Public Health Guidance

Overweight and Obese Adults – lifestyle weight management - Consultation on Draft Guidance
Stakeholder response Table

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	DRAFT Response
Specialist Weight Management Service (5 Boroughs Partnership NHS Foundation Trust).	Recommendation 3	p.7	With reference to point about GP's and PN's raising issue of weight management services in any communications about being overweight need to be conscious of the often perceived notion that patients feel about their weight being discussed at all times by a range of health professional and feeling very frustrated by this. Could include to do so in a empathetic manner.	Thank for raising this issues. This is dealt with in the first bullet of recommendation 2, i.e. 'ensure the tone and content of all communications is respectful and non-judgemental'
Specialist Weight Management Service (5 Boroughs Partnership NHS Foundation Trust).	Recommendation 4	p. 8	Although all points regarding expectations of a lifestyle service are helpful need to consider the feasibility of covering when discussing a referral e.g. in a PN or GP appointment. Are some points more relevant for the weight management programme to address in a assessment appointment.	Thank your for this comment. The updated guidance specifies what information should be communicated by (1) health professionals and (2) programme providers for adults thinking about joining a programme (see updated recommendation 7) and by programme providers at programme outset (see updated recommendation 8).
Specialist Weight Management Service (5 Boroughs Partnership NHS Foundation Trust).	Recommendation 5	p. 9	Although all points are relevant and useful to discuss prior to a referral to a weight management service. Is it realistic for a referring health professional to cover all topics within often tight time frames? A number of these points will be covered within a weight management assessment appointment.	Thank your for this comment. The guideline has been updated in line with your comments, clearly specifying what information a referrer and provider should communicate (see updated recommendations 7 and 8).
Specialist Weight Management Service (5 Boroughs Partnership NHS Foundation Trust).	Recommendation 6	p. 10	All staff trained by a multi disciplinary team (can it be an accredited CBT therapist) instead of clinical psychologist.	Thank you for this comment. The updated guidance uses the term 'practitioner psychologist'.
Specialist Weight Management Service (5 Boroughs Partnership NHS Foundation Trust).	Recommendation 9	p. 14	Needs to include something around the need for the topic to be broached in a sensitive and compassionate way with a realisation that this might have been the numerous time that the topic of weight has been raised with the patient and about their feelings surrounding this. Can this recommendation be brought forward to before recommendation 4 so the flow of recommendations is better (all recommendations surrounding pre referral and referral are collated together).	Thank you for this comment. The updated guidance has been amended to reflect your comment (see updated recommendation 6).

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Specialist Weight Management Service (5 Boroughs Partnership NHS Foundation Trust).	Recommendation 10	p. 15	Include possible ways to improve adherence and engagement e.g. regular weight ins, support systems, text and phone calls. In those who are not benefiting from the service plan to discus with patient factors/barriers to change and employ motivational interviewing techniques - if no improvement then plan action plan referral to another service, planned exit etc.	Thank you for this comment. Evidence on the effectiveness of eg texts, phone calls or other technology on adherence in lifestyle weight management programmes was not identified by the evidence reviews, but this is flagged within the research recommendations. Updated recommendation 8 addresses many of the issues you raise. ‘
Association for Improvements in the Maternity Services	Recommendation 2		We are particularly grateful for the emphasis on avoidance of stigma and respectful communication. It may help if education of all professionals involved included Information about e.g. obesogenic environments, income inequality and obesity *(1)* neighbourhood influences and the need to study small areas (*2*). We find that the work of Wendy Lawrence et al on lack of self-efficacy and control of family environment relevant to our work on the help-line.*(3)* So often health interventions are disempowering and controlling for those with lower education, whereas empowerment and increase of self-efficacy is what is needed. . It needs to be remembered that many are not just financially poor, but also time and energy poor. Even with two working adults, the household may find it difficult to afford healthier food and find time and energy to cook it. So advice on cheaper, healthier, speedily prepared and satisfying meals is needed. (much easier to lose weight if you can afford steak, smoked salmon and out of season strawberries) Some of the Mums who contact us live in a state of permanent exhaustion. *(1) Wilkinson R & Pickett K. (2010) The Spirit Level (Penguin* *(2) Edward K et al (2009) The neighbourhood matters: studying exposures relevant to childhood obesity and the policy implications in Leeds UK. J Epidem Comm Health* *(3) Wendy Lawrence et al (2011) Psychological variables predict quality of diet in women of lower, but not higher, educational*	Thank you for this comment. The final guidance will clearly highlight links to other relevant NICE guidance in the obesity pathway that address some of the issues you raise. The updated training recommendations flag the importance to understanding why many adults have difficulty managing their weight and the experiences that they may face in relation to it. The training recommendations have also been amended to flag awareness of the practical skills and behaviours that can help an individual lose or maintain weight.

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			attainment. Appetite Feb. 56(1) 46-52	
Association for Improvements in the Maternity Services	General Patient designed research		We would like to see an increase in patient-designed and patient-involved research, especially on collecting better data on adverse effects from the point of view of the receivers **which we feel is under-represented in the evidence**– eg less money to spend on relaxation and pleasure, which may be much needed, increase in smoking, increase in mood swings in already stressed households, , influence of adverse life events on maintaining weight loss or drop-out rates, etc. If those on the receiving end are involved in planning research, choosing outcomes important to them, gathering qualitative data, and so on, the resulting increase in feelings of control could also be helpful.	Thank you for this comment. Research on factors that impact on obesity per se are outside the remit of this guidance. However, the draft research recommendations flag the impact of lifestyle weight management programmes on wider lifestyle factors, psychological issues and user adherence and satisfaction.
Association for Improvements in the Maternity Services	p. 12		"a health low-fat diet". Why is sugar not included?	Thank you for this comment. This recommendation has been amended.
Association for Improvements in the Maternity Services	Exercise and privcacy		People with a weight problem are often self-conscious about exercise in public. Why not more advice on increasing exercise in the home when alonehttp://www.ncbi.nlm.nih.gov/pmc/articles/PMC3685814/– e.g. dancing to favourite music etc.	Thank you for this comment. The core components emphasise the importance of programmes being tailored to the individual and therefore exercise at home is an option within this. The qualitative review for this guidance found that supervised activity sessions were popular among users but that it was important that ways of being active after the programme had ended should be encouraged if higher levels of activity are to be maintained.
Association for Improvements in the Maternity Services			Richard Wilkinson & Kate Pickett. The Spirit Level, pp 91-94. Penguin Books 2010	Thank you for this reference.
Association for			K Edwards et al (2009) The Neighbourhood Matters: studying exposures	Thank you for this reference.

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Improvements in the Maternity Services			relevant to childhood obesity and the policy implications in Leeds UK. Journ. Epidem Comm Health	
Association for Improvements in the Maternity Services			Wendy Lawrence et al (2011) Specific psychological variables predict quality of diet in women of lower, but not higher, educational attainment. Appetite Feb. 56(1) 46-52.	Thank you for this reference.
Association for the study of obesity	General		The guidance does not make clear which interventions or type of interventions, are judged to be most effective at achieving weight loss and weight maintenance. This information would be useful to guide those commissioning services. Multi-component programmes are advocated as best practice for adult weight management; however what these comprise should be stated.	Thank you for this comment. An additional recommendation has been added to the revised guidance which asks public health England to establish a national source of information on weight management programmes suitable for commissioning. The recommendation notes the UK based programmes shown to be effective in the evidence reviews for this guidance. Multicomponent programmes are defined in the introduction and glossary.
Association for the study of obesity	General		The definitions for 'short term' and 'long term' should be stated.	Thank you for this comment, this recommendation has been revised.
Association for the study of obesity	General		A minimum definition of a programme (based on number of sessions or contact frequency) should be included by NICE. However, if the authors consider the evidence is insufficient to define, this should be stated.	Thank you for this comment. The updated recommendation provides this information.
Association for the study of obesity	General		Clinical practitioners are particularly aware of the considerable stigma that people with weight problems face. However, offering them support to lose weight and providing that help is often not reinforcing stigma but providing support. There is evidence that patients welcome this support and do not find it intrusive but often appropriate and valuable. Could any evidence that raising the issue of someone's weight in a consultation may be beneficial or the reverse be	Thank you for this comment. The PDG were aware that many health professionals find this a difficult topic to broach and this issue is included in recommendations on training. The guidance has been checked throughout to ensure that the concern

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			considered in this guideline? At present the tone of the guideline may reinforce a health professional's reluctance to tackle the issue of a patient's weight.	about minimising stigma is balanced with a positive approach to broaching the issue and commissioning services.
Association for the study of obesity	Recommendation 1 Integrated approach	5	The guidelines assume that areas where local service providers are operational would have a local obesity pathway in place to allow an integrated approach to operate. How many such pathways exist? How many areas have none in place? What should be advocated in the case where there was no obesity pathway?	Thank you for this comment. The provision of local obesity pathway is outside the remit of this guidance. However, a local strategic approach to obesity is covered in existing NICE guidance on obesity – working with local communities. A link to this associated guidance is given within the recommendation.
Association for the study of obesity	Recommendation 4 adult expectations	8	Weight loss for those with a BMI >35kg/m^2 ought to be greater than 10% of body weight to achieve health benefits. The 5-10% loss applies only to those whose BMI<35 kg/m^2	Thank you for this comment. The recommendations reflect the evidence considered by the committee (where average observed loss was around 3%, though with lots of variation) for lifestyle weight management programmes. It also reflects the existing NICE guideline on obesity (2006). The PDG considered the stated percentages as realistic. The recommendation states '*at least* 5 to 10%'.
Association for the study of obesity	Recommendation 6	10	Can the term multi-component be defined?	Thank you for this comment. Multicomponent is defined in the introduction and the glossary.
Association for the study of obesity	Recommendation 6	10	Can it be clarified how measures of behaviour change ought to be monitored up until 12 months post intervention? This ought to be	Thank you for this comment. More detailed guidance on monitoring and

