NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Obesity: prevention and management in adults

Date of Quality Standards Advisory Committee post-consultation meeting:
9th October 2015.

2 Introduction

The draft quality standard for Obesity: prevention and management in adults was made available on the NICE website for a 4-week public consultation period between 17th August and 14th September 2015. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 27 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. For each quality statement what do you think could be done to support improvement and help overcome barriers?

4. Local obesity strategies are important for the prevention of overweight and obesity. What specific measureable actions related to prevention should local strategies contain that could be included in the quality standard as an area for quality improvement?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Mixed comments were received for the draft quality standard
- Supportive feedback includes comments highlighting that the quality standard is a useful overview for lifestyle weight management
- Stakeholders commented that the quality standard will ensure that publicly available information is available to people who will benefit from weight loss programmes
- Quality standard is sensitive to culture and class as well as accurately reflecting the key areas for quality improvement to tackle obesity
- Concerns are raised over the steer and scope of the quality standard and that the included statements are unlikely to lead major change in obesity prevalence
- Stakeholders suggested that waist-to-height ratio is a better predictor of years of life lost than BMI and should be included in the quality standard
- Comments to suggest that the focus should be on nutritional aspects of food that most people eat most of the time, as well as guiding people to the healthiest versions available
- Stakeholders commented that anxiety about being weighed is most likely to be among specific populations and should be addressed in the quality standard
- Psycho-social issues should be addressed within the quality statements
- Higher rates of obesity in people with severe mental illness should be acknowledged in the quality standard
- Stakeholder comments highlighted concerns for each quality statement and that that the quality statement is a re-reporting of previous material
- Stakeholders asked for clarification and consistency for what is meant by comorbidities throughout the quality standard

Consultation comments on data collection

- Data collection for the quality standard is possible given the systems and structures are available

- Stakeholders comment that there is currently a lack of robust data on adult obesity at national level
- Comments highlight that existing data is survey based and cannot track changes at CCG level
- A nationally defined level of achievement may be a good incentive to improve services
- Overweight and obese people not registered at GP practices will not be identified and data not captured for this population

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Adults have access to a publicly available, up-to-date list of local lifestyle weight management programmes.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Stakeholders highlight that this quality statement will provide a clear overview of how regions currently stand on their provision of lifestyle weight management programmes and will allow for comparisons between local authorities
- Stakeholders suggest an additional outcome would be to ensure that each local authority has enough lifestyle weight management programmes to meet demand locally
- Stakeholders felt the quality standard is purely aimed at health and NHS sectors
- Stakeholders commented that clarification is needed as to which lifestyle weight management programmes are included/excluded in the quality standard
- Concerns about how local authorities will maintain an up-to-date list of lifestyle weight management programmes

- Stakeholders comment that including the up-to-date directory in broader community settings e.g. in local newspapers will improve awareness and encourage self-referral

5.2 Draft statement 2

Adults identified as being overweight or obese are offered information about local lifestyle weight management programmes.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Stakeholders welcomed this statement as it will encourage self-referral and minimise burden on local authorities and the NHS
- Stakeholders commented that additional specific details are needed within this statement to ensure data collection is reflective of current practice
- Stakeholders commented that this quality statement may be hard to monitor
- Stakeholders highlighted that pregnant women need to be excluded from the equality and diversity section of the document
- People with learning difficulties and severe mental health problems will require tailored programmes and this should be addressed in the quality standard
- It is unclear who the service provider is for this quality statement
- Comments received on how numerator data for the outcome will be measured
- Stakeholders commented that the manner in which information is given to overweight or obese adults is important. Communication of information needs to be conducted in a sensitive and respectful way.

5.3 Draft statement 3

Adults identified as overweight or obese with comorbidities are offered a referral to a lifestyle weight management programme.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Stakeholders welcomed this statement and suggested that physiotherapy staff have a vital role to play in weight management in people with comorbidities
- Concerns that offering referrals to those who have comorbidities is not preventative
- Stakeholders suggested a list of definitive comorbidities should be provided to ensure consistency
- Amending the equality and diversity statement and removing women who are pregnant
- Stakeholders suggest referring overweight and obese people to both commissioned and commercial programmes where possible.
- Concerns about the process measure as it does not measure what the statement aims to address
- Stakeholders highlighted concerns that this statement specifically refers people with comorbidities and those without a comorbidity would be expected to self-refer and question how this would affect current service provisions
- Monitoring whether provision meets demand

5.4 Draft statement 4

Adults about to complete a lifestyle weight management programme agree a plan to prevent weight regain.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Some stakeholders welcomed in the inclusion of this quality statement
- Important quality improvement area and is simple, measureable and easy to implement
- Some stakeholders felt this statement was too general and unrealistic
- Suggestions that adults struggling to maintain weight loss are offered booster session with a service once their weight exceeds a threshold

- Stakeholders suggested that development of a weight maintenance register would provide an overview of what behaviours are associated with successful weight regain prevention
- Comments highlight that the emphasis should be placed on providing a service to support behaviour change and developing long term skills to manage weight, rather than an agreed plan
- Weight management programmes have no control over their clients to comply once their target weights are achieved. Other services should be available to encourage people to self-manage their weight

5.5 Draft statement 5

Adults can access data on attendance, outcomes and views of participants and staff for local lifestyle weight management programmes.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Support for this statement, publishing data on attendance and outcomes will support the public, promote ownership and accountability
- Stakeholders comment that it is important that individuals are enabled to make informed choices and published data will help to achieve that
- Data on attendance, outcomes and views of staff should be regularly collected by a central source on a quarterly basis.
- Quality statement needs to be clearer on who is responsible for publishing data on a local level
- Concerns about programmes outside the control of local authority are not able to contribute to data collection.
- Monitoring completion and drop out rates

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Multiple comments concerning the lack of prevention specific statements throughout the quality standard
- Stakeholders suggest a focus on dietary habits and physical activity alongside lifestyle weight management programmes
- Stakeholders suggest an inclusion on who should measure BMI and how often

Consultation comments on question 4 included in quality standard at consultation

Local obesity strategies are important for the prevention of overweight and obesity. What specific measureable actions related to prevention should local strategies contain that could be included in the quality standard as an area for quality improvement?

- Give selected local private institutions access to the healthier food
- Controlling the number of fast food outlets in town centres
- Make healthcare professionals and frontline workers aware of the product comparison surveys on popular products conducted why Which?, Consensus on Action on Salt and Health.
- Conduct occasional surveys of supermarkets and shops to identify the availability of healthier options
- Well publicised ‘healthiest local shop of the year’ awards and other schemes

Appendix 1: Quality standard consultation comments table – registered stakeholders

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
NHS England		Thank you for the opportunity to comment on the above QS, I wish to confirm that NHS England has no substantive comments to make regarding this consultation.
City University London		1. Ashwell M, Gibson S. Waist-to-height ratio reveals early health risk being "missed" by the NICE obesity matrix. submitted for publication. 2015 2. Gibson S, Ashwell M. Non-overweight 'apples' have higher cardiometabolic risk factors than overweight 'pears': waist-to-height ratio is a better screening tool than BMI for blood levels of cholesterol and glycated haemoglobin. Obes Facts 2015;8(Supplement 1):139. 3. Khoury M, Manlhiot C, McCrindle BW. Role of the waist/height ratio in the cardiometabolic risk assessment of children classified by body mass index. J Am Coll Cardiol. 2013;62(8):742-51. doi:10.1016/j.jacc.2013.01.026. 4. Mokha JS, Srinivasan SR, Dasmahapatra P, Fernandez C, Chen W, Xu J et al. Utility of waist-to-height ratio in assessing the status of central obesity and related cardiometabolic risk profile among normal weight and overweight/obese children: the Bogalusa Heart Study. BMC Pediatr. 2010;10:73. doi:10.1186/1471-2431-10-73. 5. Ashwell M, Gunn P, Gibson S. Waist-to-height ratio is a better screening tool than waist circumference and BMI for adult cardiometabolic risk factors: systematic review and meta-analysis. Obes Rev. 2012;13(3):275-86. doi:10.1111/j.1467-789X.2011.00952.x. 6. Savva SC, Lamnisos D, Kafatos AG. Predicting cardiometabolic risk: waist-to-height ratio or BMI. A meta-analysis. Diabetes Metab Syndr Obes. 2013;6:403-19. doi:10.2147/DMSO.S34220.

