NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Obesity: clinical assessment and management

Date of Quality Standards Advisory Committee post-consultation meeting:
11 February 2016

2 Introduction

The draft quality standard for ‘obesity: clinical assessment and management’ was made available on the NICE website for a 4-week public consultation period between 14 December 2015 and 14 January 2016. 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 25 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. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Is there currently variation in the provision or quality of pre-operative psychological assessment carried out before bariatric surgery?

Stakeholders were also invited to respond to the following statement specific questions:

5. For draft quality statement 1: Is it realistic for BMI or BMI centile to be calculated at all first outpatient appointments after referral? If not, are there priority patient

groups, hospital departments or types of outpatient appointment that this statement should focus on?

6. For draft quality statement 2: Should this discussion about likely resulting health problems take place at the outpatient appointment?

7. For draft quality statement 2: Is it realistic to have a discussion about BMI and health risks at all outpatient appointments? If not, are there priority patient groups, hospital departments or types of outpatient appointment that this statement should focus on?

8. For draft quality statement 3: Are there sufficient tier 3 services available nationally to make this statement achievable?

9. For draft quality statement 4: Where should children and young people with a BMI at or above the 98th centile be referred for assessment of comorbidities?

10. For draft quality statement 8: Are there examples, or details, of shared-care models for nutritional management after discharge from the bariatric service that we could reference in the definitions section of this statement?

4 General comments

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

- A stakeholder raised concerns regarding the availability of resources needed to implement the statements (for example, staff training, clinic time and equipment).
- A stakeholder raised concern over the lack of consideration of stigma in this quality standard. They highlighted this as an important aspect of obesity management, commenting that when healthcare professionals stigmatise patients this can result in poorer outcomes for the patient.
- A stakeholder commented on the lack of tier 3 services and confusion regarding the commissioning of these services.

- A stakeholder was concerned that inadequately trained staff would provide superficial, ineffective and potentially alienating advice. Several stakeholders raised training as an important issue.
- A stakeholder commented that there should be engagement between endocrinology services and weight management services.
- The statements do not encourage a patient-focused approach to understanding how eating behaviours develop or might be influenced.
- The association between obesity and respiratory problems should be highlighted within this document. This includes comorbidities such as sleep apnoea and hypoventilation syndrome.
- A stakeholder commented that health inequalities experienced by lesbian, gay, bisexual and transgender (LGBT) people have been overlooked in the Equality Assessment. It was suggested that sexual orientation and transgender status should be monitored to help identify any trends in negative experience.
- There needs to be more emphasis on making these standards apply equitably to people with learning disabilities.
- Outcomes are missing from the Outcome Frameworks lists in the introduction to this document.
- NHS staff are key ambassadors and could be targeted.
- There should be more emphasis on the wider purpose of tier 3 services, i.e. not just as a gateway to surgery.
- Certain cancers should be added to the list of conditions associated with obesity in the introduction.
- A stakeholder highlighted the impending changes to bariatric surgery commissioning and the need for this quality standard to take this into consideration.

Consultation comments on data collection

- A stakeholder commented that tier 3 data can be collected and that a national tier 3 database is being developed for data collection.
- Data collection should be routine for people attending outpatients.

- Transfer between tier 2 and tier 3 services may be an issue for measuring some statements.
- Data collection would be easier from primary care visits than outpatient appointments.
- A stakeholder highlighted the existence of QOF and CCG Outcome Indicator Set (CCG OIS) indicators relevant to this topic.
- A stakeholder commented that we should be assessing the quality of patient-focused discussion (rather than ‘box-ticking’ if they occurred). Large scale numerical data-collection was suggested to be a backwards step. Patient satisfaction assessments would be more meaningful and help to ensure that people have a positive experience of care.
- Data collection for statements 1 and 2 was suggested to be very difficult; coding for BMI was noted as poor.
- It would be very difficult to obtain data on the local prevalence of people with BMI over thresholds specified in measures in this quality standard.

Summary of consultation feedback by draft statement

4.1 Draft statement 1

People who attend their first hospital outpatient appointment after referral have their current BMI or BMI centile calculated.

Consultation comments

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

- In appropriate to measure BMI at all outpatient appointments. *Clinical judgement* will need to be used to decide when this is appropriate – and this will make measuring these statements very difficult.
- Unless this measurement results in any action that it is unlikely to result in a positive outcome.
- Unrealistic for this to occur in all outpatient appointments.
- Several commented that BMI should be measured in primary care (where initial referrals occur and where initial advice and interventions should occur), and questioned why this statement focuses on outpatient appointments.
- It would be preferable to offer or invite someone to undertake BMI measurement.
- This is a reasonable expectation, and that they believed it was routine to measure weight for all general surgery patients in outpatient clinics already.
- The information needed to measure this statement is not available in hospital statistics or outpatient data.
- It is not clear who would measure BMI as part of ‘pre-assessment’.
- There are resource implications, these include equipment and private locations for measurement to occur and training staff in how to bring up the issue in a non-judgemental way. A stakeholder highlighted the importance of training and the need for support materials which cover raising this topic in a sensitive way and tuition in motivational interviewing techniques. The stakeholder highlighted materials produced by the RCGP Nutrition Group in conjunction with the RCN.

- Normalising weight measurement in clinical care should be encouraged but that this statement risks prioritising a box ticking measure over the quality of conversation held with a patient.
- Issues were raised regarding the use of BMI centiles; including data recording problems in primary care and hospitals and the need for widespread training in how to measure BMI centiles.
- The inclusion of children within the scope of the statement should be emphasised for clarity.
- Factors such as muscle mass, ethnic origin and puberty should be considered with BMI.
- It should be explained to patients why BMI is being measured.

Consultation question 5

For draft statement 1: Is it realistic for BMI or BMI centile to be calculated at all first outpatient appointments after referral? If not, are there priority patient groups, hospital departments or types of outpatient appointment that this statement should focus on?

Stakeholders made the following comments in relation to consultation question 5:

- Measurement of BMI should be the focus of primary care not secondary.
- It is unrealistic for BMI to be measured at these appointments – it would be more realistic for these appointments to include an invitation to be weighed or to discuss weight concerns. This will help to distinguish between people who do and don't want to engage in this setting.
- Outpatient appointments are often unable to meet the primary requirements of the reason for referral (and communicating details back to primary care) so adding additional requirements to the appointment is unlikely to be met.
- Measuring weight and height is realistic within an appointment, suggesting that self-measurement could be utilised.
- Weighing scales and private rooms are not always available in outpatient settings.
- Several stakeholders commented that the statement should apply to all patients.

- This statement should apply to all outpatient appointments, rather than just applying to a specific patient group, because:
  - (i) this would help to prevent stigma from being part of a targeted patient group,
  - (ii) it is difficult for clinicians to recognise when someone is overweight, and
  - (iii) being overweight has multiple health implications so it is difficult to select a group according to comorbidities/condition.
- Limiting this statement to conditions where there is a direct link between health risk and obesity.
- A stakeholder highlighted cancer screening – commenting that risk is high here but public knowledge of this association is less well known.
- The most relevant therapy areas/priority areas for this statement provided by stakeholders were: cardiology, orthopaedics, surgery, diabetes, CVD, respiratory disease, MSK, asthma, arthritis, sleep apnoea, fertility. Children and young people were also suggested as potential priority area.
- People with severe mental illness were suggested as a high priority group, as this group often does not access mainstream physical health services.
- Outpatient appointments are a useful opportunity to measure BMI – but shouldn't be relied on to do so. More frequent BMI checks should be utilised.
- This activity should be performed by primary care and, once logged into a database, BMI details will be available to secondary care.
- Measurement of BMI centiles would require widespread adoption of electronic growth charts to automate this process.

4.2 Draft statement 2

People identified as being overweight or obese, or at health risk due to their weight, at an outpatient appointment have a discussion during the appointment about their BMI and the likely resulting health problems.

Consultation comments

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

- It won't be appropriate to discuss health risks due to weight at all outpatient appointments. *Clinical judgement* will need to be used to decide when this is appropriate – and this will make measuring these statements very difficult.
- Questioned whether staff would have the time or expertise to carry out this statement. A stakeholder commented that there is a real risk it could distract staff from other activities.
- Highlighted the importance of a clinician's discretion regarding when this conversation should take place.
- If people are attending outpatient appointment for an unrelated reason this may not be appropriate. Patients may already have had a similar discussion in primary or secondary care.
- Very limited time available in outpatients, and noted that this is a very complex issue particularly for unrelated specialists.
- This is an issue that should be addressed in primary care unless there are specific secondary care issues. Potentially a need for this discussion to occur could be indicated back to primary care, where there would be appropriate time and expertise for this discussion to occur.
- This discussion could negatively affect relationships with health professionals. Taking every opportunity to highlight the risks of excess weigh was also suggested to be off-putting and irrelevant.
- This statement would be particularly relevant if the outpatient appointment was for an obesity-related comorbidity.

- There will be a need for adequate staff training at all levels to explain health risks if patient understanding is poor. Training would need to include how to raise the issue of weight appropriately using a non-judgemental approach.
- Training was highlighted by several stakeholders to be important to ensure that these conversations are handled appropriately and will not have a detrimental effect.
- If the issue of weight and related health problems is raised at this contact point then people will want, or expect, appropriate advice and information.
- The statement is currently non-specific and would result in brief, superficial information which may be alienating or irrelevant. Several stakeholders highlighted the potential risks that this activity could disengage and de-motivate people.
- This approach risks repeatedly emphasising harm to people who may already have low self-esteem and a strong sense of guilt. The statement wording should encourage healthcare professionals to convey optimism and support.
- The statement assumes that people do not know that they are overweight or obese and that information about health risks would promote behaviour change. It was suggested that explaining the rationale behind measuring height and weight would be beneficial. People's perception of their own weight was highlighted as a complex issue.

Consultation question 6

For draft statement 2: Should this discussion about likely resulting health problems take place at the outpatient appointment?

Stakeholders made the following comments in relation to consultation question 6:

- Several stakeholders suggested that this would not be appropriate for all outpatient appointments; it may depend on the reason for the referral.
- A brief intervention should be considered, with more formal and detailed discussion difficult to schedule due to time demands.
- This is an integral part of outpatient care; however, the discussion must be led by an appropriately trained healthcare professional.

- It should be left to a clinician's discretion as to whether this discussion should take place.
- This would be easier if a patient has been referred for an obesity-related comorbidity. If not, a different management style would be required.
- Appointment times would need to be restructured for this to occur, with implications for costs and waiting times.
- Discussions would need to be very brief, with appropriate further signposting.
- Discussion should be targeted to particular care settings or patient presentations. General obesity management is not appropriate for an outpatient appointment.
- Current resourcing doesn't allow time for this, and not many secondary care clinicians are trained in this area.
- If this discussion doesn't occur, a stakeholder questioned why BMI is being measured.
- Several stakeholders highlighted the importance of signposting to further support and local services.

Consultation question 7

For draft statement 2: Is it realistic to have a discussion about BMI and health risks at all outpatient appointments? If not, are there priority patient groups, hospital departments or types of outpatient appointment that this statement should focus on?

Stakeholders made the following comments in relation to consultation question 7:

- There is not always enough time to discuss lifestyle advice and this could overburden secondary care services. The problem/conditions that a person has been referred for should take priority.
- People could be signposted to information and other healthcare professionals with more time and knowledge to discuss risks and possible options.
- Will healthcare practitioners will have the support and information at hand to carry out this statement. A further stakeholder suggested that a database of local services that can help with obesity management would help to ensure that professionals signpost or refer onwards correctly.

- It might make sense to restrict this to areas of consultation directly impacted by BMI.
- It may be confusing if there are priority groups, however for some specific clinics time could be built into appointments for these discussions. A stakeholder commented that prioritising one group of patients over another will dilute obesity management guidelines.
- This is realistic and integral to care in an outpatient appointment – the conversation must be held by a professional trained in the complexities of obesity.

4.3 Draft statement 3

Adults with a BMI of 35 kg/m^2 or more and obesity-related comorbidities, or a BMI of 40 kg/m^2 or more, are offered a referral to tier 3 services if tier 2 interventions have been unsuccessful.

Consultation comments

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

- There is currently poor provision of tier 3 services and for this statement to be implemented it would require adequate commissioning of multidisciplinary services, with additional funds.
- There is variability in the availability of tier 3 services, and also in their make-up and function.
- Not all CCGs comply with these BMI cut-offs currently.
- Primary care is the appropriate place to make referrals to tier 3 services.
- The criteria for what constitutes success/failure at lower tiers of the pathway needs to be clearly defined.
- Funding pressures have resulted in tier 3 investment being a low priority, and often these services are just entry points for tier 4. A further stakeholder commented that this statement should clarify that tier 3 referral is not only for patients who are considering surgery (a current misconception).
- There is a lack of multidisciplinary obesity services for the paediatric population.
- Use of the phrase ‘dieting’ in this statement should be replaced with ‘making lifestyle changes’.
- Could there be more emphasis on tier 2 services as a treatment option before tier 3?
- The equality and diversity section should consider that patients with learning disabilities may not require referral to tier 3 for additional support but could access support from local community disabilities teams or tier 2 services.
- Further clarity was requested on who should make this referral.
- Barriers to access and the needs of people with serious mental illness should be considered.

Consultation question 8

For draft statement 3: Are there sufficient tier 3 services available nationally to make this statement achievable?

Stakeholders made the following comments in relation to consultation question 8:

- There is variable provision of tier 3 services nationally, and that there would be a postcode lottery in terms of implementing this statement.
- Several stakeholders commented that the number of tier 3 services needs to be increased.

4.4 Draft statement 4

Children and young people with a BMI at or above the 98th centile are assessed for comorbidities.

Consultation comments

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

- General practice has insufficient resources to carry out this work – it would need to be separately commissioned.
- It would be useful to define when this assessment should occur (for example, at the point in time at which a child or young person is identified as having a BMI above the 98th centile).
- The list of comorbidities that should be assessed (in the definitions section of the statement) is not exhaustive – so will make measuring this statement difficult. Can a few key comorbidities that are priorities for assessment be identified here?
- Paediatric obesity issues should be dealt with by current primary and secondary care services, with consideration of surgery at regional MDTs.
- The use of the 98th centile was questioned.
- Additional comorbidities that could be mentioned were highlighted, including: non-alcoholic fatty liver disease, endocrine, joint and possible mental health issues, sleep related co-morbidities, obesity hypoventilation and other causes of breathlessness.
- Further detail for the centile measurement was suggested ("*Children and young people with a BMI at or above the 98th centile <u>for age and gender</u> are assessed for co-morbidities*")
- Clarification was requested for the lower age cut-off that this statement should apply at. A stakeholder commented that presumably it doesn't apply to infants.
- More specialised services are needed for children and young people, and highlighted a need to develop such services in conjunction with paediatric secondary and tertiary services.
- Reference should be made to health visitors and school nurses who can have a role in assessing children and young people for comorbidities.

- Identifying additional health problems (in addition to obesity) risks generating additional worry, guilt and potentially denial of a problem. This statement is unlikely to provide patient benefits and may cause harm. The statement may generate confusion, concern and over-medicalisation.
- Further detail was requested on how often testing is advised, particularly as a large number of children and young people will have BMI above the 98th centile.
- There is need for greater clarity in who should carry out this statement.
- GPs do not have experience to assess for comorbidities and the number of children above the 98th centile means that this statement is not feasible for paediatricians. The statement is therefore unworkable.
- The list of comorbidities is for standard adult comorbidities, which can be difficult to assess in children.
- Refine the population that this statement refers to, for example children and young people with a BMI above 98th centile and who have family history of obesity related comorbidities, or children with extreme obesity (BMI above 99.6th centile).
- There is a need for more detail on how often such assessments should occur (for example at what age or duration of obesity would trigger assessment).

Consultation question 9

For draft statement 4: Where should children and young people with a BMI at or above the 98th centile be referred for assessment of comorbidities?

Stakeholders made the following comments in relation to consultation question 9:

- This is a specialist area and is more appropriate for secondary care (e.g. paediatric services) rather than primary care.
- Assessment for comorbidities should occur in both secondary and tertiary services. Tier 3 services can offer more specialist dynamic endocrine investigations and psychosocial assessment.
- Children and young people with a BMI above the 98th centile should be referred in the first instance to community weight management services, and be offered holistic lifestyle assessments. Screening for risk factors relating to co-morbidities should be provided via training/tools produced alongside specialist paediatricians.

- A further stakeholder commented on the lack of consideration of weight management services in this statement; commenting that often these services lack medical input or links with primary care. It was commented that additional requirements to assess comorbidity won't help with the current shortfalls in obesity management for children. It was furthermore suggested that if comprehensive child obesity services were developed than comorbidity assessment could occur in primary care under a shared care agreement (provided consideration was given to funding).
- Initial screening should be done by GPs, with assessment for comorbidities in secondary care.
- This would vary geographically; in some areas by tier 3 services, in others by referral to paediatricians or by GPs or community dietitians.
- School nurses were suggested as possible options for ordering blood tests, carrying out required measurements and referring to specialist services as needed.
- There's a need to develop relevant services/support in conjunction with paediatric secondary and tertiary care services, which are most likely led by endocrinology and diabetes specialists.

4.5 Draft statement 5

People with a BMI of 35 kg/m^2 or more who have been diagnosed with type 2 diabetes within the past 10 years are offered an expedited assessment in a tier 3 service (or equivalent) for bariatric surgery.