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	What action should they take?		standardised or guided to allow meaningful data collection nationally.	evaluation of programmes is covered in other recommendations. Elsewhere it is suggested that systems are put in place to enable information sharing between providers and referrers. It is also suggested that validated tools be used, such as the standard evaluation framework for weight management interventions.
Association for the study of obesity	Recommendation 6	10	Commissioners ought to be aware of the track record and outcomes of weight management from those providing weight management services.	Thank you for this comment. Commissioning and evaluation are in separate recommendations. An additional recommendation has been made to Public Health England to establish a national source of information on programmes that meet core components, pragmatic outcome targets and have been shown to be effective in the UK.
Association for the study of obesity	Recommendation 7 Core components of lifestyle weight management services: maintaining weight loss	11	Can the term "weight maintenance" be defined? What are "healthy eating" behaviours in this context?	Thank you for this comment. Weight loss, weight loss maintenance and weight maintenance are defined in the glossary.
Association for the study of obesity	Recommendation 8	13	Can the targets for uptake, provision and outcomes be clarified? Some settings / participants these may differ considerably from others impacting on relevant success criteria. Should cost issues be considered here?	Thank you for this comment. Pragmatic best practice targets from the DH best practice commissioning guide have been added to the text.

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Association for the study of obesity	Recommendation 13	18	Can the approach used to judge adherence be clarified?	Thank you for this comment. Pragmatic best practice targets from the DH best practice commissioning guide have been added to the text.
Association for the study of obesity	Recommendation 14 cost effectiveness	20	Areas with low service provision will have low levels of referral, how can this be resolved in areas of low provision?	Thank you for this comment. Local provision is outside the remit of NICE, but is hoped that local areas will implement the guidance in line with priorities identified in the JSNA (as recommendation 1).
Association for the study of obesity	3.2	22	Evidence needed to support a weight loss of 3% benefiting health.	Thank you for this comment. The guidance is clear that health benefits are likely to increase with increasing weight loss. The mean percentage weight loss was around 3% in programmes included in the evidence review for this guidance. The economic model suggests that interventions are cost effective with a maintained weight loss of as little as 1%. However, the PDG also noted that maintaining weight or maintaining small weight losses and not following the population upward trajectory was likely to have substantial health benefits given the increasing health risks with increasing weight.
Association for the study of obesity	3.3	23	What adverse events were the PDG thinking about?	The PDG discussed the impact of, for example, the potential health impact of 'yoyo' dieting and the psychological impact of losing and re-gaining weight or failing to meet goals. None of the

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				included studies reported on these issues and the PDG were of the view that adverse effects at the level of weight loss observed were likely to be low. However, adverse effects were not systematically investigated in trials and so a research recommendation has been made on this issue.
Association for the study of obesity	3.6	23	Can the term tailoring be clarified?	Thank you for this comment. This paragraph highlights that the research was not clear about what 'tailoring' meant in practice in the included studies.
Association for the study of obesity	3.7	24	We agree the effect of repeated dieting attempts to achieve weight loss may be important to determine health impact. However, it would appear unlikely to be able to determine this impact using standard research techniques.	Thank you for raising this issue.
Association for the study of obesity	3.11 Wider context	24	Can the PDG justify why the availability of fruit and vegetables at a reasonable price impact on current obesity incidence?	Thank you for this comment, this text has been amended.
Association for the study of obesity	3.12 Commissioning	25	We agree that the provision of long term support may favour increased weight maintenance. However, how can this support be best provided?	Thank you for this comment. The guidance highlights that the evidence is limited on this point and highlights potential options such as longer term support from programmes, primary care or local support groups. A research recommendation has been made on this point.
Association for the study of obesity	3.13	25	We challenge the statement that GP or practice led interventions are largely ineffective. The counterweight programme was largely	Thank you for this comment. Evidence from the Counterweight programme did

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			effective and delivered largely by practice nurses.	not meet the inclusion criteria for the evidence review of effectiveness. The considerations section of the updated guideline states that 'The evidence reviewed also suggests that primary care-led services may be less effective than commercial programmes, but it is unclear why. The PDG noted that local authority services may be established to support people living in particular geographic areas, or from lower income groups. This is particularly the case if their needs are not being met by commercial programmes.' The guideline applies to all programme.
Association for the study of obesity	Recommendations for research: what action should they take paragraph 2	29	We agree that unintended outcomes are worthy of review, however for some they already appears "sufficient" evidence, such as bone mass changes on weight change. Outcome such as this would be invasive to measure and an expensive addition to any study.	Thank you for raising this issue.
British Cardiovascular Society	Assessing adults who are overweight or obese	5	I would suggest measuring waist circumference is included as a 'preferred' rather than 'suggested' method of assessing overweight or obesity, if BMI is <35	Thank you for this comment. Information on the assessment of overweight and obesity is from existing NICE guideline on obesity (2006). The identification of obesity per se is outside the remit of this guidance. The wording of this recommendation has been amended for clarity.
British Cardiovascular Society	Assessing adults who are overweight or obese	5	Consider that obese parents are more likely to have obese children, so consider family interventions	Thank you for this comment. NICE has recently issued complementary guidance on lifestyle weight management in children.

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British Cardiovascular Society	Recommendation 1	6	Identifying other local services - e.g. cycle lanes, takeaway outlets etc rather than just walking groups (ie just mention a few more at this stage)	Thank you for this comment. More examples are given in the recommendation on commissioning
British Cardiovascular Society	Recommendation 2	6	Does 'other health professionals' incl Pharmacists? Can it? If so, could be throughout the document. Cost saving implications of using this resource are strong	Thank you for this comment. Pharmacies are listed in updated recommendation 1. 'Other health professionals' may apply to pharmacists as appropriate. The evidence review considered by the PDG did not include specific information on pharmacists. However, if pharmacists are providing information or referring as covered by the guidance, then the recommendations would apply to them.
British Cardiovascular Society	Recommendation 3,	7	Be aware of - national programmes incl public health interventions and communications campaigns e.g. Change4Life, and to work in parallel and in sync with these messages.	Thank you for this comment. The updated guideline includes an additional recommendation on raising awareness among the local population. This flags national sources of accurate information such as NHS choices and Change4life. The issue you raise are covered in more detail by existing NICE guidance on obesity – working with local communities. Links to this this guidance are given throughout.
British Cardiovascular Society	Recommendation 4	8	The benefits of preventing any further weight gain – on both physical and mental health	Thank you for highlighting this issue.
British Cardiovascular Society	Recommendation 5	9	Any educational needs? E.g. cooking skills, reading labels, understanding recipes and ingredients.	Thank you for this comment – practical issues such as you highlight have been added to the updated training recommendations.

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British Cardiovascular Society	Recommendation 5	9	Any access to better food needs?	Thank you for this comment. The commissioning recommendation notes that programmes should complement activities that address the wider determinants of health.
British Cardiovascular Society	Recommendation 5	9	Discussing weight in the media, and why TV programmes e/g superskinny/biggest loser, are not effecting at long term weight loss?	Thank you for raising this issue. Expectations are addressed in recommendations for individuals considering such programmes.
British Cardiovascular Society	Recommendation 6	10	Focus on long term change – I would include the recommendation for immediate pharmaceutical/surgical interventions for very high risk patients	Thank you for this comment. This guidance is for tier 2 lifestyle weight management services. Tier 3 and 4 services are outside the remit of this guidance. Recommendation 1 states that systems should be in place to allow people to progress easily through the local obesity pathway. When this guidance is published it will more clearly be part of the NICE obesity pathway and links with other relevant guidance, such as that on referral to surgery.
British Cardiovascular Society	Recommendation 6	10	Consider involving local retailers in the programmes	Thank you for this comment. This issue is addressed in existing NICE guidance on obesity – working with local communities.
British Cardiovascular Society	Recommendation 6	10	Set practical and achievable steps e.g. removing all sweetened soft drinks in the UK population average diet will get us to the average recommended sugar intake	Thank you for this comment. This guidance only covers lifestyle weight management programmes. Wider action to prevent and manage obesity are outside the remit of this guidance. Updated recommendation 9 on the core

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				components for weight loss states that specific dietary targets are agreed (for example a clear energy intake or specific reduction in energy intake) tailored to individual needs and goals.
British Cardiovascular Society	Recommendation 6	10	Any physical activity recommendations must be in addition to, not instead of, diet related recommendations	Thank you for this comment. The recommendation states that programmes should be multicomponent i.e. addressing dietary intake, physical activity levels and behaviour change.
British Cardiovascular Society	Recommendation 6	10	Diet diaries have been shown to be very effective e.g. Myfitnesspal	Thank you for this information. Evidence on diet diaries per se within lifestyle weight management programmes was not identified. Self-monitoring has been flagged in the revised guidance.
British Cardiovascular Society	Recommendation 6	11	Any other telemonitoring/technical based solutions that are cost and time efficient.	Thank you for this comment. The evidence review did not identify any information on new technologies, but this is included in the research recommendations.
British Cardiovascular Society	Recommendation 7	12	Encourage healthy eating behavours – evidence points to either a low sat fat and/or low refined carbohydrates diet. 'low fat' diet not always best course of action	Thank you, the wording of this recommendation has been amended.
British Cardiovascular Society	Recommendation 8	12	Ensure lifestyle weight managements include e.g labelling in shops, recipe reading, shopping and cooking skills etc	Thank you for this comment, the updated training recommendations address these type of practical issues.
British Cardiovascular Society	Recommendation 9	13	Can relatives ask for parents/family members to be referred? Can children and partners be jointly referred?	Thank you for this comment. The evidence review did not identify any studies that included wider family members. NICE has recently published guidance on lifestyle weight management for children and young people.