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		7. Graves L, Garnett SP, Cowell CT, Baur LA, Ness A, Sattar N et al. Waist-to-height ratio and cardiometabolic risk factors in adolescence: findings from a prospective birth cohort. Pediatric obesity. 2014;9(5):327-38. doi:10.1111/j.2047-6310.2013.00192.x. 8. Ashwell M, Mayhew L, Richardson J, Rickayzen B. Waist-to-height ratio is more predictive of years of life lost than body mass index. PLOS One. 2014; 9 (9):e103483. 9. Ashwell M, Gibson S. A proposal for a primary screening tool: 'Keep your waist circumference to less than half your height'. BMC Med. 2014;12:207. doi:10.1186/s12916-014-0207-1. 10. Ministry of Health. Understanding Excess Body Weight.New Zealand Health Survey. Wellington: Ministry of Health; 2015. 11. Thaikruea L, Yavichai S. Proposed Waist Circumference Measurement for Waist-to-Height Ratio as a Cardiovascular Disease Risk Indicator: Self-Assessment Feasibility. Jacobs Journal of Obesity. 2015;1(2):1-7.
Royal College of Physicians & Surgeons of Glasgow		
The Royal College of Anaesthetists		Pages 17 and 18 are scanned the wrong way around in the PDF file.
National Obesity Forum		All 5 statements, and indeed all 31 pages could be summarised in one sentence: “Adults identified as being overweight or obese are offered information about local lifestyle weight management programmes which include a plan to prevent weight regain and where data on attendance, outcomes and views of participants and staff can be accessed.”
City University London1		We note that figures for years of life lost (YLL) are quoted in respect of two categories of

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		obesity as measured by BMI. As mentioned above, our research[8] suggests that WHtR is a better predictor of YLL than BMI. We therefore recommend that WHtR rather than waist circumference is included in the QS as a measure of obesity alongside the traditional BMI indicator. To illustrate what our results suggest, we find that a 30 year old male stands to lose 1.7 years of life with a WHtR of 0.6, and over 20 years of life with a WHtR of 0.8.
Nutrition Policy Unit		In the first sentence, this quality standard claims to cover "public health strategies to prevent overweight and obesity among adults..." That statement is false. In the entire 31 pages of the standard there is not a single word about the prevention of overweight and obesity. The whole document is concerned with "the delivery of tier 2 weight management interventions". Thus, the quality standard does not even fulfil your own stated objectives, much less (Question 1) "accurately reflect the key areas for quality improvement." You have produced half a standard. You should immediately send it back to the drafting committee to complete the other half of its work. Like many others in the public health world, you are focused exclusively on "behaviour change" which, in this context, principally means the amount and type of foods that people choose to buy and eat. This has been the dominant approach ever since we started national obesity measurements in 1980. It has demonstrably failed. In the 35 years since, UK adults have grown continuously fatter and fatter. It is time to supplement that behaviour strategy with another. Try changing foods as well as changing people.

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		That is, if we are failing to improve people's food choices, we should start with the foods they eat now, then improve the nutritional quality of those foods. That includes their energy density, as well as their specific content of the energy-bearing macronutrients, fat, carbohydrates and protein. In short, the additional focus of attention should be on the nutritional reformulation of popular, mass market foods --- the foods that most people eat most of the time. And then on guiding people to the healthiest of the options available. I make that statement in full awareness that this NICE standard deals only with actions that can be commissioned locally. Even within that constraint there are many (Question 4) "specific measureable actions related to prevention" that "local strategies should contain". Here are a few examples: -- Nutritional standards for all food served in local catering services: in hospitals, social care residential institutions, schools, recreational facilities, and local offices, Related to that... -- All food purchasing by local institutions tied to these standards. That includes, as envisaged in London... -- Giving selected local private sector institutions access to the healthier food purchased under such local arrangements, at the reduced prices they make possible. -- Control of the number of fast food outlets in town centres, using the "saturation" concept.

Stakeholder	*Statement No*	**Comments** Please insert each new comment in a new row.
		And near local, public sector institutions, especially schools. Plus... -- Advice on the nutritional improvement of the food provided in local takeaways, including in particular adoption of the "Tips on Chips" toolkit developed by the Food Standards Agency and the National Federation of Fish Fryers. -- Widely publicise to local health professionals the results of the product comparison surveys on popular products regularly produced by Which?, Consensus Action on Salt and Health, and Action on Sugar, which also identify the healthy choices and Best Buys, as well as the worst choices. Then.... -- Make that information conveniently and easily accessible to frontline health professionals (including GPs, practice nurses, dietitians, health visitors, dentists, dental hygienists and dental health educators), so they can guide all they come into contact with to the healthiest choices available locally. And to steer them off the worst choices. And to support this... -- Conduct occasional local surveys of supermarkets and shops to identify the availability of the healthier options in each local area. And follow that up with... -- Negotiations with local food retailers to maximise the availability of the healthiest options in the local area. Inclusion on a local approved list of shops stocking healthier products, used by local professionals to guide consumers, is a significant incentive. It could be supplemented by others like... -- Well publicised "Healthiest Local Shop of the Year" Awards, and other certification

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		schemes. There is still more that could be done. But I set out these examples to demonstrate that it is feasible -- at a local level -- to increase the availability of foods that are both healthy and popular -- not just niche products for the nutritionally aware, but foods that the majority of people might actually eat, especially the potentially obese. The quality standard as its stands is grossly incomplete, even by your own standards. It does only half of what it claims to do. You should return it to the committee with firm instructions to complete what they promised to do in their opening sentence -- give guidance not just on how to cope with obesity, but on how to prevent it in the first place.
Action on Sugar		This quality standard claims to cover "public health strategies to prevent overweight and obesity among adults..." That statement is incorrect. In the entire 31 pages of the standard there is not a single word about the prevention of overweight and obesity. The whole document is concerned with "the delivery of tier 2 weight management interventions". Thus, the quality standard does not even fulfil your own stated objectives, much less (Question 1) "accurately reflect the key areas for quality improvement." This should be sent back to the drafting committee to complete the other half of its work. The standard is focused exclusively on "behaviour change" which, in this context, principally means the amount and type of foods that people choose to buy and eat. This has been the

Stakeholder	*Statement No*	**Comments** Please insert each new comment in a new row.
		dominant approach ever since we started national obesity measurements in 1980. It has demonstrably failed. In the 35 years since, UK adults have grown continuously fatter and fatter. It is time to supplement that behaviour strategy with another. Try changing foods as well as changing people. That is, if we are failing to improve people's food choices, we should start with the foods they eat now, then improve the nutritional quality of those foods. That includes their energy density, as well as their specific content of the energy-bearing macronutrients, fat, carbohydrates (sugars) and protein. In short, the additional focus of attention should be on the nutritional reformulation of popular, mass market foods --- the foods that most people eat most of the time. And then on guiding people to the healthiest of the options available. I make that statement in full awareness that this NICE standard deals only with actions that can be commissioned locally. Even within that constraint there are many (Question 4) "specific measureable actions related to prevention" that "local strategies should contain". Here are a few examples: -- Nutritional standards for all food served in local catering services: in hospitals, social care residential institutions, schools, recreational facilities, and local offices. -- Control of the number of fast food outlets in town centres, using the "saturation" concept. And near local, public sector institutions, especially schools. Plus...

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		-- Advice on the nutritional improvement of the food provided in local takeaways, including in particular adoption of the "Tips on Chips" toolkit developed by the Food Standards Agency and the National Federation of Fish Fryers. -- Widely publicise to local health professionals the results of the product comparison surveys on popular products regularly produced by Which?, Consensus Action on Salt and Health, and Action on Sugar, which also identify the healthy choices and Best Buys, as well as the worst choices. Then.... -- Make that information conveniently and easily accessible to frontline health professionals (including GPs, practice nurses, dietitians, health visitors, dentists, dental hygienists and dental health educators), so they can guide all they come into contact with to the healthiest choices available locally. And to steer them off the worst choices. And to support this... -- Conduct occasional local surveys of supermarkets and shops to identify the availability of the healthier options in each local area. And follow that up with... -- Negotiations with local food retailers to maximise the availability of the healthiest options in the local area. Inclusion on a local approved list of shops stocking healthier products, used by local professionals to guide consumers, is a significant incentive. There is still more that could be done. But these examples demonstrate that it is feasible -- at a local level -- to increase the availability of foods that are both healthy and popular -- not just niche products for the nutritionally aware, but foods that the majority of people might actually

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		eat, especially the potentially obese. Also most importantly the standards should support national actions as these are likely to be far more effective in preventing and getting obesity down across the whole population. The quality standard as its stands is incomplete. The standards should return it to the committee with firm instructions to complete what they promised to do in their opening sentence -- give guidance not just on how to cope with obesity, but on how to prevent it in the first place.
Lincolnshire County Council		Whilst the draft quality standard wording provides a useful overview of one aspect of weight management (WM) and as such is keenly welcomed given the rising costs to individuals and society of obesity. However, the Quality Standard (QS) document as a whole, would benefit from being broader in scope particularly in detailing further the prevention aspect of obesity
Lincolnshire County Council		The draft QS significantly narrows down the focus of previous guidance released by NICE (eg PH 53 / PH 42). The current paper still states that weight management (WM) programmes should be multi factorial whereas other existing NICE guidance elaborates on what this should include so as to meet the needs of different populations. The draft paper here refers only to programmes with a narrow, prescriptive range of criteria (ie lasting 3 months; weekly sessions; including a weigh-in at each session). This will exclude broader services, particularly for physical activity, where weigh-ins are not appropriate or where sessions are not at set intervals
Lincolnshire County Council		The criteria referred to above are inconsistent with previous NICE guidance and with the QS's

