Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope Stakeholder Comments Table

17th January 2012

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Association for Family Therapy and Systemic practice (AFT)	4.3	6	The Lambeth Specialist Healthy Weight Pathway has a pilot systemic model where relevant health services (family therapy, dietetic, physical health and activity) have been commissioned to provide coordinated services for children and young people who are overweight or obese with other problems. Family therapy addresses the various problems within the family so that they can address eating and weight issues within the family, as well as issues such as stigma. Although based at Tier 3, assertive outreach is used to provide access for some families. No one model of family therapy is used, but systemic family therapy will address different health issues as well as cultural, ethnic and socioeconomic factors for families.	Noted. Thank you for commenting on the scope.
Association for Family Therapy and Systemic practice (AFT)	4.3.	6	Evidence for the systemic model from Sweden, SOFT (the model used is often provided in family therapy training in the UK): Flodmark, Ohlsson, Ryden & Sveger (1993) Prevention of progression to severe obesity in a group of obese schoolchildren treated for family therapy. Pediatrics.19.5.880-884. Flodmark & Ohlsson (2008): Childhood obesity: from nutrition to behaviour. Proceedings of the Nutrition Society. 67.4.356-362. Nowicka P, Pietrobelli A, Flodmark CE. (2007). Low-intensity family therapy intervention is useful in a clinical setting to treat obese and extremely obese children. International Journal of Pediatric Obesity 2(4):211-7.	Noted. Thank you.
Association for Family Therapy and Systemic practice (AFT)	General		Access to supervision or teaching from family therapists can be helpful to promote systemic models for services as well as including families in treatments.	Noted. Thank you
Combating Obesity	4.1.2	6	**Groups not covered** Many obese and particularly morbidly obese young people have one or more	Noted. Thank you. It was

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			other conditions which impact on their ability to manage their weight; to exclude them from the guidance will severely restrict their choices and access to opportunities to improve their health. Consideration must be given to those with greatest need, they must not be excluded from weight management services. It can be precisely this exclusion that results in weight gain, increased stigmatisation and reduced self esteem. The guidance must be broadened to include this group and services designed and commissioned to specifically address the needs of this group. Equity & Excellence report 2010 focuses heavily on patients increased choice and control and excluding them goes against the aims and spirit of the report. If they are not included in the guidance, commissioners will fail to provide a comprehensive range of interventions and treatment opportunities and increase health inequalities.	not our intention to exclude obese or overweight children or young people with co-existing conditions from the guidance on lifestyle weight management services. In order to remain focused on lifestyle weight management services however, we must exclude the treatment of any co-existing health conditions (mental or physical). We have amended the scope to clarify this.
Combating Obesity	4.3	8	**Effective & Cost effective** Multi component lifestyle wm programmes tend to consist of 6, 10 or 12wks of intense interventions which bear little or no resemblance to daily living. Recidivism is a major problem. Children and young people have very differing needs at various stages of	Noted. Thank you. We intend to search for evidence as to how effectiveness and cost effectiveness varies

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			growth and development which must be considered throughout any weight management programme. Providing specialist professionals for short bursts of education and activities is very costly and generally fail to change life-long behaviour. Weight management for those already very overweight need long-term age-appropriate support. People learn and embed new learning at different paces. The focus must be on allowing the children, young people and their families time to try out new things and develop their own ways of managing weight Community–led long-term peer support is best provided by those who have successfully accessed services and are best placed to design and deliver on-going support. Many front line professionals have little real understanding of the complexity of obesity and receive very little training on engaging patients thus repeatedly wasting valuable resources. Weight management is complex and should be reflected in the commissioning of a range of alternative approaches. Realistic outcomes, not just short term weight loss Understanding multiple health outcomes Resources must focus heavily on engaging patients. If patients are engaged	according to a range of factors including the age of the child or young person, and the impact of including the parents and wider family. Sustaining behaviour change and programme duration are among the expected outcomes in the revised scope.

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			they will become a valuable resource for sustainability.	
Combating Obesity	4.3	8	**Best practice principles** Age appropriate support interventions (youth friendly) Non-directive but engaging, encouraging, empowering. Dignity and respect – non judgemental Truly patient-centred, Real choice. Long-term support for those with the greatest need. It is vitally important that staff is fully trained in non-judgemental approaches to weight management. Promoting personal responsibility **Families** Including families is important and impacts greatly on the long-term behaviour and habits of children however not all families are supportive of an obese child.	Noted. Thank you. Please see previous comment. We also anticipate that the PDG will consider the factors listed in Appendix B if evidence is available, including issues such as staff training and qualifications and the characteristics of the person delivering the programme or service.

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			Family dynamics are complex and their involvement may result in blaming, shaming, humiliating, verbally abusing and sabotaging the child's efforts. If age appropriate, ie older children may prefer not to include family in their support; this must be understood and respected. Not all obese children have other obese family members and this can result in them being undermined by the habits of slimmer family members.	
Combating Obesity	4.3	8	**Views, perceptions, beliefs** Anger, fear, frustration and misunderstandings undermine many weight management services. Patients do not feel listened to, included, respected nor treated with compassion or dignity. Professionals in the field are often slim with the misguided belief that they are good role models however many have no lived experience of obesity. Obese young people will very quickly disengage if they feel pre-judged, blamed or shamed. Weight management services which openly acknowledge these challenges are better placed to help obese people maintain attention on developing	We anticipate that the PDG will consider the factors listed in Appendix B if evidence is available including issues such as staff training and qualifications and the characteristics of the person delivering the programme or service.

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			healthy lifestyles.	
Combating Obesity	4.3	8	**Commissioners and deliverers** Commissioners often believe obese children have obese parents and siblings and commission inappropriately designed services. Media stereotypes often dominate the design of services and can result in frustrated providers bullying and pushing obese young people to do things that are not in-line with their abilities or interests. Commissioners can believe the best services will be medically or sportsman-led not community-based nor community-led. Immediate weight-loss targets can be a misguided and unrealistic outcome for some obese young people and targets such as these can waste valuable time and resources both of the provider and the child. Consideration of social returns on investment (SROI) and wider benefits.	Noted. Thank you. We intend to search for evidence on the views perceptions and beliefs of services users and their families as well as the views perceptions and beliefs of the staff responsible for commissioning and delivering the services. Noted, thank you While return on investment will be considered NICE will not be carrying out a social return on investment. This is because the

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				literature on SROI does not put any value on an improvement in quality or length of life. In addition, the standards to be used in return-on-investment appraisal for this topic can be expected to be much more stringent than those seen in the SROI literature. We will add ‘wider benefits will also be considered’ to the scope.
Combating Obesity	**General**		The draft scope is very encouraging and reasonably robust however the limitations outlined above are some of the central planks to combating obesity. The level of ignorance and stereotyping around this condition is creating negative environments where efforts are easily undermined and obstructed. Anyone commissioning or delivering weight management programmes must acknowledge and understand the complexities they are facing and act appropriately. Existing training excludes or overlooks the real psychological and social implications for obese children and young people and providers must recognise how their own actions can inadvertently contribute to increasing the difficulties these young ones face.	Noted. Thank you for commenting on the draft scope.

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			Focus must be on robust training of commissioners and providers to understand the importance of effectively engaging obese children and their families. There is a very real danger that poorly designed programmes will disengage the very people requiring the most support. We really do not want to still be in a position of ignorance in ten years time having wasted more valuable time and resources. I am very concerned for the very largest young people as these are the hardest to reach and engage because many providers design services for the quickest and easiest returns ie those with much less weight to lose. Successful outcomes must be appropriate to the person seeking help and support. Weight management specialists services for the most obese must not be limited to academics and surgeons.	
Cornwall and Isles of Scilly PCT (NHS)	General		Keep it in the family (KIITF) in Cornwall is a family based weight management intervention. The difference between this and other interventions is 1) intensity - 9 months in duration and includes home visits 2) uses activity and natural environment as a key part of its scope – this aligns well with Cornwall. 3) Is delivered by a SME not for profilt social enterprise with a passion for delivery, creativity and rigour. The age range is 7 – 13, referral criteria is on or >91st centile BMI. It is a PCT (NHS) commissioned programme and evaluated using	Noted. Thank you.