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British Cardiovascular Society	Recommendation 9	13	Measure BMI and waist circumference for those under BMI 35	Thank you, this is covered in recommendation 2.
British Cardiovascular Society	Recommendation 9	14	Fodus on BMI>30 – should BMI >40 be directly referred for surgery/pharmaceutical intervention?	Thank you for this comment. This guidance is for tier 2 lifestyle weight management services. Tier 3 and 4 services are outside the remit of this guidance. Recommendation 1 states that systems should be in place to allow people to progress easily through the local obesity pathway.
British Cardiovascular Society	Recommendation 9	14	'People's preference' – this is a lot to take into account and has not been fully explained what this means or how it might affect the programmes they are referred too	Thank you for raising this issue.
British Cardiovascular Society	Recommendation 9	14	Ensure people who are not referred are assessed for comorbidities	Thank you – the identification and assessment of obesity per se are covered by existing NICE guidance on obesity.
British Cardiovascular Society	Recommendation 10	15	Consider measuring non-invasive health outcomes e.g. blood pressure, waist measurement	Thank you for this suggestion.
British Cardiovascular Society	Recommendation 11	16	Training to asses patient motivation is very hard and complex	Thank you for raising this issue, the wording of this recommendation has been amended.
British Cardiovascular Society	Recommendation 12	17	Training staff to understand the difficulties is also extremely complex. Maybe offer training e.g. diploma	Thank you for this suggestion.
British Cardiovascular Society	Recommendation 12	17	Train programme staff to use technological systems such as telemonitoring, diet diaries etc that may help adherence	Thank you for this comment. The evidence review did not identify any information on new technologies, but

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				this is included in the research recommendations.
British Cardiovascular Society	Recommendation 12	18	Be aware of common medical AND psychological problems	Thank you, this is addressed in the recommendation as it stands.
British Cardiovascular Society	Recommendation 12	18	Again, offer family weight management programmes?	Thank you for this comment. The evidence review did not identify any studies that included wider family members. NICE has recently published guidance on lifestyle weight management for children and young people.
British Cardiovascular Society	Recommendation 13	18	Routinely collect – also waist circumference, Blood pressure, cholesterol? Seeing immediate health effects are good motivational tools	Thank you, the updated recommendation on evaluation (17) emphasises the key data that should be collected as a minimum. It flags that other measures such as changes in health outcomes should be considered.
British Heart Foundation	General	x	The British Heart Foundation (BHF) is the nation's leading heart charit vision is of a world in which no one dies prematurely of heart disease. over 2.3 million people in the UK living with coronary heart disease.1 We raise awareness of the benefits of a healthy lifestyle, advocate for environment to make the healthy choice, the easy choice and provide and support for people at risk of living with heart disease. The BHF, alongside the BHF National Centre (BHFNC) for Physical Ac Health, welcomes the opportunity to respond to this guidance. We find document to be on the whole helpful and informative, with clear guidan BHF particularly welcomes the emphasis on ensuring adequate weight management services for disadvantaged groups. Alongside this we we pleased that there was an emphasis through the guidance on long tern change, reinforcing BHF messaging that management of obesity and n a healthy lifestyle is a life choice.	Noted.

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			If you have any queries about this response or would like more informa please contact Amy Smullen, Policy Researcher smullena@bhf.org.uk	
British Heart Foundation			1 British Heart Foundation (2012) *Coronary Heart Disease Statistics* http://www.bhf.org.uk/plugins/PublicationsSearchResults/DownloadFile.aspx?docid=e3b705eb-ceb3-42e2-937d-45ec48f6a797&version=-1&title=England+CHD+Statistics+Factsheet+2012&resource=FactsheetEngland	Thank you for this reference.
British Heart Foundation	General	x	The guidance does not give adequate attention to the wider determinants of being overweight and obesity. This is surprising given other NICE Guidance on Behaviour Change.	Thank you for this comment. This guidance is focused on lifestyle weight management programmes. Obesity is a complex topic and the work to develop this guidance has been careful not to duplicate work undertaken on associated NICE guidance. Links are made to other sections of the NICE pathway on obesity. The importance of an integrated approach to the prevention and management of obesity is highlighted in recommendation 1 and updated recommendation 13 states LA should ensure programmes 'are

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				complemented by a range of activities or services that address the wider determinants of health'.
British Heart Foundation	General	x	We welcome the importance placed on the recommendation that lifestyle management should be undertaken by experienced and qualified professionals. However, it is a concern that due to the current economic climate and its impact upon health and local authority services, the move towards alternative service providers is unlikely to see such a skilled workforce in place.	Thank you for this comment. The recommendations apply to all providers.
British Heart Foundation	General	x	The BHF would welcome greater detail on the correct pathway for those who relapse within the 12month period following intervention.	Thank you for this comment. We are of the view that this is addressed throughout the guidance, but particularly in updated recommendation 8. The training recommendation for health professionals (14) also addresses re-referral.
British Heart Foundation	General/ recommendation 2	2.6	We welcome references to stigma and minimising harm which have the potential to maximise the reach and effectiveness of local services.	Thank you for this comment.
British Heart Foundation	General	4.5	The clarity and detail of the weight loss programme content is welcomed by BHF.	Thank you for this comment.
British Heart Foundation	Draft recommendations	4	In addition to the listed diseases that are associated with obesity, the BHF would welcome further research into the link between obesity and peripheral vascular disease and vascular dementia. Both of these conditions are considered by the BHF as part of the family of cardiovascular disease and as such are referenced in the recently	Thank you for highlighting this issue. We do not think it is appropriate to add this level of detail within this recommendation.

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			published Cardiovascular Disease Outcomes Strategy (March 2013).	
British Heart Foundation	Assessing adults who are overweight or obese	5	The BHF welcomes the reference to lower BMI or waist threshold for black, Asian and minority ethnic groups.	Thank you for this comment.
British Heart Foundation	Recommendation 4	8	Whilst it is important to make it clear to participants that motivation and commitment is needed to lose weight, for some the emphasis that the guidance proposes on this may be a disincentive for some. Therefore we recommend the re-ordering of the components to prioritise the health benefits that participants stand the gain from losing weight. Reference to the evidence base behind motivational interviewing may help support this re-ordering.	Thank you, the wording of this recommendation has been amended.
British Heart Foundation	Recommendation 6	10	BHF express some concern at the repeated reference of 'qualified exercise professionals'. Whilst people who are clinically obese will require guidance to avoid causing harm through in appropriate physical activity, those who are overweight need to be encouraged to adopt simple walking programmes which do not require exercise expertise. With the emphasis on behaviour change in this guidance, the guidance needs to be clearer about what expertise is required on the part of an exercise professional. Greater detail and confirmation is required that NICE are confident that such exercise professionals are trained in up to-date behaviour change techniques and whether the Register of Exercise Professionals (REPS) monitors such training. We also question whether it is necessary to recommend that training is undertaken by a multi-disciplinary team as the curriculum could be delivered by one of a number of healthcare professionals. The key aspect is to ensure that the curriculum itself covers the multi-disciplinary aspects of weight loss and weight management.	Thank you for raising this issue. We are of the view that references to qualified exercise professional are appropriate and the updated guidance clarifies the type of qualification. The PDG were of the view that it was important for multidisciplinary teams to develop programmes and training, given the span of the topic and expert input required.
	Recommendation	12-13	We welcome the emphasis on maintenance of weight loss and the	

