 4	10	We agree that children and young people over the age of 12 should be encouraged to monitor their eating, physical activity and any sedentary behaviour. We would stress the importance of using accurate, reliable, validated, and objective methods to measure and monitor these lifestyle factors in free-living conditions. Self-report instruments have acknowledged limitations in youth (Slootmaker *et al*., 2009), therefore emphasis must be placed on objective assessment techniques such as accelerometry-based activity monitors. Research presented at the American College of Sports Medicine Conference validated the accuracy of the BodyMedia Armband (Ki Fit Armband in the UK) for monitoring activity levels in children aged 10 to 16 (Calabro *et al*., 2011). The Ki Fit is a clinically proven 'multi-sensor' armband employing four sensors; galvanic skin response, skin temperature, heat flux, and a tri-axial accelerometer. From these sensors, the armband captures more than 5000 data points per minute which are interpreted by proprietary algorithms to deliver accurate information on the user's calorie burn, activity, steps, sleep duration and sleep	Thank you for your comments on the draft guidance. Noted, thank you.
Ki Performance Lifestyle Ltd.			efficiency. Thus, wearable technology, such as the Ki System, can play an important role in measuring, monitoring the progress of, and providing feedback on changes made in the aforementioned lifestyle factors in children and young people over the age of 12. Calabro M, Lee J, De St.-Maurice P, and Welk G. (2011) Validation of Pattern-Recognition Monitors in Children Using the Doubly Labeled Water Method. *Presented at the Annual ACSM conference. 2011. Denver, CO.*	

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			Slootmaker S.M., Schuit A.J., Chinapaw M.J.M., Seidell J.C., and van Mechelen W. (2009) Disagreement in physical activity assessed by accelerometer and self-report in subgroups of age, gender, education and weight status. *International Journal of Behavioural Nutrition and Physical Activity,* **6**, 17-26. Welk, Greg, PhD, Validity of consumer-based physical activity monitors during free living conditions, Iowa State University, Department of Kinesiology, College of Human Sciences (*unpublished*).	
Ki Performance Lifestyle Ltd.	Recommendation 5	12	We agree that inclusion of family members, convenience, accessibility, and flexibility are all key factors for promoting adherence to lifestyle weight management programme. In our opinion the internet is the optimum modality for delivering interventions such as this. Delivering weight loss programmes via traditional methods, such as face-to-face interactions with a practitioner, is costly and difficult to scale up. The internet has become widely accessible with internet-based interventions being shown to achieve weight loss outcomes in adults comparable to those delivered face-to-face using similar tools (Harvey-Berino *et al*., 2010; Harvey-Berino *et al*., 2004). In addition, technology-based interventions have been shown to positively influence physical activity behaviour change in children and young people (Lau *et al*., 2011). Furthermore, a recent cost analysis showed that use of the online-technology alone was the most cost-effective strategy per kilogram of weight loss (Archer *et al.*, awaiting publication). Moreover, an intervention in the form of a web-based physical activity diary with social networking and game features was shown to result in increased physical activity and decreased body mass index (BMI) in an adult population (Gotsis *et al*., 2013).	Noted, thank you.
Ki Performance Lifestyle Ltd.			While further research would be required to confirm that gamification would	Noted, thank you .

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			elicit the same effect in children and young people, there is some evidence that it can improve health-related behaviours within this population (Cafazzo *et al*., 2012). Importantly, remote access to each individual's data enables a single practitioner to maintain regular contact with a large number of users during and after any intervention. Thus, those individuals not adhering to the prescribed intervention can be identified and contacted to restore commitment, helping to promote program adherence and retention amongst users. Archer, E, Groessl E.J., Sui, X., McClain, A., Wilcox, S., Hand, G.A., Meriwether, R.A. & Blair, S. (awaiting publication). An Economic Analysis of Traditional and Technology-Based Approaches to Weight Loss: LEAN Study Cost-Effectiveness. Cafazzo, J.A., Casselman, M., Hamming, N., Katzman, D.K., and Palmert, M.R. (2012) Design of an mHealth App for the Self-management of Adolescent Type 1 Diabetes: A Pilot Study. *JMIR Research Protocols,* **14(3)**, e70. Gotsis, M., Wang, H., Spruijt-Metz, D., Jordan-Marsh, M., and	
Ki Performance Lifestyle Ltd.			Valente, T.W. (2013) Wellness Partners: Design and Evaluation of a Web-Based Physical Activity Diary with Social gaming Features for Adults. *JMIR Research Protocols*, **2(1)**, e10. Harvey-Berino, J., Pintauro, S., Buzzell, P., & Gold, E.C. (2004) Effect of internet support on the long-term maintenance of weight loss. *Obesity Research*, **12**, 320-329. Harvey-Berino, J., West, D., Krukowski, R., Prewitt, E., VanBiervliet, A., Ashikaga, T., & Skelly, J. (2010) Internet delivered behavioural obesity treatment. *Preventive Medicine*, **51 (2)**, 123-128.	

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			Lau, P.W.C., Lau, E.Y., Wong, D.P., and Ransdell, L. (2011) A Systematic Review of Information and Communication Technology-Based Interventions for Promoting Physical Activity Behaviour Change in Children and Adolescents. *Journal of Medical Internet Research*, **13(3)**, e48.	
Knowsley MBC Public Health	Recommendation 10	17	Is there any evidence that 6mths post completion is robust to measure sustainable change, it is likely that many families may not re-engage after 12mths. 12mths may be impractical.	Thank you for your comments on the draft guidance. In the final guidance, it is recommended that monitoring takes place at 6 months and 1 year, in order to maintain better contact with the programme participant.
Knowsley MBC Public Health	General		Is there any evidence / recommendation on min length of intervention /engagement for a programme to be successful, taking into consideration the longer a programme is the smaller numbers that may adhere and complete. Our local programme has struggled to engage families for longer than a 6month period. Greater than 6mths in service may be impractical, though ongoing support practical beyond 6months. .	The PDG did not make recommendations regarding the optimal length of programmes. This was because even in programmes of longer duration, the effect appears to diminish over time once the programme has been completed. For this reason, the PDG focused on providing ongoing support after programme completion.

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				Please see Consideration 3.30 in the final guidance.
Knowsley MBC Public Health	General	9	Welcome the recommendations on tailoring and adherence. With greater prevalence of obesity in areas of deprivation, is there any specific information for tailoring that works for families that face greater barriers to access and adherence.	There was a dearth of evidence as to how barriers and facilitators vary by population sub-group. The PDG therefore made a research recommendation in this area. See Research Recommendation 3 in the final guidance.
Knowsley MBC Public Health	Recommendation 16	22	Welcome the clarification of monitoring measures	Noted, thank you.
Knowsley MBC Public Health	General		The guidance does distinguish between approaches for overweight or obese children. Is there anything additional that should be provided for obese children?	The guidance makes recommendations for children and young people who are overweight or obese. Recommendations 3 and 4 highlight the importance of an individually tailored plan, which considers various factors including 'how obese or overweight' the child or young person is. Consideration 3.14 refers to severely obese children .

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Knowsley MBC Public Health	Recommendation 9	15	This does not provide any guidance on use of NCMP feedback letters to communicate weight and offer referral to support. Guidance on how this process could be used and communicated most effectively would be welcome.	The PDG was aware that staff working on the National Child Measurement Programme are well placed to raise awareness of the availability of programmes and this is reflected in Recommendation 7 and Consideration 3.26 in the final guidance. However, the PDG did not review any evidence on how the findings of the NCMP can be best communicated to parents and carers and so they have made a research recommendation in this area. See Research Recommendation 4 in the final guidance .
Knowsley MBC Public Health	1 (Recommendation 1)	6	Public Health Teams will find it difficult to dedicate long term funding (at least 5 years) to programmes, when their funding has only been agreed for two years.	Noted, thank you. this has been amended in the final guidance.
Knowsley MBC Public Health	1 (Recommendation 3)	9	Core components of Lifestyle Weight Management Programmes should include relevant local information, for example, where are the opportunities for the child to do physical activity e.g. the park, local leisure centre, and where are the shops that sell fresh produce. How does the family access this	Recommendation 3 is an overview recommendation and cannot provide this level

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			provision e.g. do they have a car or would need to get a bus? The cost of activities/food and accessing them should also be considered.	of detail. Some of these issues are addressed in later recommendations.
Knowsley MBC Public Health	1 (Recommendation 4)	11	*'Changes to diet should take into account the child or young person's likes and dislikes'* – Whilst I think this should ideally be the case, there are some children who will not like anything healthy and where there is an argument for introducing small portions of different types of food which a child may not initially like.	Noted, thank you.
Knowsley MBC Public Health	1 (Recommendation 5)	12	*'Offer programmes in venues which have the necessary facilities, are easily accessible and where the child or young person and their family feel comfortable. For example, local community venues which have space for physical activities or games, and which can be reached quickly and easily by walking, cycling or using public transport.'* – Fully agree and help could be offered to participants in order to support them to access sessions e.g. personalised travel planning.	Noted, thank you.
Knowsley MBC Public Health	1	All	Recommendations seem to lack focus on the provision of services within deprived areas, likely to have the highest rates of obesity. There could be a greater focus on provision of free services, cost effective ways to access opportunities for physical activity and healthier food, including means of travel.	Noted, thank you. Recommendation 3 in the final guidance highlights the need for programmes to provide information and help to master skills in modifying culturally appropriate recipes on a budget. And recommendation 4 focuses on ways to build physical activity into daily life, for example through active play and walking or cycling.
Knowsley MBC Public Health	General	P 7,8, 10 General	This consultation document suggests that 'mental well-being', i.e. depression; self-harm etc. is r*elated to the weight of the child/ young person* suggesting	Noted, thank you for highlighting this. The

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			that it is only a consequence of being obese. Whilst some psychological distress occurs in this way, my clinical experience (Clinical Psychologist within Childhood Obesity Service) of working with obese children/ young people, leads me to state that 'mental well-being' issues often *precede and lead to obesity*. I have found that the complex interplay of dysfunctional/ chaotic family systems together with psychosocial factors, for example, exposure to domestic violence, sexual abuse together with neglectful/ permissive/ authoritarian parenting styles often *predispose & precipitate overeating and obesity.* Children/ young people 'cope' with chaotic life experiences and subsequent psychological distress by 'comfort eating'. There is usually a degree of shame and perceived failure tied to the child's overeating together with low self-esteem, poor relationships within the family and social isolation. Offering clinical psychology 1:1 or group parent work as an integrated part of weight management services can lead to a fuller understanding of how these psychosocial issues impact upon emotions/cognitions & behaviour and be modified through evidence-based psychological treatment interventions including CBT and Positive Parenting programmes to name a few. Dr Justine Kelly, Clinical Psychologist	final guidance addresses this point in Recommendation 4 and notes that where there are concerns about the mental wellbeing of a child or young person, they should be referred to their GP for assessment and treatment and if appropriate, for onward referral to CAMHS.
Living Streets	5 Related NICE Guidance	41	We believe it is important that the NICE Guidance '*Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation*' (PH41) is included in the list of related NICE guidance	Thank you for your comments on the draft guidance.
Living Streets	*Recommendation 4 Developing a tailored programme plan to meet individual needs*	9	We would like this section to include a reference to opportunities to prevent children and young people reaching the stage of requiring lifestyle weight management services. In particular through specific reference to behaviour change interventions such as Walk to School. We would recommend looking at recommendation 8 of the NICE Guidance '*Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation*' (PH41) which recommends to schools '*activities, such*	Noted, thank you.

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			as 'Walk once a week' projects, which support and encourage walking and cycling to school'.	
Living Streets	General		The guidance as it currently stands makes very little reference to tackling the issue of childhood obesity by preventing children and young people from reaching the stage of requiring lifestyle weight management services. Recommendation 4 notes **'***For children and young people aged 5–18, aim to gradually increase the amount of moderate to vigorous-intensity physical activity they do every day*'. Programmes such as Living Streets Walk to School programme can help achieve this by encouraging more children and young people to walk to school. Walk to School (WtS) is a national campaign which has existed since 1995 and aims to encourage all parents and children to make walking to school part of their daily routine, emphasising the benefits to physical and mental health and wellbeing, the social aspects and the potential to address congestion, improve air quality and reduce carbon emissions. WtS reaches over 1.9 million children throughout the UK……..cont.…	Recommendation 4 in the final guidance includes reference to the need to build activity into daily life, including through active play and walking and cycling. Noted, thank you.
Living Streets			The best known element of the campaign, and the element around which much of Living Streets' evidence gathering has focused, is the Walk Once a Week (WoW) programme, which over 300,000 children now take part across the UK. WoW sees children record how they travel to school, on a class wall chart or individual postcards. If they walk at least four times a month, they receive a collectable badge for that month, designed in a national art competition which receives thousands of entries from children across the UK each year. These resources are obtained either by the local authority or directly by the school. The health benefits of walking to school are a key driver for the project: for example, children who travel by walking use twice as many calories as those who travel by car. Our Walk to School outreach project began as a pilot project funded by the	Noted, thank you.