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			NOOSEF with support from partners. KIITF is in its 9th delivery phase over 3 years.	
Cornwall and Isles of Scilly PCT (NHS)	General		LEAF (Lifestyle, eating and Activity for families) is an acute specialist child and family weight management clinic in Cornwall delivered by a MDT from Royal Cornwall Hospital Treliske, led by Paediatrics team. The team includes Consultant Paediatrician, Obesity specialist Dietitian, exercise specialist with wide support from partners such as Children's Centre staff and public health. The service is in infancy. The referral criteria is >98th centile + co-morbidities, SD+3.	Noted. Thank you.
Counterweight Ltd.	4.2.1	6	Counterweight Families is a programme aimed at empowering change within families. The programme is currently being evaluated in a pilot in 3 Health Boards in Scotland and 1 PCT. Counterweight Practitioners trained and mentored to deliver the programme come from backgrounds of dietetics, nutritionist, health visitor, physical activity instructors. The programme is delivered within the healthcare setting and in leisure services. We have preliminary unpublished outcomes from the pilot. The programme involves at least one adult and one child attending 10 sessions over 12 months.	Noted. Thank you. We will issue a call for evidence and have processes in place to manage data which is academic or commercial in confidence. We would welcome submission of this data to that process.
Counterweight Ltd.	4.3	8	Glasgow University are conducting a qualitative study assessing the level of interest in a family programme for weight management. They are consulting with adults attending the Counterweight Programme in general practice. This work is also asking the individuals if they did attend a family programme what type of venue would they like to attend or this type of service.	Noted. Thank you. Please see previous response.
Department of Health	General		The scope is for 2-17 years.	Thank you for your

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			I am concerned that under-twos are excluded from this guideline. The Healthy Child Programme pregnancy to 5 years states in 'Universal services 6 months to one year' : ''Monitoring growth - if there is parental concern about a baby's growth or risk to normal growth (including obesity) an assessment should be carried out....... a decision should be made as to whether follow up or an intervention is appropriate...” I believe that NICE should consider whether there are any evidence based lifestyle management services for children and/or their families that could benefit overweight or obese infants and toddlers. The toddler forum, for example, proposes lifestyle changes, which seem sensible, but may not be widely offered.	comments. We are not aware of any lifestyle weight management programmes for children under two years of age. However we have removed the lower age limit in the revised scope. If evidence for lifestyle weight management services for this age group is identified the PDG will consider it.
Dietitians in Obesity Management UK (domUK)	General		We welcome this timely investigation into an important area of child health, and that of young people.	Noted. Thank you for commenting on the scope.
Dietitians in Obesity Management UK (domUK)	4.2.1	7	We have concerns about possible adverse effects of children attending lifestyle weight management programmes designed for adults, particularly the potential for negative emotional/psychological effects.	This document does not predict the PDG recommendations but outlines the areas in which evidence will be sought and if identified will be considered by the

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				PDG. We are aware that some adult programmes do accept children or young people over a certain age and if evidence is identified for the outcomes of children or young people in those programmes then the PDG will consider it.
Dietitians in Obesity Management UK (domUK)	4.3 Subsidiary questions	9	We welcome the inclusion of adherence in the subsidiary questions, given the importance that attendance and adherence have been shown to have in adult weight management approaches	Noted. Thank you
Dietitians in Obesity Management UK (domUK)	Expected outcomes	9	We would like recognition that weight loss may not always be the most appropriate outcome measure; slowing of weight gain or weight stabilisation may be more appropriate in some instances.	Noted. Thank you. You will see in the final scope that the first bullet point under 'Expected outcomes' has been amended to: *'Weight maintenance, or changes in weight, body mass index (BMI) or waist circumference adjusted for age and gender (for example, using BMI or waist*

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				circumference z scores or BMI centiles).
Dietitians in Obesity Management UK (domUK)	Appendix B	12/13	We would like to see the addition of long term support and monitoring to the list of potential considerations.	'Duration of the programme' is covered under 'potential considerations' in appendix B and has also been added to the expected outcomes section of the revised scope. ' Follow up of participants and sustainability of weight changes have also been added to 'expected outcomes '
Education for Health	General		We welcome this new guidance. We are a charitable organisation that focuses on prevention and management of chronic disease of which obesity is a main risk factor. Having new evidence based guidance relating to lifestyle and behaviour change in managing overweight and obesity in this age group may help to curb the burden of chronic disease in later years.	Noted. Thank you.
Fit for sport	general		It is my personal belief that if we are serious about changing the nation's health we must eliminate our "quick fix" mentality. It's all too often that we hear someone say they are on another diet or have started an intensive fitness regime. We have not woken one morning to find out our nation's fitness levels and obesity statistics are an alarming 23rd in the World! It has taken many	Noted. Thank you.

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			years of families living an unhealthy lifestyle and schools not giving Physical Education the importance it deserves, on a par with core subjects like Maths and English. Therefore we must not expect to stop the decline or halt the raise on obesity overnight! It will take many years to correct the bad habits that our families have adopted.	
Fit for sport			This is why I believe that our experience of over 18 years of working with families and schools has enabled us to come up with what we believe is the answer: our SAS approach (Simple, Achievable and Sustainable) incorporating daily lifestyle habit changes. The education of families, children and communities is vital in facilitating changes to the health of our nation.	Noted. Thank you.
Fit for sport			Through media and so-called 'expert' advice we have confused and over complicated what is needed to improve our nation's health. SAS advice on daily habit changes for both families and children is the first step, and the understanding of what is required to make a difference whether to lose weight or to just get fitter must be achievable and most importantly sustainable! We do not need to eat salads for the rest of our lives, or have to go to the gym 7 days a week, but educate all on the simple changes to daily activity levels and sensible eating habits.	Noted Thank you.
Fit for sport			If we are serious about halting the rise of obesity and improving our statistics, we need to go back to basics! We do not need to overcomplicate, but to assist in "keeping the future fit". We have to start by adopting our SAS approach.	Noted. Thank you.
Food Dudes	General		Services that aim to manage and maintain the weight of **all** children and young people - i.e. by promoting healthy diet and physical activity across the whole population, regardless of weight - are excluded in the draft scope. However, as such services can be very effective in managing the weight of overweight and obese children and young people, it may be recommended	Thank you for commenting on the scope. The referral from the

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			that they do constitute a weight management service for this specific population and should be included within the final scope.	Department of Health is very clear that the focus of this guidance is on lifestyle weight management services. The primary prevention of obesity and overweight in children and young people is considered by existing NICE guidance for e.g. Obesity. NICE clinical guideline 43 (2006). Prevention of cardiovascular disease. NICE public health guidance 25 (2010). Promoting physical activity for children and young people. NICE public health guidance 17 (2009). Maternal and child nutrition. NICE public health guidance 11 (2008).

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Food Dudes	4.2.1 Activities that will be covered	7	Caution needs to be exerted regarding the inclusion of services "designed primarily for adults but which accept, or may be used by, children and young people" within the guideline. Children (particularly young children) have different dietary and exercise needs to that of adults, and also different patterns of learning. Successful adult weight management services for adults may not therefore be suitable for children, unless they are specifically adapted to meet the physical and psychological needs of this age group. It may be useful to change the inclusion criterion to reflect this consideration.	This document does not predict the PDG recommendations but outlines the areas in which evidence will be sought and if identified will be considered by the PDG. We are aware that some adult programmes do accept children or young people over a certain age and if evidence is identified for the outcomes of children or young people in those programmes then the PDG will consider it.
Food Dudes	4.3 Expected Outcomes	9	Greater emphasis should be placed on the accurate measurement of the behavioural outcomes of weight management services – e.g. improved diet and increased physical activity - as behaviour change tends to be long-lasting and as such, it may be a better indicator of the long term effectiveness of a weight management service.	As the population group under consideration is overweight or obese children or young people we feel sustainability of weight change is a better long term outcome and have added this to

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				expected outcomes in the revised scope. The modelling of cost effectiveness will also take this into account as sustainable outcomes give rise to the greatest health benefits.
Liverpool John Moores University	4.1.2	6	We disagree with the proposal to automatically exclude the following groups: - *"Children and young people undergoing pharmacological or surgical treatment for obesity"* - *"Children and young people who are receiving treatment for mental or physical health problems which may be related to obesity (such as type 2 diabetes)".* Many children and young people who are overweight require lifestyle support alongside the treatment they are receiving for their co-morbidities. Instead of automatic exclusion, we recommend a distinction is made between: a) children and young people who would benefit from participation in a lifestyle weight management service (e.g. young people with a mental or physical health condition that would be ameliorated by dietary changes or an increase in physical activity); and b) children and young people for whom a lifestyle weight management service would not be appropriate (e.g. young people with extreme obesity who are undergoing surgery) Those in group a) should be included in the scope, with specific areas of the guidance for certain groups where necessary (e.g. those also receiving	Thank you for commenting on the scope. It was not our intention to exclude obese or overweight children or young people with co-existing conditions from the guidance on lifestyle weight management services. In order to remain focused on lifestyle weight management services however, we need to exclude the treatment of