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		stated focus on equality and diversity. For instance, NICE PH53 cites evidence that some people feel anxious about being weighed and measured, which acts as a barrier against their accessing certain types of WM programme. This is most likely to be experienced by those groups referred to in the current paper's equality and diversity sections eg people with learning disabilities, mental health conditions and from certain ethnic minority groups; however no guidance is given in the draft paper on how to address this.
Lincolnshire County Council		The QS states that it covers all obesity strategies, but it appears to refer specifically to a 'Weight Watchers' type model of WM programme. It also refers to 'the wider prevention debate' but says little about broader preventative action that can be taken to improve population dietary habits or facilitate healthier choices; for example, effective/convenient access to healthy food; effective ways of targeting messages to specific communities; or the content and dissemination of Making Every Contact Count (MECC) type training etc.
Lincolnshire Health and Wellbeing Board	General	Whilst they provide a useful overview of one aspect of weight management (WM) the QS would benefit from being broader in scope.
Lincolnshire Health and Wellbeing Board	General	The QS significantly narrow down the focus of previous guidance (eg PH 53 / PH 42). The current paper still states that WM programmes should be "multi component," however whereas other guidance elaborates on what this should include so as to meet the needs of different populations (eg growing schemes, walking groups, physical activity services), this paper refers only to programmes with a narrow, prescriptive range of criteria (ie lasting 3 months; weekly sessions; including a weigh-in at each session). This excludes broader services, particularly for physical activity, where weigh-ins are not appropriate or where sessions are not at set intervals.
Lincolnshire Health and Wellbeing Board		The narrow criteria referred to above are inconsistent with previous NICE guidance and with the QS's focus on equality and diversity. PH53 cites evidence that some people feel anxious

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		about being weighed and measured, which acts as a barrier against their accessing certain types of WM programme. This is most likely to be experienced by those groups referred to in the current paper's equality and diversity sections eg people with learning disabilities, mental health conditions and from certain ethnic minority groups however no guidance is given on how to address this.
Lincolnshire Health and Wellbeing Board		The QS states that it covers obesity strategies, but it appears to refer specifically to a Weight Watchers type model of WM programme. It also refers to 'the wider prevention debate' but says little about broader preventative action that local authorities can take to improve population dietary habits or facilitate healthier choices; for example, working with planning departments with respect to fast food outlet density or healthy food access; healthy public sector procurement; effective ways of targeting messages to specific communities; the content and dissemination of MECC type training etc.
Lincolnshire Health and Wellbeing Board	1	The recommended 'directory' of WM services is very narrow in scope, referring only to LA and CCG commissioned services and evidence based programmes. A stronger focus on broader preventative strategies and a greater emphasis on healthy weight maintenance would suggest the inclusion of a greater range of services and activities (eg peer support groups, park runs, walking groups, gardening activities)
Faculty of Occupational Medicine/Society of Occupational Medicine		Personally I think the standards are basic, unlikely to lead to major and radical change and restricted to the healthcare sector s response to its own problem. Public health guidance should be far wider. Why is there nothing about guiding commissioners to commission weight management outside the NHS e.g. in large local major companies?
Royal College of Physicians of Edinburgh		These standards are very welcome in ensuring publicly available information is available to support those who would benefit from weight loss programmes. It would be for local providers to comment on the practicalities of providing the data required to measure outcomes.

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Public Health England		PHE would like to reinforce the point about the psycho social components of the cause and consequence of obesity and how psycho social issues should be addressed in any treatment offered. Should the QS also include a recommendation on who should measure BMI and how often? Example, primary care practitioners should opportunistically calculate the BMI at least once every 5 years in adults or primary care practitioners should periodically calculate the BMI in adults with co-morbidities. , To note that some of the references are inaccurate. For example on page 3, 4th paragraph, HSE data is presented, and not NAO data as referenced; the costs outlined in the final paragraph on the same page are from the Foresight report and not Healthy Lives as referenced. Could NICE consider the inclusion of the PHE 'Evidence into Action' report.
Public Health England		It would be useful to be clear whether waist circumference is a measure to be used alongside BMI to provide a more accurate measure of excess weight, or standalone from BMI.
Public Health England		In the description of a tier 2 service, it would be useful to state and clarify recommended follow up length in addition to programme length.
City University London		There is now overwhelming evidence that central obesity, as opposed to total obesity, carries most health risks. For this reason, we are pleased to see that, in this Quality Standard (QS), the National Institute for Health and Care Excellence (NICE) acknowledges limitations in the use of BMI for individuals who are highly muscular and those in certain ethnic groups e.g. Asians who tend to have more central fat distributions than Caucasians. In this QS, NICE advocates the use of waist circumference thresholds as well as different BMI thresholds to

Stakeholder	*Statement No*	**Comments** Please insert each new comment in a new row.
		overcome these problems. We suggest that the use of waist-to-height ratio (WHtR), a proxy for central obesity, is a better way to overcome the limitations of BMI and that it needs to be included in this QS. Let us explain our reasons for our proposal: For some time, NICE has suggested that waist circumference should be included with BMI within a 'matrix' to categorise health risk. We have used UK national survey data (NDNS) to compare how the adult population is distributed using this NICE matrix with the distribution using a boundary value of 0.5 for WHtR. We found that more than one third (35%) of the group who were judged to be at 'no increased risk' using the NICE matrix (i.e. using both BMI and waist circumference measures) had WHtR equal or greater than 0.5. They are 'missed' by the NICE matrix because they would not be flagged up as 'early risk'. On the other hand, only 3% of the group who would be at 'increased risk' using the NICE matrix were judged to be 'no increased risk' using WHtR [1]. Therefore, use of a simple boundary value for WHtR (0.5) identifies more people at 'early health risk' than does the complex NICE matrix. But does this matter? We believe it does because the people who are 'missed' by the NICE matrix have been shown to have increased levels of cardiometabolic risk factors compared to the people who have WHtR below 0.5: We have already published preliminary research from a different survey sample (HSE) to demonstrate that people who have 'normal' BMIs but waist-to-height ratio >0.5 show higher cardiometabolic risk than those with BMI>25 but with waist-to-height ratio under 0.5 [2]. Other

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		groups have also shown clearer relationships between waist-to-height ratio and cardiometabolic risk factors than with BMI and cardiometabolic risk factors [3] [4]. There is now a strong body of evidence to show that WHtR is more closely associated with morbidity than are BMI or waist circumference [5]; [6] ;[7] and mortality [8]. Further, the use of the simple threshold of WHtR 0.5 translates into the simple public health message "Keep your waist to less than half your height" [9]. We were pleased to note that Professor Baker of NICE told The Sunday Times on 21/6/15 *: "he (Baker) asked the Public Health team at NICE to study research on waist-to-height ratio for Guidance due to be published in 2017". He added: "We will do our best to incorporate it. We're planning to do that."* It might be helpful to NICE to know that the New Zealand Ministry of Health[10] are already including WHtR in their survey reports and that the Thai Ministry of Public Health, in their latest strategy (2012-2014), implemented a health promotion programme for general population and health personnel about reducing waist circumference to less than half of each individual height[11]. Precedents therefore exist for the inclusion of WHtR
City University London		It is the comment by Professor Baker and the evidence briefly summarised above, which gives us hope that our plea for the inclusion of waist-to-height ratio (WHtR) might be considered seriously during this consultation. We are very happy to provide any further

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		information and evidence that might be required.
Tees Esk and Wear Valleys NHS Foundation Trust		People with severe mental illness are dying 15-25 years prematurely, primarily as a result of cardiovascular disease. This is largely due to the fact that rates of obesity are much higher amongst this group than amongst the general population. They must be identified as a high risk group and there needs to be an indicator which looks at excess mortality in this group (as there is for learning disability).
Tees Esk and Wear Valleys NHS Foundation Trust		Should acknowledge the higher rates of obesity amongst individuals with severe mental illness (it currently references social disadvantage and ethnicity).
Tees Esk and Wear Valleys NHS Foundation Trust		Should the indicators include hypertension and high cholesterol?
Tees Esk and Wear Valleys NHS Foundation Trust		There should be an indicator referencing the premature mortality rates amongst individuals with severe mental illness (as per NICE, 2014 Psychosis and Schizophrenia document)
Department of Health		NICE have attributed the estimated cost of obesity to the Call to action, see line below. This should be the Foresight report (The Foresight team, which is part of the Government Office for Science, published *Tackling Obesities: Future Choices* in 2007). □ The Department of Health's obesity strategy Healthy lives, healthy people: a call to

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		action on obesity in England estimated the cost to society and the economy of people being overweight or obese to be almost £16 billion in 2007 (more than 1% of gross domestic product). It could rise to just under £50 billion in 2050 (based on 2007 prices), if obesity rates continue to rise at the current rate.
The Chartered Society of Physiotherapy		The Chartered Society of Physiotherapy welcome this quality standard. As the professional and educational body for physiotherapy staff across the UK, we will support our members to implement these standards.
National Obesity Forum		The definition of Tiers 1 & 2 is complex and variable; Primary Care often inhabits tier 1, however most GP practices will provide pharmacotherapy for obesity alongside lifestyle measures, and often referral to Commercial programmes. Drug management is neither addressed nor excluded here, although there is an incorrect implication that pharmacotherapy is confined to tier 3. Neither Primary Care, or any other weight management service is involved with the public health issue of prevention; no-one is ever referred or self-refers to any practitioner for obesity prevention saying 'could you prevent my obesity this morning please?'. Prevention is not achieved by 'obesity strategies'. There is not a single word about prevention in the entire document, except in the introduction; nothing in the actual quality standards themselves. 'Prevention' should either be removed altogether, or discussed in detail, as this is half the remit of these standards. A precise, official definition of tiers 1 – 4 would be helpful. Lip service only is given to primary care intervention; it is mentioned once alongside on-line programmes. The potential of primary care in the battle against obesity is immense, but has