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			Department for Transport which saw us work in partnership with Hertfordshire County Council to work intensively with a cluster of schools. This work included using incentive schemes, promotional events, and working with parents and schools to identify and tackle local barriers to more walking….cont…..	
Living Streets			At the end of the project, walking to school had increased from 46% to 53%. Park and Stride (where parents drop off their children at a designated point within walking distance of the school) increased from 8% to 18%, and driving rates decreased from 36% to 19%. **This is one of the most effective interventions we have seen in terms of shifting the mode of travel to school - in the UK and internationally**. As a result of our focus on breaking down behavioural barriers with parents, we saw a 33% reduction in the number of children who perceived school being too far to walk and a 44% reduction in the number who perceived that it took too long to walk to school. Our Walk once a Week (WoW) extension project for the Department of Health saw us working with 736 schools and over 118,000 children in order to increase walking levels in schools across England. 61,567 children and 6,515 parents took part in surveys which revealed a 25% increase in numbers of children walking to school (during the project lifetime) and a 35% decrease in car use….cont…..	Noted, thank you.
Living Streets			Before the WoW intervention, schools had a 43% walking proportion, and following the WoW interventions schools reached a peak of 59% walking in 2011, levelling at 54% in 2012 (the final year). In 2012, Living Streets - in partnership with Durham County Council - secured funding through the Government's Local Sustainable Transport Fund to roll out the outreach project in 11 local authority areas. The project targets to convert 4.2 million school journeys from car to walking and a further 2.8 million to Park and Stride, saving an estimated 3.59 thousand tonnes of CO2. In the	Noted, thank you.

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			first year alone we have launched Walk Once a Week (WoW) in 210 primary schools, reaching over 50,000 more children. We have also worked with 42 secondary schools and invested £70,000 in capital improvements to help remove environmental barriers to walking, which has leveraged in further match funding. By the end of the project in 2015 we will have collectively engaged over 1,000 schools (854 primary and 182 secondary). **Early results replicate the success of the pilot project, with walking rates at participating primary schools increasing from 53% to 68%.**	
London Borough of Newham			In terms of regular input it would be good to know how regular is deemed regular - weekly, fortnightly etc?	Thank you for your comments on the draft guidance. Apologies, but it is unclear as to which recommendation this comment refers.
London Borough of Newham			The report also mentioned prompt follow up for families that miss a session as soon as possible to restore commitment, particularly with disadvantage groups . It would be good if there was a bit more guidance around how to achieve this. What has been shown to work, perhaps particularly with disadvantages groups. It's a bit too simplified here and doesn't really offer much guidance in an area we already know to be challenging.	The PDG have provided as much detail as they were able to, based on the evidence available.
London Borough of Newham			The effect of weight management programmes for the under 5's remains unclear - perhaps an area of future work that could be focused on?	The PDG has made research recommendations in this area. Please see Recommendations 3 and 4 in the final guidance.
London Borough of Newham			Really good to use the NCHP to identify areas of need and also a good idea to get NCMP staff to signpost/ refer parents.	Noted, thank you.

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London Borough of Newham			Perhaps need more emphasis on making parents aware of why child's weight is important and why it is important for them to 'grow into their weight'. As parents are the main influence of a child's diet, especially when at home, it is important to assess readiness in parents.	Noted, thank you. This is addressed in Recommendations 4 and 8 in the final guidance.
London Borough of Newham			The report focuses a lot on long terms effectiveness and on-going support- how long would families need to be in the programme and how would families be retained in programmes?	The PDG did not make recommendations regarding the optimal length of programmes. This was because even in programmes of longer duration, the effect appears to diminish over time once the programme has been completed. For this reason, the PDG focused on providing ongoing support after programme completion. Please see Consideration 3.30 in the final guidance.
NHS Sussex	General		How should children and young people weight management programmes link with those for adults? it is recognised that there are often obese parents where there are obese adults, and they should also be supported to change their lifestyles.	Thank you for your comments on the draft guidance. Noted, thank you. In the final guidance it is recommended that information about local

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				lifestyle weight management programmes for adults should be offered to adults who are overweight or obese.
NHS Sussex	Section 1 recommendation 1	6	Local authority commissioners should include those commissioning childrens services ie social care and schools (Education and planning)	Noted, thank you. Local authority commissioners and children's services are listed as actors in recommendations focusing on commissioning in the final guidance.
NHS Sussex		6	whilst the national focus of the NCMP remains as a surveillance programme there is little incentive for those parts of the system who are not responsible for the target to use the information to target the interventions at those that need it.	Noted, thank you. Please see Recommendation 7, Consideration 3.26 and Research Recommendation 4 in the final guidance.
NHS Sussex	Section 1 recommendation 2	7	Training needs to include training/experience of working with children and their family. also that referral criteria are clear and adhered to, based on the experience of the staff ie additional issues with children with special needs	Noted, thank you. Recommendation 2 in the final guidance addresses these points.
NHS Sussex		7	There is now a national specification for these services - will there be a national evaluation tool or is the NOO evaluation tool that which is recommended?	Recommendation 15 in the final guidance hyperlinks to the NOO Standard Evaluation Framework.

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NHS Sussex	Recommendation 3	Page 8	Additional people to take action providers of leisure/ physical activity centres. schools with suitable environment /space	This recommendation is specifically for the providers of programmes as it focuses on the core content of the programme.
NHS Sussex		Page 9	How would you recommended that paostivie parenting training is done as providers with the other skills are confident in doing this	In the final guidance it is recognised that positive parenting skills training may be provided by staff with a particular specialism i.e. not all programme staff would be expected to be trained in this, but there should be access to some staff who can provide this input.
NHS Sussex			Education around skills should include cookery skills and menu planning	This is included in Recommendation 3.
NHS Sussex		Page 9	the range of activities included should be ones that are available locally following cessations ot the programme so that participation can be maintained	Noted, thank you. In the final guidance, this point is addressed in Recommendation 10.
NHS Sussex	Recommendation 4	Page 10	The provider needs to know how to deal with anything that is identified related to psychological distress,b y knowing how and where to refer onto	Noted, thank you. This is addressed in Recommendation 4 – If there are concerns about the mental wellbeing of any child or young person they should be referred to their GP for

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				assessment and treatment and if appropriate, for onward referral to CAMHS.
NHS Sussex	Recommendation 5	Page 11	Schools should also take action as they are where young people spend a significant amount of their time in school – there is a role for PSHE and healthy schools	The PDG discussed the role of schools in detail, however while they felt it would be appropriate for school nurses or school health care teams to make formal referrals to programmes and provide ongoing support (see Recommendations 8,9 and 13) they did not feel this would be an appropriate role for teachers or other school staff. The evidence indicates that health professionals sometimes lack the confidence to raise the issue of obesity with parents. Yet it is part of health professionals' role to point out the health implications of being obese. The PDG did not feel it was appropriate for staff to be expected to do this, or that they or

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				parents would necessarily see it as part of their role. In addition it was queried if they be in a position to provide the ongoing monitoring and support that the school nurse or school health care team could provide (see Recommendation 9 in the final guidance). Finally they were aware that some children and young people fear of being bullied by their peers. For example, the report commissioned by the PDG into the practical and process issues of delivering weight management interventions, shows that in some cases children and young people may not be willing to attend a programme delivered on school premises for fear of being bullied.
NHS Sussex	Recommendatio	Page 15	I think leaders of recreational activities will need training as most ot these wouldn't see this as their role at present	Noted, thank you. This has been removed in the

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	n 8			final guidance.
NHS Sussex	Recommendation 16	Page 23	Views of participants to include parents and young people	As the programmes are family based, parents and carers are included within participants.
Oxford Health NHS FT	Planning services	7	I think there should be input from professionals experienced at working psychologically with families e.g. family therapist or other clinicians trained in family work from CAMHS	Thank you for your comments on the draft guidance. Noted. In the final guidance, it is recommended that the multi-disciplinary team includes a clinical or health psychologist – see Recommendation 2. Recommendations 4 and 8 highlight the need to refer any children or young people for whom there are concerns re mental wellbeing to their GP for assessment and treatment and if appropriate for onward referral to CAMHS for specialist support.
Oxford Health NHS FT	Follow up	18	Evidence indicates that it is hard to maintain progress following weight loss programmes. Therefore the follow-up period should be at least two years to maximise the benefits of the programme. Ideally there should be frequent follow up sessions initially, gradually becoming less intensive as progress is maintained.	The PDG have provided as much detail as they were able to, based on the evidence available.

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Oxford Health NHS FT	Teams	19	Some more work needs to be done clarifying the range of professionals needed to carry out the work. This should ideally include CAMHS professionals such as family therapists, psychologists, CPNs, working alongside physical therapists, paediatrics and dieticians.	Please see response to the comment above.
Play England	**General**		Given the central role that play has in children's lives there should be more emphasis on unstructured, active, energetic play in line with the Chief Medical Officers' recommendations in *Start Active, Stay Active* and the British Heart Foundation's *Early Movers* publications.	Thank you for your comments on the draft guidance. Noted, thank you. In Recommendation 4 in the final guidance, active play is recommended as one way of gradually increasing activity levels.
Play England	**General**		Add opportunities to play to programmes throughout. There are local play opportunities from staffed adventure playgrounds to community temporary street closures to 'friends of' green spaces that are not fully tapped by the public health sector.	Noted, please see response to the comment above. This particular guidance focuses specifically on lifestyle weight management services. However NICE guidance PH17 Promoting physical activity for children and young people. makes recommendations regarding the promotion

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				of physical activity to children and young people and in the final guidance we cross refer to those recommendations.
Play England	**General**		The importance of children's friendship patterns in their neighbourhoods, at school and in extended families needs to be emphasised. This is the foundation of confidence, safety – and fun.	Noted, thank you.
Play England	1 Recommendation 1	6	We welcome the emphasis on a community-wide and multi-agency approach which should include play providers across the early years, play and youth sectors	Noted, thank you. Please see the comment above on the scope and focus of this particular guidance.
Play England	1 Recommendation 2	7	Play specialists should be mentioned as part of key people to be commissioned. Commissioning strategies should reference other children's services strategies including the play strategy.	Noted, thank you. Please see the comment above on the scope and focus of this particular guidance.
Play England	1 Recommendation 3	9	Add unstructured, active energetic play to reflect the CMO and BHF recommendations and 'join up' the messages. Games, dancing and aerobics are only a very small part of beneficial play activities that attract children.	In Recommendation 4 in the final guidance, active play is recommended as one way of gradually increasing activity levels.
Play England	1 Recommendation 5	12	Open access adventure playgrounds and other good quality play areas are effectively local gyms where children 'vote with their feet' to attend.	Noted, thank you. Recommendation 10 refers to local services and facilities. Recommendation 6 includes maintaining a

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				list of all services commissioned as part of the local obesity care or weight management pathway.
Play England	1 Recommendation 6	13, 14	Local play projects are free or very low-cost. Doorstep local 'playable space' is free. The 'fun aspect' is inherent and this needs to be emphasised more in the guidance.	Please see above.
Play England	1 Recommendation 14		Training in referrals should include information on how to access information on local play provision across early years, play, recreation, greenspace and so on. This should be a priority for joining up the new public health duty with other children's services strategies, including the play strategy.	Noted, thank you.
Portsmouth City Council	1	Pg 4-5	Why is there a different thresholds between clinical assessment and NCMP/Health Survey for England for classification of overweight/obesity in children? Surely one UK classification system would be more sensible.	Thank you for your comments on the draft guidance. The thresholds have not been defined by this guidance, but are standard practice. Please see A simple guide to classifying weight management in children.
Portsmouth City Council	General		Making it more explicit that there is a need to ensure a range of services/interventions are available is crucial, as there is a danger of automatically thinking about group based approaches when programmes are mentioned, but one size doesn't fit all. Group-base, 1-2-1, peer education etc. should all be considered as well as range of venues not just usual i.e. schools, leisure centres	Recommendation 2 states that services should be commissioned that meet a range of needs. Services are defined in the guidance as consisting of one or more programme. Please see also

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				Recommendation 5 and Consideration 3.22 in the final guidance.
Portsmouth City Council	General		The importance of consulting with your target audience i.e. the families of children who are overweight/obese to find out need, types of support and acceptability of potential interventions isn't explicitly threaded through the guidance and if it was the localisation and ensuring programme meet needs that is mentioned in one section (3:13 pg 30) would be less stand alone and more embedded as a way of approaching/designing interventions.	Noted, thank you. This issue is addressed in Recommendation 2 of the final guidance.
Portsmouth City Council	1	Pg 9	Providing information is vital but emphasis needs to be put on skills and confidence, practical cookery skills have been lost through removal of home economics from curriculum and local social marketing research into play in Portsmouth found that parents didn't have the skills and lacked confidence to play games with their children, so there needs to be an element of interventions that develop skills/confidence around healthy eating/physical activity.	Noted, thank you. Please see Recommendation 4 in the final guidance. please also note that this particular guidance focuses specifically on lifestyle weight management services. However it cross refers to other guidance relevant NICE guidance which makes recommendations on promoting healthy eating and physical activity to children, young people and families. For example NICE guidance PH17 Promoting physical activity for children and young people.and NICE guidance PH 11

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				Maternal and child nutrition.
Portsmouth City Council	1	Pg 9	Interventions need a robust evaluation and long-term follow-up to contribute to the evidence base that is lacking	Noted, thank you.
Portsmouth City Council	1	Pg 9	Need for a wide range of interventions that will meet the needs of target audience i.e. tailored programmes not just a singular approach	The remit of this guidance is specifically about lifestyle weight management services. However this guidance is complemented by a range of other NICE guidance which does focus on working in schools, communities and other settings. See NICE guidance PH 42 Obesity: working with local com munities, NICE guidance PH17 Promoting physical activity for children and young people. and NICE guidance CG43 Obesity which may be of interest.
Portsmouth City Council	1	Pg 11	Ensure that confidence and skills needed to make the changes have been thought about and incorporated into the programme to enable participants the best chance of success, things such as practical skills, emotional resilience, self-help tools, exploring/building social support networks etc.	Noted, thank you.
Portsmouth City Council	1	Pg 13	Ensure programmes are relevant to participants needs e.g. age appropriate resources/information, cover issues they value/need support with not just a set programme	Recommendation 4 focuses on tailoring the programme to meet individual needs.