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			pharmacological treatment, those receiving treatment for physical health problems, those with learning disabilities etc.). Those in group b) should not be included in the scope.	any co-existing health conditions (mental or physical). Likewise we will exclude surgical or pharmacological treatment. Children and young people who are receiving these treatments will not be excluded however. We have amended the scope to clarify this.
Liverpool John Moores University	4.1.2	6	In the same section *"adults"* needs some further detail. As it is, it contradicts the previous section that says *"The parents or carers and families of these children and young people"* (and thus adults) will be included.	Noted. Thank you. We have clarified this in the revised scope.
Liverpool John Moores University	4.3	8	Key question *"How effective and cost effective are lifestyle weight management programmes in helping overweight or obese children and young people to achieve and maintain a healthy weight?"* *"Effectiveness"* is referred to frequently throughout this section, but one of the greatest challenges in childhood obesity treatment is establishing what constitutes an *"effective"* outcome (and how this differs for service-users, for	Thank you for the suggested amendments to the key questions. The questions listed in the scope are for the overall guidance, not the individual evidence

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			practitioners and for stakeholders). For example, the evidence on the magnitude of BMI change required for improved health outcomes is equivocal, and even with minimal BMI change there may be other positive health outcomes (e.g. improved physical fitness or changed dietary habits). Therefore, it is inappropriate for effectiveness to be entirely based on *"achieving and maintaining a healthy weight"* (indeed this in itself is unrealistic in the timescale of most child weight management programmes). It is important this scope covers guidance to help commissioners understand how best to establish effectiveness. As such, we recommend the above question is reworded to reflect broader health outcomes, and the reference to "achieving and maintaining a healthy weight" removed. We also recommend a question such as the following is included: *"How should the effectiveness and cost-effectiveness of child weight management programmes be established (and how do perceptions of "effectiveness" vary between service-users, practitioners and stakeholders)?"*	reviews. These will be more detailed and specific research questions. As outlined in section 4.3 under 'expected outcomes' intermediate outcomes such as changes in physical activity or diet will be considered Commissioners will be a key audience for this guidance hence the question *'What are the views, perceptions and beliefs of the staff commissioning and delivering weight management services to children and young people?'*

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Liverpool John Moores University	4.3	8	Subsidiary question: *"Does including parents and their wider family in community-based weight management programmes for children and young people impact on effectiveness"?* It is well established that lifestyle interventions for children who are overweight should be "family-based." However, what is less well established is how best to involve the family, and how this varies with the age of the child/young person. We recommend this question is rephrased along the lines of: *"What are the most effective ways of engaging parents and the wider-family in community-based weight management programmes, and how does this vary with the child's age?"*	As stated above, the questions listed in the scope are for the overall guidance, not the individual evidence reviews. These will be more detailed.
Liverpool John Moores University	4.3	8	Subsidiary question: *"How does effectiveness and cost effectiveness vary for different population groups (for example, black and minority ethnic or low-income groups, or children and young people with special needs)?"* Our research suggests the facilitators and barriers to participation in lifestyle child weight management programmes vary widely for BME groups, yet obesity rates are often higher in these populations. We recommend there is a subsidiary question focussed specifically on BME populations, such as: *"What additional factors need to be taken into account when working with BME communities?"* It is crucial the scope addresses this fully and a specific section is allocated to the inclusion of BME communities in child lifestyle weight management programmes.	See above
Liverpool John Moores	4.3	8	Subsidiary question:	See above

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University			*"What are the most effective and cost effective ways of addressing and sustaining behavioural change among overweight and obese children and young people using community-based weight management programmes?"* A key challenge for child weight management services is the provision of follow-up support. Little is known about the long-term impact of child weight management programmes in this country, and the maintenance of health behaviour change in children. To ensure adequate attention is given to the long-term maintenance of changes, we recommend there is a specific question such as: *"What factors are important for sustained behaviour change in children who are overweight?"*	
Liverpool John Moores University	4.3	9	Economic outcomes We recommend this includes a section covering *Social Return on Investment*, as this is a key factor for child weight management in the community.	While return on investment will be considered. NICE will not be carrying out a social return on investment. This is because the literature on SROI does not put any value on an improvement in quality or length of life. In addition the standards to be used in return-on-investment appraisal for this topic can be expected to be much more stringent than those seen in the SROI literature. .We will add 'wider benefits will also be considered' to the scope.

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Liverpool John Moores University	Appendix B	13	We recommend *"behaviour change techniques used"* is added to the potential considerations.	See above
MEND	General		It is crucial that the scope of guidance includes the publication of evidence-based and realistic outcomes for commissioners of child weight management services. In our experience, as the largest provider of child weight management services, there is huge variability in health outcome choices (e.g. BMI vs. weight loss vs. BMI z-score) and within health outcomes (e.g. magnitudes of BMI z-score reduction) required by PCT commissioners as measures of success. Many of the stated outcomes, used by PCTs to judge success of child weight management programmes are not evidence-based and differ widely between PCTs. An essential output of this guidance should include realistic good practice, evidence-based outcomes for the commissioned child weight management services. MEND has published and unpublished RCT and longitudinal data for over 10,000 UK children who have attended a lifestyle weight management programme, delivered by teams with very different backgrounds. We would be happy to share our data in order to benchmark realistic outcomes for providers of child weight management services as well as PCT and local authority commissioners.	Noted. Thank you. We intend that the guidance will include realistic good practice, evidence-based outcomes for the commissioned child weight management services . We will issue a call for evidence and have processes in place to manage data which is academic or commercial in confidence. We would welcome submission of this data to that process.
MEND	4.3		We agree that cost-effectiveness is an essential component of this guidance. An independent cost effectiveness study demonstrated that the MEND 7-13 is	Thank you – see above.

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			available to NICE in order to inform this guidance.	could be very useful.. We will issue a call for evidence and have processes in place to manage data which is academic or commercial in confidence. We would welcome submission of this data to that process.
National Obesity Observatory	3a, 3b, 4.1.1, Appendix B - bullet point 1.	3, 6, 13.	Definitions of obesity Appendix B mentions that the review will consider issues around '*the degree of obesity',* and NOO would like to stress the importance of this issue. Sections 3a and 3b present overweight and obesity prevalence figures which use the 85th and 95th centiles of the British 1990 Growth Reference (UK90) to classify children as overweight and obese - the 'population monitoring' thresholds. However, when dealing with individual children the 91st and 98th centiles of the UK90 reference are usually used to classify children as overweight or obese - the 'clinical' thresholds. The footnote to section 4.1.1 suggests these 'clinical' thresholds will be used to identify which children will be targeted for weight management services.	Thank you for commenting on the draft scope. Thank you for making this point. The footnote in the draft scope is a statement about obesity classification and thresholds. It does not anticipate or predict the guidance

Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope Stakeholder Comments Table

17th January 2012

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			These different definitions of child obesity mean the proportion of children eligible for weight management services will be substantially lower than the proportion of the child population that is classed as 'obese' within published prevalence figures. This has important implications - for example, when considering the amount of resources required to deliver weight management services – and so should be made clear within the review. It might be beneficial if the review were to provide some indication of the proportion of English children who would be eligible for weight management services using the clinical definition. Such data (for children aged 4-5 and 10-11 years) are available through the child obesity 'e-atlas' published by the National Obesity Observatory: http://www.noo.org.uk/visualisation/eatlas	recommendations.
National Obesity Observatory	4.3	9	Expected Outcomes The following outcome measures are suggested in section 4.3 of the scope document: *'Percentage weight loss, reduction in body mass index (BMI), BMI centiles or waist circumference, or maintenance of weight loss.'* Four of the five indicators mentioned here may not be suitable for use with children - 'Percentage weight loss', 'reduction in BMI', 'reduction in waist circumference', and 'maintenance of weight loss'. As children grow their body measurements change, rather than remaining	Noted. Thank you for raising this issue. In the final scope this section has been amended so that it now focuses on '*weight maintenance or changes in weight, BMI or waist circumference adjusted*

Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope
Stakeholder Comments Table