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British Heart Foundation	8		support mechanisms required. The BHF agrees that where services are not effective that they should be decommissioned. However, the BHF recommends that when this occurs it would be useful to review why that service or approach was unsuccessful with the target audience. This would offer evidence to inform the management and content of further services. There should also be an appropriate referral service available for those who were users of the decommissioned service or target audience to redirect them to alternative services in their area, to ensure adequate opportunities are available to them. We are also concerned with the scarce mention of the obesigenic environment, which is limited to this one recommendation. Whilst we realise the responsibility of reducing this largely rests with Government and industry it would be beneficial to emphasis the role that local authorities can play through planning, active travel initiatives and public health promotion. It would also be beneficial to include awareness raising for participants in the programme to educate and equip participants about the obesigenic environment.	Thank you for this comment. The revised recommendation states 'Amend, improve or decommission programmes'. Thank you for this comment. This guidance is focused on lifestyle weight management programmes. Obesity is a complex topic and the work to develop this guidance has been careful not to duplicate work undertaken on associated NICE guidance. Links are made to other sections of the NICE pathway on obesity.
British Heart Foundation	Recommendation 9	14	This recommendation focuses mainly on adults with a BMI over 30 and those identified as overweight and obese at the NHS health check service. However, patients with existing cardiovascular disease would also benefit from weight management. Arguably they might benefit more in terms of quality of life and life expectancy. The BHF has long advocated for the provision of cardiac rehabilitation as an intervention following a cardiac event. This has a good evidence base to support improvements in quality of life and has shown a relative reduction in cardiac mortality by 26 per cent over five years.2 Cardiac rehabilitation includes advice on diet, physical activity and weight management.	Thank you for this comment. The updated recommendation notes that for funded referrals, people who are obese or with other risk factors (co-morbidities such as type 2 diabetes) will particularly benefit. It also notes that where there is capacity access for people who are overweight should not be restricted.
British Heart Foundation	Recommendation 14	19	The BHF welcomes the vital step of monitoring and evaluating programmes. The difficulty we have found, particularly with re-engineering the National Audit for Cardiac Rehabilitation in line with	Thank you for this comment. The recommendation states that validated tools should be used where possible.

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			the recently published standards from the British Association of Cardiovascular Prevention & Rehabilitation, has been that there are no validated questionnaires that can easily be used to measure and monitor eating behaviours. As the guidance mentions self-reporting measures on height and weight are unreliable, equally we think self-reported data on eating may also be less reliable than a validated tool. We therefore recommend that NICE could suggest developing a tool to address this gap.	The specific tools available are outside the remit of this guidance.
British Lymphology Society	Section 2	20	Obesity can cause obesity related lymphoedema (ORL) and increase the risk of cellulitis. Lymphoedema is most commonly found in both legs and also in the abdominal apron. The cost of treating a patient with bilateral obesity related Lymphoedema is approximately £1038-£1248 per year. Clinician time £528 + hosiery £510-720. In addition there may be a cost for emollients, dressings and donning aids or social services assistance to put the garments on and the cost would increase if the patient needs bandaging to improve skin integrity. The cost of treating cellulitis would be in addition to this. ORL will improve with weight loss and therefore there is a potential cost saving if the patient is prevented from developing lymphoedema. There is also an actual cost saving if the patient's condition reverses through weight management. The cost of treating the lymphoedema will be less if the patient reduces the size of their legs (and can therefore be fitted with less complex / less costly garments) and improves the condition through weight loss.	Thank you for providing this information.
British Lymphology Society			If the patient deteriorates further as they have not managed their weight then the cost to primary care will be far greater as the patient may require ongoing treatment with bandages and dressings.	Thank you for this comment

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British Lymphology Society	Section 3.17	26	Comment as above	Thank you for this comment
British Lymphology Society	General	General	Very obese patients who develop Obesity Related Lymphoedema often also have severe mobility problems that prohibit normal exercise programmes and also prevent them from accessing lifestyle weight management programmes as they are physically unable to attend the group meetings. Consideration of home visits to provide one to one support needs to be considered.	Thank you for this comment. This guidance only covers tier 2 lifestyle weight management services. Treatment of individuals with more severe obesity or the additional needs of those with complex needs is outside the remit of this guidance.
British Nutrition Foundation	General		We welcome this guidance, which provides a thorough overview of the issues to be aware of when managing lifestyle weight management services for adults. However, we feel there are some gaps in the guidance with regard to what constitutes a 'healthy diet' and appropriate changes to eating behaviour in the context of weight loss. There is also a lack of emphasis on the training of practitioners in the science of diet and nutrition to give them the confidence to provide appropriate, evidence-based advice to clients in this area.	Thank you for raising this issue. Thank you the remit of the guidance was to consider lifestyle weight management programmes per se rather than the most appropriate diets for weight loss or maintenance. Links are given to other, relevant existing NICE guidance. Additional information has been added to the training recommendations in line with your comments.
British Nutrition Foundation	Recommendation 6	9-11	This recommendation outlines the core components of lifestyle weight management services (weight loss) and highlights the need to set a clear energy intake target to achieve weight reduction. However, no mention is made on educating participants in such programmes about appropriate dietary strategies for weight loss in terms of having a balanced diet with appropriate proportions of food from the main food groups, as shown in the government's *eatwell plate*. This is important to ensure that dietary quality is maintained, providing essential nutrients while energy intake is restricted. As there are no complementary NICE clinical guidelines to provide this information we would suggest that reliable external sources, such as the Department of Health's NHS choices website, the British Dietetic Association or the BNF website are referenced to provide further information.	Thank you for these comments. The wording of this recommendation has been amended for clarity. The core components for weight loss reflect the evidence considered. Core components for loss flag that long term lifestyle change should be considered form the outset and the core components for the prevention of weight re-gain flag that they should encourage behaviours that are sustainable in the long term.

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British Nutrition Foundation	Recommendation 7	11-12	This recommendation outlines the core components of lifestyle weight management services (weight maintenance) and includes a point on encouraging healthy eating behaviours that are sustainable in the long-term and emphasising the benefits of eating a healthy, low-fat diet. However, neither 'healthy eating behaviours' nor a 'healthy, low fat diet' are defined and no further information is included in the guidance on what this means in practice. This may not be an issue for weight loss programmes that already have an established system for guiding eating behaviour, but for practitioners who do not already have this framework in place this may be a significant information gap. As there are no complementary NICE clinical guidelines to provide this information we would suggest that reliable external sources, such as the Department of Health's NHS choices website, the British Dietetic Association or the BNF website are referenced to provide further information.	Thank you for this comment. The wording of this recommendation has been amended for clarity. In addition, the training recommendations have been amended to include increase awareness on practical skills and behaviours that can help an individual lose or maintain weight. Link to the NHS choices website is given elsewhere in the guidance.
British Nutrition Foundation	Recommendation 11	15-16	This recommendation refers to the training, knowledge and skills of GPs and other health professionals. While a number of skills are referred to, there is no mention of improving understanding of diet, nutrition and eating behaviour in relation to weight management. As GPs and other health professionals may not routinely be trained in these areas, we feel it is important that this is highlighted as a potential training need in this recommendation. BNF provides online training courses in nutrition and is also working with health professional groups e.g. the RCM to provide relevant nutrition training for their professional development. External training courses, delivered by organisations such as BNF could be one way to meet this training need.	Thank you for this comment, the training recommendations have been amended in line with your comments.
British Nutrition Foundation	Recommendation 12	16-17	This recommendation refers to the training, knowledge and skills of programme staff. Healthy eating is mentioned as part of the training required to deliver multicomponent weight management programmes but, as above there is no mention of how these should be defined or communicated. As with previous comments we would suggest that	Thank you for this comment, the training recommendations have been amended flag practical skills and behaviours that can help and individual lose or maintain weight. Links to NHS Choices are given

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			reliable external sources, such as the Department of Health's NHS choices site, the British Dietetic Association or the BNF website are referenced to provide further information. As mentioned above, BNF has an online nutrition training platform and such resources may be of benefit for practitioners in this field.	throughout the updated guideline.
British Nutrition Foundation	Recommendation 13	18-20	This recommendation highlights the need to evaluate weight management services effectively, which we welcome. As noted in the research recommendations, there is a need for more and better quality published research in the field of weight management, particularly for longer-term follow up. It would be helpful if this recommendation could include the importance of the publication of results as well as collection of data – preferably in peer-reviewed journals where possible so that this can inform best practice in future.	Thank you, the research recommendations have been amended in line with your comments.
British Psychology Society	General		The Society welcomes this timely and helpful document that provides guidance for weight management programmes and future research in areas currently lacking or sparse. The Society welcomes the focus that on the social context within which weight management takes place and the importance of practitioners taking a supportive and non-judgemental approach to clients to help produce more effective and honest change talk and plans. We are pleased that recognition has been given to the importance of multi-component approaches to long-term change, outcomes and learning more about what supports effective weight management.	Thank you for these comments.
British Psychology Society	1	4	Whilst the Society recognises the limitations of guidance in considering co-existing conditions such as mental health problems, we would highlight that many overweight and obese individuals struggle with psychological and emotional difficulties (such as low level depression, anxiety, emotional issues, etc) (BPS Obesity Report, 2011).	Thank you, the introduction has been amended to flag that 'The guidance does not consider the additional needs of adults with complex needs (such as those who are obese and also have alcohol or mental health problems). Clinical judgment will be needed to determine whether

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			There is a complex interaction between psychological factors and obesity in relation to associations between the two and the relationship between psychological difficulties and outcome of weight management programmes. Therefore, we believe that it is important that psychological difficulties are assessed and managed appropriately at tier 2.	lifestyle weight management programmes are appropriate for people with associated conditions or complex needs.'
British Psychology Society	1	4	The guidelines lists weight management as reducing the risk of breast and kidney cancers However, we are aware that weight has also been linked to a number of other cancers including colorectal, pancreatic and endometrial cancer (American Institute of Cancer research (http://www.dietandcancerreport.org/)	Thank you, this list is given as an example only.
British Psychology Society	1	5	The caution around the use of BMI in terms of specific subgroups is welcomed.	Thank you for this comment.
British Psychology Society	1	6	The Society believes that it would be useful if this recommendation called for more transparency and accountability by LA's, commissioner groups, H & W Boards, etc. on services provided and routes to access of local obesity pathways. Many patients and practitioners are not fully aware of the full range of services available. Information about obesity pathways should be made widely available. This would be of benefit to local referrers, as examples of best practice and for individuals wanting to make changes but are struggling to identify support. In addition, we suggest links to local Improving Access to Psychological Therapies (IAPT) services and Eating Disorders services in order to refer people for appropriate interventions for mental health problems (e.g. depression; binge eating disorder) with the facility to refer back from those services to weight loss clinics when the person is ready to address weight management. This will strengthen the integrated approach mentioned,	Thank you for this comment, the text has been amended in line with your suggestion.