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Portsmouth City Council	1	Pg 13	On-going continued support to the child/family from a range of specialists e.g. healthy eating, behaviour change, physical activity at time and place convenient to them	Ongoing support is addressed in Recommendations 9 and 10 in the final guidance.
Portsmouth City Council	1	Pg 15	Very medicalised as to who should take action, esp. as now public health responsibility within local authority need to widen thinking and include other professionals e.g. social workers, parenting teams, children centre staff, youth workers, health trainers, youth workers etc. as the non-medical professionals may have a better relationship/rapport with children/families embracing every contact counts. Plus self-referral with the proviso that screening takes place to ensure suitability of intervention for individual/family (opportunity to signpost if required).	Noted, thank you. The PDG were aware of the need to increase self referrals to programmes and made recommendations in this area . The use of a locally agreed co-morbidities assessment tool, where available, has also been recommended -See Recommendations 6, 7 and 4 in the final guidance. Some of the professionals mentioned here are listed as actors in Recommendation 7. However the PDG was also conscious these groups may not be as well placed to provide the monitoring and ongoing support required as health professionals, for example in monitoring BMI centile and assessing when a

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				child or young person may need to be referred to specialist obesity services. The PDG have therefore also made recommendations which focus on making formal referrals to programmes by health professionals.
Portsmouth City Council	1	Pg 17	Again much wider group to take action i.e. non-medical professionals e.g. social workers, lead professionals, community workers etc. especially when working with children on CAFs or child protection plans around weight, wide range of multi-agency support across professional disciplines not just medical needed.	Please see above.
Portsmouth City Council	1	Pg 17	Who's responsible for monitoring child? Refer? And should there not be set additional markers not wait until 1 year e.g. 3, 6 months at very least?	In the revised guidance, it is recommended that with the participant's permission, feedback is sent by providers to the GP or referring health professional. See Recommendations 9 and 10 in the final guidance. It is also recommended that monitoring takes place opportunistically and at 6 months and 1 year post programme completion.
Portsmouth City Council	1	Pg 18	In addition to referral to alternative WM programme individual referral to specialist area for targeted support e.g. physical activity, behaviour change,	The PDG have provided as much detail as they

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			mental health etc.	were able to, based on the evidence available.
Portsmouth City Council	1	Pg 19	Training for staff needs also to cover wider determinants of health i.e. factors that can impact on why a child/children & their family are overweight/obese e.g. education, housing, socio economic, lack of access to green spaces, poverty, cultural beliefs, social norms etc.	Noted, thank you. Please see Recommendation 11 in the final guidance which highlights the importance of training staff in the reasons why some children and young people may have difficulty managing their weight.
Portsmouth City Council	1	Pg 19	Train staff in behaviour change/motivation interviewing skills/techniques and provide a range of tools/strategies to use in practice when using client-centred approach within various interventions	Please see Recommendation 12 in the final guidance.
Portsmouth City Council	4	Pg 38	Ensure there is scope to collect and report any unexpected outcomes both positive and negative to build a better understanding	This point has been addressed in Research Rcommendation 1 in the final guidance.
Portsmouth City Council	4	Pg 40	In addition to encouraging parents to participate in programmes they should be able to gain support in a ay acceptable to them i.e. not necessary a programme, back to one size doesn't fit all and need to tailored support to meet needs	Noted, thank you.
Public Health England	1 Draft recommendations	5	Footnote states that the National Child Measurement Programme uses the 85th ad 95th centiles for defining overweight and obesity. This should be reworded to make clear that these thresholds are used in the population level analysis of the NCMPdata, whereas the clinical thresholds (91st and 98th centiles) are used for the purposes of individual feedback of results to parents.	Thank you for your comments on the draft guidance. Noted, thank you. This has been amended in the final guidance.
Public Health England	1 Draft recommendation	7	Second bullet, states that programmes should be designed and developed with input from a multi-disciplinary team that specialises in children and young	Noted, thank you. This has been added to

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	s		people and can provide expertise for each component of the programme" . Could the recommendations also encourage the involvement of children, young people and parents/carers in the design and development of the programmes? If there is no evidence on which to base such a recommendation then should this be included in section 10 'Gaps in the evidence'? Bullet 4. We recommend this is amended to 'a minimum of 10% of the budget and resources…' Final bullet. It is critical that baseline measures are taken before any intervention activities begin. This is not necessarily the same as 'start of the programme'. For example baseline height and weight may be taken at the end of the first counselling or discussion session, which would be likely to bias attitudinal measures.	Recommendation 2 in the final guidance. Noted, thank you. However, since the consultation period on the draft guidance , there have been changes in funding arrangements for public health and it is not within NICE's remit to make recommendations regarding local government's funding decisions. This recommendation has therefore been revised in the final guidance. Noted, thank you. In the final guidance, it is recommended that measures are taken at recruitment.
Public Health England	1 Draft	8	The issue of poor parental recognition / acceptance of their child's weight	In the final guidance this

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	recommendations		status as a barrier to take up of child weight management services is not mentioned in the guidance. Would be useful to include mention of this the first bullet on "barriers discouraging uptake of programmes". If there is not sufficient evidence to include a reference to this, suggest it be included in section 10 'gaps in the evidence'	issue is addressed in Recommendations, 4, 8, 11, 13, and Consideration 3.21.
Public Health England	1 Draft recommendations	9	Could the point on 'tailoring of programmes to meet individual need' mention of poverty and the influence of income in relation to accessing healthy diet/ how to eat healthily on a low budget? If there is no evidence on which to include a reference to this, suggest it be included in section 10 'gaps in the evidence'	Noted, thank you. In the final guidance several additions have been made regarding meeting the needs of low income families. Recommendation 2 notes the need to specify particularly at risk groups which may be being targeted, in programme specifications and contracts. Low income families and neighbourhoods have been given as an example. Recommendation 3 includes cultural background, economic and family circumstances to the list of factors that a tailored programme plan needs to take account of. Also, 'on a budget' has been added to 'how to modify culturally appropriate recipes' In Recommendation 4 re

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				developing a tailored programme plan, 'affordable' has been added to dietary changes.
Public Health England	1 Draft recommendations	9	Could links to schools and GPs be mentioned in the point about ongoing support and follow-up for participants who have completed the programme.	Recommendation 3 focuses on prviding an overview. More detail on providing ongoing support is given in Recomemndations 9 and 10 in the final guidance.
Public Health England	1 Draft recommendation	10	In the penultimate bullet on this page a less sedentary example is provided. Is there sufficient evidence to provide a healthy eating example?	A physical activity example was given as expert paper 6 identified that stimulus control is known to be more effective in relation to physical activity and sedentary behaviours.
Public Health England	1 Draft recommendations	10	In the final bullet on this page regarding gradually increasing PA, the phrase "several hours" a day is vague, and subject to interpretation. Could this be quantified more precisely? We also suggest it would be worth adding the point that activities should be integrated into everyday life and routines, rather than just 'activities' that are 'accessible'. This might imply additional leisure activities and sport rather than walking, cycling and play.	Noted, thank you. Recommendation 4 in the final guidance links to the UK Physical Activity Guidelines, which give further detail on amounts of physical activity. Activities which can be built into daily life are also included with active play, walking and cycling given as

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				examples.
Public Health England	1 Draft recommendations	11	Both the Scientific Advisory Committee on Nutrition (SACN) and the Chief Medical Officer's found that the totality of evidence from intervention studies showed that for adults weight loss programmes based on exercise alone were not successful in achieving weight loss. Programmes that combined exercise with calorie restriction or calorie reduction alone were successful if sustained in the long term. Regular aerobic activity was shown to help maintain weight loss over time. It is likely that the same principles apply to children and young people. (Source: Dietary Reference Values for Energy, SACN, TSO 2011.) It may then be helpful to give greater preference to dietary interventions and therefore move the second bullet on page 11 to come before any text on physical activity. Within the 2nd bullet on page 11 (and through out) it is appropriate to refer to the eatwell plate as such, deleting 'NHS Choices'.	The ordering of the bullet points does not indicate any preference or priority. For reasons indicated above, physical activity is given as an example of stimulus control and so it is more logical to address physical activity in the next bullet. However both are important as for children it is unclear which aspect of multi-component programmes weight management programmes make them effective. See Research Recommendation 4.
Public Health England	1 Draft recommendations	11	In the third bullet on this page regarding small but realistic goals, could reference be made to taking a stepped approach.	Thank you for suggesting this, but as the PDG did not review evidence in this area, they were unable to make any recommendations on this approach.

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Public Health England	1 Draft recommendation	16	In the second bullet are NICE aware of any evidence relating to fears and concerns around 'giving up favourite foods', as it would be useful to provide a dietary based concern as an example?	This issue did not arise in the evidence.
Public Health England	1 Draft recommendations	16	In the last bullet on this page regarding referral to mental health services, should reference be made to the GP being advised of referrals?	Noted, thank you. This has been added in the final guidance. See Recommendation 8.
Public Health England	1 Draft recommendations	19	Under the Train staff bullet, include training to be non-judgemental	Noted, thank you . Recommendation 11 highlights the need for staff to take an empathetic approach.
Public Health England	Rec 16	22	We wholeheartedly support the focus on evaluation and monitoring of weight management programmes, and agree with your observation that few programmes to date have been evaluated adequately. The list of data to be collected (under 'what action should they take?') is good, and contains most of the essential elements. However, there are a number of additional elements that we have found would tend to enhance the evaluations that are being conducted. These are outlined in the Standard Evaluation Framework for weight management published by the former National Obesity Observatory. http://www.noo.org.uk/core/frameworks The framework has been established for a number of years now and is well used in the NHS to guide evaluation and even to inform commissioning. We would encourage you to link to the document in the final guidance.	Noted, thank you. The list of potential outcome measures given here is not intended to be exhaustive. However, the final guidance links to the Standard Evaluation Framework to provide examples of other possible outcome measures. See Recommendation 15 in the final guidance.
Public Health England	3.19	32	Include mention of the issue of poor parental recognition / acceptance of their child's weight status as a barrier to take up of child weight management services be here.	This has been added to final guidance in Consideration 3.21.

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Public Health England	3.21	32	Training –It may not be just those staff that are themselves overweight or obese who may lack the confidence to raise the issue of weight management with potential participants, and require training. The lack awareness of primary care practitioners such as GPs around how to properly assess child obesity (ie, using growth charts and BMI centiles) could be included here.	Noted, thank you. Please see Recommendation 14 and Consideration 3.29 in the final guidance. This is addressed in Recommendation 13.
Public Health England	Monitoring, evaluation and setting outcome measured	34	The Standard Evaluation Frameworks (SEF) are not mentioned (or not obviously so). Weight management programmes for children and families should follow SEF recommendations regarding what outcome measures to collect. For example, given the difficulty of gauging the impact of weight change on a child's weight status, SEF recommend the use of BMI, rather than weight as a measure of physical change. The use of additional measures of adiposity such as waist circumference is also recommended by SEF. Furthermore, there needs to be some standardisation with regards to how this information is recorded. The SEF should be marketed and promoted to relevant parties in an effective manner to increase knowledge and awareness. If a reference to the Standard Evaluation Framework is made in this section, it might be reinforced in the recommendation for commissioners. For example, "Clearly define programme objectives, outputs, outcomes and monitoring and evaluation requirements in programme specifications and in contracts. Ensure key performance indicators are agreed with programme providers. (see recommendation 16, actions 1 and 2). Ensure that providers comply with the requirements of the Standard Evaluation Framework for weight management interventions (ref).	Please see above. Recommendation 15 in the final guidance, links to the Standard Evaluation Framework.
Public Health England	Recommendatio	38	Fifth bullet. Although ensuring sufficient funding (generally 10% of the budget	Noted, thank you.