Consultation comments

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

- The resources for this statement are not available within CCG budgets and that there is currently poor provision of multidisciplinary tier 3 services. Implementation would require additional funding.
- Tier 3 and 4 services are not equipped to deal with such a large proportion of the population as the prevalence of diabetes increases.
- Both tier 3 services and bariatric surgery provision is lacking in many areas – so this statement might not be achievable in practice.
- It would be beneficial to define 'expedited' in this statement for clarity.
- Not all people in this group would be suitable for surgery (for example due to frailty or comorbidities).
- A stakeholder supported this statement, suggesting that the denominator for measures should include anyone eligible in the local population within a specified age range.
- Decisions to refer for bariatric surgery should rest with primary care (although secondary care should also be involved, e.g. diabetic services).
- The term 'or equivalent' when referring to tier 3 services is unclear. The provided definition of 'or equivalent' in this statement was suggested to be too open – and further guidance was requested regarding these services.
- Questioned how the implementation of this statement and any unintended consequences would be assessed.
- There are risks to expedited assessment without some length of time in a tier 3 service. They highlighted the importance of pre-operative education and risk reduction in tier 3 services and commented that there is a need for more than just pre-operative assessment followed by bariatric surgery.

- A stakeholder suggested modifying the statement to clarify that bariatric surgery is generally not recommended for children and young people. The statement potentially ignores an epidemic of type 2 diabetes cases in children and young people in the last decade. An amendment to the statement was suggested to specify that bariatric surgery for children and young people should be considered in specialist adolescent bariatric surgery centres for adolescents with new onset type 2 diabetes that is not controlled within 6 months of onset with standard diet/metformin.

4.6 Draft statement 6

Adults with a BMI above 50 kg/m^2 are offered an assessment for bariatric surgery in a tier 3 service (or equivalent).

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- Reading this statement along with draft quality statement 3 suggests that people cannot be referred for surgery until their BMI reaches 50 kg/m^2. This seems like a high value and consideration of surgery should not be based only on weight.
- We should define what interventions should have been tried before assessment for bariatric surgery takes place.
- Tier 3 services should facilitate preparation of this group of patients for surgery, rather than provide alternative options. The measures should cover referrals for surgery, rather than being assessed for surgery, as surgical MDTs should be given the option to assess all patients with BMI of over 50 kg/m^2.
- There should be more emphasis on referrals to tier 3/bariatric surgery being made only when other interventions have been tried.
- The statement ignores children and young people with high BMIs. There should be a corresponding statement for this group. A stakeholder commented that it is discriminatory for the management of obesity in children and young people not to be included within this quality standard.
- Given the variable provision of bariatric surgery nationally, this statement may not be achievable.

4.7 Draft statement 7

People who have had bariatric surgery have a postoperative follow-up care package within the bariatric surgery service for a minimum of 2 years.

Consultation comments

Stakeholders made the following comments in relation to draft statement 7:

- It would be useful to add a frequency at which assessment should occur at – in theory one assessment within the two years would fulfil this statement.
- Measures in this statement should take account of patients who are realistically lost to follow-up; so the measure numerator should include people who are offered follow-up as well as those who successfully complete it.
- While agreeing with the rationale for this statement, a stakeholder questioned where the additional resources that it will require will come from.
- There is variation in, or lack of, follow-up care and GP practice complaints about lack of skills and financial resources for this.
- A stakeholder highlighted follow-up of patients fitted with gastric bands (which have the highest failure rates) and noted that the private sector fit a large proportion of these bands (and consequently patients will not have attended tier 3 services).
- Patients should ideally be offered shared care follow-up models between primary care/ Tier3 and the Tier 4 bariatric medical services.
- The development of shared-care protocols between bariatric teams and primary care should be encouraged. People who have had bariatric surgery are typically under comorbidity review anyway, so guidance on what elements of bariatric care should be included in their annual comorbidity review (e.g. advice and explicit follow-up instructions from the bariatric team) would be useful.
- Children and young people who have bariatric surgery should have a minimum of 5 years follow-up.
- Further details to add to the definition of ‘care package’ were suggested.
- ‘Nutritional deficiencies’ should be given greater prominence in the rationale for this statement.

- Will this statement include people who have undergone ‘emergency’ bariatric surgery and people who have bariatric surgery privately?
- People who maintain their weight loss should be offered body contouring surgery.
- It is not uncommon for patients to have bariatric surgery a long way from where they live. Distance to travel may then be a barrier to accessing follow-up services provided by the bariatric service. More emphasis should be placed on how local services can be adapted to provide post-operative care.

4.8 Draft statement 8

People discharged from bariatric surgery service follow-up are offered monitoring of nutritional status at least once a year.

Consultation comments

Stakeholders made the following comments in relation to draft statement 8:

- It would help with clarity if the roles of services in carrying out this statement are well defined.
- GPs don't have the necessary skills to carry out nutritional assessment.
- Shared care models are used for conditions such as COPD and diabetes and this could be replicated for people who have had bariatric surgery.
- Nutritional status is only one aspect of maintaining a healthy weight: other areas should also be monitored (for example, mental wellbeing and engagement in daily life activities).
- Frequency of monitoring should be tailored to the individual depending on the procedure they underwent.
- It is essential to have a named person/unit responsible for administration of follow-up; however, this is unlikely to happen.
- Carrying out follow-up requires healthcare practitioners who understand bariatric surgery procedures and the implications of this for eating abilities, habits and behaviours.
- Linking this process with on-going annual co-morbidity reviews would be beneficial.
- The issue of who would bear the costs of tests is unclear, and GPs are refusing to test in some areas.
- A stakeholder questioned whether this statement should be time limited, rather than lifetime support.

Consultation question 10

For draft quality statement 8: Are there examples, or details, of shared-care models for nutritional management after discharge from the bariatric service that we could reference in the definitions section of this statement?

Stakeholders made the following comments in relation to consultation question 10:

- A stakeholder highlighted guidance on managing patients after bariatric care in primary care and also an audit tool to support a review of existing standards of post-bariatric care in primary care.
- This would vary geographically, depending on local resources (potentially through tier 3 services, paediatricians, GPs, community dietitians).
- This is an important area and reinforces the need for appropriate tier 3 services to be in place.

5 Suggestions for additional statements

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

- A stakeholder commented that the child obesity related statements are inadequate.
- Training is an area of quality improvement that was not addressed.
- Local planning was raised as an issue for further improvement, particularly relating to fast food outlets.
- There needs to be a statement relating to what happens once a person has been identified as overweight or obese. There should be a recommendation to refer to an evidence based weight management services.

Consultation question 4

Is there currently variation in the provision or quality of pre-operative psychological assessment carried out before bariatric surgery?

Stakeholders made the following comments in relation to consultation question 4:

- There are national discrepancies in psychological assessment in pre/postoperative assessment; this was due to both a lack of psychologists working in bariatric services and also variation in how assessment is carried out.
- Where pre-operative psychological input is present, it doesn’t always cover the right areas. People with existing mental health issues in particular require improved support.
- Psychological services provision is limited and often only available at large distances from many patients.
- People referred to tier 3 services should have access to psychological assessment and treatment appropriate to age. A further stakeholder thought that tier 3 services could help to support pre-op assessment, and highlighted variation in the availability of tier 3 services.

- There is a need for on-going psychological support after surgery, and that the 2 year follow-up period should include psychological input. However they also noted that funding pressures do not encourage this.

Appendix 1: Quality standard consultation comments table – registered stakeholders

General comments

ID	Stakeholder	Statement number	Comments[1]
1	British Liver Trust	General	In development quality standards : To complement the co-morbidities and ensure consideration is given to non-alcohol related fatty liver disease I suggest you include the in development guidelines for NAFLD and cirrhosis
2	British Medical Association	General	There are not currently sufficient tier 3 services to allow these recommendations to be fully implemented. Since the transfer of Public Health to Local Authorities, the commissioning responsibility for tier 3 has not been clear. The Public Health England report referenced in this briefing from March 2014 clarifies that commissioning for tier 3 is the responsibility of CCGs. However, not all CCGs recognise this as part of their allocated budget. This is further muddied by the fact that some PH commissioners have included tier 3 in their current weight management programmes. This will certainly be taken out when their contracts come round for re-commissioning.
3	British Medical Association	General	The tier 2 services for diabetic patients is a specific area that needs to be acknowledged. Weight management providers of tier 2 need to either work closely with local endocrinology services; have the requisite expertise within their service; or local if resources allow it local endocrinology services may choose to run specific weight management services for this cohort of patients.
4	British Obesity and Metabolic Surgery Society (BOMSS)	General	Introduction BOMSS is delighted to comment on these draft quality standards on behalf of the membership of over 160 bariatric surgeons and 300 other health care professionals, and we fully endorse the development of statements designed to improve the outcomes for those with severe and complex obesity. BOMSS notes that there are currently wide variations in practice for the provision and delivery of services for surgery for severe and complex obesity across the UK (a 'postcode lottery'), and welcomes quality standards to improve this. In response to the individual quality statements: [*Comments provided by this stakeholder on individual statements are in sections below*]
5	British Obesity and Metabolic Surgery Society (BOMSS)	General	Conclusion Going forward, as the national society for obesity and metabolic surgery, BOMSS would be very happy to engage with NICE in the development of quality standards for the management of severe and complex obesity.
6	British Thoracic Society	General	Overview comment

[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.

ID	Stakeholder	Statement number	Comments[1]
			The British Thoracic Society is very keen to see the development of a quality standard to allow management of obesity. Obesity affects patients with respiratory problems in a variety of ways and these need to be considered and perhaps highlighted. It is a disappointment that the quality statement 4 which assesses comorbidities only does so in children and young people and does not raise the specific issue of comorbidities in adults. Many patients with respiratory disease will present with breathlessness. Breathlessness is often associated with an impairment of lung function but of course if obesity coexists this will add to the breathlessness and weight loss will improve breathlessness for that limited value of pulmonary function. This is an important area given the current large number of referrals for breathlessness and this needs to be considered as part of the "comorbidities / co-presentations. It is disappointing that the association between obesity and obstructive sleep apnoea is not highlighted. This is not discussed in the NICE guidance where reference should be made to the NICE TAG for use of CPAP. That specifically raises the association between sleep apnoea and weight and recommends weight loss / lifestyle issues for mild sleep apnoea. Clearly a cross linkage between the NICE TAG for CPAP and obesity management is important. For the co-morbidities specifically asking ADULT patients with obesity if they have features of sleep apnoea is important given the strong links that exist between sleep apnoea, independent of obesity, and ischaemic heart disease, stroke, hypertension and development of diabetes. Referencing the obesity document to sleep apnoea would be a step in this direction. It is disappointing to note that the obesity hypoventilation syndrome has not been mentioned given that this is now one of the most common reasons for people to go into respiratory failure. Gross obesity around the abdomen (sometimes associated with obesity around the upper airway, leads to under breathing during sleep (nocturnal alveolar hypoventilation). This is associated with development of right sided heart failure and fluid retention as individuals slip into hypercapnoeic respiratory failure. Failure to intervene leads to death. This should be specifically screened for by questioning peoples sleepiness (as per OSA) and blood gases considered together with simple screening studies to identify such patients given that effective therapy, non-invasive ventilation, will reverse the process. The British Thoracic Society hopes these comments are useful in developing the obesity quality standard.
7	The Chartered Society of Physiotherapy	General	The Chartered Society of Physiotherapy welcome this quality standard and the opportunity to offer our comments.

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8	The National LGB&T Partnership	General	Introduction – p. 1. & Equality Assessment The National LGB&T Partnership strongly believe that the specific health inequalities experienced by lesbian, gay, bisexual and trans (LGBT) people have been overlooked in the Equality Assessment. Considering lesbian and bisexual women, whilst the one study done on lesbian and bisexual women and obesity in Britain found little difference in rates between these women and the general population,[2] multiple studies in the USA and Australia, including two large-scale population-based studies, showed that lesbians were consistently more likely to be obese than heterosexual women and bisexual women were sometimes more likely to be obese than heterosexual women.[3] As in the general population, higher body mass index (BMI) in lesbian and bisexual women is associated with older age, poorer health status and lower exercise frequency.[4] Researchers have hypothesised that women who are partnered with women may be less concerned about being overweight or obese, as they place less emphasis on having an idealised female body.[5] This is borne out by a qualitative study which focused on the experiences of lesbians who were at risk of cardiovascular disease, the majority of whom were overweight. The research found that lesbians were more accepting of a variety of body images and a number of women acknowledged that this could be detrimental to their health. Those interviewed who were obese were concerned about potential impacts on their health, but wanted a focus on better overall health rather than solely on reducing BMI.[6] Consistently also, the one population-based study (in the US) which has compared incidence of heart disease between lesbian, bisexual and heterosexual women, found that 18.6% of lesbians, 11.6% of bisexual women and 4.5% of heterosexual women had had a diagnosis of heart disease. In multivariate analyses controlling for age, race, education, income, health insurance, tobacco use and obesity, lesbians were significantly more likely than

[2] *European Health Interview Survey*, Eurostat, EU, 2009

[3] Conron, Kerith. J, et al. 'A Population-Based Study of Sexual Orientation Identity & Gender Differences in Adult Health', *American Journal of Public Health*, USA, 2010;
Barnett Struble, C, Lindley, L, Montgomery, K et al, 'Overweight and Obesity in Lesbian and Bisexual College Women'. *Journal of American College Health*, VOL.
59, NO. 1, USA, 2010; Cochran S D et al. 'Cancer-related risk indicators and preventive screening behaviors among lesbian and bisexual women'. *Am J Public Health* 91: 591–7, USA, 2001; Aaron D J et al, 'Behavioral risk factors for disease and preventive health practices among lesbians'. *Am J Public Health* 91:972–5, USA, 2001; Valanis B G et al, 'Sexual orientation and health: comparisons in the Women's Health Initiative sample'. *Arch Family Med*, 9:843–53, USA, 2000; Leonard, W et al, *Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians*, Melbourne:The Australian Research Centre in Sex, Health & Society, La Trobe University, Australia, 2012.

[4] Yancey, A et al, 'Correlates of overweight and obesity among lesbian and bisexual women', *Preventive Medicine* 36 676–683, USA, 2003

[5] Yancey, A et al, 'Correlates of overweight and obesity among lesbian and bisexual women', *Preventive Medicine* 36 676–683, USA, 2003

[6] Roberts, S.J et al, 'Lesbians' attitudes and beliefs regarding overweight and weight reduction'. *Journal of Clinical Nursing*, 19, USA, 2010

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			heterosexuals to have a diagnosis of heart disease. Bisexuals were also more likely than heterosexuals to have a diagnosis of heart disease.[7] Furthermore, more up-to-date research funded by the U.S. government, that is going into its fourth year, cites that 'nearly three-quarters of adult lesbians are overweight or obese, compared to half of heterosexual women'.[8] However, this research should be considered with caution because the sample size behind this statistic is extremely disproportionate. Significantly though, this indicates the importance of utilising the experience and expertise of specialist LGBT voluntary and community sector organisations when conducting research into the LGBT community to ensure the data is valid and accurate.[9] This point is similarly made in the recommendations within the Public Health Outcomes Framework LGB&T Companion supported by Public Health England and produced in part by the National LGB&T Partnership. It states that 'local government strategic partnerships formed to address nutrition and obesity should engage with LGB&T community groups to deliver appropriate and targeted messages to the LGB&T community'.[10] Related to physical health in this context, is the level of physical activity undertaken by LGBT people. The National LGB&T Partnership, with support from Public Health England, carried out a survey of nearly 1,000 LGBT people living in England. *Survey of Exercise & Physical Activity in LGB&T Lives in England* explored the physical activity habits of LGBT people from across the country, asking both about sport participation and about other physical activity. We found that 64% of LGBT people who identified as something other than male or female (eg genderfluid or genderqueer) were not active enough to maintain good health.[i] Additionally, it revealed that over half (52%) of LGBT people do not meet the government recommendations for physical activity. This strongly indicates that, due to a lack of physical activity, LGBT are generally more vulnerable to obesity. Considering the overall lack of research that has been done in England around LGBT people's rates of obesity as well as levels of physical activity, it is especially important that statutory bodies, sports groups and local authorities monitor the sexual orientation and trans status of obese and overweight people and people using sports groups and facilities in order to understand the needs and experiences of LGBT people. Future research into obesity and physical activity should also monitor these characteristics and analyse the data accordingly. The clinical rationale for monitoring sexual orientation and trans status across the board is given by Dr. Simon Rogers

[7] Diamant, A L et al, 'Sexual Orientation and Variation in Physical and Mental Health Status among Women', *Journal of Women's Health*, Volume 12, Number 1, USA, 2003

[8] https://projectreporter.nih.gov/project_info_description.cfm?aid=8703150&icde=21539564%C2%A0

[9] http://www.huffingtonpost.com/jodi-savitz/the-75-of-lesbians-are-fat-statistic_b_5795794.html

[10] http://lgbt.foundation/phof

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			in the Greater Manchester Building Health Partnerships summary report which member organisation, LGBT Foundation, were a key partner in. It states that 'the collection of patient sexual orientation data in healthcare settings would (i) allow epidemiological analysis to investigate health inequalities; and (ii) allow targeted campaigns to improve outcomes and the patient's experience of healthcare'.[11] This supports the point that monitoring sexual orientation and trans status could significantly improve NICE's chances of meeting outcomes and being compliant with the 2010 Equality Act. For more information on sexual orientation monitoring in particular, please visit http://lgbt.foundation/SOM
9	The National LGB&T Partnership	General	Patient Experience p. 5 Following on from the above point, in order to fully ensure all individuals have a positive experience when accessing healthcare for obesity, their sexual orientation and trans status should be monitored. Not just to indicate to the individual that their specific needs are being taken into account, but also to ensure trends in negative experience are being recognised. This is especially important considering LGBT people are vulnerable to experiencing discrimination in healthcare settings due to their sexual orientation or trans status. The Building Health Partnerships report states that up to 30% of lesbian, gay and bisexual people would expect to be treated worse than heterosexual people when accessing public services. Furthermore, 5% of lesbian, gay and bisexual people and 20% of trans people had experienced discrimination or unfair treatment from their GP based on their sexual orientation or trans status.[12] This is supported also by the attitudes of staff within mainstream services. The Building Health Partnerships research found that 1 in 5 healthcare professionals admit to holding homophobic attitudes and beliefs.[13] The barriers for older LGBT people – a group which are already more prone to obesity – are even greater: half of older LGBT respondents felt their sexual orientation would have a negative impact on getting older and many were also much more anxious than heterosexual people about their future care needs, independence, mobility and future ill health.[14]
10	The National LGB&T Partnership	General	Training and competencies p. 6 Considering LGBT people often experience health inequalities and still endure discrimination in healthcare settings, it is especially important that all staff members are consistently and regularly trained by experts on LGBT identities and