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		always been hampered by lack of support and resources, for instance a QOF which rewards an obesity register with no subsequent action required, thus perversely incentivising the maintenance of obesity; and NHS screening which rewards recording of weight without subsequent action. As these quality standards mention primary care, they should explore ways in which it could help, over and above simply referring to commercial groups, especially as novel anti-obesity agents will be available for prescribing in the near future.
National Obesity Forum	1-5	Standard 1 is obsolete as it implies prevention, which isn't offered by obesity services. Standard 3 is obsolete as it is already encompassed by standard 2. Standard 4 is obsolete, because all weight loss programmes are designed to prevent weight regain, despite strong clinical and physiological evidence of almost inevitable recidivism, and this, as well as standard 5 can be included as above. Much of the document is merely a re-reporting of previously broadcast material. Standard 2 overlooks the point of engagement of overweight & obese individuals, which comes before referral. In any event referral is not usually appropriate or possible given the numbers of individuals, and lack of provision of services. Furthermore there is no evidence, and is never likely to be, for reduction of prevalence of obesity, or diabetes by commercial weight management clinics; this could only potentially happen through GP & tier 3 intensive management.
National Obesity Forum		The standard, however, does have merit – 'fat maps' of available resources on-line have been attempted, but have lacked funding. Such a resource would be valuable for patients, providers and commercial groups to refer to.
The Royal College of Anaesthetists	1	1 – Key areas for quality improvement outlined within this QS could be:- - Maintaining an accurate list of LWMPs in each local authority (LA) - Monitoring the number of adult self-referrals to LWMPs - Monitoring whether provision meets demand in each LA

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		- Monitoring completion and drop-out rates of all LWMPs and responding to reasons for drop-outs accordingly in an attempt to increase completion rates - 2 – We believe the key to answering this question is being very explicit within this document as to what data is needed and in what format/breakdown. If this is consistent nationally it will allow easy comparison amongst providers locally and between local authorities nationally. Time should be in a member of LA staff's contract to chase up and collate this information with clear instructions as to who they are reporting to nationally and how often to submit this data. Is it also going to be displayed publically within each LA with information about the LWMPs as a 'how we are doing' section? 3 – As for question 2 response. Ensuring that a member of staff within the LA is tasked with this data collation and submission nationally. Being explicit with what data we want providers to submit, and in what format, will aid data collection and collation from both providers and local authorities. Being vague about what data collection is required, in our experience, leads to a variable and often incomplete data submission which then results in incomplete achievement of outcome measures and disengagement from providers and Las as they cannot see the fruits of their hard labour.
The Royal College of Anaesthetists	2	1 – Key areas for quality improvement in this QS could be:- - Identification of all adults in the UK who are overweight or obese - Identification of the proportion of these patients who receive information on LWMP - There are no details in this QS outlining how often healthcare providers are expected to give this information out to individual patients (annually, every 5 years etc.)

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		2 – Our respondents feel that this will be very difficult to achieve and no one system is perfect. The system which is most likely to identify the most accurate number of patients who are overweight/obese would seem to be through interrogation of GP databases. Not all patients in the UK will be registered with a GP but, that this will probably be the largest database of patient information that we have. The vast majority of patients attending hospital have a GP so it would make sense to use their systems. Is there a minimum frequency that GPs are required to monitor a patient's weight and BMI? If this was part of a CQUIN target to collect this data would it lead to more accurate data collection? 3 – Barriers will be in obtaining accurate data in an acceptable time frame. Data needs to be easily collected through interrogation of existing databases. Problems arise when patients are given information about the LWMPs in other healthcare environments out with the GP surgeries – how is this captured/fed back to GPs to ensure it is entered into their database to ensure it is there when the system is interrogated. Would it not also make sense in this QS to link in the differences in the number of overweight and obese people who have been given information on LWMPs and those who actually attend the programmes? Information as to why people do not attend these services is also important to guide provisions in the future. 4 – Education of all healthcare professionals both within the community and hospital environments on availability of LWMPs and responsibilities of providing overweight and obese patients with this information is vital. Communications between GPs and other health care professionals on whether advice has been given with regard to LWMPs is essential to ensure that these interactions can be captured onto GP databases for interrogation and data collection. Another option would be to set up an internet database that can be accessed by

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		all healthcare professionals working with overweight or obese adults. If information on LWMPs is given to the patient this could be logged on the system/database by entry of a few details of the patient (name, NHS number, DoB, weight and BMI and contact details). The system could be linked to GP databases so that they are aware when patients are given this information and can 'check' the relevant boxes on their database. If the system were also able to be accessed/have data input by LWMP providers it would link up and show the proportion of overweight or obese people who had received advice and then acted on it to attend a programme. The system could also be programmed to send information about LWMPs in the person's local area via e-mail/mobile telephone/post as requested. The system would have to be user friendly and take no more than a couple of minutes to complete by healthcare workers to make it well utilised.
The Royal College of Anaesthetists	3	1 - Key areas for quality improvement in this QS could be - Overweight and obese people with identified co-morbidities should be referred to a LWMP to improve health outcomes. As mentioned above, there needs to be an explicit list of co-morbidities outlined within this document to ensure that appropriate data is collected. Examples of obesity related co-morbidities to be included could be type 2 diabetes, hypertension, hypercholesterolemia, arthritis, heart disease and obstructive sleep apnoea. 2 – Who is going to be expected to provide this data? GPs? An explicit list of co-morbidities will ensure that local authorities are collecting the same data, allowing direct comparison between different areas across the UK. This list would help to make interrogation of databases easier for non-medical personnel – it is likely that a member of administration staff may be tasked with data collection. Going back to identification of people with increased BMI,

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		is there going to be an inclusion/exclusion cut off for how recent the BMI on record was recorded? Does it have to be within a year/5 years? Again, as in QS2 responses, how will data be collected for referral to weight management services if this has been done out with the GP setting; how will these encounters be captured? In the briefing document, service providers outlined that some patients with co-morbidities may not be referred to LWMPs but to other programmes offered by disease specific organisations. Does a referral to one of these agencies also count as referral to LWMP? 3 – We believe the key to reducing barriers here is to ensure that the final document is explicit in outlining expectations of the minimal dataset required for collection, responsibilities on who should be collecting this data and suggestions as to how this may be achieved. Ambiguity in terms of co-morbidities that authors are expecting to be referred to LWMPs will not only affect quality of interrogated data received but will also provide unclear messages to healthcare providers and commissioners regarding expectations of authors and the responsibilities of local authorities and commissioning bodies. 4 – Should some of these responsibilities be put back to people who are overweight and obese with co-morbidities? If the information is advertised and publicised widely enough within healthcare settings and with the help of national media coverage people may feel empowered to engage with services. These lifestyle programmes require commitment and engagement from participants both during the programmes and, more importantly, for a lifetime thereafter.
The Royal College of	4	Responses to questions for consultation

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Anaesthetists		1 - Key areas for quality improvement in this QS could be - All people completing a LWMP should have a plan to help them not regaining weight - All people completing a LWMP should have details on who to contact if they are struggling/failing with this plan - Contract/agreement at the beginning of a LWMP includes a commitment to preventing weight regain at the end of the plan - These plans should include an achievable target weight, sustainable in the long term, and also encourage independence and self-management 2 – Specifics are, once again, necessary if data collected is to be comparable both within and between local authorities and different provider schemes. 3 – A target figure/percentage for the proportion of people completing LWMPs that we are expecting to prevent weight gain is needed. Some specifics as to timescales over which we are looking for this weight gain are needed for providers to be able to collect comparable data (e.g. at 3, 6 and 12 months post completion of programme for example). More details about the patients who regain weight are needed such as:- - Whether they had a plan to help reduce weight regain or not - If yes, whether plans were followed once weight regain identified - If yes, were they able to get back on track with their sustainable target weight - What were the reasons for the weight regain and could these have been predicted or prevented - Was there a flaw in the management plan that contributed to the weight regain Whose responsibility will it be to collect the data here? The providers of the LWMP? Need to

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		be specific. Would it be helpful to look at how people successfully kept the weight off – maybe they are using services that people who regained weight are not and we should be looking at engaging and directing people failing to keep the weight off to these follow on services. 4 – Ongoing maintenance of a healthy lifestyle necessary to prevent weight regain can be difficult when the routines of LWMPs cease. Should the authors be asking for details within each local authority of further exercise classes and groups that are available to support people following completion of LWMP?
The Royal College of Anaesthetists	5	Responses to questions for consultation 1 - Key areas for quality improvement in this QS could be - Publishing data on LWMPs - Published outcomes to include (course completion percentages, weight loss average, retained/sustained weight loss) - Client views - What actually matters (patient experience, results (immediate and sustained), reduction in co-morbidities and burden on the NHS. 2 – Not really mentioned how this outcome will be measured…….some further work needed on this and again, specifics of minimal dataset requiring publication to each local authority along with whose responsibility it is to collect, analyse and publish the data. 3 – Nationally set minimum reporting standards would aid comparison between service providers locally and nationally. It would help service providers to tailor their programmes in response to feedback and help clients to make an informed decision about which LWMP they

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		attend rather than one based purely on geography or times of meetings.
The Royal College of Anaesthetists		'Adults with comorbidities' is a term used throughout the document which lacks consistency in the co-morbidities which are described in each quality statement. This could lead to inaccurate data collection, please consider revising. P 13 – T2DM, HTN, CAD P16 – T2DM, HTN, CAD P16(service users) – T2DM, HTN, hypercholesterolemia, arthritis, CAD, sleep apnoea P18 – T2dm, HTN, CV disease, osteoarthritis, dyslipidaemia, sleep apnoea
The Royal College of Anaesthetists		'Providers of lifestyle weight management programmes should be able to meet specific needs of women who are pregnant, planning to be pregnant or loosing pregnancy weight'. Is it expected that all LWMPs should be able to cater for this group of overweight or obese people or that each local authority should have provisions to cater for LWMP for this patient group? One could argue that it may not be achievable or realistic that every LWMP could cater for them.
The Royal College of Anaesthetists		Provision of information – no mention about provision in alternative languages, audio for visually impaired or illiterate, braille etc.
The Royal College of Anaesthetists		No suggestions of how to identify all obese and overweight people – some will not be accessing any healthcare services and may not be registered with a GP.
The Royal College of Anaesthetists		Patients at higher risk of developing type 2 diabetes should be referred to national diabetes mellitus prevention programme – how are we identifying these people? They would most likely not be referred to a LWMP as well but, if referred to this service, will have been referred to an appropriate alternative lifestyle service. How is it ensured that this referral is acknowledged and that they do not simply get labelled as having not been identified and referred to LWMP?