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			which we believe is essential.	
British Psychology Society	1.2	6	Under the section 'What action should they take' - we suggest that the first sentence should be amended as follows: 'Be aware of the effort needed to lose weight, **maintain weight loss** and avoid further weight gain...'	Thank you, the text has been amended in line with your suggestion.
British Psychology Society	1.2	7	The Society suggests considering the provision of suitable (larger) chairs in clinics/services in a bullet point for this section. We also ask that another bullet point to be considered here is: '**Be aware of emotional state'**.	Thank you, the text has been amended to flag that suitably sized chairs without arms be available.
British Psychology Society	1.4	8	The Society suggests changing the work **'Explain'** at the beginning of 'What action should they take' to **'Discuss'**. This would change the emphasis of the language used to being that of a more patient-centred approach and discussion of patient goals expected to ensure realistic expectations (see Evidence statement 1.18, page 59 of the guidance; Cooper et al., 2004). We also suggest the addition of the following bullet points: **'Discuss relapse and the risk of all-or-nothing thinking'; 'Explore the importance of timing for embarking on a lifestyle weight management programme in terms of resources, focus, motivation, etc'; 'Discuss the fact that a non-dieting approach to assist with permanent and sustainable lifestyle changes is associated with better long term outcomes (Cooper, et al., 2004)'.**	Thank you, the text has been amended in line with your comments. Thank you for these suggestions – they go further than evidence considered by the PDG.
British Psychology Society	1.5	9	This recommendation is helpful in providing a comprehensive account of what might be discussed between patient and referrer. The society suggests that the following bullet points might also be added: **'Concerns/barriers about joining the programme'; 'Emotional/psychological issues that might interact with aiding/negating behaviour change'.**	Thank you for this comment. The wording of this recommendation has been amended for clarity and we are of the view that the issues you raise are covered within the revised wording.

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British Psychology Society	1.6	10	The Society welcomes the inclusion of a practitioner psychologist among the members of the multi-disciplinary team specified to providing training, however we recommended the term 'clinical psychologist' is replaced by "practitioner psychologist" since other types of practitioner psychologists (Counselling, Sport & Exercise and Health) may, and often do, have the competencies to provide this training.	Thank you, for this comment. The term 'qualified practitioner psychologist' is used throughout.
British Psychology Society	1.6	10	The Society welcomes, bullet point 5 suggesting no foods should be 'banned' however we would propose that an alternative to counting calories may have greater impact if advice is instead framed in terms of goals and targets to form habits associated with long term weight loss, for example, eating breakfast, using a smaller plate or an eat well plate. In relation to behaviour change methods (bullet point 8) the Society suggests amending the sentence 'to read "Use a variety of clear, measurable and replicable behaviour change techniques" (see Atkins & Michie, 2013).	Thank you for this comment, the statements reflect the evidence considered.
British Psychology Society	1.6	11	The Society believes that group sessions should be included as part of the programme to address any psychological issues linked to behaviour change with managing weight, led by an expert in the field. The group leader is important in terms of managing those who sometimes find group work difficult (see evidence statement 2.5, page 65 of this guidance). Notwithstanding this point, group work will enable discussion of motivational and lifestyle changes involved with managing weight, address the need for cost effectiveness within the programme (by having a group rather than doing this one-to-one) and offer much needed like-minded support for participants. We believe that the psychological issues associated with weight management should be addressed (e.g. self-efficacy, confidence, self-esteem, motivation, general psychological health) as this is an important factor in achieving long term change. This group might	Thank you for this comment. The guidance highlights the importance of tailoring. A separate recommendation notes the importance of respecting individual preference and previous experience, but for those that have no preference they should be referred to a group programme. Thank you for raising these issues.

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			continue for maintenance purposes to enable longer term healthier weight management behavioural habits to develop. In turn this may mean that fewer people enter treatment at tier 3 (see BPS Obesity Report, 2011; evidence statement 2.2, page 63 and 2.4, page 64 of guidance).	
British Psychology Society	1.7	11	The Society recommends including reference to the wider health benefits of healthy eating and physical activity other than weight loss, for example, a reduction of sedentary behaviour. (BPS Obesity Report, 2011)	Thank you, the text has been amended in line with your comment.
British Psychology Society	1.9	13	Research suggests (Darby et al, 2009) that a high percentage of those involved in weight control programmes engage in binge eating (i.e. period when they experience lack of control over the high volumes of food consumed in a short period of time). Advice and referral of these individuals needs to address the psychological and emotional aspects of overeating as well as the practical and motivational.	Thank you for this comment. The guidance does not consider the additional needs of adults with complex needs . The training recommendations flag that GPs and other health professionals should identify people with more complex needs and refer them to appropriate services.
British Psychology Society	1.10	15	While we acknowledge that regular weigh-ins are a necessary indicator of progress, weight may also be affected by an increase in muscle mass, if exercise is involved in the weight loss programme. Additional indicators of important outcomes may be the use of body measurements, mood measurements, self-esteem measurements, anxiety/depression measurements and behavioural change,) (also see Waumsley & Mutrie; Marchant, BPS Obesity report, 2011).	Thank you for this comment, the wording of updated recommendation 8 states 'Use the regular weigh-in as an opportunity to monitor and review progress toward individual goals'. Updated recommendation 9 states 'monitor weight, indicators of behaviour change and participant's personal goals throughout the programme'.
British Psychology Society	1.11	16	This point refers to the first points made in this report (see 1, page 4 above) in terms of GPs being able to recognise psychological and emotional aspects of overweight and obesity and refer on to appropriately trained professionals, in this case, the practitioner psychologist. To this end, the term 'complex needs' requires further	Thank you, the training recommendation (14) has been amended in line with your comment.

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			clarification.	
British Psychology Society	1.12	17	As in recommendation 1.6 page 10 above, the Society recommends changing the term 'clinical psychologists' to "practitioner psychologists".	Thank you for this comment. The term 'qualified practitioner psychologist' is used throughout.
British Psychology Society	1.12	17	The Society very much welcomes that the guideline addresses staff attitudes and concerns and recommends that this is also incorporated into the referral process (see Lawson & Shoneye, 2008).	Thank you for this comment.
British Psychology Society	1.12	18	This refers to 1 (4) above. The society believes that the term 'psychological' should be added to the sentence 'be aware of common medical **and psychological** problems that are associated with overweight and obesity (e.g. low self-esteem, body image, depression, etc) (see BPS Obesity Report, 2011)	Thank you, the text has been amended as suggested.
British Psychology Society	1.13	19	The inclusion of psychological outcomes (self esteem, depression and anxiety) here is very much welcomed. We do however note that there is some inconsistency in the inclusion of psychological outcomes throughout the document.	Thank you for this comment. The guidance has been checked for consistency throughout.
British Psychology Society	1.13	19	The Society suggests a further follow up at 24 month in addition to the specified follow up at 12 months. Research suggests that the drop off in people maintaining their weight after 12 months is even greater after 2 years.	Thank you for this comment.
British Psychology Society	2	21	Mentioning the 'mental health problems' associated with overweight, such as stigma and bullying, is again welcomed but does again call for a need to be consistent with language and meaning throughout the guidelines.	Thank you for this comment. The guidance has been checked for consistency throughout.
British Psychology Society	3.4	23	We believe that the evidence that healthcare professionals have	Thank you for this comment. The term