[11] Greater Manchester Building Health Partnerships Summary Report: http://lgbt.foundation/bhp
[12] Greater Manchester Building Health Partnerships Summary Report: http://lgbt.foundation/bhp
[13] Greater Manchester Building Health Partnerships Summary Report: http://lgbt.foundation/bhp
[14] Greater Manchester Building Health Partnerships Summary Report: http://lgbt.foundation/bhp

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			issues. This is largely to ensure LGBT patients have a positive experience when accessing healthcare but also to enable healthcare staff and professionals to feel confident when speaking to and treating LGBT patients.[15] Additionally, when attempting to understand the underlying factors to obesity, it is essential that healthcare professionals are able to talk openly and confidently with their patients about this, including the possibility that an LGBT patient's obesity may be related to the mental health inequalities LGBT people are disproportionately burdened with.[16] Evidence to support this latter point for the LGBT community in Greater Manchester (GM) is found in the GM Building Health Partnership's report, but the highlights are that only 8% of LGB people in GM have never had a mental health problem and 88% of trans people had experienced depression, 80% experienced stress, and 75% experienced anxiety.[17]
11	NHS England	General	Introduction On page 5 there is a failure to list in the reducing premature mortality outcomes that there is also an indicator for reducing premature mortality in people with learning disability.
12	NHS England	General	When commenting on equality and diversity considerations you use the term learning difficulties. The term should be learning disabilities.
13	NHS England	General	There is 50% more morbid obesity in the known population with learning disability compared to the general population. (Learning Disability Public Health Observatory) Given that this is a very significant health inequality for this vulnerable group I think that there needs to be more emphasis on making these standards apply equitably to people with learning disability.
14	Obesity Group of the British Dietetic Association	General	We agree with these draft standards in principle, but have concerns about the availability of resources including equipment, clinic time and staff training needs, that would be required to fully implement them. While the costs of additional resources would be high in the short term, in our view this is likely to be litigated against by the potential for reduced longer term healthcare needs of patients if the standards are put into practice. However long term vision will be required and we question whether this will necessarily be the case across the country given straitened economic circumstances. If implemented only in parts of the country, this would potentially introduce further health inequalities through the postcode lottery.
15	Obesity Group of the British Dietetic	General	As these standards relate to management as well as prevention, we would like the additional statement that all identified tier 3 weight management clients should have timely access to not only psychological assessment but

[15] For more information on training and accreditation for health professionals on LGBT issues, see :Greater Manchester Building Health Partnerships Summary Report: http://lgbt.foundation/bhp, p. 12-14 and http://lgbt.foundation/prideinpractice
[16] Greater Manchester Building Health Partnerships Summary Report: http://lgbt.foundation/bhp
[17] Greater Manchester Building Health Partnerships Summary Report: http://lgbt.foundation/bhp

ID	Stakeholder	Statement number	Comments[1]
	Association		psychological treatment, appropriate to age if there are identified psychological problems. This is likely to have significant cost implications.
16	Royal College of General Practitioners	General	This document could be instrumental in improving standards of care in dealing with weight issues, but care is needed to limit the potential for inadequately trained staff to issue superficial, ineffective and potentially alienating advice, bearing in mind the complexities that underlie obesity and the skills required to achieve behaviour change. (RP)
17	Royal College of General Practitioners	General	Taking a numerical focus to obesity work risks embedding a box-ticking mentality to this field; the suggested list of statements are largely measurement-focused and do not currently encourage a patient-centred approach to understanding how eating behaviours develop or might be influenced. (RP)
18	Royal College of General Practitioners	General	In particular NHS staff with obesity/weight problems need to be targeted as they are key ambassadors. (PS)
19	Royal College of Paediatrics and Child Health	General	Disappointing that there is no mention of treatment options including bariatric surgery for young people.
20	Royal College of Paediatrics and Child Health	General	Diabetes NICE guidance has already been published (Sept 2015)
21	Tissue Viability Society	General	Other statements (beyond statements 1 and 2) The TVS did not feel that they were in a position to offer an opinion on the other standards as this is not their area of expertise.
22	Weight Watchers UK	General	We would welcome the inclusion of a focus on improving the equality of access and availability of weight management treatment management for adults in addition to this quality standard. HCPs should have clear clinical reasons for not referring on, rather than only referring on under pressure from patients or based on assumptions on what a patient might find acceptable. HCP's basing referral on personal judgement of what a patient might find acceptable or useful rather than offering patients a full range of possibilities narrows treatment options There is currently a postcode lottery for access to treatment and for quality standards of treatment, with disjointed commissioning of the stepped care model. Lifestyle weight management services (tier 2) currently sit within the remit of Public Health, where clinically led services sit is with CCGs, (tier 3 and tier 4). Numerous reports (HOOP and RCP) illustrate the lack of access to quality local services; describing access as "patchy". It is thought that very little is invested in weight management services in comparison to other public health issues, disproportionally when impact on health and social care and wellbeing is considered. Greater emphasis should be placed on commissioning tier 2 lifestyle weight management services on a scale that meets demand, in order to reduce the need for progression into more costly and higher risk tiers of treatment and potentially more invasive surgical procedures and in order to enhance the entire care pathway. For example, Weight Watchers have recent insights that men are less likely to be offered weight management on

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			referral (WRS) by their GP than women as there is an assumption that men would not be interested in this option. However, when men are written to directly by GP surgeries and offered WRS uptake increases Additionally, generally, presently obesity services throughout the public system, are restricted and do not meet volume needs. In 2013, the American Medical Association (AMA) reclassified obesity as a disease, to enable improvements in treatment planning, access and outcomes. Whilst it is consensus that obesity is complex and requires multilevel actions, improving access and quality standards for treatment across tiers 2-4 would play one part in offering significant benefits.
23	Weight Watchers UK	General	There did seem to be an emphasis in this Quality Standard on tier 3 being primarily being a gateway to surgery. It would be helpful to include some recommendations on the wider purpose of tier 3 as being a high intensity, clinical intervention for people to deliver an effective weight management treatment on its own, in addition to being the place to assess criteria for bariatric surgery, and for treating thosesubsequently assessed as ineligible due to contraindicated mental or physical health problems, or who do not want surgery.
24	Weight Watchers UK	General	Introduction, page 1 We would suggest the inclusion of 'certain cancers' in the list of illnesses linked to obesity.
25	WLSinfo	General	Patient experience and safety issues, and training and competencies. As a patient based organisation we have some serious concerns about health care professionals skills in bringing up the issue of weight management – especially in the first issue – more training is needed and patients need to be involved.

Consultation question 1

ID	Stakeholder	Statement number	Comments[18]
26	Bristol Tier 3 Weight Management Service	Questions 1 & 4 & 8	Doesn't reflect the need for tier 3 services to be permanently commissioned and access being equal across the UK. Bristol and Wiltshire tier 3 services have not been permanently commissioned. There are national discrepancies in psychological assessment in pre/postoperative assessment. Good links should be built with tier 2 services, which should be fully supported and well defined with a smooth patient

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			pathway between each tier. Where tier 3 hasn't existed, this has put pressure on tier 2 and 4 services.
27	British Thoracic Society (all comments endorsed by the Royal College of Physicians)	Question 1	This draft quality standards does reflect the key areas for quality improvement but it is essential that the co-morbidities to consider are explicit, including sleep disordered breathing and alveolar hypoventilation (obesity hypoventilation) the latter which can lead to respiratory failure.
28	Central Manchester University Hospitals NHS Foundation Trust	Question 1	Yes it reflects the key areas for quality improvement
29	The Chartered Society of Physiotherapy]	Question 1	One of the key areas for quality improvement is to maximise the role of health and social care professionals in Making Every Contact Count. This is covered by the first two quality statements, and we believe this accurately reflects one of the key areas for quality improvement.
30	Medtronic UK	Question 1	Yes, especially in terms of having the necessary conversations with patients as early as possible, psychological assessment, Tier 3 services and follow up. It's still important to understand the role of the GP and what conversations they will be having with the patients prior to referral - - - Information at the identification stage. Definitely an area to improve: good delivery of good quality information. Currently lies largely at the door of the GPs, but implementing some kind of Obesity Management Service (OMS) to act as an 'intake, triage and direct to treatment' for overweight patient with medical issues would be a much more rapid and effective way of dealing with this issue. Assessment again could be improved through an OMS, rather than relying on primary care or initial appointment within secondary care - Tier 3 for sure need addressing due to current geographic inequality - Psych assessment certainly seems important from the patient perspective (this was raised by WLSInfo in the consultation – the UKs foremost bariatric surgery patient group) - Follow up outside of the specialist treatment centre does need looking at, to ensure a better standard of care after discharge. Again this could be dealt far more effectively by an OMS - Outcome auditing for surgery is the only measure I didn't see any mileage in, as this should be covered by the mandatory reporting into the NBSR
31	Obesity Group of the British Dietetic Association	Question 1	As these standards relate to management as well as prevention, we would like the additional statement that all identified tier 3 weight management clients should have timely access to not only psychological assessment but psychological treatment, appropriate to age if there are identified psychological problems. This is likely to have significant cost implications.
32	Public Health England	Question 1	The Quality Standard is likely to represent an accurate reflection of the current areas. However, and acknowledging

ID	Stakeholder	Statement number	Comments[18]
			that it is difficult to predict how have NICE considered the potential impact on the system of the impending commissioning changes around bariatric surgery?
33	Royal College of General Practitioners	Question 1	The document does not accurately reflect the key areas for quality improvement: a. The need for training staff is the most important step because of widespread myths, misconceptions and historically simplistic and sometimes judgmental attitudes to obesity that are still widespread amongst health professionals. Many health professionals recall either scant or no obesity education during their training. Without putting in obesity training first, a big push to raise awareness of obesity may backfire, generating potential upset and resentment in patients plus complaints against health professionals. b. Child obesity statements are inadequate. (RP)
34	The Royal College of Surgeons of England	Question 1	The *NHS Atlas of Variation* shows that obesity prevalence is very varied dependant on geography and there is a direct link with the number of fast food outlets available in the area and volume of obesity. With public health funding now sitting in local council control there is potential for an improved link between commissioning and local councils who are able to address local planning The key areas requiring surgical improvement are access to surgery for those with obesity who have failed non-surgical methods and post bariatric body contouring surgery. At present the availability of this service is very variable and dependant on location. This could potentially get a lot worse when Bariatric surgery (tier 4) commissioning is handed over to CCGs as is planned by NHS England
35	Slimming World	Question 1	This quality standard predominantly highlights secondary care (outpatient appointments) for where BMI and BMI centile will be assessed and health risks discussed. It is vital that these conversations also happen in primary care, please can you confirm where this will be picked up if not within this guidance document?
36	Slimming World	Question 1	This quality standard document implies that training and competencies are outside of the remit of this document. Appropriately and sensitively discussing weight with patients is an area in which the vast majority of health care professionals in primary and secondary care have little or absolutely no training in. Patient outcomes will vary depending on whether these conversations are handled appropriately and therefore identifies a training need for the health care workforce. If it isn't an appropriate statement for a quality standard then please can you confirm where will it be captured to ensure that quality improvement in this key area occurs?
37	Weight Watchers UK	Question 1	In response to consultation questions, please see the following: **Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?** We welcome the approach to make the assessment of weight status an 'opt out' approach as opposed to 'opt in' as there is strong evidence that overweight has become the norm at population level, underestimation of weight is increasing (Johnson, F., Beeken, R. J., Croker, H., & Wardle, J. (2014). Do weight perceptions among obese adults in Great Britain match clinical definitions? Analysis of cross-sectional surveys from 2007 and 2012. *BMJ open*, *4*(11), e005561). Weight underestimation is a real concern and has potential to cause a great deal of harm through

ID	Stakeholder	Statement number	Comments[18]
			underestimation of risk and subsequent failrues to chage behaviours.. Assessing weight status and checking for associated co-morbidities should be standard practice with HCPs following standardised, recommended techniques for assessing weight status. However, we were disappointed to see that once a patient has been identified as overweight or obese, there is no clear pathway of what action to take and where HCP's should refer on to, or what action they should take. The inclusion of the recommendation to refer to an evidence based weight management service (be that tier 2,3 or 4 or indeed a diabetes prevention programme if eligible) should be made.
38	WLSinfo	Question 1	In our opinion yes

Consultation question 2

ID	Stakeholder	Statement number	Comments[19]
39	Bristol Tier 3 Weight Management Service	Question 2	Tier 3 data can be collected and national tier 3 data base is being developed for data collection. Including quality of life and other psychometric measures. Data collection should be mandatory for all UK tier 3 services.
40	British Thoracic Society	Question 2	Data collection should be routine for individuals attending out-patients. It may not be quite so easy to routinely collect this information for inpatients though this is not specifically part of the NICE quality standard which should perhaps be considered.
41	The Chartered Society of Physiotherapy	Question 2	Collecting the proposed quality measures locally would be possible, given that the appropriate systems are in place locally. An audit tool based on these quality standard statements would be useful for localities to adapt as necessary, and make it easier to gather this data.
42	Medtronic UK	Question 2	On balance – Yes. Referring to the specific statements: Statements 1 + 2 : really this is the GPs job, and so this data should be available on their electronic health records (accessed through CPRD as mentioned in pg 13 of the briefing paper) Statement 3 : Current Main issue with data collection is seamless transfer between services, eg tier 2 to tier 3. This

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			would be much easier to track and measure through an OMS type setup Statement 4 : Role of GP/primary care, therefore should be easy to track on their systems Statement 5 + 6 : As in statement 3 Statement 7 : This is generally the current standard and will be measured through NBSR data input Statement 8 : As in statement 3 In terms of assessing the value of OMS, we support this prospoal and could recommend certain NHS trust sites who that would be willing to participate/engage as a 'test bed' for OMS.
43	NHS England	Question 2	Data collection would be easier from primary care visits than from OPD visits
44	Public Health England	Question 2	PHE note that NICE has previously prepared relevant QOF and Clinical Commissioning Group Outcomes Indicator Set (CCG OiS) indicators in relation to these clinical services. The indicators in relation to tier 3 and bariatric surgery would, if operationalised, help to complement and assist with the delivery of quality care and services. Public Health England (PHE) note that tier 3 level approaches and services, in general, could benefit from further support in terms of what is working in practice – PHE is currently commissioning a scoping review of such services to help inform the development of materials to support tier 3 services. PHE is also aware of National Institute for Health Research (NIHR) related research which will explore the empirical evidence base on such multidisciplinary team (MDT) clinical services to support obese patients.
45	Royal College of General Practitioners	Question 2	Seeking mass numerical data-collection will do a disservice to generating patient-focused discussions that build on behaviour change theory. The focus should be on the quality of conversations not box-ticking. Patient satisfaction assessments would probably be more meaningful even if more complex to collect. Bearing in mind the QS aim of 'ensuring that people have a positive experience of care is vital in a high-quality service', the suggested focus on BMI-orientated decision making and lack of mention of psychological support and patient choice risk this document promoting a numerical approach to obesity which, even though measurable, would be a backwards step. (RP)
46	The Royal College of Surgeons of England	Question 2	For some of these quality standards it would be very difficult. Quality 1 and 2 would have to be done through local audit as outpatient coding and coding for BMI is very poor. There is no good data available about the prevalence of obesity in adults in the population for those >40 kg/m² or >50kg/m².The only data that is available is at a LA level (not at CCG or provider level) and defines obesity as weight >30kg/m². therefore there is no ability to obtain the denominator number for quality standard 3,5,6,7 There is some data available about the prevalence of obesity in children, but not at a CCG or provider level: http://www.noo.org.uk/visualisation
47	WLSinfo	Question 2	Yes it would

Consultation question 3

ID	Stakeholder	Statement number	Comments[20]
48	British Thoracic Society	Question 3	There are several examples on how to implement this quality standard and one would include the attached example given by Newcastle sleep service.
49	Public Health England	Question 3	PHE is aware of some long standing approaches to supporting obese patients (adults and children) – the above scoping review aims to work with a handful of such services to drill down into what is working.
50	Royal College of General Practitioners	Question 3	The RCGP Nutrition Group have worked extensively on developing materials to support training for primary care staff, and in encouraging ongoing long-term management of post-bariatric patients in primary care. These materials are freely available and are hosted on the RCGP Nutrition and Obesity pages. http://www.rcgp.org.uk/clinical-and-research/a-to-z-clinical-resources/nutrition/obesity.aspx The RCGP and RCN collaborated on developing a self-directed training programme called the RCGP Introductory Certificate in Obesity, Malnutrition and Health, which is shortly to be submitted for NICE endorsement. The materials (6 online e-learning sessions, interactive workbook and slide set) can be used for cascade training to small groups. (RP)
51	The Royal College of Surgeons of England	Question 3	No comment
52	WLSinfo	Question 3	We are a patient organisation