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			relatively constant over time as for adults. As a result many of the outcome measures used to monitor weight management in adults are not applicable to children. As these indicators do not take account of the likely changes in that measure with age, it is impossible to determine whether any observed change represents an increase or decrease in obesity risk or whether the change could simply be a result of normal patterns of child growth. Converting weight, BMI or waist circumference to a centile value (which can all be done using the UK90 reference) produces a more appropriate outcome measure. Such centiles are essentially a measure of 'weight/BMI/waist circumference adjusted for age and sex', and so can be used to make more meaningful comparisons over time. Furthermore, a reduction in actual weight, BMI or waist circumference would be inappropriate for many children. It is usually preferable to try to maintain the current measurement until the child is of an age where that is considered a 'healthy' value. However, it is appropriate to try and achieve centile decreases in weight, BMI, and Waist circumference measures over time, as a child moves from an unhealthy centile to one considered healthy. However the disadvantage of centiles is that they are constrained to a scale of 0-100. Extreme values are compressed across a small range of centiles, and there is a loss of sensitivity to change for children with very high or low values. This means an obese child will need a large decrease in their BMI to achieve a small decrease in BMI centile, whereas a child at a healthy weight will only need a small decrease in BMI to achieve a much larger jump in BMI centile.	*for age and gender (for example using BMI or waist circumference z scores or BMI centiles'.* We are conscious that research studies will report a variety of outcome measures and if the evidence is reported for other measures we will consider those also. We expect to find variation in studies therefore BMI z-scores will be recalculated using the reported age, sex, and means from studies against the UK 1990 population reference.

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Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope Stakeholder Comments Table

17th January 2012

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			A better outcome measure would be weight, BMI or waist circumference z score (standard deviation score), rather than centile These are equally sensitive to change, regardless of whether the child has an extreme value. Summary measures such as 'mean change in BMI z score' can be easily produced, and can be used to compare across different population groups etc. Z scores are calculated in the same way as centiles and so should not require any additional work or analysis – they simply provide a better metric when trying to detect change over time among children with a high weight/BMI/waist circumference for age.	
National Obesity Observatory	4.2	6	NICE may wish as part of this process to consider the use of the term 'lifestyle'. Some people reject this term as being appropriate more to higher socio-economic groups.	The term 'lifestyle' has been used as this is the term used in the ministerial referral from the Department of Health.
National Obesity Observatory	4.3	8	We note that you include programmes run by commercial providers in the scope. We agree with this, but wonder if a subsidiary question might be 'what is the relative effectiveness of commercial programmes compared to those run by the statutory or voluntary sector'?	This guidance will consider programmes provided by the public, private or voluntary sector, in the community or in (or via) primary care

Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope Stakeholder Comments Table

17th January 2012

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				organisations, social enterprises or others. The purpose of the guidance is to determine the essential elements of effective and cost effective programmes regardless of provider organisation.
NHS Bolton	4.1.1	6	In support of the comments submitted by Royal Bolton Foundation Trust under the section – 'Groups that will be covered' it doesn't mention anything about children with special educational needs or disabilities. This is a group worth covering as they will need a slightly different approach and there would be other potential considerations to take into account with this group (appendix 5) in terms of the effectiveness/outcomes of programmes for this group.	Thank you for commenting on the draft scope. Please see the first subsidiary question on page 8: 'How does effectiveness and cost effectiveness vary for different population groups? (Examples may include children and young people from different black and minority ethnic groups, from low-income groups, of different ages or genders, or *with special needs*.)
NHS Bolton	4.2.1	6	"Lifestyle approaches focus on diet, physical activity, behaviour change or any combination of these factors". Will this also include an emotional and health	Please see the' expected outcomes' on page 9. *Validated*

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			and wellbeing component and addressing psychological issues as these are often barriers to successful weight loss.	*measures of mental wellbeing, for example:* *emotional wellbeing (including happiness, confidence and self-esteem)* *psychological wellbeing (including autonomy, problem-solving, resilience and attentiveness)* *social wellbeing (relationships with others, bullying or social isolation).*
NHS Bolton	4.3	8	"Does including parents and their wider family in community-based weight management programmes for children and young people impact on effectiveness?" Weight needs to be tackled in the context of the family so the whole family are supporting these lifestyle changes. MEND have successfully demonstrated that this approach is effective.	Noted. Thank you
NHS Bolton	4.3	9	Expected outcomes need to include that long term weight loss/healthy lifestyle changes are maintained.	Noted. Thank you. *sustainability of weight changes* has been added to the revised scope

Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope Stakeholder Comments Table

17th January 2012

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NHS Coventry – Public Health	4.3	8	Effectiveness and Cost effectiveness – The 1990 BMI index reference curves for the UK are outdated . These need to be updated for the whole child population. Added information is required for Asian children as BMI in Asian children is lower relation to Caucasian children . Updating the BMI index reference curves will ensure effectiveness of measurement and ensure appropriate interventions are used for different populations .	The referral from the Department of Health for this guidance is confined to lifestyle weight management services for children and young people. Updating the BMI reference index for children is beyond the remit of this particular piece of guidance.
NHS Coventry – Public Health	4.3	8	Programmes for special needs children are more costly due to the programme design and people hours to carry out the programme . A special measure needs to be devised for special needs children . For example in the Food Dudes programme special needs children are costed at double the rate of mainstream children .	Noted. Thank you. Please see the first subsidiary question on page 8: 'How does effectiveness and cost effectiveness vary for different population groups? (Examples may include children and young people from different black and minority ethnic groups, from low-income groups, of different ages or genders, or *with special needs*.)
NHS Coventry – Public Health	4.3	8	Sustained behaviour change needs to occur at 12 weeks , 6 months and a	Noted. We acknowledge

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			year . Programmes based in children's immediate community incorporating , broader healthy lifestyle programmes for the whole community need to be offered. Incorporating healthy eating, physical activity and continued support. Schools and surrounding community need to offer the healthy options.	the importance of a supportive environment. However, the referral from the Department of Health is very clear that the focus of this particular piece of guidance is lifestyle weight management services. Broader healthy lifestyle programmes have already been considered by existing NICE guidance for e.g. Obesity. NICE clinical guideline 43 (2006). Prevention of cardiovascular disease. NICE public health guidance 25 (2010). Promoting physical activity for children and young people. NICE public health guidance 17 (2009). Maternal and child nutrition. NICE public health guidance 11

Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope Stakeholder Comments Table

17th January 2012

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				(2008).
NHS Coventry – Public Health	4.3	8	Involving parents and the wider community is crucial for behaviour change. But the difficulty of involving parents needs to be understood.	You will see from the key questions that it is our intention to consider the views of the families of the children and young people using these services.
NHS Coventry – Public Health	4.3	8	Facilitates – programmes at times suitable for families not just office hours . Programmes need to illustrate that they are open to all the community.	The timing of the programme is included under 'potential considerations' in appendix B
NHS Coventry – Public Health	4.3	8	Beliefs of service users – overweight and obesity has become the norm there is a poor understanding of own weight and effects on health. Therefore very difficult to engage with service users	You will see from the key questions that it is our intention to consider the views of the children and young people using these services.
NHS Coventry – Public Health	4.3	8	Staff commissioning and delivering service – need for more investment – need to build evidence base – programmes often small scale therefore effectiveness very difficult to measure . Broad healthy lifestyle programmes may be more effective .	Noted. Thank you
NHS Coventry – Public Health	4.3	9	Incentives very important – ask service users what would incentivise them to attend ? Incentive with healthy rewards and positive encouragement . Link	You will see from the key questions on page 9 that if

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			healthy eating and being active to positive mental health . Use mentors to support clients.	evidence is available it is our intention to consider how more overweight and obese children and young people be encouraged to join, and adhere to, lifestyle weight management programmes
NHS Coventry – Public Health	4.3	9	Expected outcomes – maintaining weight – it is recommended that children grow into their height . Do not measure weight loss in children – lower BMI is a more acceptable measure .Weight loss only suitable for older children who are very overweight .	In the final scope this section has been amended so that it now focuses on '*weight maintenance or changes in weight, BMI or waist circumference adjusted for age and gender (for example using BMI or waist circumference z scores or BMI centiles'.* We are conscious however that research studies will report a variety of outcome measures and if the evidence is reported for

Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope Stakeholder Comments Table

17th January 2012

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				other measures we will consider those also.
NHS Coventry – Public Health	4.3	9	Intermediate measures such as change in diet and physical activity over time are key outcomes . Investment required to put measures into place – follow up of individuals is time consuming and costly .	Intermediate measures such as changes in diet and physical activity are included in the 'expected outcomes 'on page 9.
NHS Coventry – Public Health	4.3	9	Mental wellbeing strongly connected to healthy weight and general health .	See page 9. Measures of mental well being are included in the expected outcomes.
NHS Coventry – Public Health	4.3	9	Satisfaction of service important but also more dedicated work is required with the community , allow children and parent/carers to have a say on what sort of healthy weight programme would work for them .	You will see from the key questions that it is our intention to consider the views of the children and young people using these services.
NHS Doncaster	4.3	8	As well as seeking the views of those engaged in programmes it would be important to identify views of those who don't engage and why. It would also be interesting to identify the impact of the weight status of those who are delivering information or sessions on the outcomes of those engaged in the programme.	Noted. Thank you. You will see from the key questions on page 9 that if evidence is available we intend to consider how more overweight and obese children and young people can be encouraged to join, and adhere to, lifestyle weight management programmes?

Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope
Stakeholder Comments Table

17th January 2012

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NHS East Riding of Yorkshire	4.2.1	6	We believe lifestyle approaches should focus on all three elements, diet, physical activity and behaviour change, not just one or two of these.	Noted. Thank you.
NHS Gloucestershire	4.3	8	Useful to include in subsidiary questions a question that differentiates by age group – i.e. which types of intervention are most acceptable and effective for preschool, 4-7 years, 8-11 years, young adolescents, older teens / school leavers	Noted. Thank you. The questions here are for the overall guidance not the individual reviews, the questions for which will be more detailed. However we have added ' *[children of] different ages and genders* ' to the first subsidiary question.
NHS Gloucestershire	4.3	8	Helpful to consider pros and cons of parental only, parent plus child or young person only interventions i.e. believe that there is some evidence to suggest that weight management interventions for children under the age of 6-7 years are equally effective and less risk to self-esteem if they are targeted at the parents only.	Noted thank you. If such evidence is identified it will be considered.
NHS Gloucestershire	4.3	8	Would be helpful to differentiate between appropriate approaches for overweight vs obese vs morbidly obese. This would assist prioritisation at local level and reduce risk of harm (to self-esteem / mental health) of children who are overweight with no increased risk to health provided they do not become obese	Noted. Thank you. You will see 'the degree of obesity' is listed in the potential considerations in appendix B.
NHS Gloucestershire	General		Further to the above comment it would be helpful to emphasise the aims of a WM intervention for most children are not to lose weight but to limit excess	Noted. Thank you . In the revised scope this

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			weight gain as the child grows.	section has been amended so that it now focuses on '*weight maintenance or changes in weight, BMI or waist circumference adjusted for age and gender (for example using BMI or waist circumference z scores or BMI centiles'*.
NHS North Somerset	4.3	8	The effectiveness (and cost-effectiveness) of interventions may vary according to age and gender, as well as for different population groups like BME etc. What works for what age groups is a key subsidiary question to be addressed in the guidance.	Noted. Thank you. The questions here are for the overall guidance not the individual reviews. The research questions for each review will be more detailed. We have added '*[children of] different ages and genders*' to the first subsidiary question
NHS North Somerset	4.3	8	As well as barriers and facilitators to delivery, the guidance should address barriers and facilitators to recruitment and retention.	We anticipate that this would be covered under the final subsidiary question '*How can*

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				more overweight and obese children and young people be encouraged to join, and adhere to, lifestyle weight management programmes?
NHS North Somerset	4.3	8	What training is needed for people involved directly or indirectly with lifestyle weight management for children and young people? This question should also encompass the needs of practitioners expected to bring up the subject of weight and refer children & young people to interventions.	Please see appendix B – 'potential considerations', which includes training needs under 'factors which prevent or support effective implementation?'
NHS North Somerset	4.1.1	6	Clarify the definition used for overweight and obesity e.g. UK 1990 BMI age for gender centiles >98th for obese	This has been addressed in the final scope.
NHS North Somerset	4.2.1	6	Under the activities that will be covered add (indicated in italics): 'They may include *individual or group sessions provided in hospital, primary care or community health clinics*, programmes, courses or clubs…	We have not specified inindividual or group sessions as we expect different programmes will have different models of provision. For the same reason we have not specified the setting as we expect programmes

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				might be provided in a range of different settings.
NHS North Somerset	4.3	8	Bullet points 2 and 3 include 'community-based' and this is not referred to previously. These lifestyle interventions may be community based but it is not clear if these two questions are only with reference to community-based interventions	The term 'community-based' in these questions is intended to be inclusive. These questions are for the guidance. The research questions will be more specific.
NHS North Somerset	4.3	8	Add 'cost-effective' to bullet point 3	Effectiveness is the main issue for this question Cost effectiveness may be considered if relevant data is available.
NHS North Somerset	4.3	8	Add a question: How does effectiveness and cost effectiveness vary by dose (frequency and duration)	Noted. Thank you. The questions here are for the overall guidance not the individual reviews, the questions for which will be more detailed. The potential considerations in appendix B do cover frequency and duration.

Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope
Stakeholder Comments Table

17th January 2012

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NHS North Somerset	4.3	9	Bullet point one: reduction in BMI should be changed to BMI z score; reduction in waist circumference should be changed to waist circumference z score. This takes account of differences by gender and age for children.	Noted. Thank you . In the final scope this section has been amended so that it now focuses on '*weight maintenance or changes in weight, BMI or waist circumference adjusted for age and gender (for example using BMI or waist circumference z scores or BMI centiles'.*
Royal College of Nursing	4.1.1	6	We note that the guidance is aimed for children aged two years and onwards. Whilst we welcome proposals to encourage behavioural change at an early age, we also consider that guidance should focus on childcare/working mothers and protected family mealtimes, i.e. this is more about behavioural change in adults/parents than the children. We know of some 2-4 year olds who will eat what you put in front of them but this is only what parents/adults provide – they cannot shop for themselves or make a rational decision here.	Noted. We acknowledge the importance of these issues however, the referral from the Department of Health is clear that the focus of this particular piece of guidance is on lifestyle weight management services. We are not aware of any lifestyle weight management services for children under 2 years but in the

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				revised scope have removed the lower age limit so that if relevant evidence for this age group is identified it will be included. Previous NICE guidance has addressed some of the issues you describe here e.g. Maternal and child nutrition. NICE public health guidance 11 (2008). , Obesity. NICE clinical guideline 43 (2006).
Royal College of Nursing	4.2.1	6	This should also include the societal and economic influences on the parents and their lay knowledge in relation to nutrition and physical activity – i.e., it is not just about the food or activity but the whole societal package, including media and food industry influences.	See above response and Maternal and child nutrition. NICE public health guidance 11 (2008). , Obesity. NICE clinical guideline 43 (2006).

Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope
Stakeholder Comments Table

17th January 2012

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Royal College of Paediatrics and Child Health	General	General	We cannot see any problems with it. The only comment is that the scope mentions sustainability, but not over any particular timescale. There is no definition for how long the interventions have an effect.	The guidance may make recommendations on in this area if evidence is identified. We have added' follow up of participants' and 'sustainability of weight changes' to the expected outcomes in the final scope.
Royal College of Paediatrics and Child Health	General	General	The guidance should include how obese children should be identified with particular reference to providing clear guidance in the younger age groups, e.g. pre-school age group: how is a health visitor best placed to bring up the subject of obesity with parents/ carers to maximise their engagement; or how this is approached with the older children and teenagers.	The referral from the Department of Health for this guidance is confined to lifestyle weight management services. Identification of obesity and overweight in children and young people is beyond the remit of this particular piece of guidance. We are aware from previous guidance on obesity that raising the issue can be difficult for many health professionals and if

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				evidence is identified on this issue, the PDG will consider it when making recommendations.
Royal College of Paediatrics and Child Health	General	General	Many children become obese between the ages of 2 and 5 years, an age when they are not likely to be weighed regularly by a health visitor. The guideline should cover how obesity is identified and how this is discussed with parents and by whom (obesity is likely to have been identified as an issue by a non-health professional such as nursery/school staff and/or parents/carers).	See above
Royal College of Paediatrics and Child Health	Section 4.3	8	On the paragraph about subsidiary questions we think it would be good to include an analysis of 'engagement' (which influences effectiveness) throughout the different age groups: this will have different factors in children of pre-school age, to those in 'middle' childhood and in teenagers, for example.	Noted. Thank you. The questions here are for the overall guidance not the individual reviews, the questions for which will be more detailed. However we have added ' *[children of] different ages and genders* ' to the first subsidiary question
Royal College of Physicians (RCP)	4.1.1	6	The age range is not contiguous with other NHS ranges for adolescents - which often/normally include young people up to age 19. Thus 'the local authority will remain responsible for pupils until the end of the academic year in which they turn 19 if they continue in their education'	In the final scope, the age range has been amended to '*children and young people under 18'*. We recognise that