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			reported concerns about a lack of confidence in raising issues about weight with clients, supports the argument for the term 'psychological practitioner' to be used within multidisciplinary teams. The BPS Obesity Report (2011) found similar evidence for a lack of confidence in some clinical psychologists when addressing weight and exercise issues with clients (see evidence statements 2.9 and 2.10, pages 67 and 68 of this guidance).	'qualified practitioner psychologist' is used throughout.
British Psychology Society	4.1	28	The Society suggests adding 3 further questions as follows: 1. 'Are programmes that focus on behaviour change rather than weight loss more effective?' 2. 'What behaviour change techniques are most effective in maintenance of weight loss?'	Thank you for this comment, the text has been amended to reflect your comments.
British Psychology Society	4.3	30	Including details of the specific behaviour change techniques used in the programme, it may enable the drawing out of which techniques are most effective.	Thank you, the text has been amended in line with your comments.
British Psychology Society	4.5	31	The Society suggests adding a further bullet point: 'communication skills – developing an 'asking' rather than 'telling' approach, focusing on open questioning rather than information and advice giving.	Thank you for the comment, the wording has not been amended as it goes further than the evidence considered by the PDG.
British Psychology Society	6	33	We suggest the term behaviour change should read 'behaviour change techniques' since behaviour change is the outcome. (see BPS website for a breakdown, http://www.bps.org.uk)	Thank you, the text has been amended as suggested.
British Psychology Society	General		The Society questions the exclusion of binge eating disorder BED and emotional eating at tier 2. Both are prevalent in terms of inclusion of psychological issues for those struggling to control their weight (Carter & Jansen, 2012; see BPS Obesity Report, 2011).	Thank you for this comment. The introduction to the guidance flags that it does not consider the additional needs of adults with complex needs (such as those who are obese and also have alcohol or mental health problems). Clinical judgement will be needed to determine whether lifestyle weight

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				management programmes are appropriate for people with associated conditions or complex needs.
British Psychology Society	General		The Society suggests that some inclusion of some guidance on making services available for Health Care Professionals who themselves are overweight but for whom it may be inappropriate to join a local weight management service might be useful.	Thank you for this comment. This issue is addressed in existing NICE guidance on obesity – working with local communities (recommendation 9).
British Psychology Society	General		The Society suggests that GPs and other referrers need access to a regularly updated portfolio of weight management services within their area. We suggest it might also be useful for GPs to refer to online programmes of self-monitoring services, some of which are free (Johnson & Wardle, 2011).	Thank you for this comment. The guidance applies to all programmes, including online programmes.
British Psychology Society	General		Behaviour change interventions are often complex, comprise many interacting components (Craig et al., 2008) and their effectiveness is variable. Weight loss is an end point of a behavioural intervention which involves a sequence of actions over time. In order that behaviour change is successful, the behaviour change techniques (BCT) through a scientific understanding of theoretical underpinning (see BPS Obesity Report, 2011) need to be detailed in the guidance. (Dombrowski, et al., 2012; Michie, et al, 2009; Waumsley & Mutrie, 2011).	Thank you – the theoretical underpinning of behaviour change techniques is outside the scope of this work. Links have been made to other NICE guidance on behaviour change.
British Psychology Society			Armstrong, M. J., Mottershead, T. A., Ronksley, P. E., Sigal, R. J., Campbell, T. S. and Hemmelgarn, B. R. (2011), *Motivational interviewing to improve weight loss in overweight and/or obese patients: a systematic review and meta-analysis of randomized controlled trials*. Obesity Reviews, 12: 709–723. doi: 10.1111/j.1467-789X.2011.00892.x	Thank you for this reference.
British Psychology Society			Atkins, L. and Michie, S. (2013), *Changing eating behaviour: What can we learn from behavioural science?*. Nutrition Bulletin, **38**: 30–35.	Thank you for this reference.

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			doi: 10.1111/nbu.12004	
British Psychology Society			British Psychological Society – Waumsley et al (2011) Obesity in the UK: A psychological perspective – British Psychological Society publication http://www.bps.org.uk/sites/default/files/images/pat_rep95_obesity_web.pdf	Thank you for this reference.
British Psychology Society			Carter, F.C. & Jansen, A. (2012). Improving psychological treatment for obesity. Which eating behaviours should we target? Appetite, **58**, 1063 - 1069.	Thank you for this reference.
British Psychology Society			Cooper, Z., Fairburn, C.G. & Hawker, D.M. (2003). *Cognitive behavioural treatment of obesity*. New York: Guilford Press.	Thank you for this reference.
British Psychology Society			Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: *the new Medical Research Council guidance*. *British Medical Journal, **337**,* 1655.	Thank you for this reference.
British Psychology Society			Darby, A., Hay, P., Mond, J., Quirk, F., Buttner, P. and Kennedy, L. (2009), *The rising prevalence of comorbid obesity and eating disorder behaviors from 1995 to 2005*. Int. J. Eat. Disord., **42**: 104–108. doi: 10.1002/eat.20601	Thank you for this reference.
British Psychology Society			Dombrowski, S.U., Sniehotta, F.F., Avenell, A., MacLennon, G., & Arau`jo-Soares, V. (2012). *Identifying active ingredients in complex behavioural interventions for obese adults with obesity-related co-morbidities or additional risk factors for co-morbidities*: A systematic review. Health Psychology Review, **6**, 7-32.	Thank you for this reference.
British Psychology Society			Johnson, F., and Wardle, J. (2011) *The association between weight loss and engagement with a web-based food and exercise diary in a commercial weight loss programme: a retrospective analysis*,	Thank you for this reference.

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			International Journal of Behavioral Nutrition and Physical Activity, **8(83)** doi:10.1186/1479-5868-8-83	
British Psychology Society			Knowles, L., Anokhina, A. and Serpell, L. (2013), *Motivational interventions in the eating disorders: What is the evidence?*. Int. J. Eat. Disord., **46**, 97–107. doi: 10.1002/eat.22053	Thank you for this reference.
British Psychology Society			Lawson, V., and Shoneye, C. (2008).*Overweight health professionals giving weight management advice: The perceptions of health professionals and overweight people*, London: Weight Concern.	Thank you for this reference.
Cambridge Weight Plan	General		Cambridge Weight Plan would like to thank NICE for providing us with the opportunity to comment on this piece of draft guidance.	Noted, thank you.
Cambridge Weight Plan	1.1	6	Cambridge fully supports the recommendation that individuals should be referred through the different tiers of weight management services. We are concerned, however, that commissioners may be reluctant or unable to easily refer individuals through the various tiers. We look forward to the release of the guidance currently being developed by the Department of Health to address this issue.	Thank you for this comment.
Cambridge Weight Plan	1.1	6	Cambridge strongly endorses the recommendation that staff should be aware of the lifestyle weight management services available in the community that patients can be referred to. We believe that knowledge of the services available in the community is absolutely crucial for staff to be able to refer patients to the most appropriate services.	Thank you for this comment.
Cambridge Weight Plan	1.1	6	Cambridge also agrees that the services offered by local weight management providers should meet local needs, as laid out in the Joint Strategic Needs Assessment for that respective area.	Thank you for this comment.
Cambridge Weight Plan	1.2	6	Cambridge concurs that all organisations involved in assisting	Thank you for this comment.

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			individuals manage their weight must be aware of the effort that patients are required to make to lose weight and avoid continued weight gain. We particularly endorse this recommendation as it seeks to tackle the stigma experienced by some overweight and obese adults, even in situations in which they should be treated with great sensitivity. Cambridge is particularly aware of this issue, given that many of our counsellors have been overweight or obese in the past, allowing them to empathise and understand the importance of maintaining respectful dialogue at all times. Cambridge therefore endorses the recommendation that the tone and content of all communications or dialogue should be respectful and avoid apportioning blame in order to help patients feel supported in their efforts to manage their weight.	
Cambridge Weight Plan	1.3	7	Cambridge agrees that awareness of the approach being offered by local commercial providers and of the research underpinning these services is imperative to ensuring that commissioners are able to assist individuals seeking to manage their weight. Cambridge also strongly believes that all those commissioning local lifestyle weight management services should be aware of the approach being offered by local commercial providers.	Thank you for this comment.
Cambridge Weight Plan	1.3	8	Including sources of information about lifestyle weight management services to literature on overweight or obesity by all healthcare practitioners about is absolutely crucial. This extends to information and advice provided by pharmacists and other healthcare practitioners with strong ties in local communities. Cambridge believes that having one organisation fund the collection and dissemination of all information on weight loss services offered by	Thank you for this comment.

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			the NHS, the voluntary sector or local commercial organisations would be an effective way of ensuring the information assembled reaches a large group beyond traditional settings.	
Cambridge Weight Plan	1.4	8	We find this recommendation sensible and we strongly welcome it. Cambridge endorses the need to both set realistic expectations regarding lifestyle weight management programmes and ensure that individuals are aware of what is expected of them whilst following the weight loss programme they have chosen.	Thank you for this comment.
Cambridge Weight Plan	1.5	9	Cambridge endorses this recommendation and believes that individuals should always be able to make an informed choice on whether or not to proceed with a lifestyle weight management programme. At Cambridge, we provide individuals with on-going tailored support through a one-to-one to an assigned consultant, who is able to fully take into account their preferences. In addition, prior to commencement of any Cambridge programme, individuals undertake a consultation which includes a health questionnaire to ensure suitability for different programmes, an outline of the educational component (nutrition, diet, lifestyle, weight maintenance) and a description of how each programme works.	Thank you for this comment.
Cambridge Weight Plan	1.6	10-11	We agree with the core elements outlined in the draft guidance that lifestyle weight management services will be required to meet in order to be eligible for recommendation or commissioning.	Thank you for this comment.
Cambridge Weight Plan			Cambridge's weight management programmes provide one-to-one and group counselling with professionally trained consultants who offer support to individuals seeking to lose weight. Individuals are set clear targets and monitored closely throughout the duration of the programme in one-to-one sessions.	Thank you for this information.