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The Royal College of Anaesthetists		What methods are proposed to increase the awareness of LWMPs to all healthcare professionals coming into contact with overweight and obese patients out with the GP setting? P15 'stakeholders commented that every contact with every patient should be seen as a chance to prevent obesity and related comorbidities and use these to give brief advice on how to lose weight'
The Royal College of Anaesthetists		P22 – evidence suggesting that all LWMPs should be at least 12 weeks in duration……are they?
The Royal College of Anaesthetists		Patients with psychiatric co-morbidities – would there be scope to have groups within inpatient facilities? It is important in this situation to educate staff and have dieticians. Weight gain and changes to appetite are linked with psychoactive medications. Should access be restricted to 'junk foods' and promotion of a healthy lifestyle in these environments instead?
The Royal College of Anaesthetists		P40 – points 1.1 and 1.2 Both VERY good points and not mentioned at all in this draft document. People should take increased responsibilities for their own health. As healthcare providers we should be able to empower and assist them in these lifestyle improvement choices and direct them to resources and services which can help them to achieve this. Nil in the document about pre-emptive weight control. Is it/should it be a CQUIN target that all patients registered with their GP should be submitting annual weight and BMI calculations. This would help us to get a true handle on the enormity of this current epidemic and data for trends in its increase/decrease over the coming years.
The Royal College of General Practitioners		This is a thoughtful document sensitive to issues of culture, class and environment. It is practical and pragmatic and deals with the great mass of people overweight or obese where there is some evidence that lifestyle change, support and long term supervision can make a realistic difference i.e. 10% weight loss. If the data collection system suggested works, it

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		should be possible to examine the effectiveness of interventions and to improve the therapeutic/social model suggested.
LighterLife		LighterLife agrees that this draft Quality Standard accurately reflects the key areas for quality improvement in relation to tackling obesity – namely the lack of awareness of weight management services available in local areas that overweight and obese individuals can access and lack of existing support to assist these individuals in making informed decisions about their involvement in such programmes.
Stockport Council		Having QSs is useful for service design and delivery. We agree that this QS draft is reflecting key areas for improvement.
Cambridge Weight Plan		Cambridge believes that this draft Quality Standard successfully addresses the main areas for quality improvement in terms of combatting existing levels of obesity.
Cambridge Weight Plan		Cambridge suggests that one broad step that could be taken to generally support improvement in this area and help overcome foreseeable barriers would be if NICE were to engage with the weight loss sector, acquire an understanding of the diversity of weight management programmes offered in the sector and then ensure that an appreciation of this diversity is reflected in the statements drafted.
Royal College of Nursing		The quality standards are helpful. As this quality standard is for obesity and weight management, we are concerned that there is nothing about the weight management service providing support/guidance on preparation and cooking of healthy food. Many people do not know how to shop for and cook reasonably priced healthy meals. It would be helpful to have

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		some standards on how the service can support this group of people.
Royal College of Nursing		There is nothing about the training for staff providing the services or what constitutes a good service. It would be helpful to have some standards here.
Royal College of Physicians		The RCP is grateful for the opportunity to respond to the NICE quality standards consultation on obesity: prevention and management in adults. We have liaised with the RCP's Advisory Group on Weight and Health and the British Society of Gastroenterology and wish to make the comments below.
Royal College of Physicians		Our experts have some concern regarding who will be expected to take on this new work in obesity medicine.
Royal College of Physicians		The RCP's Advisory Group on Weight and Health have highlighted that prevention needs to be more widely emphasised and incorporated into this important guideline. Our experts have noted that there are preventative measures that could be observed, including better information to frontline health professionals from Example, Which and other sources. The following recommendations could also be included to emphasize prevention: • Reducing the energy density (for example) of sugary drinks. • Nutritional standards for all foods served in local catering services including hospitals, residential institutions, and schools.

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		• A control of the number of fast food outlets in urban areas.
British Obesity Society		We acknowledge that Training is outside the scope of this guidance but welcome the statement that practitioners should have appropriate training and competencies. We highlight that the evidence base for what constitutes appropriate training and competence has yet to be established and that currently there exists a quality issue regarding the establishment of evidence based, effective , accredited training in this specialty
Lincolnshire County Council	QS5/QS2	There is currently a lack of robust data on adult obesity at the national level. Much of what exists is survey based and cannot accurately track differences and changes even at the district or CCG level granularity. It is important to identify ways through which effective data sharing with LA Public Health can be established, both to improve understanding of the topic generally and also so that the situation, progress, pathways and outcomes can be fully investigated.
Lincolnshire Health and Wellbeing Board	5 and 2	There is currently a lack of robust data on adult obesity. Much of what exists is survey based and cannot accurately track differences and changes even at the district or CCG level. It is important to identify ways through which effective data sharing with LA Public Health can be established, both to improve understanding of the topic generally and also so that the situation, progress, pathways and outcomes can be investigated.
The Royal College of Anaesthetists		Should levels of achievement be locally defined? Would this be subject to abuse by local authorities who are struggling to improve their services. A nationally defined level of achievement may be a good incentive to improve services. P27 of briefing document suggests that we should be commissioning programmes with above 60% participant completion, likely to lead to average weight loss of greater than 3% within more than 30%

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		participants with loss of 5% weight initially. Is this not the sort of information that we should be using to guide levels of achievement? We should be providing this sort of information to ALL participants and potential participants in LWMPs to ensure that they do not have unrealistic expectations regarding their weight loss.
The Royal College of Anaesthetists		P39 of documents suggests that most weight loss programmes achieve a weight reduction by 5 – 10% with approximately 80% people returning to baseline weight. In order to tackle the ever increasing epidemic of overweight and obese people do we not need to look at why such a huge proportion of people are regaining the weight?
LighterLife		LighterLife also believes that, if the systems and structures were available, it would be possible to collect the data required for the proposed quality measures. In relation to statements 1- 4, the data required could be captured by weight management providers when registering individuals that have either self-referred or been referred to their programmes.
Society for Endocrinology		The SFE welcomes NICE quality standard on prevention and lifestyle weight management for obesity in adults. In answer to the questions raised by the consultation: 1. It is important to ensure that the proposals by the quality standard are aligned with those of the NICE obesity guidelines CG189. On the whole, feel that the draft quality standard reflects reasonably accurately the key areas for quality improvement. 2. If the systems and structures were in place it would be possible to collect data for the proposed quality measures

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		3. The main barriers to implementation of the quality standards are 1) Lack of time by PCPs 2)Lack of training and education in obesity 3) Lack of financial rewards for tackling obesity These would need to be addressed. A system of QOF points for obesity would help with measurable targets eg % weight loss, number of patients referred to weight loss programmes, (see 4). Training and education in obesity needs to be addressed at both undergraduate and postgraduate level as it is lacking in the curriculum. In the meantime, PCPs and other HCPs should be able to access on-line or other courses on how to tackle the obese patient/motivational interviewing etc 4. We propose the following specific measurable actions related to prevention: 1. Number of patients referred to a lifestyle weight management programme who attended the programme/total number referred to the programme 2. Number if patients who attended and completed a lifestyle weight loss programme/number of patients who attended (completers and non-completers) 3. For adults who completed a lifestyle management programme, it would be useful to assess how many maintain their weight over a period of 12 months
Cambridge Weight Plan		Cambridge is of the view that there could be a range of problems associated with collecting data for the proposed quality methods, namely that it would rely on a range of private