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	ns for research		and resource) for monitoring and evaluation is accepted. If only a small budget is available the data may be less informative.	
Public Health England	5 Related guidance	41	Would be appropriate to list relevant guidance addressing mental health/ emotional health and wellbeing due to the possible association between mental health and diet.	All NICE guidance on related topics will be accessible via NICE pathways and where there are direct links these will be indicated. In the guidance itself only a limited number of links can be provided.
Public Health England	General		The potential to use social media tools to communicate with the public should be emphasised.	The use of new technologies is included within Research Recommendation 4 of the final guidance.
Public Health England	General		Consider use of the term 'teaching and learning providers' rather than 'schools' to encompass the range of settings through which children learn - this term would be more inclusive, for example of Academies, FE colleges, Pupil Referral Units etc.	Noted, thank you.
RCGP	Section 1	5	Under Whose health will benefit? it is conceivable that the families – parents and siblings, of obese children and young people may also benefit from addressing this problem. (RP & KB)	Thank you for your comments on the draft guidance. While other family members may benefit, they are not the main target of this guidance, which is what this section has to state. However,

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				Recommendation 4 in the final guidance acknowledges that the programme may benefit for the whole family.
RCGP	Recommendation 4	10	Under 'Work with children over 12 to identify situations to eat more healthily and be less sedentary...' the example given is an exercise example, whereas evidence suggests that calorie restriction is a more logical target of change – hence I would suggest the example given hints at this – eg, for example, recommending a regular breakfast to reduce risk of unhealthy snacking later in the morning, or reserving less healthy snacks for eating at the weekend rather than daily. (RP & KB)	A physical activity example was given as expert paper 6 identified that stimulus control is known to be more effective in relation to physical activity and sedentary behaviours
RCGP	Recommendation 9 And Recommendation 10, relating to using feedback from a programme And Recommendation 14 page 20	15 17 20	I would like to highlight the current difficulties of recording child weight measurements on GP computer software systems. Whilst height and weight can be recorded, recording of a child's BMI and interpretation using appropriate age and sex BMI charts is not possible on many GP computer systems. The RCGP are currently trying to address this issue but it is likely to be some time before the problem is solved across all GP software systems. (RP & KB) Training has also be lacking re interpreting information for the majority of clinicians, even where there is knowledge of which chart to use. Clinicians typically use the 'Red Book' – are the recommendations given here consistent with using the 'Red Book'? (RP & KB)	Noted, thank you. Your comments have been passed to our ImplementationTeam. Please see Recommendations 8 and 13 in the final guidance and in particular the link to the UK growth charts. You will see that there are training resources for health professionals here which focus on the use of growth charts.

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			This recommendation suggests two entirely different websites to access appropriate growth charts for different ages, which is likely to add further confusion to clinicians. Has the committee been aware of these practical issues when making this recommendation? Clear guidance that flags up the issues of appropriate data recording and need for training in interpreting the information might be very valuable in driving forward the steps to address these barriers. (RP & KB)	There has been recent work on the UK Growth Charts and in the final guidance, charts for children aged 4 and over and under 4 are available on the same website. See Recommendation 8 in the final guidance and the link above.
RCGP	Recommendation 9	16	In relation to 'Explain what can realistically be expected in terms of results...' there should be some reference to the fact that goals will depend on whether the child has reached adult height yet. Whilst addressing weight gain trajectory is always worthwhile, weight loss will be required to alter BMI if already at full height, and no longer able to 'grow into one's weight' from maintaining existing weight. Is this explained elsewhere in the document?	Noted, thank you. This issue has been addressed throughout the final guidance and in particular in the Introductory section 'Lifestyle weight management programmes', in Recommendation 9 and Consideration 3.36.
			I also believe that broadcasting other varied, albeit harder to measure, health gains can help with motivation and engagement. Hence flag up that the gains to health from attending a programme go further than potential BMI change and may include improved self esteem, fitness, co-morbidity management etc. I think it is vital that clinicians are aware of the need to flag up potential broad health gains rather than take a narrow focus on weight loss otherwise there is an increased risk of participants sensing 'failure' (no significant BMI change)	Noted, thank you. The PDG was very aware of this. Please see Recommendation 9 in the final guidance and the focus on agreeing goals of value to the

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			despite taking part in something that improved their health in other domains. (RP & KB)	child or young person themselves, in Recommendation 4.
RCGP	General		http://ourcommunityourkids.org/partners/5-2-1-0.aspx Mary Rudolf has recommended this approach – the 5-2-1-0 Which is very clear and memorable. I think it could be transferred here. (JA)	Noted, thank you.
RCGP	General		Few professionals realise the difficulty in GPs having access to known data re a baby or child's weight. The NCMP does not routinely send data to the GP, even though it would be straightforward to put in a clause that the data would be sent unless the parent wished not. (JA)	Noted, thank you. As this guidance focuses specifically on lifestyle weight management services, it is beyond the scope to make recommendations for NCMP at a national level.
RCGP	General		GP software systems do not calculate the child's BMI with reference to any growth charts – the resent calculation is based on adult charts and is very misleading! A link could be made to NHS Choices calculator but isn't. (JA)	Noted, thank you. Your comments have been passed to our ImplementationTeam. Please see Recommendations 8 and 13 in the final guidance and in particular the link to the UK growth charts. You will see that there are training resources for health professionals here which focus on the use of growth charts.

Public Health Guidance

Overweight and obese children and young people - lifestyle weight management services - Consultation on the Draft Guidance from 19 April 2013 - 18 June 2013

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RCGP	General		Attitudinal issues. GPs who have been qualified for 10-20 years have commonly not done paediatrics and have little sympathy for the importance of the child's weight and height and the trajectory to adult weight. They resist attempts to change this situation. There is an urgent need for CPD to identify situations where a different approach would have improved outcomes for the child and the parents. (JA)	Noted, thank you. Please see Recommendation 13 which considers some of these points in relation to the continuous professional development of health professionals.
RCGP	General		Accountability – the is becoming a political issue and there will be joint responsibility locally – perhaps this could be clearer because each professional group could wriggle out of responsibility?? (JA)	Where action is intended for one specific professional group, this is noted in the guidance.
RCGP	General	5	The recommendations should explain what a health and well being board is i.e. what does a health board comprise of, which health care professionals or professionals provide input into it. (SD)	Noted, thank you. Health and Wellbeing Boards have been defined in the glossary and a hyperlink will take the reader to the glossary definition fro the main text.
RCGP	General		The recommendations should discuss further how funding is arranged and how it will be distributed. How will commissioning affect the funding? My reason for bringing up this point is that if there is greater understanding of where the funding originates from then there may be greater ownership of the stakeholders. (SD)	Noted, thank you. It is not within NICE's remit to make recommendations regarding funding
RCGP	General	P10	The recommendations need to describe or explore further how a family history for an ethnic family can be explored. I perceive that there may be significant cultural barriers to addressing this in families from a south Asian background. This is because what we diagnose as an overweight or obese child is in fact a culturally normal or acceptable for some families. (SD)	Noted, thank you. In the final guidance Recommendations 11 and 13 highlight the importance of ensuring that programme staff and health professionals

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				referring participants to programmes , are aware that obesity is perceived differently by different communities and the issues they may need to consider to ensure activities are culturally acceptable.
RCGP	General	P10	Is the last statement on this page realistic? The recommendations are that a child should be performing 60 minutes of moderate to intense physical activity per day. This should then progress to several hours. I don't think this is realistic for a child to achieve especially if they are at school and involved in sedentary lessons. (SD)	This is taken from the UK physical activity guidelines Some physical activity may be carried out in school, or built into daily life through for example, walking or cycling to school .
RCGP	General	P16	The recommendations should highlight that professionals that are referring patients to the weight management programme should also have experienced some of the programme themselves in order to better understand what their patients are going through. (SD)	Recommendation 6 in the final guidance suggests that providers offer training sessions to health professionals.
RCGP	General		There has been no specific mention of a child's school as a stakeholder in this process. The recommendations should include this. (SD)	The PDG discussed the role of schools in detail, however while they felt it would be appropriate for school nurses or school health care teams to make formal referrals to programmes and provide

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				ongoing support (see Recommendations 8,9 and 13) they did not feel this would be an appropriate role for teachers or other staff. The evidence indicates that health professionals sometimes lack the confidence to raise the issue of obesity with parents, yet it is part of health professionals' role to point out the health implications of being obese. The PDG did not feel it was appropriate for staff to be expected to do this, or that they or parents would necessarily see it as part of their role. In addition it was queried if they be in a position to provide the ongoing monitoring and support that the school nurse or school health care team could provide (see Recommendation 9 in the final guidance). Finally they were aware

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				that some children and young people fear being bullied by their peers. For example, the report commissioned by the PDG into the practical and process issues of delivering weight management interventions, shows that in some cases children and young people may not be willing to attend a programme delivered on school premises for fear of being bullied.
Royal College of Nursing	General	General	The Royal College of Nursing welcomes proposals to develop this public health guidance on Managing overweight and obesity among children and young people: lifestyle weight management services. It is timely.	Thank you for your comments on the draft guidance.
Royal College of Nursing	Recommendation 1	5	Planning: The guidance is aimed at local authorities clinical commissioning groups, providers, families and anyone interested in public health – but list of contributors involved in the development of the guidance were mainly public health professionals, academics, researchers. There appears to have been no input from lay members (members of the public), young people themselves (through the National Children's Bureau for example), nurses or GPs on the programme development group.	Opportunties to participate in the PDG were advertised on the NICE website. Unfortunately no practicing nurses or GPs applied to become members of this PDG. Two community (lay) members were appointed, one of whom has experience of

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				working as a peer supporter for other young people attending weight mangement programmes.
Royal College of Nursing	Recommendation 1	6	It is good to see recommendation of long term resourcing (at least five years duration) of intervention – better than short term which have poor record of sustainability	Noted, thank you. However, since the consultation period on the draft guidance, there have been changes in funding arrangements for public health and it is not within NICE's remit to make recommendations regarding local government's funding decisions. This recommendation has therefore been revised in the final guidance.
Royal College of Nursing	Recommendation 1	6	It is good that this is based on needs assessed by Joint Strategic Needs Assessment (JSNA)	Noted, thank you.
Royal College of Nursing	Recommendation 2	7	Commissioning: Ensuring providers train staff appropriately – This is welcomed. It has to happen to ensure accountability of lead staff for skill mix	Noted, thank you.
Royal College of Nursing	Recommendation 3	7 - 8	Lifestyle and weight management: Ensuring height and weight, BMI are measured at baseline, completion and 1 year post completion – It would be best to include that this should be done in individual's health record, not separately so that consistency of data is promoted, reducing duplication.	Noted, thank you. This has been added to Recommendation 8 of the final guidance.
Royal College of Nursing	Recommendatio	10	Tailored to meet individual Needs - offer to weigh parents and carers – This is	Noted, thank you.

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	n 4		welcomed. It would help them along with the overweight child, but as previously mentioned, it would be best to also get their weights onto own GP record to reduce duplication. An electronic mode of communication and record would be preferable	Your comments have been passed to our Implementation Team.
Royal College of Nursing	Recommendation 5	12	Encouraging Adherence: It is good to have a range of activities to suit tastes. Especially good to proactively follow up those who miss sessions early in the programme, particularly those from disadvantaged backgrounds.	Noted, thank you.
Royal College of Nursing	Recommendation 6	13	Raising Awareness of lifestyle management programmes with commissioners and providers. Publicity – It is good to use local venues, including children's centres and libraries – many of these venues are being closed, particularly, libraries, potentially widening inequalities. We agree with importance of informative publicity including prices.	Noted, thank you.
Royal College of Nursing	Recommendation 7	14	Raising awareness of lifestyle management programmes with healthcare professionals – Staff involved in National Child Measurement Programme and Healthy Child Programme: More clarity is needed about the systems and processes of inputting height, weight and BMI measurements into the child health record (red book) and the individual health record at GP practice, in order to reduce duplication, improve efficiency and accuracy. Electronic patient records accessible by all health professionals will assist in reducing duplication and increasing communication	Noted, thank you. Your comments have been passed to our ImplementationTeam.
Royal College of Nursing	Recommendation 8	14	Raise Awareness with other professionals and voluntary organisations. There is some overlap between recommendations 6, 7 and 8 requiring clarification	Noted thank you. In the final guidance, draft Recommendations 7 and 8 have been merged to reduce duplication and clarify roles. See Recommendation 7 in the final guidance.
Royal College of Nursing	Recommendation 9	16 - 17	Formal Referral to lifestyle management: Comprehensive guidance. It is good to offer follow up appointment in 3-6 months – this is possible in schools where school nurses have regular confidential sessions available (for example	Noted, thank you.