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Consultation question 4

ID	Stakeholder	Statement number	Comments[21]
53	Bristol Tier 3 Weight Management Service	Questions 1 & 4 & 8	Doesn't reflect the need for tier 3 services to be permanently commissioned and access being equal across the UK. Bristol and Wiltshire tier 3 services have not been permanently commissioned. There are national discrepancies in psychological assessment in pre/postoperative assessment. Good links should be built with tier 2 services, which should be fully supported and well defined with a smooth patient pathway between each tier. Where tier 3 hasn't existed, this has put pressure on tier 2 and 4 services.
54	British Thoracic Society	Question 4	From limited clinic experience there is variation in the quality and the ability to provide psychological assessments prior to bariatric surgery and this reflects the overall limited provision of psychological therapies.
55	Medtronic UK	Question 4	Anecdotally, this would appear to be the case. Some services offer it, some don't. Main issue seems to be that this entails high investment (in terms of HCP cost and time) for this patient pathway, and while a few patients are screened out, some psychologically 'challenging' patients still make it through and prove to consume significant resource as post-op patients.
56	Public Health England	Question 4	PHE is aware, through the PHE Weight Management Services mapping work and the Royal College of Physicians audit of tier 3 services, that variability in the provision of and access to tier 3 services across local areas exists. Whilst, this work did not necessarily assess pre-op psychological assessment it is not unlikely that some variation exists – the supposition being that tier 3 type services could help to support the delivery of such pre-op assessments. PHE is aware that there is a variation in the grade of psychologist post, quality and intensity of input, process of assessment, interventions offered and dedicated service by specialised psychology practitioners with special interest and training in obesity.
57	Royal College of General Practitioners	Question 4	There is a variation in access to pre-op psychological assessment but the evidence base in this area is incomplete with regards to patients with disordered eating and complex emotional problems undergoing bariatric surgery. Some cases of patients have done poorly after bariatric surgery despite psychological assessment because there was no ongoing support after surgery – yet the psychological problems are deeply embedded. Ideally the 2 year bariatric follow up should include ongoing psychological input not just nutritional monitoring, but funding pressures do not encourage this. (RP)
58	Royal College of General Practitioners	Question 4	Provision is limited and at a distance unacceptable to many patients. (JD)
59	The Royal College of	Question 4	No comment

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ID	Stakeholder	Statement number	Comments[21]
	Surgeons of England		
60	Weight Watchers UK	Question 4	**Question 4 Is there currently variation in the provision or quality of pre-operative psychological assessment carried out before bariatric surgery?** There is a great deal of variation and follow up for patients referred for pre-bariatric assessment. This is due to both a lack of psychologists working in bariatrics and huge variation in how assessment is carried out; An audit of psychology posts in bariatric services across England found that some Trusts had no psychology input (British Psychological Society, Psychologists working in obesity management group). A report by the National Confidential Enquiry into Patient Outcome and Death in 2012 called for a 'greater emphasis on psychological assessment and support and this should occur at an earlier stage in the care pathway for obese patients." ("Too Lean a Service." NCEPO, p.9). In addition, despite the number of of well validated measures for assessing suitability for bariatric surgery, anecdotal evidence indicates that these are infrequently used.
61	WLSinfo	Question 4	In our experience psychological pre operative input is patchy at best. Where it exists it doesn't always cover the right issues. Concern needs to be given to concentrating on the groups that need assistance the most. Patients with binge eating, those susceptible to alcohol issues, those with un resolved issues around abuse issues. Improved support needs to be given to those with existing mental health issues.

Draft quality statement 1

ID	Stakeholder	Statement number	Comments[22]
62	British Medical Association	1	Unless any action results from this measurement, having the current BMI or BMI centile calculated on first outpatient appointments is unlikely to achieve a positive outcome.
63	British Obesity and Metabolic Surgery Society (BOMSS)	1	**BOMSS response**. We believe it is realistic for BMI to be calculated at the first outpatient appointment after referral, but our view is that this is also within the remit of primary care, and that all patients could have a BMI documented on the referral by primary care and if not measured in the hospital clinic. We believe that weight is routinely measured for

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			all (general surgery) patients in the out-patient clinics already. Bariatric surgery is commonly performed on patients between the age of 25 – 64 (95% of those in the NBSR report) and >80% are female so these two factors (age particularly) could be incorporated into the quality measure.
64	British Thoracic Society	1	This seems appropriate to collect as discussed above, however this information is not available in hospital episode statistics nor in hospital outpatient activity and therefore would be difficult to formally collate without specific measurement tools being available.
65	The Chartered Society of Physiotherapy	1 / Question 5	We are pleased to see physiotherapy mentioned as one of the key professions that can take a role in measuring BMI at initial outpatient appointments. Whilst we suspect that this would be challenging given the current time restraints in many outpatient appointments, we are confident that this is a standard that we should be aspiring to. Therefore having this mentioned in a quality standard increases the probability of this happening. Given the health implications of being overweight, we agree that this should be a blanket approach during outpatient appointments, rather than just being targeted at specific patient groups. There are a few reasons that influence our stance on this: - The stigma associated with being overweight. Having a blanket protocol where every new patient has their BMI measured decreases the possibility that overweight patients feel they are being targeted. - Clinicians' ability to recognise when somebody is overweight. Research has shown that recognising overweight and obesity is not always accurate without measuring BMI: http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1754.2006.00890.x/abstract?userIsAuthenticated=false&deniedAccessCustomisedMessage= This could lead to some people with borderline overweight BMI not being measured and receiving appropriate advice as a preventative measure - The sheer number of health implications of being overweight makes it difficult to choose patient groups according to condition/comorbidities We are keen to support our members to incorporate the measurement of BMI/ BMI centile into their routine assessment for every new outpatient appointment.
66	NHS England	1	Why is the proposal to measure BMI when people come to hospital OPDs? Why not focussed in primary care? I would suggest BMI is measured once a year or when a patient visits their GP practice whichever is the less frequent
67	Obesity Group of the British Dietetic Association	1 / Rationale	We agree that opportunistic opportunities should be taken to measure and record BMI/centiles and secondary care appointments represent a pragmatic opportunity. However the role of primary care practitioners is also critical and they have more frequent appointments and more opportunities to discuss weight-related risks with their patients.
68	Obesity Group of the British Dietetic Association	1	What the QS means for service providers: We have some concerns that the wording 'whenever possible' will represent a 'get out' clause which may mean that this standard is not put into practice at all.
69	Obesity Group of the	1	What the QS means for healthcare professionals:

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	British Dietetic Association		It is not clear who would carry out the measurements as part of 'pre-assessment'. It is critical that if BMI/centiles are recorded that they are based on actual measurements and therefore should not be based on self-reported weight and/or height, since evidence suggests that this will result in an underestimation particularly in those who are overweight or obese. We would like to see waist circumference included as part of pre-assessment.
70	Obesity Group of the British Dietetic Association	1	There are substantial resource implications for putting this standard into practice. BMI is only as good as the measurements of weight and height so staff training in the measurements and recording, as well as calculation of BMI centiles where appropriate will be needed. Appropriate equipment including Class III scales for children will be required, as well a stadiometer, private space for the measurements to be carried out. Staff training in how to bring up the issue of weight and take measurements in an empathetic and non-judgemental way will also be required. In addition staff will need knowledge of local care pathways, referral systems and services will be needed. In our view dietitians with a weight management specialty would be ideally suited to deliver this training. Appointment times may need to be modified to include measurements.
71	Public Health England	1 and question 5	It is possible to collect body mass index (BMI) data and whilst the recommendation asks for the availability of equipment to do this - it should also state that this equipment should be calibrated. It would also be useful to provide standardised training, guidance and also consider a level playing field for interventions offered.
72	Royal College of General Practitioners	1	Training requirements – re QS1 In view of repeated findings of poor uptake of obesity training by generalist staff and lack of clarity as to what components should be covered, it would be of great value if the first quality statement could clarify the requirement for staff to attend structured weight management training before engaging in obesity work and that appendix material could set out the basic components that non-specialist obesity training should cover. Although there is, as yet, no standardised curriculum for obesity training, the fundamentals of obesity training for non-specialist primary care staff advising about obesity are listed here. Support materials to facilitate these points are also required as they are not widely available at present. 1. Raising the topic of weight in a sensitive way. 2. Understanding nutritional facts, metabolic nature of adipose tissue and brief intervention concepts that can be used in a short consultation. 3. Understanding how eating/activity behaviours develop in order that they may be influenced. 4. Tuition in using motivational interviewing techniques that can promote long term behaviour change. 5. Guidance on goal setting to ensure patient-directed goals are realistic, e.g. SMART. Furthermore, bearing in mind the incidence of weight problems amongst health workers themselves, training should address concerns that overweight health workers might have in being asked to discuss a problem that they struggle with personally. RCGP Nutrition Group in conjunction with RCN have produced course material that would support this type of training. See http://www.rcgp.org.uk/clinical-and-research/clinical-resources/nutrition.aspx for free access to the

ID	Stakeholder	Statement number	Comments[22]
			course materials and further information. (RP)
73	Royal College of General Practitioners	1	QS1 p.7 Whilst normalising measuring weight within routine clinical care is to be encouraged, this QS runs the risk of box-ticking overriding the quality of the conversation with the patient. Routine questioning/measuring risks adding to stereotypical fears by many obese patients that they will be judged by their appearance and their access to healthcare potentially rationed according to their BMI. (ref - *Why there's no point telling me to lose weight*. BMJ 2015; 350 doi: http://dx.doi.org/10.1136/bmj.g6845 (Published 20 January 2015) Cite this as: BMJ 2015;350:g6845) In order to avoid this, the QS should flag up the importance of the 'opening sentence' and voluntary engagement to ensure a positive platform for discussion is set up. This requires training. An alternative and measurable QS would be "to 'offer/invite' to undertake BMI measurement." This would encourage the health professional to consider that the patient may already be watching their weight, might already be in the process of losing weight or may feel that weight is not a pressing health concern right now for any number of competing reasons. The offer to measure BMI should be pitched within an offer to explore an array of lifestyle-related health risks such as physical activity, alcohol intake, smoking, drug use and weight concerns. (RP)
74	Royal College of General Practitioners	1	QS1 – BMI Centile There are specific practical barriers to recommending widespread use of BMI centile, which are currently being discussed with PHE, RCGP and RCPCH. At present hospital and primary care IT systems are not able to record this data electronically, read coding for z-score is not possible on most GP IT systems and recording a child's growth measurements over time to track progress is not possible. There is no interlinking at present between NCMP data and primary or secondary care records. Primary care do not any longer routinely use paper growth charts (although this is possible). The plotting, interpretation and use of interpreting BMI z-score has not been part of typical medical training (other than for those clinicians that might have done paediatric attachments,) and so this QS would require widespread availability of and incentivisation to partake in specific training to understand growth data recording and management of child obesity. But resolving the data recording problem would be essential before effective training could be rolled out. (RP)
75	Royal College of Paediatrics and Child Health	1	The statement says 'people'. Suggest clarify to ensure this includes children e.g. say 'children and adults'. There is a danger that 'people' will be interpreted to only mean adults. We would argue this should also apply to primary and community care. To restrict this to hospital services is to miss the great majority of opportunities to influence the BMI of children. Re measure: There should be electronic systems in place in all hospitals to record measured BMI and calculate BMI

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			centile. Paper-based systems are inaccurate for centile measurement. Re question for consultation: All children seen in hospital outpatients are routinely weighted and heighted, relatively accurately. Thus obtaining the raw data for BMI calculation does not require a new collection of data. However, the translation of this into BMI and calculation of centiles requires two steps – these would be made possible only by the widespread adoption of electronic growth charts that automate this process. These are easily available and increasingly adopted by hospitals – their use should be part of this standard. Children and adolescents <18 years should be a priority group for this statement.
76	Royal College of Paediatrics and Child Health	1	Calculating BMI at the first hospital appointment especially for all children and young people may not realistic. Unfortunately even the overweight children have not had their BMI checked or centiles plotted. This is mainly being calculated by physicians (doctors) in our current practice. It is well established BMI is only a proxy indicator of body fatness; factors such as muscle mass, ethnic origin and puberty can alter the relationship between BMI and body fatness. Should we look at other factors especially in children?
77	Royal College of Paediatrics and Child Health	1	Should the BMI in adults be measured at point of referral i.e. in primary care, where initial advice & interventions should take place? BMI in children should be measured at first OPA in secondary care.
78	The Royal College of Surgeons of England	1	This will only capture a small percentage of the population as most patients with obesity are managed in primary care. Does this represent all referrals to outpatients, whether obesity related or not? E.g. are you expecting a patient in an eye clinic to have BMI and discussion about obesity?
79	Slimming World	1	While it's important that an accurate and up to date BMI or BMI centile is calculated for each patient, it is important to bear in mind that it is possible that this will also have recently been done in primary care. We feel it's essential that it is explained to patients why these measures are being taken.
80	Tees Esk and Wear Valleys NHS Foundation Trust	1	This seems like a very good idea. Would it include both physical and mental health initial outpatient appointments?
81	Tissue Viability Society	1	We do not think it is realistic that all patients attending outpatient appointments after referral will have their BMI calculated. It may be appropriate for this to happen within some specialist areas, but generalising it may result in it becoming just a tick box exercise. We think it would be more effective for general practice to lead on this.
82	The University of Nottingham	1	We would like to bring to your attention that we feel the rationale for quality standards 1 and 2 are selective in that they imply that people (1) do not know that their BMI is such that they can be classified as overweight or obese, and

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			(2) do not know of the health risks but provision of such information would motivate behaviour change. The data used to support the assumption for quality standard 1 is that the overall population increase in the prevalence of obesity has normalised higher weights, and indeed there are many studies demonstrating that adults (and parents) underestimate their (or their children's) weight and weight classification. The phenomena of normalisation might well be at work but it is also very important to consider exactly what these studies are measuring, and the context in which the research is taking place. In a society that has a significant pro-thin bias and substantial anti-fat attitudes, we should reflect on how likely is it that higher weight people do not consider their worth with reference to their body shape in the same way as others. Body shape is a highly visible physical attribute and research has demonstrated that children as young 5 years of age make judgment of figures on the basis of their size. Furthermore the terminology of obesity and – to a lesser extent – overweight is not only medicalised but also highly value-laden. Previous research has demonstrated that higher weight people can react emotionally to, and reject, these terms. So when studies ask participants if they consider themselves (or their children) to be overweight or obese, it is surely feasible that participants might be cognisant of their higher weight status but avoid applying these highly emotive categorisations to themselves or their loved ones. It, therefore, suggests to us that a person should be offered the opportunity to have their weight and height measured along with a rationale for why this activity is beneficial to them.

Consultation question 5

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83	Adult Specialist Weight Management Service (University Hospitals Bristol NHS Foundation Trust)	5	**Response to question:** Yes, it could be realistic for height, weight and BMI to be calculated within a short appointment. If there are time restraints, could patients be encouraged to take their own measurements themselves in the waiting area?