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		individuals collecting and accurately tabulating the information required without, it would seem, any guidance or suggested designated group that would then validate the information as being accurate.
Faculty of Occupational Medicine/Society of Occupational Medicine	QS1	The guidance feels very much directed purely at the healthcare and largely NHS sector. It misses the benefits of considering community non NHS and workplace settings. In the latter there is evidence of successful implementation of workplace based weight management programmes which is not considered.
Weight Watchers	Quality Statement 1	Weight Watchers would welcome further clarification on which lifestyle weight management programmes should be included/excluded in local directories and what guidance is given to adults to help identity the programme most suited to their personal requirements. For example, how closely a programme meets the existing NICE guidance on what constitutes an effective programme, perhaps using a simple rating scale. It would also be helpful if further guidance could be offered concerning services that have been commissioned by LA/CCG's that are not evidence based on the outcomes stipulated in this QS. If utilising self-referral, adults should be given some guidance on likely waiting times. This should include both initial response time from first enquiry and also waiting times for enrolment into a programme. There is a need to ensure that response time and intervention enrolment are timely so maintain a window of opportunity for change when an individuals motivation is likely to be higher. Are NICE able to provide any further detail on how directories will by compiled and by whom? Can a schedule be published? With such a complicated and time-consuming task ahead operating on such limited budgets, it would be useful to know how and who will compile these directories and how they will be made available to the public. Additionally, simply providing

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		information is unlikely to change behaviours. If making such efforts to compile directories, NICE will need to ensure that their use is maximised (along with self referral).
Lincolnshire County Council	QS 1 and 2	The paper's main focus is on adults who are 'identified as overweight' and on the dissemination of information about 'Weight Watchers' type WM programmes. This again is contrary with the NICE 2015 guidance (NG7) that highlights the importance of addressing misconceptions about healthy weight maintenance, particularly the belief that education and awareness is unnecessary for people who are currently at a healthy weight (ie BMI between 18.5 & 24.9). A broader focus on healthy dietary habits and physical activity rather than just WM programmes would address this. The paper refers to *prevention of [being] overweight* and obesity rather than just obesity; however, preventing being overweight does not entail this type of WM programme.
Lincolnshire County Council	QS1	The recommended 'directory' of WM services is narrow in scope. It should not just fall to LA and CCG commissioned services and evidence based programmes. A stronger and realistic focus on broader preventative strategies and a greater emphasis on healthy weight maintenance would suggest the inclusion of a greater range of services and activities provided across the community (eg peer support groups, park runs, walking groups, gardening activities)
Lincolnshire Health and Wellbeing Board	1 and 2	The paper's main focus is on adults who are 'identified as overweight' and on the dissemination of information about Weight Watchers type WM programmes. This is inconsistent with 2015 guidance (NG7) that highlights the importance of addressing misconceptions about healthy weight maintenance, particularly the belief that education and awareness is unnecessary for people who are currently at a healthy weight. A broader focus on healthy dietary habits and physical activity rather than just WM programmes would address this. The paper refers to *prevention of overweight* and obesity rather than just

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		obesity; however, preventing overweight does not entail this type of WM programme.
Slimming World	Quality statement 1	We would like to stress the importance of accurate and up to date details with regards to any information a Local Authority provides to people about available weight management programmes. For many people, starting out at a weight management service is a huge and daunting step therefore it is vital that information is up to date in order to prevent someone arriving to find the day or time of a programme has changed. If someone has taken this important step it's vital that barriers aren't put in place which will prevent engagement. We would like to understand how Local Authorities will manage this and ensure all details are up to date all the time. On a national level we provide details of our UK groups to NHS choices and they are searchable on the main website (http://www.nhs.uk/Service-Search/Weight-loss-support-groups/LocationSearch/1429). To avoid any out of date information being on the website we provide updates to the database daily. We would suggest that a similar system is used to ensure no errors occur.
The Royal College of Anaesthetists	1	We agree with this being the first QS. It will provide a clear overview of how regions currently stand on their provision of lifestyle weight management programmes (LWMP) and allow easy comparison of one local authority's provision with another. Outlining the responsibilities of local authorities, providers and commissioners in this document is excellent - everyone knows what they, and other bodies, will be expected to provide and contribute in terms of data etc. However more specific details within the QS would be useful. For example:- - Providers are expected to submit the following data at the end of each LWMP – length of programme (number of sessions over number of weeks), number of adults enrolled onto course at start (and what the capacity of the programme is), number of adults completing LWMP, successful weight reduction (weight lost per individual and then

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		average weight loss calculated), for adults not completing the course reasons why and response from provider as to how they aim to address these issues/problems in order to increase retention rates (this does tie into QS5). - Providers are expected to submit the above data within a certain timescale following the completion of the LWMP. If this timescale is exceeded a member of staff from the local authority will contact the provider for this overdue data. - Local authority should provide contact details of a staff member/team whose responsibility it will be to collate data from providers, chase non-submitted data and act as a trouble-shooter for questions and queries from both providers and commissioning groups. - An important secondary outcome would be to ensure that each local authority has enough LWMPs to meet demand locally. Where should this date be made publically available, will there be a minimum requirement? If this is to be audited it needs to be able to be easily followed up. E.g. – local authority websites, links from GP website and council health facilities.
LighterLife	1	LighterLife fully supports the creation of a publicly available, up-to-date list of both public and private weight management programmes in local areas. However, creating this list alone may not in itself raise awareness amongst the local population of the various weight management services available to them. Members of the public must be informed where the list can be found and how it can be accessed. It is important, therefore, that information about where to find this list online is directly given to individuals wherever possible, perhaps through inclusion in local newspapers or in any existing local authority publications that are delivered to every household. Equally, providing this information in broader community settings where

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		individuals likely to self-refer may come across them, such as libraries, local leisure centres and pharmacies, will serve to improve awareness and increase the number of people accessing the list.
The Royal College of Pathologists	1	Agree – accessible information (especially online) about available programmes is an essential prerequisite to delivery of programmes.
Stockport Council	1	We are concerned that statement this makes no mention of **evidence-based** lifestyle weight management programmes and could leave us in a situation where we're required to list programmes of which we don't approve/ e.g. which don't meet NICE guidance or a given set of criteria. Or, conversely, that we are expected to inspect or monitor a vast range of initiatives so that we can agree that they meet the definition of a lifestyle weight management programme/give our seal of approval by listing them.
Cambridge Weight Plan		Although set out in NICE Guideline PH53, Cambridge would like to note that individuals do not necessarily need to stay on a weight loss programme for a minimum period of three months - especially if they only need to lose a small amount of weight -in order to reach a healthy weight and this should be acknowledged by NICE. In some cases, a therapeutic benefit can be achieved with a loss of just 10kg, which (at 1kg a week average) would take less than three months. Some people are more motivated by the prospect of a specific weight loss (amount) goal than a specific time period goal for their programme.
Cambridge Weight Plan	1	Cambridge welcomes the move to create a publicly available list of up-to-date weight management programmes in local areas - lack of awareness of existing weight management

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		services is certainly a key issue when it comes to helping overweight and obese people help themselves to lose weight. The creation of this list alone, however, will not increase awareness amongst the local population of the range of weight management services available to them. It is essential that people are told exactly where this list can be located and how it can be accessed. Key to achieving this will be informing the local population in a direct manner of where the list can be found online, potentially via local newspapers or in any existing local authority publications that are delivered to all residents. Additional steps that should be taken to increase awareness and improve the likelihood of people accessing the list include providing information about the list in non-traditional settings, such as pharmacies, leisure centres and libraries, where individuals may see them when browsing. Furthermore, it is vital that the diversity of weight management providers is taken into account as this could impact on the feasibility of certain providers giving 'up-to-date' information depending on the scope of the information required. For example, the manner in which Cambridge delivers its programmes could mean that we have a dozen independent Consultants providing Cambridge Weight Plan programmes in a given area and possibly many more in the larger conurbations. As a result, certain issues would arise in relation to what information should be provided and keeping this information up-to-date. Given this, whilst the publicly available, up-to-date list of local lifestyle weight management programmes for adults should detail the range of options available in an area, it may not be practical for it to include specific contact details for every person delivering those programmes.
The Royal College of Anaesthetists	2	Again, more specific details are needed within this statement to ensuring that data collected is an accurate reflection of the current situation and practices. As it is the responsibility of all

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		health and care workers to offer information about weight management how do we collate if this has been given? There are community, inpatient and outpatient settings with medical personnel, physiotherapists, occupational therapists and dieticians to name but a few. Obtaining accurate data on the number of adults who are overweight or obese in the UK will be challenging, especially if details on how to achieve this data are not outlined specifically within this document. Accurate data on the number of adults offered information on weight management services will therefore be ever harder – expectations from the authors must therefore be explicit.
Faculty of Occupational Medicine/Society of Occupational Medicine	QS2	Is there really anyone in the UK who is not aware of local weight management orgs? Weight Watchers and Slimming World adverts appear frequently on roadside lamp posts, local free newspapers and media.
Faculty of Occupational Medicine/Society of Occupational Medicine		Offering referral only to those who have co morbidities is not prevention , its closing the stable door after the horse has bolted
Public Health England	Quality Statement 2	Could NICE clarify if this statement includes commercial services. Suggest that a range of opportunities for where this information is held are considered to ensure equity in access. We recognise that this might be a very difficult standard to monitor.