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			weekly lunchtime or after-school clinic).	
Royal College of Nursing	Recommendation 10	17	Providing ongoing support: – we agree with proposals. Important point about follow up measurements at 1 year post-intervention, and opportunistically - links with comment on documentation in GP's record in recommendation 7.	Noted, thank you
Royal College of Nursing	Recommendation 11	18	Ongoing Support – this is welcomed.	Noted, thank you
Royal College of Nursing	Recommendation 16	23	Monitoring and evaluation of programmes – Some inconsistency in that self-reporting of weight and height are 'not to be relied on', in contrast to verbal reporting of physical activity and diet, which are acceptable. Suggest looking more strategically at the system of measurement to reduce duplication where possible. The key source of growth data should be the child health record (red book) and the child's GP record. Electronic patient record systems will assist with reducing duplicated effort and enhance communication across all health professionals	The guidance doesn't suggest verbal reports of improvements in diet and physical activity. In the final guidance a hyperlink to the former National Obesity Observatory's Standard Evaluation Framework to provide examples of outcome measures which may be used.
Royal College of Paediatrics and Child Health	Recommendation 2	6	In 2000 one of our members assembled a research-based team of dietician, exercise specialist and psychologist in collaboration with the University of Chichester for obese children (1). Activities were held after school. The PCT showed no interest in commissioning and at present they are not commissioning MEND or HENRY. As such we question whether in spite of the recommendations, will Commissioning Groups, under financial restraint, implement the Guideline? (1) Potter JA, Laws CJ, Candy DCA. Classification of body composition in 11-14 year olds by both body mass index and bioelectrical impedance. International Journal of Pediatric Obesity 2007;2:126-8.	Thank you for your comments on the draft guidance. Noted, thank you.
Royal College of Paediatrics and Child Health	Recommendation 3	8	It is likely that a substantial proportion of overweight children will have psychological problems; this is not mentioned as part of recommendation 3.	Recommendation 3 is intended to provide an overview of the core

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			Currently, CAMHS will not support children with 'medical' problems and will only see children with major mental health problems. If tackling psychological problems associated with obesity is added to recommendation 3, a sea change will be required if CAMHS is to accept referrals for children with obesity.	components of programmes. Recommendation 4 provides the detail on identifying any concerns re a child or young person's mental wellbeing. The PDG were aware of capacity issues, but felt that referral to their GP for onwards referral to CAMHS, is the most appropriate course of action where there are concerns about a child or young person's mental wellbeing.
Royal College of Paediatrics and Child Health	Section 3.3.1	35	The guideline focusses on children in whom maintenance of body weight while growth occurs. Many of the children seen in hospital have BMIs of >+3.5 SD to +4.5 SD. Such children do not succeed with MEND (or relapse rapidly) and more consideration needs to be given to morbidly obese children, other than to say that interventions in this group are unlikely to be cost-effective.	Noted, thank you. The remit for this guidance is lifestyle weight management services delivered in the community, as opposed to specialist clinical obesity services for children with severe or complex obesity. As outlined in Consideration 3.14, the PDG did not

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				make specific recommendations in this area. However, they acknowledged that some severely obese children may attend lifestyle programmes for example, to support lifestyle change alongside receiving individual clinical support and highlighted the importance of developing an individually tailored plan that includes appropriate goals for all children attending the programme.
Royal College of Paediatrics and Child Health	General (and section 10)		It is a shame that some guidance has not been offered specifically in relation to children and young people with disabilities. Admittedly, as acknowledged in section 10, there is a lack of evidence on weight management programmes in children with disabilities. However, such children tend to be more prone to overweight and obesity due to restricted exercise and this has a disproportionate effect on their lifestyle and functional abilities (since the overweight/obesity occurs in the context of a pre-existing disability). So, even if evidence is currently lacking of treatment efficacy, it still seems justified to comment that it is important for weight control programmes to include children and young people with disabilities and that reasonable adjustments may need to be made to a programme to incorporate such children.	Noted, thank you for raising this issue. In the final guidance, the PDG has made a recommendation regarding the provision of services for children and young people. Please see Recommendation 2, Considerations 3.18 and 3.19 and Research Recommendations 3 and

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				4.
Royal College of Paediatrics and Child Health	Section 1 and section 6	4 and 42	In the section explaining BMI, caution should be taken, as BMI may not reflect adiposity in certain situations. In particular, young, fit, athletic children can have high BMIs which do not indicate adiposity and also children with earlier than average pubertal development will have a high BMI appropriate to their advanced stage of development in the same way that they have an advanced bone age.	Noted thank you. The PDG has included a Consideration on this point in the final guidance. Please see Consideration 3.15 in the final guidance.
Royal College of Paediatrics and Child Health	Section 1	7	The multidisciplinary team needs paediatric input from a paediatrician or experienced paediatric nurse in order to identify those with serious co-morbidities and contributing conditions early.	Noted thank you. Recommendation 2 in the final guidance has been amended to address this issue.
Royal College of Paediatrics and Child Health	Section 1	7, last paragraph	The guidance does not suggest how long the programme should take and how frequently they recommend contacts.	The PDG did not make recommendations regarding the optimal length of programmes. This was because even in programmes of longer duration, the effect appears to diminish over time once the programme has been completed. For this reason, the PDG focused on providing ongoing support after programme completion. Please see Consideration 3.30 in the final guidance.

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Royal College of Paediatrics and Child Health	Section 1	8, last paragraph	There are a high number of psychosocial and child protection concerns amongst the obese population and there should be a recommendation to include assessment and management of these problems.	All health professionals have a duty to comply with statutory requirements and local policies relating to safeguarding.
Royal College of Paediatrics and Child Health	Section 1	11, second paragraph	Healthy eating advice is often not structured enough for obese families and sometimes this should progress to a calorie controlled plan. There is also evidence that high protein low glycaemic index diets are safe and effective in children and that they help to improve satiety.	As noted above, this guidance is for lifestyle weight management services delivered in the community, as opposed to specialist clinical obesity services. Recommendations 11 and 13 highlight the importance of programme staff and health professionals being able to identify if lifestyle weight managements services are appropriate for a child or young person or if they should see their GP for referral to a specialist obesity service or other specialist services. Referral to a dietitian would be included within this.
Royal College of Paediatrics and	Section 1	15, last	Does this mean that if they are not ready and willing a referral should not be	Noted, thank you. All

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Child Health		paragraph	made? There is huge potential to miss child protection concerns here and many families who are not initially motivated become motivated after engagement with services and further information. We do not believe initial readiness to change is an important indicator of success in weight management programmes.	health professionals have a duty to comply with statutory requirements and local policies relating to safeguarding.
Royal College of Paediatrics and Child Health	Recommendation 10	17	In addition to monitoring the young person's BMI, morbidities associated with obesity should also be considered and monitored such as BP, any signs of diabetes or sleep disorders.	Noted, thank you.
Royal College of Paediatrics and Child Health	Recommendation 10	18, first paragraph	We agree, tertiary obesity services are required here, but often these have not been commissioned or set up and therefore this is often a referral to a general paediatrician. Commissioners and providers also need to commission and provide tertiary obesity services for children and families	Noted, thank you. The PDG was aware that specialist obesity services may not exist in all areas. In the final guidance , referral to a paediatrician is noted as an alternative to referral to specialist obesity services. As noted previously, the remit of this guidance is lifestyle weight management services and the PDG was unable to make recommendations regarding tertiary services. However, Recommendation 1 highlights the importance of these services being

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				commissioned as part of a comprehensive locally agreed obesity care or weight management pathway which spans both prevention and treatment of obesity.
Royal College of Paediatrics and Child Health	Recommendation 11	18, paragraph 3	Obesity is now considered to be a chronic disease and therefore long term follow-up will be required with a frequency determined by the individuals level of success in maintaining a healthy weight	Noted, thank you.
Royal College of Paediatrics and Child Health	Recommendation 12	19, paragraph 3	There is no mention of co-morbidity assessment or investigation. Should this be included here?	In the final guidance Recommendations 4 and 11 highlight the use of a locally agreed co-morbidities assessment tool, where available. See also Consideration 3.16 and Research Recommendation 4 in the final guidance.
Royal College of Paediatrics and Child Health	Section 1 Section 3.22	20, paragraph 1 33	Time needs to be taken to adopt the multiple lifestyle changes required to maintain a healthy weight in the long term. We would suggest at least monthly contacts and a minimum intervention time of 1 year. Sometimes significant psychological work needs to be done before any changes can be adopted and these young people may need a longer intervention.	Noted, thank you. The guidance is underpinned by a long term approach. For example see Consideration 3.36 in the final guidance.
Royal College of Paediatrics and Child Health	Section 1	22	Maintaining BMI z scores at the completion of the programme is only appropriate for very short term interventions and in those with mild obesity without co-morbidity. Morbidly obese young people should be aiming to reduce BMI z score by at least 0.5 by the end of any intervention programme.	As noted above, the PDG did not make specific recommendations for children and young people with severe

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				obesity. However, the final guidance recognises that the aims of programmes for children or young people who may no longer be growing, may differ to those who are still growing. This is discussed in the introductory section of the guidance under 'lifestyle weight management programmes' , in Recommendation 9 and in Consideration 3.36 of the final guidance. However, the focus of the recommendation on monitoring remains on sustaining changes in BMI and BMI z score over the longer term. Please see Recommendation 15 in the final guidance.
Royal College of Paediatrics and Child Health	3.3.1	36	Reducing BMI z scores by 0.5 leads to an improvement in obesity co-morbidities and metabolic profiles. In those already experiencing co-morbidity this can have huge and immediate cost saving, therefore, this needs to be taken into account when calculating whether treating morbid obesity is less cost effective.	We agree with your point that a fall in BMI z score of 0.5 would usually be cost effective if it were to reduce comorbidities that

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				were expensive to treat. However, the Consideration was pointing out the difficulty of modelling for this group, as the evidence is sparse and the answer depends critically on the assumptions made, even when co-morbidities are modelled
Royal College of Paediatrics and Child Health	Section 4	38, paragraph 4	Caveat: Dietary reports and exercise questionnaires are often inaccurate in this situation and more objective assessments may be required.	Noted, thank you.
Royal College of Paediatrics and Child Health	Section 4	40, fifth bullet point	Engagement of the family with services is important and needs to be done sensitively, it is not always helpful to write a letter to parents simply telling them their child is obese without further assessment of their maturity and body habitus (see the first point).	Noted, thank you.
Royal College of Paediatrics and Child Health		Recommendations 7-10	A flow Chart would be easier to follow.	The guidance will also be available as part of NICE pathways, which is similar in format to a flow chart.
Royal College of Paediatrics and Child Health	Section 1	22, Recommendation 16	Table(s) of minimum dataset, plus additional recommended useful data would be helpful. Should there be an annual report of outcomes of the service recommended to ensure that interventions are having an impact? A high DNA rate is often a problem in families with obese children and how to mitigate this can be difficult. This may need to be specifically resourced also.	An audit tool will be produced alongside the guidance to support data collection.
Royal College of Paediatrics and Child Health		General	Is there a role for the use of appropriate IT/social media technology where possible as this can be more appealing to young people and their families? There are already various nutritional information/exercise apps which can be used easily. These technologies will also facilitate data collection for outcome	Please see Research Recommendation 4 which includes this issue.

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			monitoring and may be more acceptable to young people.	
Royal College of Paediatrics and Child Health		General	There should be recommendations for GP referral to General Paediatrics/Tier 3 Obesity Services.	This occurs in several places in the guidance, for example see Recommendations 4 and 8 in the final guidance.
Royal College of Paediatrics and Child Health		General	There should be a discussion/advice around safeguarding and child protection issues. This can be particularly challenging as can be seen by the evidence statements (1.2.3, 2.1.8- 2.1.18, 2.1.38-) and the importance of trying to keep families engaged. However, there will be situations where the child's best interests and long term health risks are not addressed if the families will not recognise there is an issue and engage with professionals.	All health professionals have a duty to comply with statutory requirements and local policies relating to safeguarding. Recommendation 11 recommends training for programme staff.
SEPT Community Health Services, Bedfordshire	S1: Principles of weight management for children and young people	4	Highlight that BMI is not a suitable tool for assessing overweight or obesity in children under 2 years of age. There is no evidence	Thank you for your comments on the draft guidance. Please see Recommendation 8 which provides hyperlinks to the UK growth charts and the Standard Evaluation Frameworks for practical advice on weighing and measuring children.
SEPT Community Health Services, Bedfordshire	S1: Principles of weight management for	5	Is this document advocating weight loss in children? If so, clearer guidance must be provided. Weight loss is not an appropriate aim for children under the age of 7 years. Over this age a slow, weight loss can be advocated in some	Please see the intrroductory section of the guidance under

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	children and young people		circumstances but should be monitored by a paediatric dietititan with appropriate training. Should the risks of weight loss in relation to children's growth and nutritional status be highlighted or referenced in this document?	'lifestyle weight management programmes' , Recommendation 9 and Consideration 3.36 of the final guidance. Here it is recognised that maintaining existing weight while a child grows taller is an appropriate short term aim as it can result in an improved BMI over time as they 'grow into their weight' Young people who are no longer growing taller, will ultimately need to lose weight to improve their BMI . However preventing further weight gain while they acquire the knowledge and skills they need to make lifestyle changes, may be an appropriate short term aim.
SEPT Community Health Services, Bedfordshire	Recommendation 2	7	A state registered dietitian/ registered nutritionist with *knowledge and experience of paediatric weight management and preferably public health knowledge & experience* should be involved in the development and on-going delivery of the programme. This is vital for providing evidence-based, appropriate dietary information and advice.	Noted, thank you. The need for professionals in the multi disciplinary team to specialise in children, young people

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				and weight managment has been added to this recommendation in the final guidance. Please see Recommendation 2
SEPT Community Health Services, Bedfordshire	Recommendation 2	7	What is appropriate training? Guidance about content of training should be offered or referred to. Recommend that staff have training in childhood nutrition (not just nutrition in general), have an understanding of child growth, parenting skills and behaviour change techniques. Also need training or experience in delivering group sessions.	Please see Recommendations 11 and 12 in the final guidance which provide details on training for programme staff.
SEPT Community Health Services, Bedfordshire		7	What about measurements outside these specifications? There are reports that some programmes weigh children every week. What is the evidence for this? Should 'over-measuring' be discouraged in the guidance?	The PDG did not review evidence in this area and this was not an issue raised by the commissioned report into practice and process issues of implementing lifestyle weight management programmes.
SEPT Community Health Services, Bedfordshire			Recommend that the commissioned lifestyle programme exists as part of a community care pathway and providers of the programme liaise with referral agents and other obesity services that are on the pathway to discuss referral criteria to ensure this meets the local need. i.e. referrals into the programme and referrals during or post programme. Current providers are the best source of information on what the local population requirements will be. i.e. dietetics, 0-19 teams, CAMH, paediatricians.	Please see Recommendations 1 and 2 in the final guidance.
SEPT Community Health Services, Bedfordshire	Recommendation 4	10	• How will providers be able to identify children with mental wellbeing concerns? What specific training or tools will be required? Commissioners need to know providers are skilled to do this.	Please see Recommendations 11 and 12 in the final guidance which provides