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84	Bristol Tier 3 Weight Management Service	1 / Question 5	Weight appropriate scales are not always available in outpatient settings. As well as a private room for weighing patient who may be sensitive about their weight.
85	British Thoracic Society	Question 5	Yes, all patients should have their BMI calculate when they attend clinic. Most patients are routinely weighed and height would need to be collected only once and of course for many individuals who attend from a respiratory service they will have some basic pulmonary function tests which include height and weight and therefore there is the possibility of this information being provided to clinics by pulmonary function laboratories where it is routinely measured and calculated. One BMI measurement should be made at least on an annual basis. It is difficult if you start to select different patient groups as some may, or may not, fall in these groups. It should be a "blanket" assessment. This is especially so given the impact that obesity has on healthcare resources.
86	Central Manchester University Hospitals NHS Foundation Trust	Question 5	Outpatient appointments are a useful opportunity to discuss BMI however we should not rely on outpatient appointments to raise awareness of BMI at an individual level. Developmental check points should be timetabled into a child's development and a child's BMI should be checked annually until aged 11 years old in the first instance or beyond if an issue is identified. Adult BMI could potentially be calculated annually by General Practice teams prior to Outpatient referrals.
87	The Chartered Society of Physiotherapy	1 / Question 5	We are pleased to see physiotherapy mentioned as one of the key professions that can take a role in measuring BMI at initial outpatient appointments. Whilst we suspect that this would be challenging given the current time restraints in many outpatient appointments, we are confident that this is a standard that we should be aspiring to. Therefore having this mentioned in a quality standard increases the probability of this happening. Given the health implications of being overweight, we agree that this should be a blanket approach during outpatient appointments, rather than just being targeted at specific patient groups. There are a few reasons that influence our stance on this: - The stigma associated with being overweight. Having a blanket protocol where every new patient has their BMI measured decreases the possibility that overweight patients feel they are being targeted. - Clinicians' ability to recognise when somebody is overweight. Research has shown that recognising overweight and obesity is not always accurate without measuring BMI: http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1754.2006.00890.x/abstract?userIsAuthenticated=false&deniedAccessCustomisedMessage= This could lead to some people with borderline overweight BMI not being measured and receiving appropriate advice as a preventative measure - The sheer number of health implications of being overweight makes it difficult to choose patient groups according to condition/comorbidities We are keen to support our members to incorporate the measurement of BMI/ BMI centile into their routine assessment for every new outpatient appointment.
88	Medtronic UK	Question 5	Effectively, as first line recommendation as part per QoF measure, this should be performed by primary care/GPs Once logged onto a database, BMI details of all obese patients, will then be available for secondary care. To

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			reinforce this and make the information up to date it would be better to mandate that any referral into secondary or tertiary care should have up to date height and weight measurements. Arguably the most relevant therapy areas for this (linking weight to the disease state) would be diabetology, cardiology, orthopaedics, respiratory physicians Once again, an OMS setup could carry out all this triage type activity, identify the best treatment for that patient, then prepare the patient and either deliver the treatment in house or onward refer.
89	NHS England	Question 5	I would propose that BMI is sent from primary care to secondary care as a routine part of the electronic referral process. This is particularly relevant for surgery, diabetes, CVD, respiratory disease, MSK, but arguably should be included for all. As above I would focus the measurement in primary not secondary care
90	Obesity Group of the British Dietetic Association	1 / Question 5	If specific groups were to be prioritised then these should relate to outpatient services related to weight-related co-morbidities such as rheumatology, endocrinology, cardiology, specialist sleep clinics, fertility clinics, mental health clinics, orthopaedics and diabetes services. For weight-related cancers the appointment may be the first post-treatment appointment.
91	Public Health England	1 / Question 5	It is possible to collect body mass index (BMI) data and whilst the recommendation asks for the availability of equipment to do this - it should also state that this equipment should be calibrated. It would also be useful to provide standardised training, guidance and also consider a level playing field for interventions offered.
92	Royal College of General Practitioners	Question 5	It is neither realistic nor necessary for BMI to be calculated at all first outpatient appts. Instead it would be realistic and valuable for each appt to include an invitation to be weighed or to discuss weight concerns. It may have already been done or the time may not be right to thrust this issue at the patient. Re children, as for BMI centile, the points re QS4 above outline why there is essential groundwork to be done re training and resolving IT data recording problems before being able to recommend all health professionals start measuring child BMI centile. By extending an invitation to engage, (e.g “would it be useful to you to be measured or to discuss your weight today?”) ths will highlight those people that wish to have suppiort in that particular setting and distinguish others that don’t wish to engage at that point or in that setting for whatever reason. Priority groups would include patients that would benefit from understanding how weight influences operative risk, or who would benefit from getting healthier before expected surgery or where weight has a direct impact upon the presenting condition (eg DM, asthma, arthritis, sleep apnoea, fertility/PCOS). (RP)
93	Royal College of General Practitioners	Question 5	Current resourcing means that many first outpatient appointments are unable to meet the original remit of the appointment and communicate that back to primary care in an appropriate manner. It would appear unlikely that they could take on further issues and have what are likely to be challenging and sensitive discussions regarding obesity in the same time frame. In terms of key target groups, those attending with diabetes ,heart disease and osteoarthritis would appear to be key target groups initially. (JD)
94	Royal College of	Question 5	The statement says ‘people’. Suggest clarify to ensure this includes children e.g. say ‘children and adults’. There is a

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	Paediatrics and Child Health		danger that 'people' will be interpreted to only mean adults. We would argue this should also apply to primary and community care. To restrict this to hospital services is to miss the great majority of opportunities to influence the BMI of children. Re measure: There should be electronic systems in place in all hospitals to record measured BMI and calculate BMI centile. Paper-based systems are inaccurate for centile measurement. Re question for consultation: All children seen in hospital outpatients are routinely weighted and heighted, relatively accurately. Thus obtaining the raw data for BMI calculation does not require a new collection of data. However, the translation of this into BMI and calculation of centiles requires two steps – these would be made possible only by the widespread adoption of electronic growth charts that automate this process. These are easily available and increasingly adopted by hospitals – their use should be part of this standard. Children and adolescents <18 years should be a priority group for this statement.
95	The Royal College of Surgeons of England	Question 5	Yes this is probably appropriate
96	Tees Esk and Wear Valleys NHS Foundation Trust	Question 5	Patients with a severe mental illness must be considered as a high priority group. These individuals often do not access mainstream physical health services. A mention in this guidance would reinforce the messages in the NICE (2014) psychosis and schizophrenia guidelines.
97	Weight Watchers UK	Question 5	**Question 5 For draft statement 1: Is it realistic for BMI or BMI centile to be calculated at all first outpatient appointments after referral? If not, are there priority patient groups, hospital departments or types of outpatient appointment that this statement should focus on?** We believe BMI should be calculated for all upon contact with HCPs. HCPs relying on personal judgement before deciding to assess weight status is likely to be problematic. Assessing weight status and checking for associated co-morbidities should be standard practice with HCPs following standardised, recommended techniques for assessing weight status. However, we would also like to see the appropriate use of obesity pathways at this point. Once a patient has been identified as overweight or obese, HCP's should have a clear pathway of what action to take and where to refer on. A lack of shared knowledge of local services and care pathways that are not joined up increase inequalities. Patients should receive the very best evidence based services across the board. At the very least we recommend 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 specifically. 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.

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			This position is supported by a report published by Public Health England in December 2015, mapping tier 2 and tier 3 services in England. Only 61% of Local Authorities had any tier 2 service, and only 2/3 of these were as recommended by NICE. The measurement of BMI in secondary and primary care adds continuing support to the argument that responsibility for the funding for tier 2 weight management services should be moved to the NHS, as is happening with Public Health England's Diabetes Prevention Programme Although Weight Watchers welcomes the opportunity to make every contact count in the assessment of overweight/obesity, we do have continuing concerns about the extremely inconsistent provision of tier 2 and tier 3 weight management services across the country. In addition to this challenge, there are a number of other barriers to the across board introduction of BMI monitoring in outpatients, including resources, HCP training, time constraints, HCP's own weight status and inconsistent availability of local services to signpost to. Therefore, we would suggest that in the short to medium term the measurement of BMI in secondary care is limited to conditions where there is the most obvious and direct link between health risk and obesity, particularly cancer screening (e.g. breast and colorectal), where the risk is high but public knowledge of this association is less well known. We are assuming that there is already extensive BMI monitoring in other outpatients settings with a clear obesity risk such as cardiology and diabetes where the connection is more clearly established. Indeed, these outpatient settings will no doubt be able to provide some clear models on how to take forward BMI monitoring in secondary care. In raising the issue of weight in secondary care it would be very helpful to provide healthcare professionals who are likely to have limited experience and training in discussing weight, with some clear guidance on how to do so. For example, within smoking cessation the National Centre for Smoking Cessation has developed the Very Brief Advice model for GP's which enables a brief, structured, evidence based approach to be taken, thereby reducing GP burden.
98	WLSinfo	Question 5	Yes it is it, its is not just the measurement, but where and how it takes place and the training of of the staff carrying out the task.

Draft quality statement 2

ID	Stakeholder	Statement number	Comments[24]
99	British Medical Association	2	Unless there is staff available in outpatient departments with the knowledge, expertise, and time to do this work, this is likely to become a tick-box exercise with no useful outcomes. Distracting staff from other activities is a real risk. Resources for this work should be concentrated in clinics that deal with the complications of obesity, where management of the obesity will improve the condition under review.
100	British Obesity and Metabolic Surgery Society (BOMSS)	2	**BOMSS response**. Whilst this would be ideal we accept that there is very limited time in outpatients, of unrelated specialist, to address this complex issue in addition to the referral problem. BOMSS feels that where a clinic measured BMI falls within NICE guidelines for consideration of, or first line, bariatric surgery that this should be highlighted to primary care in the clinic letter, so that proper time can be given over to the none-judgemental discussions needed.
101	British Thoracic Society		The BMI can be discussed in secondary care and it is appropriate for this discussion to take place however if the patient is attending for another reason and a high BMI is noted it is not always easy from a time perspective to have a detailed discussion about management of obesity and nor is perhaps the clinician skilled in such a conversation. Surely such conversations should be between the patient and primary care unless there are specific secondary care issues.
102	The Chartered Society of Physiotherapy	2 / Question 6	We agree that if somebody is identified as having an increased BMI, a discussion about the health risks associated with this should happen at the appointment. However, it should be left to the clinician's discretion as to when this conversation takes place (e.g. in subsequent appointments rather than straight away).
103	College Of Occupational Therapists	2	"People identified as being overweight or obese, or at health risk due to their weight, at an outpatient appointment have a discussion during the appointment about their BMI and the likely resulting health problems." For many people they are already aware of the issues which they may face due to being overweight. Simply having a discussion about the potential health problems may not result in lifestyle changes and could potentially negatively affect the relationship the person has with the health professional. Working with the person to establish realistic opportunities to change aspects of their life which affect their weight may be a better use of time and resources.
104	NHS England	2	The discussion during the consultation, whether in secondary or primary care, if its not the main reason for the

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			consultation will be difficult to fit into the time available. Would need to be simply very brief advice and signposting
105	Obesity Group of the British Dietetic Association	2	Statement and rationale We agree with this QS in principle, and that every possible opportunity to highlight risk is taken. In particular if the outpatient appointment relates to a weight related co-morbidity, it is possible that patients who understand the links between excess weight and their co-morbidity may be more motivated to tackle their weight. The links between excess weight and risks of specific co-morbidities must be made clear to patients.
106	Obesity Group of the British Dietetic Association	2	Statement and rationale However there is a risk that by taking every opportunity to highlight the risks of excess weight, that some patients will find this off-putting and irrelevant, and may become less rather than more motivated to tackle their weight. We have some concerns that this may be an unintended potential consequence of this QS. In our view it would be ideal if healthcare professionals involved in patient care check that patients understand the health risks; however this will require adequate staff training at all levels to explain the health risks if patient understanding is poor.
107	Obesity Group of the British Dietetic Association	2	What the QS means for service providers We agree that specific population subgroups may have greater risk health risks at lower BMI and that healthcare professionals need to take this possibility into account.
108	Obesity Group of the British Dietetic Association	2	We have concerns about implications for increased resources as a result of putting this QS into practice, although we feel that the additional costs will be required in the short term may be mitigated against by a reduction in ill-health in the longer term as a result of implementation
109	Obesity Group of the British Dietetic Association	2	Resource implications include additional appointment times, staff training & knowledge in particular of the links between weight and specific conditions, understanding of BMI and centile cut-off points and how to discuss these with patients, understanding of the type of language which is likely to encourage discussion, how to raise the issue of weight appropriately, a non-judgmental approach, where and how to refer appropriately and local service provision. In our view staff training, particularly in relation to communication skills, needs to occur at all levels of expertise and experience so that regardless of the seniority of the healthcare professional checking patient understanding, the patient experience will be non-judgemental and helpful. Such training ideally should require practical demonstration of communication skills and is likely to involve a significant cost.
110	Public Health England	2 / Question 6	Raising the issue early and at an opportune moment is vital. However, would appropriate Healthy Child Programme (HCP) have had or have access to appropriate support through standardised training? PHE is aware that health professionals have raised 'raising the issue' as an area for further support. Also, if raising the issue of health problems then HCP's should also be in a position to offer advice and support.
111	Public Health England	2 / Question 7	Comments as for question 6 are relevant here and vice versa. If HCP are assessing and raising the issue of weight and related health problems at this contact point then surely the patient will wish/expect advice and appropriate information on the care and support they can expect to receive or be referred into? Will the relevant HCP have the support and information at hand to do this? Such considerations might in fact help to scope out the nature of relevant

ID	Stakeholder	Statement number	Comments[24]
			outpatient appointments and or groups where such a discussion can take place.
112	Royal College of General Practitioners	2	Content of the suggested 'discussion' As the potential issues that could be discussed are so wide, obesity training should encourage the discussion at a health-care appointment to relate to the context that the patient is attending about – eg discussion about how obesity may affect anaesthetic risk, impact of how increased fitness or nutrition may alter pain control or management of a long-term condition. Although this suggestion may appear less focused on long term weight loss, it is more likely to produce relevant patient-focused health improvement and make use of targeted brief-intervention opportunities, bearing in mind that achieving long-term weight loss requires ongoing multi-disciplinary support. Telling more and more health professionals to quickly lecture patients about 'needing to lose some weight' will be a disaster. It would be a missed opportunity if Quality Statement 2 remained as non-specific as currently worded, as it might risk staff issuing superficial, shallow information which for someone with longstanding obesity, may appear alienating or irrelevant rather than useful. (RP)
113	Royal College of General Practitioners	2 / Question 1	The following statements (p13) negative approach risks repeatedly emphasising additional harm to people who may already have very low self-esteem and a strong sense of guilt about their own failures. Fear is well-known to be a poor motivator. People with obesity may have several co-morbidities, which would trigger repeated warnings – but with no mention of what can be done about the risk. The wording should encourage health professionals to convey optimism and support in generating self-efficacy, not doom, gloom and pressure. (RP)
114	Royal College of Paediatrics and Child Health	2	Discussion about BMI in adults is more appropriate in primary care prior to attendance at secondary care. The social determinants of obesity including historical abuse and mental health issues are better addressed in primary care. BMI in children should be discussed at first OPA in secondary care.
115	Royal College of Paediatrics and Child Health	2	We support this statement. For children and young people (CYP) there will be training issues for practitioners to give this feedback in a motivational and child-friendly way. Again we suggest the term people be replaced by CYP and adults. Re question for consultation: we believe it is realistic to have these discussions in the first outpatient appointment for CYP, provided training is provided.
116	Royal College of Paediatrics and Child Health	2	Assessment to include identification of syndromes - Use of HEADDS tool- http://www2.aap.org/pubserv/psvpreview/pages/files/headss.pdf
117	Royal College of	2	Discussion about BMI/overweight/obesity needs time and it's not always possible to do this at all outpatient

ID	Stakeholder	Statement number	Comments[24]
	Paediatrics and Child Health		appointments. This could be focussed on children and young people whose weight is above the 91st centile.
118	The Royal College of Surgeons of England	2	If they are attending outpatients for an unrelated reason this may not always be appropriate
119	Slimming World	2	Again it is vital that consideration is given to the fact that patients may have also had a recent conversation with a healthcare professional in primary or secondary care along these lines. It is important that this is broached in a sensitive manner, that no assumptions are made and that a fuller weight history is established. It could be that an adult patient is presenting at the appointment with a BMI of 31kg/m2 but a year ago their BMI was 36kg/m2. It is important not to make assumptions, find out the history, how the patient feels about their weight, what they already know of the risks and importantly if they have already started to make changes1. If not we risk people feeling told off, blamed and frustrated that they are hearing the same messages when they have already started to make some positive changes, which really should be praised. It is also important to consider what happens after this conversation, it is vital that when this is identified and discussed with patients that, if appropriate, they are offered support through a local care pathway. We feel that training for health care professionals is key to ensuring that these conversations are handled appropriately and do not have a detrimental impact on patients and their outcomes2. 1. Percival, J. 2015. Nursing in practice (87) 2. Jackson et al, 2014. Obesity. Dx.doi.org/10.1002/oby.20891
120	Tees Esk and Wear Valleys NHS Foundation Trust	2	Would staff be given a guide on what to say to the patient? Emphasis needs to be placed on the fact that BMI classifications are based on levels of health risk. They can often be misinterpreted as judgement statements and this risk would be greater if the person initiating the discussion lacked understanding in this area.
121	Tissue Viability Society	2	Realistically, we don't think this would/ could happen within routine OPAs. Firstly, it may not be relevant to the referral speciality and secondly, you would need to ensure that staff had the time and expertise to offer advice about weight loss etc. Again, this may be appropriate to some clinical areas, particularly if weight loss is required before a clinical intervention is possible. Discussions on BMI and health risks should predominantly come from general practice.
122	The University of Nottingham	2	We would like to bring to your attention that we feel the rationale for quality standards 1 and 2 are selective in that they imply that people (1) do not know that their BMI is such that they can be classified as overweight or obese, and (2) do not know of the health risks but provision of such information would motivate behaviour change. The data used to support the assumption for quality standard 1 is that the overall population increase in the prevalence of obesity has normalised higher weights, and indeed there are many studies demonstrating that adults (and parents) underestimate their (or their children's) weight and weight classification. The phenomena of normalisation might well be at work but it is also very important to consider exactly what these studies are measuring, and the context in which the research is taking place. In a society that has a significant pro-thin bias and substantial

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			anti-fat attitudes, we should reflect on how likely is it that higher weight people do not consider their worth with reference to their body shape in the same way as others. Body shape is a highly visible physical attribute and research has demonstrated that children as young 5 years of age make judgment of figures on the basis of their size. Furthermore the terminology of obesity and – to a lesser extent – overweight is not only medicalised but also highly value-laden. Previous research has demonstrated that higher weight people can react emotionally to, and reject, these terms. So when studies ask participants if they consider themselves (or their children) to be overweight or obese, it is surely feasible that participants might be cognisant of their higher weight status but avoid applying these highly emotive categorisations to themselves or their loved ones. It, therefore, suggests to us that a person should be offered the opportunity to have their weight and height measured along with a rationale for why this activity is beneficial to them.
123	The University of Nottingham	2	In addition, the quality statements make a leap between BMI in QS1 and weight categorisation in QS2. The process of categorising BMI (according the WHO recommendations) in-effect problematizes a person's BMI and the rationale in statement 2 states that it is important that people are aware of this problematization. We would, therefore, suggest that it is imperative that the person understands what BMI means and how it will be used for – i.e. categorising them based on population risk. Furthermore, Statement 2 provides a slim rationale for communicating risk information, merely suggesting that it is "important." While many people might not be able to enter a discussion on the physiological mechanisms and health consequences of excess adiposity, the media rhetoric makes it hard to believe that most people in the UK do not believe that overweight and obesity are harmful to health. It would, of course, be highly offensive to suggest that higher weight people have somehow not got the message that everyone else has. We do, however, concede that there is an ethical argument for the importance of checking that people have accurate information on their health to ensure informed choice, and providing more information if they wish to have it. Previous research has demonstrated that higher weight people value honesty in their interactions with healthcare professionals around their weight, and so accurate personalised information is essential. We also believe that it is essential to be explicit as to the role of this risk information. Is it to solely there to allow informed choice, or is it also to motivate behaviour change? The emphasis on using "…every possible opportunity to ensure that people understand the risks…" suggest that it is has some behaviour change function. Health promotion has a long history of utilising highly emotive, fear-appeals to personalise risk (perceived susceptibility in psychological terms) and perceived severity of the health consequences of not following health recommendations. The theory being that if you give a person a really convincing reason to change his/her behaviour, then the positives outweigh the negatives (Expectancy Value Theory) and she/he will change behaviour – if she/he is rationale. However, research demonstrates that people do not always react rationally, particularly in highly emotional states and when they have

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			low self-efficacy for behaviour change. Indeed, research takes us further and shows us how fear and negative emotions can lead to learned helplessness and disengagement with healthy behaviours - a de-motivational effect. We, therefore, suggest that it is vital that these quality standards spells out that a healthcare professional should check first the individual's perception of risk before correcting any inaccuracies, avoids scare-mongering, and balances risk with positive information that allows him/her to be motivated and builds on self-efficacy for behaviour change.