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		It would be helpful to recognise that the NHS Health Check is a key mechanism for identifying 40 – 74 year olds that may be overweight or obese. Suggest that on page 14 under 'Equality and diversity' pregnant women are excluded given NICE guidance that weight loss programmes are not recommended during pregnancy as they may harm the health of the unborn child. This statement is recurrent throughout the QS.
Weight Watchers	Quality Statement 2	Weight Watchers welcomes this quality statement '**Raising awareness of lifestyle weight management programmes'** to encourage self-referral. We would also encourage that Local Authorities, in partnership with Clinical Commissioning Groups, publish their care pathways for weight management services across all tiers, enabling signposting across public health, primary and secondary care touch points and professionals and promote self-referral access routes into tier 2. This would enable the many people who are overweight or obese and highly motivated to lose weight to identify for themselves what is available and how it can be accessed. Improving access for all is a key area for quality improvement. It is becoming increasingly prevalent, but not yet best practice, to enable self-referrals into tier 2 services. Self-referrals are screened by providers to ensure eligibility under locally agreed terms, but self-referral vastly facilitates engagement and uptake from service users and minimises burden on NHS and Local Authorities. Promoting and enabling self-referral pathways has the potential to improve access and ultimately the quality of care received by the service user. However, we do have a concern around funding for self-referrals. What would NICE

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		recommend if a LA or CCG did not have the funds to offer self-referral? What would be recommended if services could not meet the increased demand? With regards to health inequalities, simply saying that programmes should be suitable for people who traditionally experience health inequalities in weight management is unrealistic. People with learning difficulties and mental health challenges, particularly those at the more severe end of the spectrum, are going to need tailored programmes. This should be incorporated into this guidance.
Weight Watchers	Quality Statement 2	In practice, ensuring that healthcare professionals provide information about local lifestyle weight management programmes is extremely problematical. Are the QS Advisory Committee able to offer include any advice to commissioners on how they can ensure that healthcare professionals provide information and how this could be monitored? Additionally, we would recommend the introduction of a centralised, national list of providers (as well as local) would enable policy makers and/or commissioners to have a truly national viewpoint to help them make future decisions and facilitate comparison between these programmes and indeed their efficacy in the long term.
Slimming World	Quality statement 2	In this quality statement it is unclear who the 'service provider' is, whereas the other quality statements are very clear. We would suggest this is clarified and the detail added. One of the quality measures under this statement gives 'number of self-referrals of overweight or obese adults to lifestyle weight management programmes' as an outcome. The majority of membership to commercial weight management organisations is through self-referral and people join for many reasons through various prompts (e.g word of mouth, local promotion, leafleting). We would like to understand how this data will be collected. It will be difficult to relate the number of adults accessing a service to information provided by a health care

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		professional and it is unclear how they would be identified. It also states that people will be given information about local lifestyle weight management programmes including what it involves and how to take part. Similarly to our comment to quality statement 1, how will this be managed and the accuracy of information ensured? We are pleased to see this quality statement (as well as numbers 3-5) acknowledging the needs of women who are pregnant, planning to become pregnant or trying to lose weight postnatally. We feel this is a key area and ensures that a whole lifestyle approach is adopted and strengthens this document in terms of prevention.
LighterLife	2	Offering information about lifestyle weight management services to individuals identified as overweight and obese could well drive improvements in the number of individuals who self-refer to these programmes. But the manner in which this information is provided is crucial. Whether the information is raised verbally by the healthcare professional who has identified a patient as overweight or obese, or is posted to those on the register of obese individuals kept by GP surgeries, it is important that the subject of losing weight is approached in a respectful and sensitive manner that avoids blaming the individual for their excess weight. Additionally, a brief outline of the effectiveness and support provided by weight management services – or perhaps information on how to access the information listed in statement 5 – would further increase the likelihood of overweight and obese individuals making use of the information they have been provided with.

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
The Royal College of Pathologists	2	The data source for the denominator seems quite clear. How will data on the numerator be recorded and collated?
The Royal College of Pathologists	2	Men are less likely than women to attend lifestyle weight management programmes. Should the need to encourage men to engage with weight management programmes be mentioned?
Stockport Council	2 & 3	Why the restriction of “offered a referral” only to those with co-morbidities? Referral is a specific clinical term – is this what we’re talking about here. Locally we use a system of “points” for prioritising our lifestyle support to individuals (as we have limited capacity), incorporating factors such as:- other risky behaviours (such as smoking), pregnancy, living in a Priority 1 (more deprived) area, being at high-rsik of CVD, etc. Our “Universal offer” is access to web-based lifestyle advice (mediated via libraries etc for those without web access); our targeted offer is one-to-one and group support, using health trainers, commercial providers and a tailored group-based programme for specific sections of the population wich as those with learning disabilities, and working men. This prioritising system helps to ensure that we don’t just reinforce inequalities.
Cambridge Weight Plan	2	Providing individuals identified as overweight and obese with information available lifestyle weight management services may well lead to a greater number of people self-referring to these schemes. Cambridge wish to stress, however, the importance of the way in which this information is given to the individual identified as overweight or obese: Any communication of the need to take up a weight management plan – whether verbally by the healthcare professional that has identified the patient as overweight or obese or in writing – must be respectful and avoid apportioning blame to the individual for their weight.

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		Furthermore, the probability of overweight and obese individuals actually utilising the information they have been given on weight management services would be increased if they were provided with an overview of the effectiveness of these programmes and the level of support they give to their participants. It would be particularly useful if the information provided mentioned how to access the information listed in quality statement 5. Cambridge would also like to emphasise the importance of GPs and Healthcare Professionals providing this information recording the proportion of overweight and obese individuals that have been given information so that self-referrals can be tracked.
Public Health England	Quality Statement 3	Given the breadth of co-morbidities associated with obesity, suggest NICE could provide a list of the co-morbidites to help localities collect data on this as PHE is aware that localities find it difficult to develop a definitive list. Could NICE provide the rationale for rationing referral to weight management programmes to individuals with co-morbidities? This seems to be inconsistent with other NICE guidance which suggests making referrals where individuals have a BMI >25
Weight Watchers	Quality Statement 3	With reference to the following statement: "**Providers of lifestyle weight management programmes should be able to meet the specific needs of women who are pregnant**" As per NICE guidance PH27, women who are pregnant should not embark upon a weight loss regime "**Dieting during pregnancy is not recommended as it may harm the health of the**

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		unborn child"; in conflict with this statement. There is limited/no evidence of what is a safe and effective approach to weight management for pregnant women, particularly within a tier 2 community service, therefore 'women who are pregnant' should be included in this statement.
Slimming World	Quality statement 3	We note that this statement specifically refers to people with comorbidities being referred (implying that anyone who has yet to develop a comorbidity would not be referred but be expected to self-refer). This seems to be new and the first time that a criteria has been applied at a national level for commissioning of services. We feel this needs to be considered in terms of how this might affect current services being commissioned (many patients are able to access a service via a paid referral without a co-morbidity). We would also question what this would mean for someone who has pre-diabetes and how this fits with the national diabetes prevention programme where the primary objective is weight loss. Also in terms of inequalities, what would this mean for someone who maybe couldn't afford to 'self-refer'? .
The Chartered Society of Physiotherapy	3	We welcome this statement, and feel that physiotherapy staff have a vital role to play in weight management for those who are obese with comorbidities. Exercise and movement are the keystone of the scope of Physiotherapy practice.(1) Along with a holistic, patient-centred, and problem solving approach, physiotherapists have advanced knowledge and skills in: • anatomical, physiological, and psycosocial mechanisms of health and disease • assessment and diagnosis • behaviour change • biomechanics • exercise prescription and therapeutic exercise • management of long term conditions. We are therefore ideally suited to address the physical and psychological complexities of

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		obesity.(2) Physiotherapists provide valuable input and expertise in the multi-disciplinary management of obesity,(3) helping to optimise clinical outcomes and patient experience. In light of this, please consider adding physiotherapy staff to the professions mentioned as part of this standard. References 1. The Chartered Society of Physiotherapy. Scope of practice: Introduction. London: The Chartered Society of Physiotherapy; 2014.**http://www.csp.org.uk/professional-union/professionalism/csps-approach-professionalism/scope-practice-staff-only/introduct** 2. Canadian Physiotherapy Association. Physiotherapists and the management of obesity. Ontario: Canadian Physiotherapy Association; 2007. **http://www.physiotherapy.ca/public** 3. O'Connell J. Management of obesity: lessons learned from a multi-disciplinary team. European Diabetes Nursing. 2012;9(1):26-9.
The Royal College of Anaesthetists	3	There are several different options for these patients dependent on the co-morbidities that they have – diabetic teams are setting up national programmes and it may be unlikely that patients would go to this and another LWMP (may be significant overlap in programmes). Would it therefore not be better to stipulate that all these patients should be referred to at least one of these lifestyle programmes? A specific list of co-morbidities needs to be identified and explicitly documented within this consultation. Throughout the draft 'co-morbidities' refers to varying conditions; consistency is the key.