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				details on training for programme staff.
			• Facilitating discussions around bullying in a group can be difficult and require certain skills. Is this appropriate for a programme outside school and the family unit to be providing? What is the evidence for this being managed as part of a healthy lifestyle programme? Surely raising self-esteem should be the goal?	Please see Expert Paper 3 re discussions around bullying.
			• CAMH services will only take children with very specific concerns that are affecting their health. Pathways will need to be agreed between providers as they need to be aware of what children trigger referrals and this should be explicit in the guidance. Psychological distress is very vague.	The PDG were aware of capacity issues, but felt that referral to their GP for onwards referral to CAMHS, is the most appropriate course of action where there are concerns about a child or young person's mental wellbeing. Please see Recommendations 4, and 8 and Consideration 3.17.
			• Children under the age of 12 like to monitor their progress and this should be encouraged in regards to sedentary behaviour, physical activity and diet, the parents should still be in charge and 'oversee' their progress. Suggest rewording as it reads as if self-monitoring is being discouraged.	Please see Recommendation 4 re monitoring progress which has been amended in the final guidance.
			• Do you mean children should aim for several hours of physical activity a week, rather than day?	The recommendations re physical activity are daily

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				and are based on the UK physical activity guidelines
SEPT Community Health Services, Bedfordshire	Recommendation 4		Need to be aware that the Eat Well Plate is NOT appropriate for children under the age of 5 years.	The Eatwell plate does not apply to children under the age of two. Please see 'Is the eatwell plate for me?' at this link Eatwell plate. There are further links from this page to advice for younger children.
SEPT Community Health Services, Bedfordshire	Recommendation 4		Also is not just about the Eat Well Plate. Should signpost to where more appropriate dietary information can be gleaned i.e. Caroline Walker Trust information (but must be aware that this is appropriate for institutions, such as nurseries and schools and will need to be adapted for families, but provides a good grounding in evidence-based childhood nutrition) What about snacking and drinking habits, mealtime routines and family meals??	Please see the response to the above comment.
SEPT Community Health Services, Bedfordshire	Recommendation 5	12-13	• 1:1 interventions will need to be provided by a trained, experienced professional. Preferably a paediatric dietitian or a registered nutritionist with experience of working with obese and overweight families.	Effective lifestyle weight management interventions were identified as being multi-component hence the the focus in this guidance on them being designed and devloped by a multi-disciplinary team who are responsible for designing and developing training

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			• Families should be informed that the programme lasts a certain number of weeks but that they will be expected to attend follow-up sessions over the course of a year. Need to emphasise that this is a long term commitment • If referred onto a programme and they don't attend or drop out. Referrer should be informed • What about tips or evidence for building value into a programme i.e. charging a small fee for attendance or programme incentives i.e. shopping vouchers, prizes, certificates	for programme staff. Noted, thank you. This has been added to Recommendation 5 in the final guidance. No evidence was identified on the use of rewards and so no recommendations have been made in this area.
SEPT Community Health Services, Bedfordshire	Recommendation 6	14	Recommend awareness is raised with health professionals on a rolling basis, as staff change and priorities shift, so teams need constant reminders and updates	Noted, thank you. Regular dissemination of the list of providers has been added to Recommendation 6 in the final guidance.
SEPT Community Health Services, Bedfordshire	Recommendation 9	15	Why just community dietetic teams? Just state dietitians	Noted, thank you. This has been amended in the final guidance.
SEPT Community Health Services, Bedfordshire	Recommendation 9	15	Need to state explicitly height should be measured, as well as weight. Needed to calculate BMI and is often overlooked by community health professionals	Noted, thank you. Please see Recommendation 8 in the final guidance.
SEPT Community Health Services, Bedfordshire	Recommendation 9	15	What would an inappropriate referral be? Need to be explicit. Should a child that has a BMI centile that is well above the 99.6th and is a pre-teen be referred to a lifestyle programme as first-line intervention? Many children present with comorbidities already i.e. PCOS, diabetes and this will not be picked up in the community. A child will need a paediatrician referral for this.	Please see Considerations 3.14 and 3.16 and Recommendations 11 and 13 in the final

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			Also is it the responsibility of the health professional to ensure that the weight management programme commissioned by public health contains all of the elements recommended in this guidance?	guidance.
SEPT Community Health Services, Bedfordshire	Recommendation 10	17	What should feedback entail? Post-programme recommend BMI score history (beginning, mid-way and post programme), goals agreed and summary of changes made and attendance rate.	Noted, thank you
SEPT Community Health Services, Bedfordshire	Recommendation 10	18	Recommend referral to tier 3 services but not all areas have this service available, you will need to provide further appropriate examples i.e. dietetics, specialist trained nurses, GPs or paediatricians	Noted, thank you. The PDG was aware that specialist obesity services may not exist in all areas. In the final guidance , referral to a paediatrician or other sepcialist services is noted as an alternative to referral to specialist obesity services.
SEPT Community Health Services, Bedfordshire	Recommendation 13		Recommend that staff have training in childhood nutrition (not just nutrition in general), have an understanding of child growth, parenting skills and behaviour change techniques. Also need training or experience in delivering group sessions. This training should be developed and provided by qualified, experienced professionals i.e. dietitians, specialist nurses, psychologists ? Whether it is appropriate to recommend qualifications or past experience of staff who deliver the programme?	Noted, these issues have been added in the final guidance. Please see Recommendation 12.
SEPT Community Health Services, Bedfordshire	Recommendation 14	21	Health professionals need to be aware of the local obesity care pathways.	Noted, thank you. This has been added to Recommendation 13 in the final guidance.
SEPT Community Health Services, Bedfordshire	Recommendation 15	21	Feel this area is completely lacking. Need to include information on how the provider provides appropriate clinical supervision for their staff to ensure best practice and that they are providing evidence-based information. i.e. 1:1 with	Noted, thank you. In the final guidance, it is recommended that staff

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			appropriate clinical specialist, shadowing opportunities with local dietetic team etc..Do they have appraisals to assess their training needs on a regular basis? Particularly as you are suggesting clinicians should be part of the team who develop and possible deliver the sessions, this is key to their future progression. Furthermore, it is extremely patronizing to theorise if staff lack of confidence is due to staff being overweight themselves and then suggest offering a weight management programme. This should be re-worded or omitted completely. It may be more appropriate to just state something like 'staff should have access to health and well-being services as part of supporting them to deliver a quality service'. This guidance will be widely disseminated and will only serve to create more divisions if this is stated so bluntly.	training needs are regularly reviewed and that training is developed with the input of, and regularly reviewed by a multi-disciplinary team of professionals. The PDG made a recommendation regarding this issue as there is evidence from the Childhood Obesity National Support Team's findings in 44 areas, that a lack of confidence to deliver weight management interventions was in some cases related to staff being overweight themselves. Please see Expert paper 1.
SEPT Community Health Services, Bedfordshire	Recommendation 16	22	What level of reduction in BMI z scores at 1 year post-completion is being advocated? Would advise providing a percentage range for a suitable reduction, so children who lose too much weight post programme are triggered and those that don't change their BMI z score or increases are flagged up.	The guidance focuses on developing an individual programme plan including appropriate individual goals.
SEPT Community Health Services, Bedfordshire		22	What about attrition rates? What does completing the programme mean? Otherwise a reduction in BMI	Please see Recommendation 15 in

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			may not be successfully attributed to the programme itself.	the final guidance which recommends collecting data on the numbers recruited, percentage completing and percentage followed up.
SEPT Community Health Services, Bedfordshire		23	Recommend using validated tools where appropriate, list what these should be or signpost to appropriate sources (NOO) What about self-reported changes etc…?	In the final guidance Recommendation 15 hyperlinks to the NOO Standard Evaluation Framework which provides examples of outcome measures which might be included.
SEPT Community Health Services, Bedfordshire	3.18	32	Also need to raise the risk of raising issues with vulnerable adults. And the need for providers to aware of services that may support them if they raise issues which need addressing i.e. depression, domestic violence etc.. Such as family therapy	The remit of this guidance is children and young people under 18 years of age. Guidance on the provision of lifestyle weight management services for adults is currently in development.
SEPT Community Health Services, Bedfordshire	3,24	33	Is essential that these services are commissioned as part of a wider assessment of obesity services related to a clinical and/or community care pathway	Noted, thank you. The remit of this guidance is specifically about lifestyle weight management services. Please see Recommendation 1 and Consideration 3.32. which acknowledges this

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				issue and also links to NICE guidance PH 42 Obesity: working with local com munities, which addresses this issue in more detail.
SEPT Community Health Services, Bedfordshire	3.31	36	Therefore should morbidly obese children be accepted onto a lifestyle programme? How can we be certain that providers are able to effectively monitor this weight loss and ensure optimum nutrition for the growing child?	As outlined in Consideration 3.14, in the final guidance, the PDG did not make specific recommendations for children with severe obesity. However, they acknowledged that some severly obese children may attend lifestyle programmes for example, to support lifestyle change alongside receiving individual clinical support and highlighted the importance of developing an individually tailored plan that includes appropriate goals for all children attending the programme.
SHINE	General		I was really excited to see the recommended changes within the document which reflects the good practice we have been delivering at SHINE for the	Thank you for your comments on the draft

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			past 10 years. I am particularly relieved that there is now reference to psycho-social aspects of obesity, which we know greatly influences obesity outcomes and health benefits and I am pleased that there is reference to maintenance strategies, albeit ambiguous at present. I think these guidelines are definitely a move in the right direction and more detailed comments will now follow. Well done to the team.	guidance.
SHINE	Section 1	4 & 5	The lack of consistency in relation to obesity definition in terms of BMI is concerning and these appear to be ever changing. Over the past ten years I have been working in childhood obesity, the definition has changed from 91st centile, to 95th centile and is now referenced as 98th centile. This has implications for long term measures such s the National Weight Measurement Programme. Results may not represent changes in obesity rates if the base line measure keeps changing – it just means we are categorising less children in the obesity range. Also studies show that the higher the BMI, the harder it is to achieve effective weight loss. Surely we need to be identifying children at an earlier risk BMI for interventions to become more effective rather than increasing the level. I feel reassured that there is now some acknowledgement that maintaining weight is a positive health outcome as height will reduce BMI in these cases.	Noted, thank you. The thresholds have not been defined by this guidance, but are used as standard practice. The 85th and 95th centiles are used to define overweight and obesity respectively, in the population level analysis of surveys such as the National Child Measurement Programme and Health Survey for England. The 91st and 98th centiles are used for the clinical assessment of individuals. Please see A simple guide to classifying weight management in children.
SHINE	Recommendation 1	6	Although family based interventions are important, it needs to be recognised that adolescents do not wish their parents to be an active part of their healthy lifestyle programme. It may be necessary to develop different strands to	Noted, thank you. This issue has been addressed in

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			incorporate parents in these situations.	Recommendation 5 and Consideration 3.9 in the final guidance.
SHINE	Recommendation 1	6	The paper refers to long term funding (5 years) our experience is that obesity funding is not ring fenced and is often subsumed into budgets to pay off other debts. It is essential that funding for these programmes is monitored and maintained. Funders often also allocate funding to organisation which present the cheapest model of delivery which is often not the best quality that can be delivered. If the recommendations advocate multi-agency approaches – then the funding needs to match the calibre of professionals who may be required i.e. nutritionists, lifestyle coaches, counsellors, psychologists etc. Funding strands also need to be more transparent for community and voluntary sectors who often find it difficult to access joint strategic needs assessments or other relevant data.	Noted, thank you. However, since the consultation period on the draft guidance , there have been changes in funding arrangements for public health and it is not within NICE's remit to make recommendations regarding local government's funding decisions. This recommendation has therefore been revised in the final guidance.
SHINE	Recommendation 2	7	It is reassuring that highly specialised staff are identified to have input into designing programmes for this vulnerable group of young people and that staff are to be trained to deliver specific programmes commissioned. Again this should help move away from delivery by unqualified or non skilled practitioners	Noted, thank you.
SHINE	Recommendation 3	8/9/10	It is disappointing that although the action point states that accounts should be made of the child's self esteem, self perception and mental well being, depression, self harming – there is no mention of these topics in the 'core components' (page 8), which traditionally refers to healthy eating, physical activity and behaviour modification, similar to the previous guidelines. . There is no point in making reference to these if they are not addressed as part of the lifestyle weight management programme, even though there is ample evidence that these issues are closely correlated to obesity.	Recommendation 3 is an overarching recommendation. Further detail is provided in the following recommendations. Please see Recommendation 4

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				which focuses on developing an individually tailored plan and provides more detail on these issues.
SHINE	Recommendation 4	10	All these bullet points are excellent and it is reassuring that they are included. However, there may be blocks and barriers to achieving these. There needs to be specialist input to deliver these aspects of the course. GPs are not all geared up to the management of childhood obesity and often give conflicting information and there may be long waiting lists for access into CAMHS, where obesity is not considered to be a high priority. Specialised staff also come at a cost, where budgets are already stretched.	Noted, thank you. Please see Recommendations 11 and 12 in the final guidance which focus on training programme staff. .
SHINE	Recommendation 5	12	There are several references to providing programmes on a group or 1:1 basis according to need. Who will provide 1:1 programmes? Who will fund this as its very time consuming?	Noted, thank you. In the final guidance, this point has been amended. Please see Recommendation 5 and Consideration 3.22
SHINE	Recommendation 6	14	There is reference to raising awareness of programmes available for young people and there should be options based on needs. My experience is that commissioners can be selective & block variation i.e. they will only make referrals to services that are directly commissioned. There needs to be an element of choice for families to opt into.	Noted, thank you.
SHINE	Recommendation 9	16	There needs to be more clarity on ethical decision making if a family chooses not to engage when there are high health risks to the child. Obesity if a form of neglect but the guidelines for referral appear ambiguous. The role of the practitioner in these circumstances should be made clearer. Waiting 3-6 months for another follow up appointment , which they are likely not to keep in these situations, leaves the child vulnerable.	All health professionals have a duty to comply with statutory requirements and local policies relating to safeguarding.
SHINE	Recommendation 9	16	Further reference to referrals to CAMHS team for signs of psychological distress. How will these needs be met when the waiting lists for these services in our area are already reaching 18 months!!	The PDG were aware of capacity issues, but felt that referral to their GP