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Cambridge Weight Plan	1.7	11-12	Cambridge concurs that weight management services should only be recommended or commissioned on the basis that they provide advice and support for maintaining or continued weight loss. Cambridge's programmes help individuals achieve long-term changes in their relationship with food. In addition, the Cambridge Active programme provides on-going support to help them be more active and exercise more.	Thank you for this information.
Cambridge Weight Plan	1.8	12-13	Cambridge endorses the actions outlined in this recommendation but wish to stress the importance of commissioners possessing full knowledge of those weight management services that are available locally and of the need for commissioners not to hold any prejudice against said services. Commissioners should also be aware of local commercial weight management providers with strong evidence bases.	Thank you for this comment, an additional recommendation has been added for public health England to develop a national source of information on lifestyle weight management programmes that meet the core components. It also states the information providers should make available.
Cambridge Weight Plan	1.9	13-14	Cambridge agrees with the point made in the recommendation that the preferences of individuals and their former experience of weight management programmes should be taken into consideration. We believe that, to achieve this, it is essential future patients receive sufficient information about the services available in the local community, including those offered by commercial weight management providers.	Thank you for this comment, an additional recommendation has been added on raising awareness of services among the local population.
Cambridge Weight Plan	1.10	15	Cambridge agrees that GPs that have referred patients to weight management services should be able to assess their progress on weight management programmes in order to ensure adherence and positive outcomes. However, Cambridge also notes that in some cases there may be bias	Thank you for this comment. The guidance applies to all programmes and providers. An additional recommendation has been added for public health England to develop a national source of information on

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			against commercial weight management services amongst GPs. This may influence the referral decisions of some GPs or affect their assessment in instances where individuals seek out weight management services without their GP's involvement.	lifestyle weight management programmes that are suitable for commissioning.
Cambridge Weight Plan	1.10	15	Cambridge agrees with this recommendation and wish to emphasise the importance of discussing the motivation behind participants' desire to manage their weight. As outlined in earlier, Cambridge's weight management programmes provide both one-to-one counselling sessions to facilitate discussing participants' motivation to change.	Thank you for this comment and information.
Cambridge Weight Plan	1.11	16	Cambridge agrees that health professionals should be trained on the best method and time to raise the issue of weight management with a patient. This is an essential yet often overlooked step in managing overweight and obesity in adults. The training provided should encompass identifying those with complex needs and refer them to appropriate services.	Thank you for this comment.
Cambridge Weight Plan			Health professionals are well placed to address the issue of overweight and obesity with patients and Cambridge believes that the Royal Colleges should be considering offering further training to healthcare professionals in view of the obesity epidemic that needs to be tackled.	Thank you for this comment.
Cambridge Weight Plan	1.12	17-18	Cambridge Weight Plan fully agrees with this recommendation and the actions set out in it. We already provide a comprehensive initial training for our Consultants at an appropriate level for their role in supporting dieters in the community, followed by testing to ensure competence. Continuous education modules are provided and are a requirement for continuation of Consultant status. Quality is further assured by audit processes and 'mystery shoppers'. Standards are further raised by provision of a medical advisory service provided within the	Thank you for this comment and information.

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			Company by registered nurses and doctors.	
Cambridge Weight Plan	1.13	18-19	Cambridge welcomes the proposed collection of validated outcome data and of data on the views and experiences of all participants and staff referring or delivering weight management programmes. We believe this information can be used constructively to set out general improvements for weight management programmes and also to draw attention to those weight management services that have met the criteria set out in this draft guidance and can be deemed effective in helping overweight and obese adults manage their weight.	Thank you for this comment.
Cambridge Weight Plan	Recommendation 14	19	Cambridge strongly endorses the need to monitor local provision. We believe that the awareness among health professionals of available weight management services and of the possible issues that may arise during the delivery of services, such as potential conflict in relation to the payment of different tiers of weight management, are areas in particular that need to be monitored.	Thank you for this comment.
Counterweight Ltd	General		Definitions for 'short term' and 'long term' should be stated: additionally there is a key contradiction around this in relation to provision by commercial organisations where the suggestion is that they are 'likely to be effective: at least in the short term' but accepted as a key element of weight loss services while the focus of outcomes is noted to be 'long term'	Thank you for this comment, the wording of the guidance has been amended to provide more specific times as appropriate. We are of the view that the statement highlighted reflects the lack of evidence rather than a contradiction.
Counterweight Ltd	General		The guideline speaks of overweight and obesity but then focuses only on obesity**.**	Thank you for this comment. The guidance is for both overweight and obese tier 2 services. The modelling showed that programmes appear to be most cost effective for BMI 30 to 40. (It should also be noted that this is where the majority of evidence available was).

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				The updated recommendation states that 'where there is capacity, access for adults who are overweight should not be restricted'.
Counterweight Ltd	General		There is a sense throughout of the value of commercial organisations delivering weight management interventions. There is also then a suggestion that people maintain engagement with these organisations once the 'referral period was over'. Is the guidance therefore suggesting that weight management is effectively moving toward patient payment? An explicit message around this would be helpful and needs wider exposure.	Thank you for this comment, the guidance has been amended to flag a range of sources of long term support.
Counterweight Ltd	General		While this does focus on Tier 2 there is a clear need for focus on people with BMI>35 and appropriate services therein. The majority of lifestyle programmes fail to achieve the loss required for these higher BMI. Guidance other than bariatric surgery is very much needed for this population with growing evidence for successful 'lifestyle' interventions with more intensive weight loss phases achieved through methods such as total diet replacement followed by structured food reintroduction and weight loss maintenance.	Thank you for this comment. The evidence available did not distinguish between the effectiveness of approaches for BMI <35 and BMI>35. The additional need of adults with more complex needs is outside the remit of this guideline. You may be interested in a partial update of existing NICE guidance on obesity (CG43) which is focusing on VLCDs and bariatric surgery for individuals with type 2 diabetes.
Counterweight Ltd	Recommendation 4	8	Weight loss for those whose BMI is >35kg/m2 ought to lose greater than 15-20% of body weight to achieve health benefits (as per SIGN) The 5-10% applies only to those whose BMI<35 kg/m2	Thank you for this comment. The statement re *at least* 5-10% reflects existing NICE guidance on achievable goals. It's worth noting that the included studies in the evidence reviews for this guidance found, on average a loss of around 3%.
Counterweight Ltd	Recommendatio	10	Multi-component needs to be defined more clearly?	Thank you for this comment. The text

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	n 6			has been amended in line with your comment. Multicomponent is also defined elsewhere in the guidance.
Counterweight Ltd	Recommendation 6	10	Can it be clarified how measures of behaviour change ought to be monitored up until 12 months post intervention? This ought to be standardised or guided to allow meaningful data collection nationally. However does mean challenges around data collection and handling	Thank you for this comment. More detail on monitoring and evaluation is given in a separate recommendation. The revised guidance more strongly emphasises the importance of using validated tools such as the standard evaluation framework. Updated recommendation 16 flags the importance of information sharing between providers and referrers to support monitoring and evaluation (such as weight at 12 months).
Counterweight Ltd	Recommendation 6		'Monitor and review participants' goals throughout the programme'. This should be clear that behaviour goals and weight change goals should be monitored.	Thank you, the text has been amended in line with your comments.
Counterweight Ltd	Recommendation 7	11	Weight loss maintenance needs to be defined?	Thank you for this comment. Weight loss maintenance and the prevention of weight re-gain is defined in the glossary.
Counterweight Ltd	Recommendation 8	13	Can the targets for uptake, provision and outcomes be clarified?	Thank you for this comment. The updated recommendations refer to DH best practice criteria for weight management services.
Counterweight Ltd	Recommendation 9	14	What about people with BMI>25 and high WC? Focus does seem to be on BMI>30	Thank you for this comment. The updated recommendation states that 'where there is capacity, access for adults who are overweight should not be

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				restricted'.
Counterweight Ltd	Recommendation 14	20	Areas with low service provision will have low levels of referral, how can this be resolved in areas of low provision?	Thank you for this comment. This is an implementation issue outside the remit of NICE.
Counterweight Ltd	3.12	25	Agree that the provision of long term support may favour increased weight loss maintenance. How would this best be provided and under what funding? For effective weight management this service provision is key: support for patients self managing will involve some kind of strategy.	Thank you for this comment. The evidence available on the best approach to maintenance was very limited and the PDG were not able to make more specific recommendations than is stated. You will see that research recommendations focus on long term follow up.
Counterweight Ltd	3.13	25	The statement that GP or practice led interventions are largely ineffective is queried. Counterweight has publications outlining the effectiveness of the interventions and importantly at 12m and 24m	Thank you for this comment. The statement is based on trials that met the inclusion criteria for this guidance. The considerations section states that the evidence reviewed 'suggests that primary care led services may be less effective than commercial programmes, but it is unclear why'. The guideline recommendations apply to all programmes.
Counterweight Ltd	3.13	25	This is a key aspect of weight management services: begins to acknowledge that patient payment is required and indeed expected. This has never been explicitly stated and would be helpful if this was the case. Long term engagement with services and for what purpose is also important to be clear on.	Thank you for this comment, the guidance has been amended to flag a range of sources of long term support.
Counterweight Ltd	3.13	25	CONTRADICTORY - suggests commercial programmes effective, at least in short term - which goes against the advice that long term outcomes are part of the overall 'outcomes' measure and if not met	Thank you for this comment. We are of the view that this is not contradictory – it reflects the evidence currently available