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				various cut- off points could be used and there are advantages and disadvantages to each. We are consistent with the scope for the complementary guidance on 'Weight management in adults - lifestyle weight management services' and previous NICE guidance on obesity, where recommendations for adults begin at 18.
Royal College of Physicians (RCP)	4.1.2	6	All children and young people undergoing pharmacological and surgical treatment will need lifestyle management. These treatments may also be valid options for those undergoing primary lifestyle interventions. For these reasons it seems illogical to have this separation. Metformin is commonly used to treat metabolic sequelae and would be appropriate to be included in this evaluation	Noted. Thank you. We had intended to exclude surgical or pharmacological treatment for obesity but not the children or young people who may be receiving such treatment. We have amended the revised scope to clarify this. Children and young

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				people receiving pharmacological treatment, including metformin will not be excluded from the guidance but the guidance will not cover the pharmacological treatment.
Royal College of Physicians (RCP)	4.2.2 a	7	See above	See above
Royal College of Physicians (RCP)	4.2.2 b	7	See above	See above
Royal College of Physicians (RCP)	4.2.2 d	7	Although there are few data our experts believe that it is unsound to exclude 'very low calorie diets or meal replacements' since these are amongst the most effective interventions in adults.	The focus of this guidance is for children and young people. VLCD were reviewed in the clinical guideline Obesity. NICE clinical guideline 43 (2006) and recommendations regarding their use were made only for adults. Recommendations for the clinical management in children included the following: '*A dietary approach alone is not*

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				recommended. It is essential that any dietary recommendations are part of a multi- component approach. and *'Any dietary changes should be age appropriate and consistent with healthy eating advice'.* Very Low Calorie Diets may be considered by the guidance on weight management services for adults if they are used as part of a multi- component intervention but not if used in isolation.
Royal College of Physicians (RCP)	4.3	9	This should include the study of clinical outcomes eg metabolic, cardiovascular (BP) benefits.	If such outcomes are reported they will be included.
Royal College of Physicians (RCP)	4.3	9	There are unlikely to be data on life expectancy from weight loss in this age group. These would need to be extrapolated from intermediate/surrogate end points (see above) which might be more appropriate.	Noted, thank you
SHINE Health Academy Ltd	General		We have provided weight management services for young people aged 10-17 years for the past ten years and still find the complexities of this disorder difficult to comprehend. Every single child is individual and there are distinct differences between managing the weight of an overweight 10 year old,	Noted. Thank you.

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			compared to managing the weight of a severely obese adolescent. These differences rarely seem to be acknowledged and applying 'generic' principles of weight management across the board may not be effective. However we do think basic guidelines provide structure and enable some consistency in weight management programmes in relation to good practice.	
SHINE Health Academy Ltd	3 a) 3 b)		While the increase of obesity in young children is well documented, there is little evidence of national weight measures beyond Year 6. We ran a pilot measuring 12-13 year olds in secondary schools - obesity rates (>91st centile and not including those classified as overweight) averaged 41%. (over 500 young people in 8 schools) As stated in the scope document, these rates were higher in schools based within deprivation wards (as high as 61% in some areas).	Noted. Thank you.
SHINE Health Academy Ltd	General (relating to uncertainty of numbers of obese adolescents)		Obese adolescents are much harder to reach and more difficult to engage with than younger children and therefore require specialist weight management programmes that will meet their needs. Obesity is more complex due to puberty and changes in body images, bullying and social stereotyping. Obesity in adolescents also creates stigma and discrimination which is difficult for them to manage within a school environment. These issues need to be considered within the scope.	Noted. Thank you. The questions here are for the overall guidance not the individual reviews, the questions for which will be more detailed. However we have added ' *[children of] different ages and genders* ' to the first subsidiary question
SHINE Health Academy Ltd	3 c)	4	Although there is some mention of psycho-social effects of obesity, there is	Noted. Thank you.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			little mention of mental health status in relation to anxiety and depression in young people and its association with obesity (Reeves et al 2008, Dockray et al 2007). Many adolescents use food to cope with stressors in their lives the way an adult might use smoking, drugs or alcohol. It is imperative to address psychological issues, not separate to, but part of the intervention weight management programme so that they can learn to understand and manage the links between obesity and low mood, low self esteem to promote longer term outcomes. This may be more costly in the short term but more cost effective in the long term. It is hard to get commissioners to accept this due to initial cost implications and lack of research and hard evidence.	
SHINE Health Academy Ltd	3 d)	4	79% of obese children are likely to remain obese as adults' – this will have great implications on the health reserves and more concerning is that this aageneration are then more likely to rear obese children. Within the next few decades obesity will become the norm and life expectancy will begin to drop for the first time in decades.	Noted thank you
SHINE Health Academy Ltd	3 e)	4	It's an interesting point about the schools buying specialist equipment! In our experience 82% of young people accessing our courses 'opt out' of physical education in schools, yet when they do sports with us they have high levels of competence but little confidence in their abilities. There needs to be a surge of education in managing PE in schools for obese young people to meet their needs and potential. Taking a whole school approach would enable obese young people to be more active. Only 4% of young people on our programmes actually attend after school clubs, mainly because of the taunts and bullying. PE teachers say to us they don't have time and worry about obese young people having injuries or heart attacks.	Noted. Thank you.
SHINE Health Academy Ltd	3 f)	5	There is no identified intervention that will be effective in all cases. There	Noted. Thank you. '

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			needs to be a wide variety of options available where young people and their families can make informed choices about what will suit them best. There should be a collaborative approach with working partnerships. This could provide a 'stepped care' management model where mild interventions are offered and then if more complex interventions are required they can be 'stepped up' to the next phase. In our experiences it is much easier to manage a 10 year old with overweight issues – they are more likely to sustain their weight and grow into their BMI with good education and support. We can usually achieve this within 12-26 weeks. A 15 year old with a BMI of 36, low self esteem, issues at home, not attending school, will have far more complex needs and will require more specialist input. It is likely that this young person will have experienced years of unhealthy eating and will not have engaged in physical activity for some time. Behaviour modification in this case will require far more than 12 weeks (the norm funded time for programme delivery). It is essential that these	*[children of] different ages and genders* ' has been added to the first subsidiary question and we intend to search for evidence on the views of children and young people. Please see the 5th bullet on page 9.
SHINE Health Academy Ltd	4.1.2.	6	Groups that will not be covered include children and young people who may be receiving treatment for mental and physical health. This is ironic as the majority of recruits to our community based programmes fit this category. We take referrals from GPs, Learning Disabilities, Social Services, CAMHS. Having an illness or mental health problem does not mean that these young people cannot achieve good outcomes on a community weight management programme - we have proof of this. What it does mean is that it is initially more costly as the facilitators need to be highly skilled specialists to work in this field which is more expensive than a health trainer. This is why we have worked as a community base project with no support from our PCT or tertiary services for the past 10 years and have remained reliant on small grants and	Noted. Thank you. It was not our intention to exclude obese or overweight children or young people with co-existing conditions from the guidance on lifestyle weight management services. In order to remain focused on lifestyle weight

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			community funds. Your scope document states that there is a high risk of co-morbidities and then you exclude this group from the focus of the scope. Will there be something else that will cover this high	management services however, we will exclude the treatment of any co-existing health conditions (mental or physical). We have amended the revised scope to clarify this.
SHINE Health Academy Ltd	4.2.1.	6	In our experience it is very difficult in a 12 – 26 week lifestyle approach programme to 'achieve and maintain' a healthy weight, particularly for those with higher BMIs . It maybe worth stating to help them 'work towards a healthier BMI'. Many services won't be able to achieve this otherwise. Would suggest changing 'diet' to healthy eating to avoid misunderstandings.	Intermediate measures are also listed in the 'expected outcomes' on page 9.' Duration of programme' and 'sustainability of weight' changes have been also added in the revised scope.
SHINE Health Academy Ltd	4.3	8	I think the range of subsidiary questions are really good and appropriate and should cover a wide range of dimensions. Many of our difficulties have been in managing the behaviours and attitudes of school staff and the school environment, as young people spend a good deal of their time there. I understand this isn't a part of the scope but it may be an area to consider as a barrier.	Noted. Thank you.