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				for onwards referral to CAMHS, is the most appropriate course of action where there are concerns about a child or young person's mental wellbeing.
SHINE	Recommendation 10	17	Again reassuring that the outcome measures are broadening to include psycho-social outcomes which is long overdue. After the programme is completed it states that BMI should be monitored by health professionals when opportunities arise and 1 year following completion. Who would be responsible for this i.e. course trainers? Schools nurses? GP	Noted, thank you. In the revised guidance it is recommended that BMI centile is monitored opportunistically and at 6 months and 1 year post completion of the programme. A range of actors is noted, including GPs, school nurses, dietitiians etc, any of whom could provide this ongoing support.
SHINE	Recommendation 10	18	If the parents become concerned about their child's weight – there are studies that show that parents are very poor at recognising obesity in their children due to poor perceptions. How will they refer if they don't perceive there to be a problem?	Noted, thank you. In the final guidance the issue of parental recognition of obesity is addressed in Recommendations 4 and 8 and staff training on this issue is addressed in Recommendations 11 and 13.
SHINE	Recommendatio	18	Suggestion to offer ongoing support every six months for the first year – 6	Noted, thank you. In the

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	n 11		months is too big a gap and weight gain is often rapid following an intervention so require more regular monitoring – we offer 4-6 weekly appointments which allows for early intervention when relapse takes place which is inevitable within first 6 months.	final guidance the PDG has recommended that support be offered for at least the first year following programme completion. Please see Recommendation 10 in the final guidance.
SHINE	Recommendation 13	19	Feel the adequate training is essential and also the inclusion of cognitive behavioural changes but I am guessing there are not many courses which provides specialist input in this domain, again because of the lack of funding.	In the final guidance, the PDG has clarified this point as training in behaviour change techniques and psychological approaches. Please see Recommendation 14 in the final guidance.
SHINE	Recommendation 16	22	Again monitoring is essential and reassured that this should account for 10% of the budget. Another cost implication however. How will this be assessed to see if it is achieved?	Noted, thank you. However, since the consultation period on the draft guidance , there have been changes in funding arrangements for public health and it is not within NICE's remit to make recommendations regarding local government's funding decisions. This recommendation has therefore been revised in

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				the final guidance.
SHINE	Section 2	24	Proportion of those who are overweight has remained largely unchanged – this may be because of my comment made earlier when the BMI for overweight keeps being changed. This was initially 85th centile now reports are 91st centile or 95th centile. This has potential for skewering the data!	Please see the response to the earlier comment on this issue.
SHINE	Section 2	24	If it is reported that 79% of obese children will remain obese as adults – this means only 21% could potentially change their obesity status (congruent with Wing et als study). Perhaps this needs to be considered when looking at specifications and outcomes	Noted, thank you.
SHINE	Section 2	25	There is evidence of all the potential psychosocial links; bullying, depression, self harm, low self esteem, poor quality of life. This is the rationale for why these issues need to be addressed as part of the lifestyle weight management programme if outcomes are to be sustainable. Young people need to learn how to manage these issues as part of their programme.	Noted, thank you.
SHINE	General	26-31	Good points raised and evidence to back up	Noted, thank you.
SHINE	Section 3	31	I still raise concerns around the CBT work with young people. This requires specialist training and input and therefore has a further cost implication.	Please see the response to the earlier comment, In the final guidance, the PDG has clarified that staff are trained in behaviour change techniques and psychological approaches. Please see Recommendation 14 in the final guidance.
SHINE	Section 3	33	There is reference and research based evidence of the need to provide ongoing support once the programmes are completed but again there is little reference to how ? by who? And cost?	The PDG have provided as much detail as they were able to, based on the evidence available.
SHINE	Section 3	35	Agree that z scores are better and that weight (BMI) should not be a primary	Please see the response

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			indicator of success. Again even in this document there is no consistency in obesity BMI (states 98th centile page 4 and between 95th and 99.5th on page 35).	to the earlier comment on this issue.
SHINE	Section 3	34	Need to also outline acceptable practice for young people above 99.6 centile (morbidly obese – tertiary care). We provide services for this group of young people in the community – not considered a primary care need or a hospital based needs – where does this group fit?. We provide very cost effective services within the community but it's very hard to tap into funding because of these reasons.	Noted, thank you. As outlined in Consideration 3.14, of the final guidance, the PDG did not make specific recommendations in this area,. However, they acknowledged that some severly obese children may attend lifestyle programmes for example, to support lifestyle change alongside receiving individual clinical support and highlighted the importance of developing an individually tailored plan that includes appropriate goals for all children attending the programme.
SHINE	Section 3	35	The costings are very vague and not clear i..e cost effective if less than £1000 but for what i.e. a 12 week programme, or for multi agency care pathway	The model is a "what if?" model, which does not specify what kind of programme is referred to. It will calculate the cost per QALY gained,

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				for example, IF a programme costs £1000 and IF the average weight loss is one BMI point, and IF the weight loss is maintained for the whole of life (or regained at a certain rate). The numbers or condition after each "IF" can be changed. In that way, the model does not need to specify the kind of programme. If you know how much your programme costs and the average weight lost for the group (and you can assume that the weight loss is not regained) you can estimate whether the intervention is cost effective.
SHINE	Section 3	36	Research shows that children with the highest BMIs have the slowest and poorest outcomes due to other contributing factors and they are usually a very complex and needy group. There is little chance therefore that for cost economy they would 'lower their BMI considerably' – does this mean nothing would be offered for this group of children? Is this why bariatric surgery is increasing for this group?	Please see the response to the previous comment on this issue. In addition, the PDG has recommended that lifestyle weight management services

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				are provided as just one part of an overall weight management or obesity care pathway . Please see Recommendation 2 in the final guidance and further information on obesity care pathways via the hyperlink to the glossary
SHINE	Section 3	36	It's very difficult to know what would be the outcome if the young people did not have the intervention – how do you achieve a change that is 'maintained for life' and how do you monitor this?	The model, as stated in a previous response, is a 'what if' model. Predicting what would happen in the absence of an intervention is based on what has happened in the past to children of a given BMI z cohort. It is not perfect, but on average it should be better than simple guesswork. The model does not answer how a change can be maintained for life: what it tries to answer is what would happen IF the change were to be maintained for life. And for the same reason it does not answer how

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				this could be monitored. Importantly, the model tells us where we might wish to place our effort: it is the maintenance of the initial effect of an intervention over long time periods that seems to matter most.
SHINE	Section 4	37	Who would be responsible for longevity measures pre/post/6months/1yr/2yrs?	These are research recommendations, so the investigating researchers would be responsible for follow up.
SHINE	Section 4	39	BME groups in our experience are very hard to reach and reluctant to engage yet have some of the highest health risks in relation to CHD and diabetes. Need some research on how to reach and engage these groups. There also needs to be specific BMI charts for these groups as only available at present for Asian men	Noted thank you. Please see Research Recommendation 3 in the final guidance and Consideration 3.15.
SHINE	General		There are some really good pointers in this document and definitely advances in relation to recommendations. I look forward with interest to reading the final copy and hope the government will review the finances to meet these needs.	Noted.Thank you for your comments.
SHINE	General		What will be the power and influence of local authorities in obesity management as part of the public health agenda? How will they control the budget? Do they have the skills to commission, manage and monitor such a complex condition?	Noted, thank you. It is not within NICE's remit to make recommendations regarding funding.
Slimming World	Recommendation 2	8	This recommendation suggests one year follow up data should be collected. While we agree this is a useful outcome to measure it should be made clearer in the guidance document who would be responsible for this data collection – providers could only really do this for people who are still engaged with the programme and therefore I would suggest it is made clear that it would be the	The PDG has noted concerns re loss to follow- up and in the final guidance, It is recommended that data

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			referrers who are responsible for this overall.	is collected at 6 months and 1 year, in order to maintain better contact with the programme participant.
Slimming World	Recommendation 3	8	Suggest add 'healthy' into the section describing what the programme should focus on e.g. 'diet and healthy eating habits'.	This has been amended in the final guidance. Please see Recommendation 3.
Slimming World	Recommendation 3	9	The guidance suggests that 'a range of physical activities' should be included. This might not always be appropriate as part of a session and also may well put off a number of participants. Increasing activity levels should absolutely be encouraged but there are other ways to increase activity without insisting that participants take part as part of the programme delivery. More suitable and sustainable in the longer term (i.e. help participants when the programme comes to an end) would be signposting to, breaking down barriers to and exploring what the young person would enjoy and can build into their everyday lives along with lots of praise and recognition for achievements however small along the way. We would suggest that the wording is changed for this recommendation to say something along the lines of: Support and encouragement of physical activity should be given to help the children or young people to become increasingly more active.	The PDG has made recommendations based on multi-component programmes for children and young people which included diet, physical activity and behaviour change strategies. This is therefore reflected in their recommendations. Recommendation 3 notes the importance of strategies for implementing and sustaining changes at home. Recommendation 4 highlights the importance of building activity into daily life and Recommendation 10, the need to signpost families to local services and activities that can help

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				them manage their weight.
Slimming World	Recommendation 10	17	This recommendation suggests that health professionals should 'regularly' monitor progress. It would be useful to specify how regularly so that a guide is given as to what is appropriate.	Noted, thank you
Slimming World	Recommendation 16	22	The primary aim of the programme is given as the following 'to maintain BMI z scores at programme completion and to reduce BMI z scores at 1 year post-completion'. This is the first time in the guidance that this aim is specified. How was this aim agreed? It would be useful if the aim was in line with that suggested in the recent DH guidance – at the moment they are slightly different. I would also be keen to know what would happen if someone's BMI z score reduced during the programme – if the above aim is kept in the guidance? Would this be seen as not meeting the primary aim? From our research we have seen that young people (especially those accessing us with BMI centiles over the 99.6th centile) may well reduce their BMI z score overall. For example in our study we saw an average reduction in BMI z score over about 20 weeks attendance of -0.5 (a significant reduction).	The final guidance recognises that the aims of programmes for children or young people who may no longer be growing, may differ to those who are still growing. This is discussed in the intrroductory section of the guidance under 'lifestyle weight management programmes', in Recommendation 9 and in Consideration 3.36 of the final guidance. However, the focus of the recommendation on monitoring remains on sustaining changes in BMI and BMI z score over the longer term. Please see Recommendation 15 in the final guidance.

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Slimming World	Recommendation 16	22	The recommendation specifies that data monitoring should include the number/percentage who 'complete' the programme. How is completion defined? It would be useful for this to be specified in the guidance. Will it be the same as suggested in the recent DH document?	There was insufficient evidence for the PDG to define 'completion' as attendance at a certain proportion of sessions. The evidence indicated that attendance at 75% or more of sessions in high intensity programmes resulted in better outcomes, but 'high intensity' spanned too wide a range of sessions to make recommendations. The PDG therefore recommended that completion criteria be agreed between the commissioner and provider when agreeing key performance indicators. Please see Recommendation 2. The DH commissioning guide has been developed separately to this guidance and based on their own review.
Sustrans	General		Thank you for the opportunity to comment on this guidance. We restrict our comments to Sustrans' area of operation, physical activity and	Thank you for your comments on the draft guidance.