Consultation question 6

ID	Stakeholder	Statement number	Comments[25]
124	Adult Specialist Weight Management Service (University Hospitals Bristol NHS Foundation Trust)	Question 6	**Response to question:** Patients may not be ready to hear the risks of overweight/obesity if they have attended a consultation to discuss another matter. Staff should be well trained in order to sensitively raise the issue of weight with a patient as deemed appropriate.
125	British Thoracic Society	Questions 6 and 7	A brief intervention should be considered (along the lines of smoking) when individuals are seen in clinic with regards to their weight although a more formal and detailed discussion is often difficult to schedule into clinics. The question perhaps of a greater importance is who should take "ownership" of managing the obesity issue. Individuals will turn up to a variety of clinics, including respiratory. Is it the responsibility of the clinic to undertake a brief intervention and refer this back to the general practitioner who should "hold the ring" on managing the issue of obesity and onward referral. Again if there are priority groups this will get confusing though in some specific clinics time should be perhaps built into the appointment to allow for the conversation around weight related issues and nutrition in general.
126	Central Manchester University Hospitals NHS Foundation Trust	Question 6	Yes if it is an integral part of the patient's care in relation to the Outpatient Appointment - however the conversation must be led by a health professional trained specifically in the complexities of obesity.
127	The Chartered Society of	2 and	We agree that if somebody is identified as having an increased BMI, a discussion about the health risks associated

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	Physiotherapy	Question 6	with this should happen at the appointment. However, it should be left to the clinician's discretion as to when this conversation takes place (e.g. in subsequent appointments rather than straight away).
128	Medtronic UK	Question 6	Important query – to ascertain why has the patient was referred in the first instance? a) If the patient has been referred knowing that it is due to obesity or an obesity related comorbidity then this would be a lot easier to achieve. From our experience HCPs may not have the knowledge, understanding or confidence in handling these conversations and may require training in how to approach such an emotive topic. It would also depend how long the appointment is as to whether this is achievable. With the relevant training and adequate time allowance this could be achievable. b) If the patient has been referred for a non-obesity related condition but has been identified as being overweight/obese during this outpatient appointment then this will require a slightly different management style. If the HCP involved, is sufficiently confident to manage (appropriate training) or, if not, to refer on to a colleague with such training on how to appropriately engage/question the patient.
129	Obesity Group of the British Dietetic Association	Question 6	For such conversations to take place and to be meaningful in practice, it is likely that appointment times will need to be restructured and lengthened and this has implications both for costs and for waiting times. New patient appointment times tend to be longer than follow up appointments, so pragmatically as well as clinically it makes sense to focus upon first appointments, however this should be at the discretion of the clinician.
130	NHS England	Question 6	See my comment for QS2 above.
131	Public Health England	2 and consultation question 6	Raising the issue early and at an opportune moment is vital. However, would appropriate Healthy Child Programme (HCP) have had or have access to appropriate support through standardised training? PHE is aware that health professionals have raised 'raising the issue' as an area for further support. Also, if raising the issue of health problems then HCP's should also be in a position to offer advice and support.
132	Royal College of General Practitioners	Question 6	Specific discussions should be targeted to be relevant to the particular care setting/ patient presentation – in which case it should happen in secondary care/OPA. Generic obesity management however, requires ongoing support so would not be appropriate in an OPA. Any mention of weight problems in any setting should be accompanied by appropriate signposting to further help or services and not just focus on the increased risks from obesity. Staff would need training to know what these options included and how patients could access help. As obesity is a chronic relapsing condition, staff should also recognise that they may have a valuable role in helping patients re-engage over time with first-line community /tier 2 services – it is often not the service that failed, but failure to keep attending. (RP)
133	Royal College of General Practitioners	Question 6	This discussion about likely resulting health problems should take place at the outpatient appointment, but current resourcing does not allow the time for this, nor are many secondary care clinicians trained in this area. (JD)
134	Slimming World	Question 6	We feel this should be discussed at the outpatient appointment, if it is not addressed at the time then it could be questioned as to why their BMI is even being measured. It is vital though that this conversation is handled sensitively

ID	Stakeholder	Statement number	Comments[25]
			and that health professionals have the relevant and necessary training. Please see comment below in relation to quality statement 2 for further details.
135	The Royal College of Surgeons of England	Question 6	This may not be appropriate, depending on the reason for outpatient referral and expertise of the clinician. Would this not be more appropriate in primary care?
136	Tees Esk and Wear Valleys NHS Foundation Trust	Question 6	As per comment for statement 2.
137	Weight Watchers UK	Questions 6 and 7	**Question 6 For draft statement 2: Should this discussion about likely resulting health problems take place at the outpatient appointment?** **Question 7 For draft statement 2: Is it realistic to have a discussion about BMI and health risks at all outpatient appointments? If not, are there priority patient groups, hospital departments or types of outpatient appointment that this statement should focus on?** We agree that a discussion should take place upon contact with a HCP however we would also like to recommend that as well as the health implications being discussed, signposting to the local weight management treatment pathway is offered. A discussion of the health risks associated with one's BMI without the resultant discussion about how to tackle it is disjointed, and potentially highly detrimental to the patient as they will not be provided with advice on how to take action to change their behaviours. The publication of care pathways as part of a quality standard would enable health professionals to signpost effectively to local services. It would also ensure public accountability for engagement in their own health and services, ultimately improving equality of access for people. Engaging 'hard to reach' overweight/obese families, particularly those from the most deprived communities is challenging. Numerous reports have identified primary care as the key NHS setting for screening, management and prevention of obesity in families (National Audit Office, 2001, Royal College of Physicians, 2013, Academy of Medical Royal Colleges, 2013). On an individual basis 90% of NHS contact is with primary care. Signposting and referrals from primary care is essential. It is becoming increasingly prevalent, but not yet best practice, to enable self-referrals into tier 2 services. Self-referrals can be screened by providers to ensure eligibility under locally agreed terms and to control volumes where needed, but vastly facilitates engagement and uptake from service users and minimises burden on NHS and Local Authorities. Promoting and enabling self-referral pathways has the potential to improve access and ultimately the quality of care received by the service user.
138	WLSinfo	Question 6	As a patient based charity we agree with this but feel training in how to raise the issue of weight and health is most

ID	Stakeholder	Statement number	Comments[25]
			important. Our members experience shows this is still a real issue.

Consultation question 7

ID	Stakeholder	Statement number	Comments[26]
139	Adult Specialist Weight Management Service (University Hospitals Bristol NHS Foundation Trust)	Question 7	**Response to question:** There may not always be enough time in consultations to discuss lifestyle advice for weight management. Patients could be sign posted to literature or a health care professional who has more time/knowledge to discuss the risks and possible treatment options. Information could be shared on available support services (e.g. specialist weight management services), not solely 'voluntary organisations and support groups'.
140	Bristol Tier 3 Weight Management Service	Question 7	Health care professionals should be appropriately trained on discussing weight with patients. When it comes to assessing the appropriateness of discussing BMI and Weight management issues would it might make sense to restrict this to areas of consultation directly impacted by BMI if time is an issue.
141	British Thoracic Society	Questions 6 and 7	A brief intervention should be considered (along the lines of smoking) when individuals are seen in clinic with regards to their weight although a more formal and detailed discussion is often difficult to schedule into clinics. The question perhaps of a greater importance is who should take "ownership" of managing the obesity issue. Individuals will turn up to a variety of clinics, including respiratory. Is it the responsibility of the clinic to undertake a brief intervention and refer this back to the general practitioner who should "hold the ring" on managing the issue of obesity and onward referral. Again if there are priority groups this will get confusing though in some specific clinics time should be perhaps built into the appointment to allow for the conversation around weight related issues and nutrition in general.
142	Central Manchester University Hospitals NHS Foundation Trust	Question 7	Yes it is realistic if it is an integral part of the patient's care in relation to the Outpatient Appointment - again, the conversation must be led by a health professional trained in the complexities of obesity.
143	The Chartered Society of Physiotherapy	Question 7	It may not be feasible to have this discussion at all appointments, as the problem/condition that the person has been referred for would need to take priority. Groups that should be prioritised are adults and children who are classified as obese, and people whose primary issue that they have been referred for is exacerbated by being overweight or

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ID	Stakeholder	Statement number	Comments[26]
			obese. One of the barriers to the implementation of this quality standard is the lack of clarity around which services are available locally. If health and social care practitioners are taking a more active role in Making Every Contact Count (which this quality standard suggests) it would be useful for them to have a database of local services that offer specialist input (tier 2 and tier 3) in order to ensure that they are signposting/referring patients on accordingly
144	Medtronic UK	Question 7	As per question 5 above; depends on the time allowance for these appointments. After the first appointment where BMI and health risks have been discussed, this would be easier to approach for all further appointments. Expectations should be set at the initial appointment that these conversations will be ongoing.
145	Public Health England	2 and Question 7	Comments as for question 6 are relevant here and vice versa. If HCP are assessing and raising the issue of weight and related health problems at this contact point then surely the patient will wish/expect advice and appropriate information on the care and support they can expect to receive or be referred into? Will the relevant HCP have the support and information at hand to do this? Such considerations might in fact help to scope out the nature of relevant outpatient appointments and or groups where such a discussion can take place.
146	Royal College of General Practitioners	Question 7	Covered above – the discussion should relate to the patient setting and the background of the health professional. Eg. Anaesthetists should discuss impact of weight on anaesthetic risk, rheumatologists should relate their discussion to impact of obesity on joints etc. GPs should, for example, help patients understand the perspective of competing health risks and where to find help – eg should someone lose weight or stop smoking or in which order? Obesity management should not be superficially attempted by staff who are not in a position to offer ongoing regular support; instead increased signposting to support would be of value. (RP)
147	Royal College of General Practitioners	Question 7	It is not realistic to ask such patients to attend their GP or primary care nurse for these discussions within current constraints. (JD)
148	The Royal College of Surgeons of England	Question 7	Again this may not be appropriate, depending on the reason for outpatient referral and expertise of the clinician. It may also place a large burden on secondary care services and over burden outpatient clinics. Would this not be more appropriate in primary care?
149	WLSinfo	Question 7	As a patient group we feel it is essential that time should be made available. Prioritising one group over another will only lead to a dilution of the obesity management guidelines.

Draft quality statement 3

ID	Stakeholder	Statement number	Comments[27]
150	Adult Specialist Weight Management Service (University Hospitals Bristol NHS Foundation Trust)	3	**Comment on 'Equality and Diversity' sub-section:** Patients with Learning Disabilities may access and benefit from specialist services, such as a local community learning disability team, or Tier 2 services. The patients may not require a referral to Tier 3 services for additional support. **General comment:** We appreciate 'Development Quality Standards QS94' mentions lifestyle weight management programmes in greater detail. However, in the current draft quality standard, there is little mention about Tier 2 services. Could there be a bigger emphasis on this as a treatment option before referral to Tier 3?
151	British Medical Association	3	The resources for this to be applied to all such patients are not presently available within CCG budgets. There is currently poor provision of multidisciplinary tier 3 services, and for this quality standard to be implemented it would need to be supported by the adequate commissioning of multidisciplinary weight management units to which patients can be referred, and additional funds would be required to ensure that this did not result in cuts to other areas of service.
152	British Obesity and Metabolic Surgery Society (BOMSS)	3	**BOMSS response**. This is a fundamentally important quality standard to ensure equity of service delivery across the country. There is currently high variability in availability and referral to Tier 3 services, without any evidence base justification, of patients who clearly meet NICE guidelines. BOMSS strongly supports this measure, at primary care or CCG level, with a denominator of all of those who are eligible within the local population of a specified age range. CCG's should be held to account for the provision of Tier 3 services according to local population requirements.
153	British Society of Gastroenterology	3	Supportive of this although notable that not all CCGs are complying with these BMI cut-offs
154	British Thoracic Society		Referral to tier 3 services should be considered by primary care. There is an element of who "owns the patient journey" and it would probably be appropriate for primary care to make onward referrals to tier 3 services and should also be responsible for the data collection / management.
155	Obesity Group of the British Dietetic Association	3	We agree that Tier 3 services should be commissioned in line with local needs and that care pathways with clear referral criteria are needed. Referral criteria and what is considered success or failure at different tiers of the pathway needs to be explicitly stated.

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ID	Stakeholder	Statement number	Comments[27]
156	Public Health England	3 / Question 8	PHE support the appropriate referral of adults with a BMI of 35+ co-morbidities and BMI 40 into tier 3 services. PHE knows, through the PHE Weight management services mapping work and the Royal College of Physicians audit of tier 3 services, that variability in the provision of and access to tier 3 services across local areas exists. There is also variation in model, duration, functions of Tier 3 services as well as MDT composition. However, opportunities do exist to enable clinicians to appropriately refer and the current apparent inequity of service should not prevent the system from pursuing this goal – it should in fact act as the driver for making this quality statement achievable. This does require cross system working and PHE is aware that approaches are in place, which will consider this as part of the commissioning changes to bariatric surgery.
157	Royal College of General Practitioners	3	Tier 3 services are currently patchy and inconsistent. Funding pressures in some areas have resulted in Tier 3 investment being a low priority and seen as merely an entry point into Tier 4, for patients wanting bariatric surgery, rather than an independent complex service for those non-surgical patients that need additional support, especially psychological help with disordered eating. QS3 could usefully clarify that Tier 3 referral does not only apply to patients considering surgery. (RP)
158	Royal College of Paediatrics and Child Health	3	There are not enough tertiary services providing MDT obesity service in the paediatric population. There seems to be a huge waiting list and unfortunately children have been lost to follow-ups. Mostly tier 2 interventions have not helped in tackling this condition and arrangements have to made for them to access the specialist services.
159	The Royal College of Surgeons of England	3	No comment (See **Statement 6** comment for problematic consequence of both statements being taken together)
160	Slimming World	3	It would be useful to define what is meant by 'unsuccessful' in this quality statement. Are we referring to no weight loss, weight loss below a certain level within a given time frame or something else? Within this statement on page 18 it states '… if they have not been able to lose weight by dieting or participating in weight-loss programmes'. We would suggest that the word 'dieting' is changed here as this implies a short-term fix. Using something like 'through making lifestyle changes' would be more appropriate.
161	Tees Esk and Wear Valleys NHS Foundation Trust	3	How would this happen? Would the professional taking the measurement pass the BMI information onto the patient's GP to make the referral to the appropriate service?