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			Also recruitment is a big issue, young people rarely ask for support. They are normally sent which creates initial resistance to any intervention. Would be happy to discuss further or share our experiences. I have attached our research paper (unpublished at present for information). Thank you for the opportunity of enabling us to comment on the scope. I look forward with interest to reading more.	Noted. Thank you. Unfortunately we can't accept your paper as part of this process but we may issue a call for evidence and have processes in place to manage data which is academic or commercial in confidence. We would welcome submission of your paper to that process.
Slimming World	4.1.2	6	We are concerned that 'children and young people who are receiving treatment for mental or physical health problems which may be related to obesity (such as type 2 diabetes) is a group that will not be covered by this guidance. In reality many children who access weight management programmes will have other conditions and should not be excluded from this guidance. In fact many may improve their symptoms or management of the condition through managing their weight. There is a risk that through the guidance excluding this group, health professionals may not offer patients this type of support as a result. While the management of these conditions may not be covered in this guidance, support for weight management should not be	Noted. Thank you. It was not our intention to exclude obese or overweight children or young people with co-existing conditions from the guidance on lifestyle weight management services. In order to remain focused on

Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope Stakeholder Comments Table

17th January 2012

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			excluded.	lifestyle weight management services however, we will exclude the treatment of any co-existing health conditions (mental or physical). We have amended the scope to clarify this.
Slimming World	4.3	8	Subsidiary question: What are the views, perceptions and beliefs of the children, young people and their families who use weight management services? We have conducted some research around this area with the young members accessing our services, looking at weight history and goals and what changes they have made to their lifestyle as a result of accessing the service and how. This research has been accepted for publication in the Journal of Human Nutrition & Dietetics. In addition to that in the publication, insights were also seen from the research in terms of what led them to access the service, what concerned them about their weight, how they felt about the programme before joining and after joining. This data can be made available on request.	Thank you. We will issue a call for evidence in May2012 and have processes in place to manage data which is academic or commercial in confidence. We would welcome submission of your data to that process.
Slimming World	4.3	8	Subsidiary question: What are the views, perceptions and beliefs of the staff commissioning and delivering weight management services to children and young people? We have conducted some research looking at how Slimming World group Consultants felt about the young members integration into the	Thank you. As noted above, we will issue a call for evidence and have processes in place

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			adult weight management service, the characteristics of the adult attending with the young members and any health professional recommendations given. This data has been accepted for publication in the Journal of Human Nutrition & Dietetics, we are awaiting the publication date. Again this data can be made available on request.	to manage data which is academic or commercial in confidence. We would welcome submission of your data to that process.
StreetGames	General		We warmly welcome the development of this new guidance, in particular the focus on the needs of different ages, low income groups and the transferability of services from one place to another. On this last point, we are very aware that customisation of programmes to suit local circumstances, needs and expectations plays a very important role in making that programme both effective and sustainable. Any general conclusions the review may reach may need to be underpinned by stressing the importance of local ownership and empowerment.	Noted. Thank you.
StreetGames	Appendix B	13	Could the factors also include: Socio-economic status of the children and their families; The role of volunteers and peer mentors (both in terms of benefits for the volunteers themselves, and their contribution to making a programme sustainable); The use of incentives and rewards; Price: Marketing styles and techniques; Partnership approaches (i.e. a number of agencies working in consort delivering complementary services & opportunities)	The socio-economic status of the children and their families will be captured under subsidiary question 1 and evidence on issues such as price, marketing and use of incentives maybe identified under the subsidiary question 'How can more overweight and

Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope Stakeholder Comments Table

17th January 2012

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				obese children and young people be encouraged to join, and adhere to, lifestyle weight management programmes? The 'characteristics of the person delivering the programme or service' in appendix B would include the consideration of peers, volunteers, health professionals etc .
The British Psychological Society (BPS)	2b) & general	1	The BPS recommend that the guideline should provide practical guidance and models on how to implement the "key components" of the "successful approach" recently outlined by the Department of Health (2011, p.6) in order to achieve the new national ambition of achieving "a sustained downward trend in the level of excess weight in children by 2020" (p.3). *Reference:* Department of Health (2011). *Healthy Lives, Healthy People: A call to action on obesity in England.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130401 Accessed February 2012.	NICE public health guidance is supported by resources designed to support implementation.
The British Psychological Society (BPS)	4.1.2	6	The BPS recommends that the exclusion criteria be reconsidered so that children being treated for mental or physical mental health problems may be covered by the guideline, as such children and their parents/carers may	It was not our intention to exclude obese or overweight children or

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			present specific challenges in relation to the management of obesity and therefore require specific support. For example, the treatment a child receives for a mental health issue may exacerbate their obesity, and particular guidance would be helpful in relation to the level and type of support they require (Postgrad Med, 2003). If these groups are to be excluded because of overlaps with other guidance, the BPS would welcome this being made explicit. If they are to be excluded for any other reason, the BPS recommends that specialist guidelines be developed to address these gaps in the obesity pathway. *Reference:* Postgrad Med (2003). The Relationship Between Severe Mental Illness and Obesity. *Postgrad Med*, *114(6 Suppl. Managing Metabolic)*, 28-39. www.ncbi.nlm.nih.gov/pubmed/19667651#. Accessed 7 February 2012.	young people with co-existing conditions from the guidance on lifestyle weight management services. In order to remain focused on lifestyle weight management services however, we will exclude the treatment of any co-existing health conditions (mental or physical). We have amended the scope to clarify this.
The British Psychological Society (BPS)	4.1.2	6	The management of obesity in young women under 18 who are pregnant does not appear to be addressed in other guidance, thus presenting a gap and a need in obesity management and treatment. The BPS therefore recommends that the scope of the guideline be reconsidered to include recommendations for this group. If this issue *is* addressed in other guidance, then the BPS recommends that this be made explicit here.	There was no age limit to the scope of the guidance on PH27 Weight management before, during and after pregnancy. The recommendations apply to all pregnant women.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				The Public Health Interventions Advisory Committee (PHIAC) noted however in consideration 3.11 that needs of pregnant teenagers may differ from those of pregnant older women; that their social circumstances and health professionals they come into contact with may differ and that in addition to supporting the growth of the baby, pregnant teenagers may still be growing themselves.
The British Psychological Society (BPS)	4.2.1	6	The BPS recommends guidance be included on the appropriate assessment/screening of children and young people that should be carried out before any weight management intervention, in order that the aggravation of any pre-existing medical conditions and the increasing of any risk of psychological disorders (e.g. eating disorders, depression) be avoided.	The referral from the Department of Health for this guidance is confined to lifestyle weight management services. Assessment/ screening and identification of

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				obesity and overweight in children and young people is beyond the remit of this particular piece of guidance.
The British Psychological Society (BPS)	Appendix B	13	*4th bullet point:* From the limited available evidence (please see SIGN, 2010; British Psychological Society, 2011; Simpson *et al.*, 2012), one area of agreement in the outcome and maintenance studies examining weight management programmes is that the longer the support offered, the better the outcome (including a greater chance of weight loss being maintained, thereby improving cost-effectiveness). *References:* SIGN (2010). *Management of Obesity: A National Clinical Guideline.* Edinburgh: Scottish Intercollegiate Guidelines Network. British Psychological Society (2011). *Obesity in the UK: A psychological perspective.* Report of the Professional Practice Board's Obesity Working Group. Available online: http://www.bps.org.uk/sites/default/files/images/pat_rep95_obesity_web.pdf Accessed February 2012. Simpson, S.A., Shaw, C. & McNamara, R. (2011) What is the Most Effect Way to Maintain Weight Loss in Adults? *British Medical Journal*, *344*, d8042.	Noted. Thank you.
Weight Concern	Section 3b	3	It would be a good idea to add the prevalence of obesity in children and young adults with learning disabilities, since data continue to show that this population group is in high risk of being obese.	Thank you. We expect the guidance will include this consideration. We

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				aim to include data for England from a reputable source.
Weight Concern	4.1.2	6	Lifestyle weight management programmes may be relevant and beneficial to children and young people undergoing pharmacological or surgical treatment for obesity, therefore this group should not be excluded from the guidelines (unless separate guidance on lifestyle modifications for children receiving drug or surgical treatments for obesity are to be produced).	It was not our intention to exclude obese or overweight children or young people with co-existing conditions from the guidance on lifestyle weight management services. In order to remain focused on lifestyle weight management services however, we will exclude the treatment of any co-existing health conditions (mental or physical). We have amended the scope to clarify this.
Weight Concern	Section 4.3 And general	9	It is important to define weight loss maintenance and the principles that could support children to maintain their weight. Studies tend to report mixed results for weight loss and weight loss maintenance. This issue needs to be	Noted. Thank you. In the revised scope this section has been

Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope
Stakeholder Comments Table

17th January 2012

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			addressed and the guidelines for weight loss maintenance should be clearly separated from weight loss guidelines – it is essential to define weight loss maintenance when developing the guidelines and searching the evidence reported from studies.	amended so that it now focuses on '*weight maintenance or changes in weight, BMI or waist circumference adjusted for age and gender (for example using BMI or waist circumference z scores or BMI centiles'*.
Weight Concern	4.3	9	Where possible, changes in diet and physical activity should be supported by objective measures rather than self-report alone.	Noted. Thank you.
Weight Concern	General		Clinicians working in primary care and in the community are looking forward to clear guidelines regarding special groups such as different ethnicities and children with learning disabilities.	As you can see from the first subsidiary question we will make every effort to identify evidence for children and young people from black and minority ethnic groups and for children with special needs. However the PDG will only be able to make recommendations for these groups if the evidence is available.
Weight Management Centre Ltd	2(c)	2	Should GP's/GP consortiums be listed as other groups that the guidance may	Thank you for your

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			be of interest to?	comments. These should be covered under 'health professionals' and 'commissioners'.
Weight Management Centre Ltd	4.1.1	6	Should it be stated that people aged 18 years and over are to be considered for adult services?	We have a strict template and cannot cross- refer to other guidance in this section. The guidance on adults services is listed in Section 6 'Related NICE guidance'.
Weight Management Centre Ltd	4.2.1	6	Is there a need for guidance on the safety of 'online services' that are being considered as a childhood overweight and obese lifestyle approach?	The PDG may consider this issue if they feel there is a need to do so.
Weight Management Centre Ltd	4.3	8	Would it be useful to provide guidance on best practice for improving attrition rates?	Attendance and adherence rates have been added to the 'expected outcomes' section of the scope.
Weight Watchers (UK) Ltd	General		Obesity runs in families and many parents of children with excess weight will be obese themselves. For these reasons it is recommended that it be recognised that interventions targeted at supporting adult parents to manage	We will liaise closely with colleagues working on the complementary

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			their own weight, could have a positive familial impact. Is there sufficient evidence to commission adult lifestyle weight management programmes to support the target of tackling childhood obesity?	guidance on:' overweight and obese adults: lifestyle weight management services' to ensure that any data from adult programmes on impacts on the family are considered by our PDG and vice versa
Weight Watchers (UK) Ltd	General		It may be useful for the NICE team to be aware of the Weight Watchers family programme which has been specifically developed to address childhood obesity. Is not a structured 'diet' programme and as such, focuses on healthy behaviours not weight. It is targeted at parents of overweight/obese children (aged 2 to 16 years) and designed to educate and empower them to create a healthy home. . The programme applies to all family members whether siblings have weight issues or not and is delivered to parents through 10 weekly sessions. There has been some formal evaluation of the programme in the US, please see below: Family-focused Program Shows Benefit in Treating Excess Weight in Children. SL Rost, K Miller-Kovach, T Angelopolous, JM Rippe. *FASEB Journal* 2010; 24:322.7. Parents as Change-agents: Pilot Program Shows Positive Impact on	This is very helpful. Thank you for brining this to our attention.

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			Childhood Overweight. C Horning, K Miller-Kovach, R Wilde, J Hartman. *The FASEB Journal* 2007; 21(5): A301. Parent-Focused Intervention Shows Promise in Treating Excess Weight in Children. K Miller-Kovach, C Horning, RWilde, J Hartman. *Obesity* 2006; 14 (Suppl):A155. The programme has been piloted with a small number of Primary Care Organisations in England, with recommendations to make some operational changes for example to support recruitment and adapting the venues of the sessions to parents. This programme shows promise to become a service offering to the NHS and Local Authorities across Britain.	
Weight Watchers (UK) Ltd	General		Weight Watchers provides a weight-loss programme with a strong scientific foundation, one that is in line with current recognised guidelines for the treatment of overweight in adults. Membership eligibility is extended to those between the ages of 10-16 years with strict restrictions of: ▪ Having written approval from their doctor which gives them permission to join the Weight Watchers programme, and includes a suitable target weight. ▪ Having their target weight checked and reviewed by their doctor every 6-9 months ▪ Having a parent or guardian accompaniment to meetings ▪ With adaptations to the weight loss programme, designed to support a weight loss of around 1 lb a month	This is very helpful, thank you.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			Weight Watchers does not currently offer tailored services, nor target the paediatric market in its advertising, promotions or partnerships with the NHS or Local Authorities.	
YMCA England	4.3 - Question 2	8	*Active lifestyles must be key in any lifestyle change; both nutrition and exercise are the essential components for this type of programme. Lifestyle change is not just about the individual involved but is also about the role of the whole family unit if change is to be achieved and sustained for children and younger people.*	Noted thank you. We acknowledge the importance of parents carers and the wider family and will be looking for data which represents their views see the 5th subsidiary question on page 9.
YMCA England	4.3 - Question 3	8	*With regards to nutrition, the programme needs to be sympathetic and adaptable to people's diets, as people from different cultures may not eat certain foods, vegan' and vegetarians will also have different requirements for example. In relation to those on low-income although being affluent gives more choices it is believed that you can still sustain a healthy diet on lower incomes and that the prevalence for overweight children in this socio-economic group is not just about money.*	Noted. Thank you.
YMCA England	4.3 - Question 4	8	*Engaging local community groups and voluntary sector organisations such as the YMCA is an effective tool for local authorities to use in combating and managing overweight and obesity in children and young people.*	Noted. Thank you. We will issue a call for evidence and have

Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope
Stakeholder Comments Table

17th January 2012

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			YMCA has some excellent examples of community-based weight management programmes. Once such programme is Y-Active, which is the umbrella term for the children's programme delivered by Central YMCA. Y-active is delivered in partnership with local schools in the area and whilst not being open to all the community, it does work specifically with schools on improving pupils' physical activity levels. *When engaging young people in schools there was a demonstrable positive impact where students reported improvements in self-confidence and competence, self-discipline, perceptions of better fitness levels, improved well-being through more relaxation and energy, interpersonal skills, and better relationship with other students and members of staff as a result of good teamwork.*	processes in place to manage data which is academic or commercial in confidence. We would welcome submission of your data to that process.
YMCA England	4.3 - Question 5	8	*There is a clear need for parents and other family members to be involved in, or at least aware, of the programme which their young person is partaking in. If a child/young person is changing their diet and becoming involved in exercise then the rest of the family need to be accepting of this and, hopefully, supportive.* *Overweight / over eating* ***in younger*** *children must ultimately be the responsibility of the parents as they will control access to food and the dietary balance. As some poor diet provision revolves around a lack of understanding about food types, calories, fat content etc more information should be made available and in an accessible way in order give guidance to those parents wanting to do more to sustain a healthy and balanced diet.*	Noted. Thank you.

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Public Health Programme Guidance

Overweight and Obese Children and Young people - lifestyle Weight Management Service- Consultation on Draft Scope Stakeholder Comments Table

17th January 2012

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YMCA England	4.3 - Question 6	8	*Early indication from YMCA workshops supporting the Young Health Champions project which is funded by the Department of Health, is that young people do not necessarily know about, have access to or know where to access Public Health Services or physical activity opportunities in their local areas. Consequently, any social health messages targeted at young people – particularly hard to reach groups, that promote physical activity and its health related benefits are not getting through. There is also concern that issues around body size may prevent children and young people actually attending programmes around these issues.*	Noted. Thank you. The last subsidiary question on page considers *'How can more overweight and obese children and young people be encouraged to join, and adhere to, lifestyle weight management programmes?'*
YMCA England	4.3 - Question 9	9	*From the evaluation of the Y-Active programme it was clear that good signposting of students who had succeeded in the programme would encourage others to get involved. Alongside this, the role of programme champions could be beneficial in the effective implementation and maintenance of the programme, which has been demonstrated through the Young Health Champions programme.* *Having a reward system in place may also lead to more young people being encouraged to join programmes and also maintain attendance. These rewards could in turn be related to sporting events, with tickets being available to sporting events to encourage a healthy lifestyle.*	Noted. Thank you.

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