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
LighterLife	3	Referring individuals with co-morbidities to weight management programmes will indeed help improve their chances of losing weight in a sustainable way. This weight loss will, in turn, help them better manage their obesity-related secondary illness. LighterLife wishes to emphasise, however, that referrals should be made to all available weight management services in the area – both commissioned and commercial programmes - where possible. The reason for this is simple: levels of obesity have continued to increase whilst local authority budgets – including the ring-fenced public health budget – continue to be reduced. It is possible that there will be an inadequate number of commissioned weight managements with capacity to assist referred individuals with comorbidities – the recent survey by the Royal Society for Public Health which found that weight management services are already being rationed heavily indicates the strong likelihood of this outcome. In order to ensure that the needs of the local overweight and obese population are adequately met, private weight management interventions should therefore be regarded in the same manner as public interventions when referrals are made and there is the possibility for individuals capable of doing so to 'self-fund' their participation in a weight management programme.
The Royal College of Pathologists	3	There is a mismatch between what the quality statement aims to address (being offered a referral) and what the measure will actually capture (those referred) – i.e. the measurement process would not capture those who were offered a referral but declined this offer. Not sure how to address this, however, as the number referred would be a much easier number to identify than the number offered a referral
Cambridge Weight Plan	3	Cambridge fully supports this statement which will help individuals with comorbidities lose

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		weight and, in so doing, improve their ability to manage their secondary illness. It is vital though that, where possible, referrals are made to both public and private weight management services operating in the area – not only those that have been commissioned. This is to ensure that the needs of the local overweight and obese population are sufficiently met – an outcome that could be difficult to achieve given that levels of obesity and type-2 diabetes continue to rise. On top of this, a survey by the Royal Society for Public Health has revealed that weight management services are being rationed by local authorities already under pressure to meet their savings target and who have further had their public health budget slashed for this year. Treating public and private interventions in the same way when referring individuals who may be able to fund their involvement in a weight management programme will therefore be vital to preventing individuals being denied assistance by public weight management services that would otherwise be oversubscribed. In order to ensure that public and private interventions are given the same treatment, GPs and Healthcare Professionals should be comprehensively informed of the options available so that referrals to effective programmes are not denied purely on the basis of personal prejudice against or misunderstanding of private interventions or the type of programme being offered. The proven effectiveness of the programme and its ability to assist overweight and obese individuals with comorbidities lose weight should be the sole consideration.
British Obesity Society	3	We confirm support for the implied quality intervention, namely that the lifestyle intervention patient referred to should operate to best and optimal practice standards extant at the time i.e. including dietary, exercise and pharmacotherapy (i.e. not just non-pharmacological interventions)

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
Public Health England	Quality Statement 4	Would there be opportunity to develop a weight maintenance register (similar to the US register) to provide an overview of what behaviours are associated with the greatest success in weight regain prevention from this indicator? It is an area where understanding is developing and we know that weight regain is such a significant problem. PHE recognises that this goes further than the QS. Should this statement include some numerator data on post intervention weight status?
Weight Watchers	Quality Statement 4	Although we welcome the recognition of the importance of the prevention of weight regain, we find this statement too general and unrealistic. Although 'a plan' is defined, it is not clear how this will be implemented in the 'real world'. We recommend the addition of a recommendation to discuss weight regain frequently throughout the intervention with strategies for weight loss maintenance discussed upon completion. We would also suggest that adults who have successfully lost weight on a tier 2 programme, but are struggling to maintain this in the longer term are offered the option for booster sessions within a service once their weight goes over a certain pre-agreed threshold. These could be pre-defined at local commissioner level.
Slimming World	Quality statement 4	The wording within this quality statement stresses the need for a 'plan to be agreed' to help people prevent weight regain. We feel the emphasis should be on providing a service which supports behaviour change and developing long term skills to overcome lapses and prevent weight regain. This should be implicit within a programme from the start and not rely on a different programme/approach.

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
LighterLife	4	LighterLife strongly believes that it is important that individuals about to embark on a weight management programme agree a plan to prevent weight regain with their weight management provider. Ensuring that a system is in place to monitor and support the progress of individuals with self-managing their weight, whether that be through follow up meetings with health care professionals or participating follow up programme such as LighterLife's Management Programme which supports individuals with maintaining their weight loss, will be key to delivering the objective sought by this quality statement.
The Royal College of Pathologists	4	Agree this is very important – nothing to add.
Stockport Council	4	Like this standard. Simple, measurable, easy to implement and useful.
Cambridge Weight Plan	4	Cambridge firmly believes individuals about to commence a weight management programme should agree a plan to prevent weight regain with their weight management provider, however weight management programme providers in the community have no direct control over their clients to comply once target weights have been achieved. Other messages and support services should also be available to encourage the progress of participants with self-managing their weight once their participation in the programme has concluded. This may take the form of follow up meetings with health care professionals or taking part in follow up programmes provided by the weight management service.
British Obesity Society	4	We acknowledge that the evidence base for efficacy of weight maintenance interventions is limited. We would stress that evidence and intervention should not be restricted to non-pharmacological interventions

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
Public Health England	Quality Statement 5	PHE supports this statement and suggests that approaches to collate such data needs to be investigated and considered further to ensure that there is a consistency of approach for local authorities. For example PHE has the Standard Evaluation Framework (SEF) for Weight Management Interventions.
Weight Watchers	Quality Statement 5	Weight Watchers welcomes this quality statement requiring interventions to publish data on attendance rates outcomes and participant and staff views. Making these outcomes easily accessible would support the general public greatly and promote ownership and accountability.
Slimming World	Quality statement 5:	This statement suggests that service providers (including providers of lifestyle weight management programmes) ensure that they publish data on attendance, outcomes and views of participants and staff. Where services are commissioned, as standard as an organisation we provide detailed data reports to commissioners on a local level i.e. to the commissioning public health team. Nationally we publish data audits on both our referral service and also our standard service (where people self-refer and pay to attend). It needs to be clear within this quality statement who is responsible for publishing data on a local level.
LighterLife	5	This quality statement is welcomed by LighterLife. It is important that individuals are enabled to make an informed choice when deciding on the best weight management option for them. LighterLife suggests that this information is collected, made available and managed by one source, i.e. collected by the local authority and published on the local authority website. Additionally, the data on attendance, outcomes and views of staff should be regularly collected by this central source, perhaps on a quarterly basis, to ensure that the information is

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		truly up-to-date. Finally, this information should be collected from all available weight management services in the area, not just public weight management providers.
Stockport Council	5	Again, our concern is that many such programmes are outside the Council's control, and we are not able to ensure that this data etc is available apart from those areas where we commission services directly or with partners.
Stockport Council		Concerns about Statement 5 as expressed above.
Cambridge Weight Plan	5	It is essential that individuals are provided with as much information as possible to help them make to make an informed decision when choosing the weight management programme that they will join. In order to make do this in the most effective manner, Cambridge would suggest that this information is collated and managed by a single source that is well known to all prospective participants, such as the local authority. Cambridge would further suggest that the data on outcomes, attendance and the views of staff are collected at regular intervals by this central source - potentially on a quarterly basis – to guarantee that the information provided is still accurate and should cover both public and private interventions so that individuals can compare information on all available schemes.
Slimming World		Within the NICE guideline PH53, training of GPs and other health and social care professionals to identify when to raise the subject of weight management, and the importance of being able to do this confidently but with empathy and in a non-judgemental, supportive manner, is highlighted as key. This is an area for quality improvement across many health care professionals. Within this quality standard document it is implied that training and

Stakeholder	***Statement No***	**Comments** Please insert each new comment in a new row.
		competencies are outside the remit of this document. If it isn't an appropriate statement for a quality standard then where will it be captured to ensure that quality improvement in this key area occurs?
Royal College of Physicians		Our experts in gastroenterology wish to highlight the absence of endoscopic methods for countering obesity within the document.

Registered stakeholders who submitted comments at consultation

- Action on Sugar
- British Obesity Society
- Cambridge Weight Plan
- City University London
- Department of Health
- Faculty of Occupational Medicine/Society of Occupational Medicine
- LighterLife
- Lincolnshire County Council
- Lincolnshire Health and Wellbeing Board
- National Obesity Forum

- NHS England
- Nutrition Policy Unit
- Public Health England
- Royal College of Nursing
- Royal College of Physicians
- Royal College of Physicians & Surgeons of Glasgow
- Royal College of Physicians of Edinburgh
- Slimming World
- Society for Endocrinology
- Stockport Council
- Tees Esk and Wear Valleys NHS Foundation Trust
- The Chartered Society of Physiotherapy
- The Royal College of Anaesthetists
- The Royal College of General Practitioners
- The Royal College of Pathologists
- Weight Watchers

Appendix 2: Quality standard consultation comments table – non-registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
9	Kate Gardner		One question: Why are physiotherapists, as relevant professionals, not referenced in this draft Quality Standard for Tier 2 services? Physiotherapists (public, private and voluntary sector) already have a key role, using core skills, to risk assess the people, place and equipment; deal with co-morbidities, and refer onwards. They should also have a role in training those who deliver physical activity services in particular, to meet this NICE Quality Standard. Thank you References http://www.csp.org.uk/sites/files/csp/secure/physio_works_obesity_2015_v2.pdf Bury T, Moffat M Physiotherapists have a vital part to play in combatting the burden of noncommunicable diseases.Physiotherapy Volume 100, Issue 2,June 2014,Pages 94–96 DOI: 10.1016/j.physio.2014.03.004

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

Appendix 3: Quality standard internal checks table

[Please include any feedback from Gill and other quality standards colleagues (e.g. CCA, SCA, ADs, Tech Advisers) that needs to be considered by the QSAC as being from 'QS team' – **DO NOT** attribute comments specifically to Gill or other individuals within the team. Please attribute other comments from NICE to the individual team e.g. NICE Implementation.]

Comment number	Page number Or **'general'** for comments on the whole document	Statement number Or **'general'** for comments on the whole document	Comments
[insert name of team here]			
1	General	General	Include in introduction of quality standard, background information highlighting the aims and objectives of the 5 year forward view
2	General	General	It would be helpful to – where possible – align the prevention and management of obesity QS with the children and young people QS (already published)

[NOTE: Appendices 2 and 3 should be deleted before publication.]