Consultation question 8

ID	Stakeholder	Statement number	Comments[28]
162	Adult Specialist Weight Management Service (University Hospitals Bristol NHS Foundation Trust)	Question 8	Response to question: The 'National mapping of weight management services: Provision of tier 2 and tier 3 services in England' (2015) suggests there is not a sufficient nationwide spread of Tier 3 services: 'One or more tier 3 adult WM services were reported by 43 respondents, with a geographical coverage of 13% (19/152) of local authorities and 12% (26/209) of CCGs'.
163	Bristol Tier 3 Weight Management Service	Questions 1 & 4 & 8	Doesn't reflect the need for tier 3 services to be permanently commissioned and access being equal across the UK. Bristol and Wiltshire tier 3 services have not been permanently commissioned. There are national discrepancies in psychological assessment in pre/postoperative assessment. Good links should be built with tier 2 services, which should be fully supported and well defined with a smooth patient pathway between each tier. Where tier 3 hasn't existed, this has put pressure on tier 2 and 4 services.
164	British Thoracic Society	Question 8	There are probably insufficient tier 3 services available but information on this would be available looking at waiting times for such interventions across the county to allow targeted expansion. Again whether this takes place in a community environment or in primary care may well depend upon local facilities.
165	Medtronic UK	Question 8	In reality,unlikely to be sufficient tier 3 services offered nationally. There is a large disparity of true tier 3 service prevalence across the UK therefore, the number of tier 3 centres needs to be increased.. In terms of who would fund these services; theoretically this is the responsibility of the CCGs to raise funding for such services.
166	Obesity Group of the British Dietetic Association	Question 8	In our view provision of Tier 3 services is variable across the country and in effect this may mean a postcode lottery in terms of implementation of this QS.
167	Public Health England	3 / Question 8	PHE support the appropriate referral of adults with a BMI of 35+ co-morbidities and BMI 40 into tier 3 services. PHE knows, through the PHE Weight management services mapping work and the Royal College of Physicians audit of tier 3 services, that variability in the provision of and access to tier 3 services across local areas exists. There is also variation in model, duration, functions of Tier 3 services as well as MDT composition. However, opportunities do exist to enable clinicians to appropriately refer and the current apparent inequity of service should not prevent the system from pursuing this goal – it should in fact act as the driver for making this quality statement achievable. This does require cross system working and PHE is aware that approaches are in place, which will consider this as part of the

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			commissioning changes to bariatric surgery.
168	Royal College of General Practitioners	Question 8	There are not enough Tier 3 available nationally to make this statement achievable. It would be beneficial for this document to give more clarity about Tier3 providing non-surgical support for patients unsuccessful at Tier 2, rather than encourage persistence of the misconceptions that Tier 3 is merely a hurdle to get to Tier 4. (RP)
169	Royal College of General Practitioners	Question 8	There are not enough Tier 3 available to make this statement achievable. (JD)
170	The Royal College of Surgeons of England	Question 8	Unsure about availability of this data. There is definitely difficulty accessing tier 4 services and post bariatric plastic surgery
171	Tees Esk and Wear Valleys NHS Foundation Trust	Question 8	Not at present; provision is patchy. Please again consider specific barriers and needs of those with a serious mental illness.
172	Weight Watchers UK	Question 8	**Question 8 For draft statement 3: Are there sufficient tier 3 services available nationally to make this statement achievable?** We believe this statement to be unrealistic and unachievable due to the lack of tier 3 services available nationally. Greater emphasis should be placed on commissioning tier 2 lifestyle weight management services on a scale that meets demand, in order to reduce the need for progression into more costly and higher risk tiers of treatment and potentially more invasive surgical procedures and in order to enhance the entire care pathway. At present obesity services throughout the public system, are restricted and do not meet volume needs. Evidence based weight management services must be provided at a scale to meet both national and local demand. There is recent evidence to show that there has been a significant reduction in the provision of obesity services over the last two years despite the scale required. HOOP, a charity acting as the voice to champion obesity treatment, released a report on obesity treatment and investment in 2013 and recently released a follow up report (HOOP, 2015). Key findings of note were as follows (from 132 local authorities): • On average 2.26% of the public health allocation was spent on weight management services, this represents a 10% reduction compared to 2013. • 0.74% of the allocation was spent on children's weight management services, this represents a 17% reduction compared to 2013. • Approximately 1 in 3 local authorities are not providing any support for overweight or obese children, young people or adults. • Of the funding for the commissioning of weight management services, the distribution is 73% for tier 2 and 27% for tier 3 • Local authorities are providing services for less than 1% (0.86%) of children in need. • This disparity is more problematic when the direct and indirect costs of each public health issue

ID	Stakeholder	Statement number	Comments[28]
			are considered: Obesity (£6.1bn (direct) & £27bn (indirect)); Drugs misuse (£488 m & £14.9bn); Alcohol misuse (£3.5bn & £21bn) and Sexual health (£1.5bn & £14.1bn) respectively. Without effective partnership working, guidance and active commissioning the entire obesity pathway is at risk of being imbalanced; with inadequate volumes of services for people at the less intensive / complex tiers, resulting in preventable progression towards sparse tier 3 and 4 services. Equal access to safe and effective treatment services for people is vital, especially to stop Foresight's prediction of 60% obesity prevalence by 2050 becoming reality. NHS England has in place a clinical commissioning policy for surgical interventions but none for the lower tiers of obesity's stepped care model. Treatment, using structured lifestyle weight management which should be the constant element of any obesity care, currently sits in the remit of Public Health in Local Government. Although the health system itself has limited capacity to provide the regular support which is a key efficacy element for lifestyle weight management interventions (Dr Foster 2005, Johnston et al 2013), and in many instances it make sense for Local Government to be the drivers for protecting and improving their population's health; obesity treatment is a specialist area and in order to ensure the nation is able to work towards stemming the tide of resultant illness and burden we are facing, obesity treatment in all its treatment tiers should become a specialist service within health. Obesity treatment requires specialist services, organised and commissioned at a national level. The Darzi Review recommended that 'systematic and industrial scale' interventions are needed to make any meaningful impact on obesity and the resultant long term conditions like type 2 diabetes and coronary heart disease (Darzi, 2008). The only way this is likely to happen is through national, health led ownership.
173	WLSinfo	Question 8	There are not sufficient Tier 3 services nationally.

Draft quality statement 4

ID	Stakeholder	Statement number	Comments[29]
174	British Medical Association	4	There are insufficient resources within general practice to do this work without detriment to other services, and this would need to be separately commissioned.
175	British Obesity and Metabolic Surgery Society (BOMSS)	4	**BOMSS response**. Paediatric bariatric services are highly specialized and only performed in a few units nationally. As such paediatric obesity issues should be dealt with by current primary and secondary care services and for consideration of surgery at regional MDTs.
176	British Society of Gastroenterology	4	Not clear why the cut-off is set at 98% - was a lower value considered? Would be helpful to include non-alcoholic fatty liver disease as a co-morbidity when using the lower BMI cut-off.
177	British Thoracic Society		The British Thoracic Society would only highlight the issue of assessment of co-morbidities for children and young people around sleep, obesity hypoventilation and other causes of breathlessness. Specific advice should be sought from the British Paediatric Respiratory Society for this issue.
178	Obesity Group of the British Dietetic Association	4	For clarity, we would like the QS amended with the following words: Children and young people with a BMI at or above the 98th centile ***for age and gender*** are assessed for co-morbidities. We would also like clarification of the age cut-offs; what is the lower age for children covered by this standard?
179	Obesity Group of the British Dietetic Association	4	We agree with the QS and its rationale.
180	Public Health England	4 / Question 9	PHE support this statement - collecting information on health data related to childhood overweight is important as there is a lack of robust data in this field. It would therefore be of great benefit to understanding the consequence of child obesity and how best to plan and deliver services. These are more specialised services than for adults and currently provided within Tier 4 services. There is a need to develop any such services/support in conjunction with Paediatric secondary and tertiary care services, which are most likely led by endocrinology and diabetes specialists. Also a need for transition services.
181	Public Health England	4	Section on ' What the quality statement means for service providers, healthcare professionals and commissioners': HCP and Service providers including general practitioners (GP) practices and paediatric services are currently referenced in this section. NICE may also consider including reference to health Visitors and School Nurses both of which could be acknowledged as having a role in assessing children and young people for comorbidities and

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ID	Stakeholder	Statement number	Comments[29]
			appropriate referral.
182	Royal College of General Practitioners	4	It seems incongruous that this document highlights one aspect of childhood obesity impact – comorbidity monitoring – yet does not make any recommendation about offering long-term support, establishing rapport, signposting to a service or encouraging repeated measurements over time. Laying on additional worry or parental guilt is not an effective motivator; emphasising that a child may have further health problems in addition to obesity risks generating denial – a common response to any problem that feels insoluble. It is not clear that this QS will produce benefits from a patient perspective, and may achieve harm. Asthma is a clinical diagnosis that seems unlikely to be made purely because of a child's weight – it is likely to present independently due to symptoms. Is there evidence of under-diagnosis in obese children? It would be useful to know the incidence of type 2 DM in different age groups in order to help clinicians weigh up who best to consider testing, bearing in mind the large numbers of children with BMI above 98th centile. How often is testing advised? This statement could generate confusion, concern, over-medicalisation and under-treatment, whilst failing to encourage rapport, support and understanding of how health professionals can help families. (RP)
183	Royal College of Paediatrics and Child Health	4	We are unclear why primary care and paediatrics (secondary care) are both mentioned together here. This is a more specialist area, more appropriate to secondary care i.e. paediatric services. The social determinants of obesity need to be addressed in addition to co-morbidities, and this is best undertaken by children's secondary healthcare services.
184	Royal College of Paediatrics and Child Health	4	Assessment of co-morbidities can be performed in both secondary and tertiary services. However, more specialist dynamic endocrine investigations and psychosocial assessment should be offered by tier 3 services.
185	Royal College of Paediatrics and Child Health	4	We note that statement 3 for adults suggests referral for treatment, whereas for CYP there is only statement 4 i.e. assessment for comorbidities. We see *some rationale for this – but are very concerned* that this will continue the current situation where there are no commissioned obesity management services for CYP. The statement is confused – it appears that the guidance applies to hospital outpatient appointments however it then suggests that GPs or paediatricians undertake assessments for comorbidity. This is confused and unworkable. GPs do not have the experience to assess for comorbidities and the numbers of children >98th centile (likely 10% of the population) means that this is not feasible for paediatricians. We suggest that this statement is unworkable and impractical. What is also unclear is the meaning of 'comorbidities'; the definitions given are for standard adult comorbidities, each of which can be difficult to assess in children because of development – one of the reasons why GPs are not trained to do this.

ID	Stakeholder	Statement number	Comments[29]
			Additionally, the presence of comorbidities in obese CYP is not the only reason for treatment. Suggest that this statement be replaced by one such as exists in expert guidance (OSCA guidance; Archives of Disease in Childhood June 2012) which suggests that assessment of comorbidities occur i) in those with BMI>98th centile in whom there is a positive family history of diabetes/other obesity comorbidities/early cardiovascular disease, particularly those from a South Asian background, or parents report psychosocial concerns; or ii) those with extreme obesity (BMI >99.6th centile) regardless of history/background. Question for consultation: see above. This should occur in secondary care paediatrics – but with initial screening by GPs.
186	The Royal College of Surgeons of England	4	This should specify an age. This presumably does not apply to infants?

Consultation question 9

ID	Stakeholder	Statement number	Comments[30]
187	British Thoracic Society	Question 9	For obese children / young people the discussion about on-going management should be within primary care as should discussion of some of the co-morbidities. Of course this will depend upon why the child / young person is attending that particular clinic. If it is around diabetes or alveolar hypoventilation then clearly detailed discussion about weight management issues needs to take place.
188	Central Manchester University Hospitals NHS Foundation Trust	Question 9	A children or young person identified as having a BMI above the 98th centile should be referred in the first instance to a community weight management service offering individual consultations with highly trained, specialist dietitians and nutritionists. The children and young people should be offered holistic lifestyle assessments which should involve parents/carers, family, early years settings and schools. Children and young people identified as being above the 98th centile should be screened for risk factors relating to co-morbidities via training/tools produced alongside specialist paediatricians. The community weight management service should have strong links with both universal and tertiary services.

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ID	Stakeholder	Statement number	Comments[30]
			Children and young people should be assessed annually until aged 11 years old in the first instance or beyond if an issue is identified.
189	Medtronic UK	Question 9	In current NHS setup this would probably vary geographically depending on local resources. Some places this may be done in tier 3, other via referral to paediatrician, others done by their own GP service or community dietitian. An OMS service could take care of this as a central treatment point within a region
190	Obesity Group of the British Dietetic Association	Question 9	We would like endocrine, joint and possible mental health issues added as examples of other possible problems
191	Obesity Group of the British Dietetic Association	Question 9	In our view GPs, paediatricians and possibly school nurses are the best options for ordering blood tests, carrying out required measurements and referring to specialist services as needed.
192	Public Health England	4 / Question 9	PHE support this statement - collecting information on health data related to childhood overweight is important as there is a lack of robust data in this field. It would therefore be of great benefit to understanding the consequence of child obesity and how best to plan and deliver services. These are more specialised services than for adults and currently provided within Tier 4 services. There is a need to develop any such services/support in conjunction with Paediatric secondary and tertiary care services, which are most likely led by endocrinology and diabetes specialists. Also a need for transition services.
193	Royal College of General Practitioners	Question 9	This question cannot be addressed without considering where these children should receive structured support regarding their weight too. The document seems to have skimmed entirely over this hugely important point. NCMP feedback (NCMP reference group meetings) has shown widespread variation and a general lack of weight management provision for obese children other than in a few tertiary referral centres. An example of substandard care in Worcestershire is the child weight management service which claims to offer a 12 week programme to families highlighted by NCMP, but it is run by a school nurse without any medical input, and involves offering 2 phone calls over a 12 week period. Further input is at the request of the family to which uptake has been extremely low. There is no link with primary care. This service is currently being reviewed due to concerns about its effectiveness whilst funding is being directed towards community prevention initiatives which reach a larger proportion of the population. There are concerns about the level of training of staff who offer this service as well as the capacity of the service and lack of experienced medical input. Tacking on instruction to consider co-morbidity risk will not address the current fundamental shortfalls of existing obesity treatment services for children. If a comprehensive child obesity service was developed then initial co-morbidity assessment could take place in primary care under a shared-care agreement, as long as due consideration was given to how this work was funded. This would allow the child's medical care to remain generally within primary care and for the child's general health concerns to be overseen by the family doctor. In addition, there is a need for more specific guidance as to how often such assessments should take place and at

ID	Stakeholder	Statement number	Comments[30]
			what age or duration of obesity the assessment might be triggered in order for this to be a clinically meaningful recommendation. (RP)
194	The Royal College of Surgeons of England	Question 9	No comment
195	Weight Watchers UK	Question 9	Question 9 For draft statement 4: Where should children and young people with a BMI at or above the 98th centile be referred for assessment of comorbidities
196	WLSinfo	Question 9	To an appropriate well developed multidisciplinary team locally.

Draft quality statement 5

ID	Stakeholder	Statement number	Comments[31]
197	British Medical Association	5	The resources for this to be applied to all such patients are not presently available within CCG budgets. There is currently poor provision of multidisciplinary tier 3 services, and for this quality standard to be implemented it would need to be supported by the adequate commissioning of multidisciplinary weight management units to which patients can be referred, and additional funds would be required to ensure that this did not result in cuts to other areas of service. What is more, many people within this group would not be suitable for bariatric surgery, due to frailty, other co-morbidities or limited life expectancy. Therefore, this group should be qualified to exclude them, or we would suggest to change the wording to include 'considered'.
198	British Obesity and Metabolic Surgery Society (BOMSS)	5	**BOMSS response**. As with statement 3, this is a fundamentally important quality standard to ensure equity of service delivery across the country. Diabetic patients have been shown to have the most to gain from bariatric surgery, and the cost effectiveness of surgery is significantly greater. BOMSS welcomes the highlighting of surgery for diabetes, reinforcing the latest NICE guideline, with this quality standard, as important in the early management of newly diagnosed obese diabetic patients. BOMSS strongly supports this measure, at primary care or CCG level, with a denominator of all of those who are eligible within the local population of a specified age range, to ensure equity of service delivery.

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ID	Stakeholder	Statement number	Comments[31]
199	British Thoracic Society		The decision to refer on for bariatric surgery should rest with primary care even though this could be flagged up in secondary care unless of course the individual is attending a diabetic service. GP's need to be key at managing obesity and taking ownership of onward referrals, the same is true for assessment for bariatric surgery, quality statement 6.
200	Obesity Group of the British Dietetic Association	5	Rationale It is not clear what is meant by 'or equivalent, if Tier 3 services are not available locally'. Given that Tier 3 service provision may be patchy, it is important in our view that this is clarified
201	Obesity Group of the British Dietetic Association	5	While we agree with this QS in principle, in our view it is not just tier 3 service provision which may be lacking in many places, but bariatric surgery provision also. Given this, we question how likely and/or achievable this QS is in practice
202	Public Health England	5	PHE support this proposition. However, how will the operationalisation of this implementation be assessed and monitored along with any unintended consequences? PHE suggest that there is a need to be very clear about the evidence underpinning this statement for individuals with lower BMIs.
203	Public Health England	5	Rationale: The standard makes reference to 'or **equivalent** if tier 3 services are not available locally'. There is some reference later as to what this might comprise in terms of pre-op medical assessment, though the definition seems quite open to interpretation. Have NICE assessed what these 'equivalents' might look like in practice? If not will NICE seek to build a consensus on what these 'equivalents' are – this seems important in terms of ensuring quality of service for patients.
204	Public Health England	5	Expedited assessment: PHE recognised the driver relating to the criterion for expedited assessment. However, has NICE assessed the risk of expediting patients in this manner as opposed to offering some form/length of a tier 3 service? Also has NICE considered what such an expedited assessment comprises of in terms of ensuring quality of delivery across the system? PHE is aware that post -surgical compliance is a significant issue and that poor compliance can result in failure of primary surgery and requests for revision surgery as a result of pre op weight gain. At least 6 months of Tier 3 (pre-op) is necessary for education, demonstrating adherence to life style, dietary and physical exercise measures as well as reducing pre – operative risk by optimising weight, diabetes and other co-morbidity/s management. The two patient groups flagged are likely to need more than just pre –operative assessment followed by bariatric surgery.
205	Royal College of Paediatrics and Child Health	5	The background to this statement is out of date. The statement refers to 'people' thus we assume it includes CYP. Yet later the statement notes that bariatric surgery

ID	Stakeholder	Statement number	Comments[31]
			is not generally recommended for CYP. This statement about bariatric surgery ignores the epidemic of type 2 diabetes in CYP over the past decade, the evidence that type 2 diabetes onsetting in adolescence is usually an extremely severe phenotype, and that bariatric surgery for type 2 in adolescents can be extremely effective. We suggest that the statement be modified to read Bariatric surgery is generally not recommended in CYP however adolescents with new onset type 2 diabetes that is not controlled within 6 months of onset with standard diet/metformin should be considered for bariatric surgery within specialist adolescent bariatric surgery centres.
206	The Royal College of Surgeons of England	5	No comment
207	Weight Watchers UK	5	Again, we reiterate our concerns raised with regards to statement 3 around the availability of tier 3 services nationally in order for this to be realistic and meaningful. With tier 3 services so sparse, and tier 4 stretched, we would be concerned about how likely positive outcomes and value for money would be. In addition, diabetes is an increasing concern, with Diabetes UK recently reporting that prevalence of diabetes has increased to 4 million adults and children, of course appropriate, accessible and proven structured education programmes must be in place. Currently, tier 3 and 4 services are not equipped to respond to the huge need of a significant proportion of the population.