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			active travel, but some may have a wider relevance.	
Sustrans	Section 1	Page 9	At lines 14 and 15 the guidance addresses physical activity promotion in the form of led group sport and recreation, but does not make reference to other forms of physical activity, such as active travel. We feel it should do so.	Noted, thank you.
Sustrans		Page 10	Bullets 5 and 6 could also usefully refer to 'lifestyle' physical activity such as active travel: bullet 5 addresses nutrition and sedentary behaviour but omits activity per se, while bullet 6 appears to suggest that physical activity is primarily achieved through 'pastimes' Some is, but much is not.	Noted, thank you. Please see Recommendation 4 in the final guidance which notes the importance of building activity into daily life, through for example, active play, walking and cycling.
Sustrans		Page 12	At bullet 4, thank you for the recommendation that services should be delivered at community venues reachable by active modes of transport. That kind of detail is often overlooked, but is important in that it reminds professionals that the provision of a service can itself create conditions for physical activity, going beyond the service itself.	Noted, thank you.
Sustrans		Page 19	At recommendation 13 we would like to see it noted that programme staff should have an understanding of the wider lifestyle context within which the programme is delivered, and should seek to encourage a healthy lifestyle beyond the parameters of the service itself, including through personal example. So from the active travel point of view, staff should ensure that materials and advice to clients offer positive encouragement to travel actively to the service venue, and should not lead with information about car parking. Staff can themselves offer a good example of travelling actively to and for work.	Noted, thank you. Recommendation 11 in the final guidance notes the importance of programme staff understanding why some children and young people find it hard to mange their weight and Recommendation 10, the need to signpost families

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				to local services and activities that could help them manage their weight e.g. walking or cycling groups.
Sustrans	Section 5	Page 41	We suggest that PH 41 should also be listed as relevant.	All NICE guidance on related topics will be accessible via NICE pathways and where there are direct links these will be indicated. In the guidance itself only a limited number of links can be provided.
Weight Watchers UK	General		**Practical Summary needed up front -** Weight Watchers welcomes guidance from NICE with a specific spotlight on lifestyle services to help children and young people manage their weight. This is a huge step forward in specificity of guidance for this particular target group. The draft guidance holds a wealth of practical pointers to maximise the effectiveness of these types of lifestyle services. However, the important nuggets of information are currently lost within the text and information overloaded commissioners will find it difficult to access.Weight Watchers suggests including a 2 page summary at the front of the document which contains between 10-12 major take home messages emerging from the review of the evidence and weight management landscape undertaken by NICE.	Thank you for your comments on the draft guidance. NICE has a standard format for all guidance. However the guidance will also be available as part of NICE pathways in which commissioners can click on links to rceommendations relating specifically to planning and commissionning.
Weight Watchers UK	General		**Encouragement needed to utilise/buy in existing services with proven effectiveness and established outcomes** – There is a multitude of existing	The guidance makes recommendations which

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			lifestyle services which target childhood obesity. The review, cited on page 25 of the guidance, established that currently there are over 300 child centred obesity services in the UK. Some of these services have quantified outcomes demonstrated by high quality studies published in peer reviewed journals. However, there is also a strong emphasis within the guidance on developing services. To develop an evidence based lifestyle weight management service from scratch and then evaluating effectiveness in order to prove outcomes, requires massive investment. Surely in this financially challenging public health environment where budgets for services are extremely limited and efficiency savings are of paramount importance then emphasis within the guidance should not be on re-inventing the wheel – but commissioning existing services with proven effectiveness and then investment in tailoring these to local needs.	are applicable both to services which are bought in by commissioners and to those which are developed 'in house'. Recommendation 3 highlights the core components of effective programmes.
Weight Watchers UK	General		**Precision of language needed in targeting of services** – Currently there is some confusion within the draft guidance around the targeting of services. This could be usefully tightened up. The scope of the document is lifestyle weight management services to help children control and manage their weight. These services could be targeted at: * parents/carers of overweight/obese children (i.e. parents/carers take responsibility for their child's weight and attend sessions in order to put behavioural change processes in place) * Families (including parents and carers) and overweight/obese children (families and the overweight /obese child attend sessions together and behavioural change is jointly negotiated) * Overweight /obese children (children attend sessions with minimal input from parents – more commonly found in older children) The wording within the guidance often infers the latter, when in fact the evidence strongly suggests that parental involvement and responsibility is key to behavioural change in children. In many cases (especially for younger children) services will be targeted at parents as they are custodians of	Please see Considerations 3.8 -3.11 in the final guidance which discuss the family based approach underpinning this guidance.

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			children's habits. Suggest the wording within the draft guidance is consistently changed to communicate this. (e.g. on page 2 should read 'those providing weight management services to help children and young people manage their weight).	
Weight Watchers UK	General		**Adult lifestyle weight management services are a critical part of services to tackle childhood obesity** Parental BMI is a significant predictor of childhood obesity (Dahly and Rudolph, 2010). In other words, obesity is prevalent in families and there is increasing evidence that the most effective way in which parents can help their obese child lose weight is to lose weight themselves. For example, a recent study evaluated the impact of 3 types of parent/child targeted interventions on children's weight (Boutelle et al 2012). The researchers found that it was only when the parents lost weight that their children did likewise. Parents play a significant role in any weight loss programme targeted at children, but this study confirms the importance of role modelling in establishing healthy eating and activity behaviours for their children. It makes sense that if overweight or obese parents lose weight by modifying their eating and activity behaviours, then there is an effect on family habits. Indeed there is good evidence that referral of overweight and obese adult patients to Weight Watchers resulted in improved dietary intakes from healthier eating habits (Eberhard et al 2010). Many of these referrals were women and mothers in charge of food provision within the home. Parents are the most significant people in a child's environment; They serve as leaders and reinforce the establishment and maintenance of eating and activity behaviours. If they are learning to manage these behaviours to control their own weight; their children benefit. In summary, adult targeted lifestyle weight management services can reach 'at risk' children by helping overweight/obese parents inculcate healthy lifestyle habits within the home.	Noted, thank you. The important role of parents and carers is noted throughout this guidance. As above, please see Considerations 3.8-3.11 and Recommendation 4 which highlights that the whole family may benefit and suggests signposting adult family members who are oeverweight or obese to local lifestyle weight management services for adults.

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Weight Watchers UK	General		**England needs industrial scale services** Scratching the surface of the problem by providing services for a handful of adults and children in England will have little or no impact. NICE's draft guidance carefully sets out the astronomic size of the obesity crisis. The bottom line is that around one third of children are either overweight or obese and this affects 4.1 million children across the country. An industrial scale service response is needed. However, experience drawn from Weight Watchers and MEND's partnerships with health agencies in England suggests that commissioning of the necessary services is either static or decreasing. This could be for a number of reasons. The new commissioning architecture is taking time to embed and responsibilities for commissioning lifestyle weight management services remain unclear, Additionally Local Authorities appear not to have the funding, or do not prioritise funding for such services. Given this reality of front line service provision, NICE's draft guidance is unlikely to have any impact and its recommendations become merely academic. Weight Watchers suggests that this context should be acknowledged within the guidance in order to ground it in the real world.	The guidance acknowledges that lifestyle weight management services are just one part a community-wide and integrated approach to preventing and treating obesity and that these services are commisisoned as part of a wider obesity care or weight management pathway. Please see Recommendation 2 in the final guidance which also hyperlinks to existing NICE guidance PH 42 Obesity: working with local com munities which takes a broader perspective and may be of interest.
Weight Watchers UK	General		**Public funding should be used to commission services with proven outcomes.** Since the release of NICE's guidance on obesity management in 2006, much more evidence has emerged regarding the effectiveness of different types of obesity interventions conducted in a primary care setting and specifically referral of suitable patients to commercial programmes. Different weight management interventions and services have different outcomes. The level of evidence underpinning different interventions also	This guidance identifies the core components of effective programmes for children and young people for all programmes. Please see Recommendation 3 in the final guidance.

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			varies. Some services (such as Weight Watchers) have good quality evidence, based on randomised controlled trials published in high impact peer reviewed journals. Others have little or no evidence. Public health departments, commissioners, Health and Wellbeing Boards, Clinical Commissioning Groups need to concentrate on commissioning services which are known to work with proven outcomes with specific target audiences. Evidence should be the core basis for commissioning and this should be strongly emphasised within the guidance.	
Weight Watchers UK	General		**NICE's guidance should make reference to commissioning guidance issued by DH in March 2013**. On March 18, DH released best practice guidance to help improve commissioning of weight management services in local areas. http://www.dh.gov.uk/health/category/policy-areas/public-health/obesity-healthy-living/. The guidance is aimed at local authorities, in particular Directors of Public Health and commissioners of weight management services. The document includes:: • explanatory notes for developing a specification for tier 2 lifestyle weight management services • two best practice example service specifications, one for adults and one for children. These specifications are voluntary and their usage will assist commissioners to think through the main issues at the start of the procurement. • information on outcomes that a commissioner should expect from a tier 2 service Weight Watchers suggests that this 'best practice' commissioning guidance from DH should be included in the guidance on lifestyle services for	Noted, thank you. The DH commissioning guide and the NICE guidance have been developed independently, based on each groups' own evidence reviews. The remit of the NICE guidance is broader, i.e. it considers needs assessment, programme content and staff training needs as opposed to focusing solely on commissioning. Where areas do overlap however, there is broad agreement between the two documents.

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			overweight and obese children currently being formulated by NICE	
Weight Watchers UK	General		**Weight Watchers welcomes inclusion and recognition of the value of qualitative data -** Weight Watchers has consistently commissioned a raft of qualitative studies to understand the user and referrer perspective of the services they provide for the public sector. These studies have provided a wealth of insight into recruitment, referral, adherence and the content of Weight Watchers services for NHS patients plus a platform for continuous improvement. In the past these types of studies have been reluctantly accepted as part of the evidence underpinning weight management services, when in reality they are vital to understanding how to maximise the effectiveness of these services and interventions. Weight Watchers is pleased to see that NICE has formally recognised these types of studies within the present draft guidance.	Noted, thank you.
Weight Watchers UK	Introduction	Page 2	Who is this guidance for? Suggest that the term 'commissioners' is too vague, feel that this should be more specific and include commissioners in CCGs, commissioners of public health services in Local Authorities. The guidance is also useful to Health and Wellbeing Boards, Clinical Commissioning Groups, Local Health Watch personnel. Widening the target audience will position this guidance more specifically within the new public health commissioning landscape.	Noted, thank you. More detail has been given in the fiinal guidance.
Weight Watchers UK	Section 1	Page 7	First sentence should read: Commission services with proven outcomes to meet local needs.	Please see the response to the earlier comment.
Weight Watchers UK	Section 1	Page 9	First sentence should read: Behaviour change techniques targeted at parents and children to increase motivation and confidence in the ability to change.	Noted, thank you.
Weight Watchers UK	Section 1	Page 19	First bullet point should read – Ensure staff have the necessary knowledge, empathy and skills to deliver multicomponent programmes to parents, carers	Noted, thank you. Please see Recommendation 12

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			and their children. Weight Watchers has some experience of piloting a parent based programme for treating excess weight in children 7-14 years. Based on this experience we know that facilitator empathy and insight into parental struggles to encourage children to eat healthily and be more physically active was essential for effective delivery of the programme.	in the final guidance.
Weight Watchers UK	Section 3	Page 32	When piloting a parent based programme in Essex in 2009, Weight Watchers found that the recruitment of families proved to be a huge challenge. Suggest that this part of the guidance is expanded to provide much more practical guidance on attracting families into services.	The PDG has made recommendations to increase referrals and self referrals to programmes in Recommendations 6 and 7 in the final guidance.
Weight Watchers UK	Section 3.26	Page 34	Outcome measures – Weight Watchers recommends that these are as simple as possible and suggest that these should simply be no weight gain amongst children and parents/carers over a one year period. Weight Watchers recommends that parental weight be included in the main outcome measure of a child weight management programme	The final guidance recognises that the aims of programmes for children or young people who may no longer be growing, may differ to those who are still growing. This is discussed in the intrroductory section of the guidance under 'lifestyle weight management programmes', in Recommendation 9 and in Consideration 3.36 of the final guidance. While parents and carers may also benefit

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				from the programme, they are not the main target of the intervention.
Weight Watchers UK	Section 9	Page 61	Evidence statement 1.2. 2 Parenting skills – this paragraph is difficult to understand – suggest re-wording for clarity	Noted, thank you. This has been re-drafted to improve clarity in the final guidance.
Weight Watchers UK	References used in this response		Boutelle, K N (2012) Parent only treatment for childhood obesity: A randomized controlled trial, Obesity, 19, 574-580. Dahly, D and Rudolph, M (2010) Identifying obesity risk in the early years, Report completed as a project funded by the Cross Government Obesity Unit. Eberhard, M et al (2011) Greater Improvements in Diet Quality in Participants Randomised to a Commercial Weight Loss Programme Compared to Standard Care Delivered in GP Practices, Proc Nutr Soc. Vol 70, Issue OCE4, p. E252.	Noted, thank you.

Document processed	Stakeholder organisation	Number of comments extracted	Comments
African Health Policy Network.doc	African Health Policy Network	13	
Association for Improvements in the Maternity Services.doc	Association for Improvements in the Maternity Services (AIMS)	12	
Association for the Study of Obesity	Association for the Study of Obesity	16	
British Heart Foundation.doc	British Heart Foundation	23	

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British Psychological Society.doc	British Psychological Society	47	
Children's Food Trust.doc	Children's Food Trust	4	
Department of Health.doc	Department of Health	1	
Diabetes Management and Education Group.doc	Diabetes Management and Education Group	38	
domUK.doc	Dietitians in Obesity Management (domUK), a specialist group of the BDA	33	
Durham County Council.doc	Durham County Council	5	
Hartlepool Borough Council.doc	Hartlepool Borough Council – Healthy Weight, Healthy Lives Group	7	
Kent Community Health NHS Trust.doc	Kent Community Health NHS Trust	4	
Ki Performance Lifestyle Ltd.docx	Ki Performance Lifestyle Ltd.	5	
Knowsley MBC Public Health.doc	Knowsley MBC Public Health	12	
Living Streets.doc	Living Streets	6	
London Borough of Newham	London Borough of Newham	6	
NHS Sussex.doc	NHS Sussex	13	
Oxford Health NHS FT.doc	Oxford Health NHS FT	3	
Play England.doc	Play England	9	
Portsmouth City Council.doc	Portsmouth City Council	17	
Public Health England.doc	Public Health England	21	
Royal College of General Practitioners.doc	RCGP	15	
Royal College of Nursing.doc	Royal College of Nursing	15	
Royal College of Paediatrics and Child Health.doc	Royal College of Paediatrics and Child Health	24	

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SEPT Community Health Services, Bedfordshire.doc	SEPT Community Health Services, Bedfordshire	25	
SHINE.doc	SHINE	31	
Slimming World.doc	Slimming World	6	
Sustrans.doc	Sustrans	6	
Weight Watchers UK.docx	Weight Watchers UK	17	