Draft quality statement 6

ID	Stakeholder	Statement number	Comments[32]
208	Adult Specialist Weight Management Service (University Hospitals Bristol NHS Foundation Trust)	6	**Comment on 'What the quality statement means for service providers, healthcare professionals and commissioners' sub-section:** Could there be a larger emphasis on referral to Tier 3/bariatric surgery being made only when other interventions have been tried and not effective?
209	British Obesity and Metabolic Surgery Society	6	**BOMSS response**. Again, this is a fundamentally important quality standard to ensure equity of service delivery across the country, as current NICE guidelines are clear that surgery should be the primary option for those with a

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ID	Stakeholder	Statement number	Comments[32]
	(BOMSS)		BMI >50. In this setting Tier 3 should be a facilitator of preparing these patients for surgery, rather than an alternative management or obstacle to referral for surgery. BOMSS strongly supports this measure, at primary care or CCG level, with a denominator of all of those with a BMI >50 within the local population of a specified age range, who seek surgery as a therapeutic option. The numerator should be the number referred on for surgery and NOT just assessed for surgery, as the surgical MDT must be given the option of assessing all patients with a BMI >50.
210	Obesity Group of the British Dietetic Association	6	We agree with this QS in principle, but owing to variable bariatric surgery provision across the country, we question how likely and/or achievable this QS is in practice. It is also unclear why a cut-off point of ten years for diabetes has been used.
211	Royal College of Paediatrics and Child Health	6	This statement ignores children and young people who have very high BMI. Recent data (Ells et al. Archives of Disease in Childhood 2015) shows that approximately 1% of 11 year olds (and up to 3% in some ethnic groups) have a BMI equivalent to that over 35 or 40 for adults. In clinical practice we see a small number of adolescents with BMI >50. There should be an equivalent statement for the management of morbid obesity in CYP. This should recommend multidisciplinary assessment and management for all CYP with BMI >35kg/m2 or >99.6th centile, with potential for referral for bariatric surgery within a specialist adolescent bariatric surgery service (4 such exist in the UK). Clearly not all with BMI >50. We believe it is discriminatory for NICE not to include management of morbid obesity in CYP in these quality standards.
212	The Royal College of Surgeons of England	6	This looks like it suggests that those with obesity >40kg/m² are referred to a tier 3 service but they cannot be referred to surgery until they reach 50kg/m². 50kg/m² seems extremely high and surely referral should be based not purely on weight but also on any associated dysfunction. (This seems to follow logically from this statement when taken with **Statement 3** above)

Draft quality statement 7

ID	Stakeholder	Statement number	Comments[33]
213	Adult Specialist Weight Management Service (University Hospitals Bristol NHS Foundation Trust)	7	General comment: 'Emergency' bariatric surgery may happen on occasions. Are these patients offered the same 2 year after support as all other bariatric surgery patients? What about patients who choose to have bariatric surgery done privately- will they receive NHS follow up?
214	British Obesity and Metabolic Surgery Society (BOMSS)	7	**BOMSS response**. BOMSS strongly supports the importance of follow up for all patients who have had bariatric surgery. This is an important standard for all those who have had surgery on the NHS or abroad or in other sectors. Weight loss and resolution of co-morbidities after surgery is strongly linked to successful follow up, and the monitoring, assessment and support listed in the quality statement is to be encourage as standard. Care must be taken to allow for those patients who are realistically lost to follow up, so the numerator should include a measure of those offered 2 years of follow up care package, as well as those who successfully complete it.
215	British Thoracic Society	7	Follow up after bariatric surgery the bariatric surgeons should be the individuals who are providing answers to this question and the British Thoracic Society does not have a specific view on this, nor does it on quality statement 8
216	College Of Occupational Therapists	7	"People who have had bariatric surgery have a postoperative follow-up care package within the bariatric surgery service for a minimum of 2 years." This care package should be multi-disciplinary to support the person to address existing occupations and habits that are unhealthy and potentially put them at risk. These need to be replaced with occupations, routines and habits that support health and wellbeing. Individuals may require support to: • Review and understand the meaning and role of food and drink, eating, drinking and food preparation in their life. • Help to identify their strengths and assets and support (existing and potential). • Identify barriers to change, such as routine, family culture, the environment and occupations in order to set goals and adopt occupations that support their health and wellbeing. See services such as: Aintree Specialist Weight Management Service and Aintree Liverpool Obesity Support Service
217	Obesity Group of the	7	Rationale:

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ID	Stakeholder	Statement number	Comments[33]
	British Dietetic Association		We agree with the rationale for this QS. However it is not clear where the additional resources required to put it into practice will come from.
218	Obesity Group of the British Dietetic Association	7	Rationale: We would like to see 'nutritional deficiencies' listed first in the rationale for post-bariatric surgery follow-up.
219	Public Health England	7	PHE accept that the underpinnings for CG 189 will have informed the minimum level of follow up care of 2 years. However, is there information available as to what happens in practice? Did NICE look at longer periods of follow up care which might provide for more effective monitoring and longer term care and support for patients? PHE is aware that lack or variation in follow up is a real issue for adults and children and that GP practices complain about the lack of skills and financial resources to do this. A particular issue is follow up of patients with bands who have the highest failure rate as well as demand from the private sector who fit a very high proportion of bands in patients who have not attended Tier 3 services. These patients should ideally be offered shared care follow up models between primary care/ Tier3 and the Tier 4 bariatric medical service. The very least is a formalised annual follow up review by the Tier 4 medical service.
220	Royal College of General Practitioners	7	This QS could provide a good opportunity to encourage shared-care protocol development between bariatric teams and primary care, to ensure that follow-up is lifelong. These patients are typically under co-morbidity review in primary care in any case, and so guidance on what elements of bariatric care should be included in their annual co-morbidity review would make efficient sense for all. Maintaining easy access to advice from the bariatric team and mandating explicit follow-up instructions from the bariatric team regarding blood testing and supplement prescribing would be valuable. It would be helpful to recommend that post-bariatric patients are put on a primary care register to facilitate audit, set up repeat prescribing and ensure ongoing follow-up. (RP)
221	Royal College of Paediatrics and Child Health	7	We support this. We would suggest it be amended to add that CYP who receive bariatric surgery <18 years of age should have minimum of 5 years follow-up.
222	The Royal College of Surgeons of England	7	This seems reasonable follow-up, but there is no mention of those that maintain their weight loss being offered body contouring surgery. This is being rationed and should be offered to those patients that meet criteria and manage to maintain weight loss
223	Slimming World	7	It would be useful to understand what support mechanisms would be in place post 2 years to ensure that patients are well supported and weight regain is avoided once the support ceases. Appropriate, considered on an individual basis, consistent long term support should be defined and protocols set up locally to ensure this is achieved.
224	Weight Watchers UK	7/ General	Post-operative bariatric care is patchy, and subject to further complication as the Trust performing the surgery may not be patients local care provider, therefore will not be able to refer patients to local dietetics or psychological support. If the Trust performing the bariatric procedure is able to offering on-going MDT support, the patient may face

ID	Stakeholder	Statement number	Comments[33]
			barriers to accessing this support if they do not live in the local area. For example, it is not uncommon for patients to have their surgery performed by a Trust 50+ miles from where they live. Therefore more emphasis needs to be placed on how more local services could be adapted to include the behavioural and psychological needs of post-op bariatric patients.

Draft quality statement 8

ID	Stakeholder	Statement number	Comments[34]
225	British Medical Association	8	General practices do not have the skills required for nutritional assessment and this needs to be separately commissioned.
226	British Obesity and Metabolic Surgery Society (BOMSS)	8	**BOMSS response**. BOMSS strongly supports the importance of life-long follow up for all patients who have had bariatric surgery, as part of a shared care model of chronic disease. This reflects the fact that complications of surgery and nutritional problems can happen at any time after surgery, and need constant monitoring. Shared care models for chronic diseases are used for chronic respiratory conditions, such as COPD, inflammatory bowel disease and also for diabetes, and these could be replicated for those who have had bariatric surgery. BOMSS is aware of some areas where there has been the development of a Tier 5 service, such as in South West London and Surrey Downs Health partnership, for the lifelong follow up of bariatric surgery patients, as an aid primary care.
227	College Of Occupational Therapists	8	"People discharged from bariatric surgery service follow-up are offered monitoring of nutritional status at least once a year." Nutritional status is only one aspect to the person maintaining a healthy weight. This should also include monitoring of their engagement in daily life activities as this impacts on the persons' physical fitness, and also on how they feel about themselves and their mental wellbeing. This could prevent relapses into poor habits which lead to weight gain.
228	Obesity Group of the British Dietetic	8	We agree that at least annual nutritional monitoring post bariatric surgery is required. However frequency of monitoring should be individualised depending on the procedure undergone.

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ID	Stakeholder	Statement number	Comments[34]
	Association		
229	Obesity Group of the British Dietetic Association	8	What this means for commissioners: It is essential that a named person or unit is responsible for administration of the follow up. In our view without this it is unlikely to happen.
230	Obesity Group of the British Dietetic Association	8	What the QS means for patients and carers: In our view this definition is over simplified. It is not just about ensuring that patients are getting all the nutrients that they need, but also about monitoring behaviours and weight to reduce the risk of weight regain post-surgery. This therefore requires suitably trained health care professionals who understand bariatric surgery procedures and the implications of this for eating abilities, habits and behaviours to undertake follow ups.
231	Royal College of General Practitioners	8	As above – linking this with on-going annual co-morbidity review would be beneficial. (RP)
232	The Royal College of Surgeons of England	8	Do they need nutritional support for a lifetime? Or is this time limited?
233	Slimming World	8	We would suggest that more than just nutritional deficiencies are monitored and that a full review be done at least annually to ensure that the patient is progressing well, any additional support needs are identified and provided. Ultimately to ensure that patients are well and appropriately supported dependent on their needs and less likely to experience weight re-gain. As a tier 2 service we have seen an increase in the number of post-bariatric surgery patients requesting further support as they feel they aren't getting the level of support they need within the NHS.
234	WLSinfo	8	We agree with this but who bears the cost of tests is proving a minefield for many patients. GP's are refusing to test in some areas.

Consultation question 10

ID	Stakeholder	Statement number	Comments[35]
235	Bristol Tier 3 Weight Management Service	Question 10	There are no local shared care examples based secondary care regarding nutritional management.

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ID	Stakeholder	Statement number	Comments[35]
236	British Thoracic Society	Question 10	Shared care models for nutritional management would best be discussed with bariatric services and the Thoracic Society does not have a particular view on this area.
237	Medtronic UK	Question 10	In current NHS setup this would probably vary geographically depending on local resources. Some places this may be done in tier 3, other via referral to paediatrician, others done by their own GP service or community dietitian. An OMS service could take care of this as a central treatment point within a region
238	Obesity Group of the British Dietetic Association	8 / Question 10	We have nothing to add.
239	Public Health England	Question 10	PHE view this area as very important and consider that this reinforces the requirement for CCGs and local areas to ensure that appropriate tier 3 services are in place to, and alongside bariatric teams, act as an operational guardian for such care packages. PHE are aware that Salford Royal have such a service - it is provided by the Tier 4 Bariatric Medical Service.
240	Royal College of General Practitioners	Question 10	The RCGP Nutrition group in conjunction with BOMSS and a consultant dietician have produced 'Ten Top Tips' guidance on managing patients after bariatric surgery for primary care at http://www.rcgp.org.uk/clinical-and-research/a-to-z-clinical-resources/nutrition/~/media/Files/CIRC/Nutrition/Obesity/RCGP-Top-ten-tips-for-post-bariatric-surgery-patients-in-primary-care-Nov-2014.ashx. In addition there is an audit tool to support a review of existing standards of post-bariatric care in primary care. (RP)
241	The Royal College of Surgeons of England	Question 10	No comment
242	Weight Watchers UK	Question 10	Question 10 For draft quality statement 8: Are there examples, or details, of shared care models for nutritional management after discharge from the bariatric service that we could reference in the definitions section of this statement?
243	WLSinfo	Question 10	We are not aware of any.

No comment

ID	Stakeholder	Statement number	Comments[36]
244	Department of Health	Thank you for the opportunity to comment on the draft for the above quality standard. **I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.**	

Registered stakeholders who submitted comments at consultation

- Adult Specialist Weight Management Service (University Hospitals Bristol NHS Foundation Trust)
- Bristol Tier 3 Weight Management Service
- British Liver Trust
- British Medical Association
- British Obesity and Metabolic Surgery Society (BOMSS)
- British Society of Gastroenterology
- British Thoracic Society (all comments endorsed by the Royal College of Physicians)
- Central Manchester University Hospitals NHS Foundation Trust
- The Chartered Society of Physiotherapy
- College Of Occupational Therapists

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- Department of Health
- Medtronic UK
- The National LGB&T Partnership
- NHS England
- Obesity Group of the British Dietetic Association
- Public Health England
- Royal College of General Practitioners
- Royal College of Paediatrics and Child Health
- The Royal College of Surgeons of England
- Slimming World
- Tees Esk and Wear Valleys NHS Foundation Trust
- Tissue Viability Society
- The University of Nottingham
- Weight Watchers UK
- WLSinfo

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

ID	Stakeholder	Statement number	Comments[37]
245	James Hopkins	Introduction	As an individual bariatric surgeon and a council member of BOMSS I am delighted to comment on these draft quality standards. Having helped draft the official BOMSS council response, with our society president, I strongly support these comments. I am aware that there are currently wide variations in practice for the provision and delivery of services for surgery for severe and complex obesity across the UK (a 'postcode lottery'), and welcomes quality standards to improve this. In response to the individual quality statements:
246	James Hopkins	1	I believe it is realistic for BMI to be calculated at the first outpatient appointment after referral, but our view is that this is also within the remit of primary care, and that all patients could have a BMI documented on the referral by primary care and if not measured in the hospital clinic. We believe that weight is routinely measured for all (general surgery) patients in our out-patient clinics already. Bariatric surgery is commonly performed on patients between the age of 25 – 64 (95% of those in the NBSR report) and >80% are female so these two factors (age particularly) could be incorporated into the quality measure.
247	James Hopkins	2	Whilst this would be ideal there is often very limited time in outpatients, of unrelated specialists, to address this complex issue in addition to the referral problem. Where a clinic measured BMI falls within NICE guidelines for consideration of bariatric surgery that this should be highlighted to primary care in the clinic letter, so that proper time can be given over to the none-judgemental discussions needed.
248	James Hopkins	3	**This is a fundamentally important quality standard** to ensure equity of service delivery across the country. There is currently high variability in availability and referral to Tier 3 services, without any evidence base justification, of patients who clearly meet NICE guidelines. I strongly support this measure, at primary care or CCG level, with a denominator of all of those who are eligible within the local population of a specified age range. CCG's should be held to account for the provision of Tier 3 services according to local population requirements.
249	James Hopkins	4	I feel that paediatric bariatric services are highly specialized and only performed in a few units nationally. As such paediatric obesity issues should be dealt with by current primary and secondary care services and for consideration of surgery at regional MDTs.

[37]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.

ID	Stakeholder	Statement number	Comments[37]
250	James Hopkins	5	As with statement 3, this is a fundamentally important quality standard to ensure equity of service delivery across the country. Diabetic patients have been shown to have the most to gain from bariatric surgery, and the cost effectiveness of surgery is significantly greater. I welcome the highlighting of surgery for diabetes, reinforcing the latest NICE guideline, with this quality standard, as important in the early management of newly diagnosed obese diabetic patients. Surgeons would strongly supports this measure, at primary care or CCG level, with a denominator of all of those who are eligible within the local population of a specified age range, to ensure equity of service delivery.
251	James Hopkins	6	Again, this is a fundamentally important quality standard to ensure equity of service delivery across the country, as current NICE guidelines are clear that surgery should be the primary option for those with a BMI >50. In this setting Tier 3 should be a facilitator of preparing these patients for surgery, rather than an alternative management or obstacle to referral for surgery. As a surgeon I strongly supports this measure, at primary care or CCG level, with a denominator of all of those with a BMI >50 within the local population of a specified age range, who seek surgery as a therapeutic option. The numerator should be the number referred on for surgery and NOT just assessed for surgery, as the surgical MDT must be given the option of assessing all patients with a BMI >50.
252	James Hopkins	7	Any surgeon should strongly support the importance of follow up for all patients who have had bariatric surgery. This is an important standard for all those who have had surgery on the NHS or abroad or in other sectors. Weight loss and resolution of co-morbidities after surgery is strongly linked to successful follow up, and the monitoring, assessment and support listed in the quality statement is to be encouraged as standard.
253	James Hopkins	8	Again I would strongly support the importance of life-long follow up for all patients who have had bariatric surgery, as part of a shared care model of chronic disease. This reflects the fact that complications of surgery and nutritional problems can happen at any time after surgery, and need constant monitoring.
254	Jenny Setchell	General	I wanted to comment on your quality standards for obesity. I am concerned about the lack of consideration of stigma in the document. There is now a considerable body of research that indicates that stigma is an important aspect of obesity, including the management of it. For example, when health professionals (usually inadvertently) stigmatise, there can be poorer outcomes for patients including more disordered eating, less compliance with exercise, reduced attendance at health consultations etc. I have attached an article that reviews the literature on this topic and I would suggest that these factors are included in your standard. My own research has been on the importance of considering stigma in weight-related interactions in physiotherapy settings. I have attached a paper I published about patient experiences of stigma in this context, however there has been similar work in most health professional environments.

ID	Stakeholder	Statement number	Comments[37]
			Links to papers provided: • http://onlinelibrary.wiley.com/doi/10.1111/obr.12266/abstract • http://www.manualtherapyjournal.com/article/S1356-689X(15)00070-3/fulltext