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			programmes should be considered for de-comissioning	but the need for a longer term view to be taken. Local outcome measures can be established (and there is best practice guidance to support this) and the guidance suggest monitoring at 12 months for outcomes for commissioning, but we hope the guidance makes clear that longer term support needs to be in place.
Counterweight Ltd	3.16	26	Training - guidelines apply to all including commercial: how is this going to be monitored by commissioners?	Thank you for this comment. The training recommendations are for a range of bodies, not just commissioners.
Counterweight Ltd	Eating behaviours	33	NICE recommend this data is collected: extremely resource intensive and needs robust methods for analysis and evaluation. Increases resource significantly where at a premium already	Thank you for this comment. This recommendation is part of research recommendations, not routine monitoring. The updated recommendation on evaluation and monitoring (17) states the data that should be collected as a minimum.
Department of Health	General		I wish to confirm that the Department of Health has no substantive comments to make regarding this consultation.	Noted, thank you.
Diabetes Management & Education Group	Recommendation 1:	Page 6.	There is no mention of engaging with the third sector and industry to enhance an integrated approach. Both sectors provide services that can help facilitate behaviour change and should be included in a collaborative, integrated approach to treating and preventing overweight and obesity. Could make reference to NICE PH guidance 27 for weight management before, during and after pregnancy.	Thank you for this comment. This issue is covered in more detail in existing guidance on obesity – working with local communities. A link is given from this recommendation. PH27 is listed in linked guidance.
Diabetes Management &	Recommendation	Page 6.	Regarding respectful and non-blaming communications; a brief	Thank you for this comment. The

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Education Group	2:	Page 7.	description of the role of empathy in communication would be beneficial here. Empathy is a step further than being respectful and non-blaming as it encourages the practitioner to fully appreciate the person's perspective.	revised recommendation uses the term 'non-judgemental'. The role of empathy goes further than the evidence considered.
			There is mention of measuring waist circumference but no description on how to conduct this appropriately. Should there at least be a link in the document to guide readers on the process?	Thank you, this is an implementation issue outside the remit of the guidance. The training recommendation flags the need for health professionals to know how to measure BMI and waist circumference.
			Regarding respect for individual preferences; this could be improved by adding 'Where practitioners are not aware of patient privacy preferences they should respectfully ask the patient this' (for example, using weighing scales).	Thank you for this comment, we are of the view that the recommendation is clear as it stands.
			Additional information regarding appropriate seating for patients as there is potential risk of harm. Venues where services are delivered should have a risk assessment and provide appropriate space.	The wording has been amended to note that appropriate seats without arms should be available.
Diabetes Management & Education Group	Recommendation 3:	Page 7.	Highlight the need for consistent and uniform evidence based messages and keep commissioners informed of service developments. Any economical analyses completed or projected should be reported to commissioners.	Thank you for this comment. The recommendations make clear that the results of monitoring should be transparent to all. The research recommendations make it clear that study results should be published in peer reviewed journals.

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Diabetes Management & Education Group	Recommendation 4:	Page 8.	Additional point regarding autonomy; discuss in collaboration with patient what the service has to offer and respect patient autonomy (right to choose) in the decision making process When discussing realistic goals explain that there is no pressure from the service for the patient to lose weight. There are numerous benefits of preventing further weight gain as increasing age is linked to increased weight. Point 4 may therefore refer to 'realistic goals which may also refer to weight maintenance as well as weight loss'	Thank you for this comment. The introduction to this recommendation has been amended to 'discuss' from 'explain' to emphasise that this is collaborative. Further amendments have also been made in line with your comments.
Diabetes Management & Education Group	Recommendation 5:	Page 9.	Information on what the programme is about should iterate the fact that they are not 'diets' or 'fitness regimes' but rather an holistic lifestyle management programme focusing on small behavioural changes that can be incorporated over the longer term.	Thank you, we are of the view that this is the tone of the recommendations throughout.
Diabetes Management & Education Group	Recommendation 6:	Page 10.	**Point 5**: This could be edited as programs should not have to provide targeted calorie reduction. This is usually beneficial when this is requested by clients and not incorporated into weight management as 'standard practice'. However, general goals that promote energy reduction are beneficial. Suggest amend as follows; Set behavioural goals that promote energy reduction and when appropriate (i.e. in line with patients' wants and personal goals) provide calorie reduction targets that are tailored to individual needs. We would recommend stating 'Note that an approach that is not costly to follow and that avoids 'banning' specific foods or food groups is recommended'. Also, ' One-to-one contact and advice from a registered dietitian should be available where need arises. Professional dietetic support for staff delivering services would be essential. **Point 8**: Use a variety of behaviour change methods: worth adding 'respect for patient autonomy and decision making'. Additional information on local public health, third sector and industry services should be included to help improve patients' options to seek	Thank you for this comment. The wording has been amended in line with your suggestion. We are of the view that the guidance as it stands would cover this point. This is addressed elsewhere, such as in commissioning recommendation and in recommendations on information needs

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			additional support with weight management. Programmes should highlight the importance of discussing lifestyle goals with family and/or friends as this improves commitment to change and social support network.	for individuals considering programmes
Diabetes Management & Education Group	Recommendation 7:	Page 11.	Repeat above - Additional information on local public health, third sector and industry services should be included to help improve patients' options to seek additional support with weight management. Programmes should highlight the importance of discussing lifestyle goals with family and/or friends as this improves commitment to change and social support network.	Thank you for this comment. Additional options for support have been included to updated recommendations 7, 8 and 10.
Diabetes Management & Education Group	Recommendation 8:	Page 12.	As a tier 2 service should this be consider to include adults who are overweight (i.e. BMI over 25) as well as obese (i.e. BMI over 30)? Could an indication be given regarding the range of level of obesity a tier 2 service applies to.	Thank you for this comment. Definition of tier 2 is given in the introduction. Updated recommendation 6 states that referrals for people who are overweight should not be restricted where there is capacity.
Diabetes Management & Education Group	Recommendation 10: Last bullet point.	Page 15.	Last point: Some people may choose not to participate in regular weigh ins and this should not be seen as lack of motivation or an indication of lack of change. Weight change is not necessarily an indication of motivation as a person could be very committed to change but a crisis/event may have got in the way. Motivation can fluctuate within a day. The person's language is a more useful indicator of motivation and change, e.g. different levels of change talk and commitment language. To use this as a motivational tool requires skills which has training implications.	Thank you for this comment, this recommendation has been revised to Use the regular weigh-in as an opportunity to monitor and review progress toward individual goals.
Diabetes Management & Education Group	Recommendation 11.	Page 16.	Train to assess motivation Again motivation can vary depending on the behaviour that the person is talking about, e.g. exercise, eating regular meals, controlling portion sizes. It is also not about the clinician or health professional to make	Thank you for this comment. The wording of this recommendation has been changed.

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			their judgement on this but to discuss it with the client and for the client to decide how they feel about making change. Therefore would' Train to discuss motivation' be a more person-centred way of saying this. Train GPs to identify pts with more 'complex needs'. Greater clarification about the levels and definition of appropriate services for example tier 3 multi disciplinary services, which could include people post bariatric surgery.	
Diabetes Management & Education Group	Recommendation 12:	Page 17.	Additional information regarding training: Where possible, programme staff should receive accredited training programs and be subject to quality assurance on an annual basis. There is no reference to training the people delivering groups on group facilitation skills which is vital for engagement and on-going attendance.	Thank you for this suggestion. General group facilitation has not been added to the recommendation as this was not considered to be specific to this topic. The updated training recommendation does state that staff should be train to communicate effectively.
Diabetes Management & Education Group	Recommendation 14	Page 20.	Service specifications should include clear outcome measures for monitoring and evaluation.	Thank you for this comment. This issue is covered in the recommendation on commissioning. The revised recommendations include the criteria as set out in DH best practice on commissioning.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	General		We welcome this timely and important guidance.	Thank you for this comment.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Assessing adults who are overweight or obese	5	We welcome the acknowledgement that some population subgroups are at greater health risks at lower BMI. Although specific cut-off points have not been recommended as yet, we feel it is pragmatic to suggest lower cut off points for BMI and waist circumference in line	Thank you for this comment.

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			with reducing risk of type 2 diabetes.	
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 2: minimising harm	6	'*Ensure the tone and content of all communications or dialogue is respectful and non-blaming'*. We welcome the fact that this is made explicit in the guidance. We would like further guidance on how this may be achieved and monitored in practice.	Thank you for this comment – this is an implementation issue outside the remit of the guideline.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 4: Addressing adults' expectations of a lifestyle weight management programme	8	With regard to the % weight loss which might reasonably be expected, evidence from primary care (e.g. Counterweight) suggests that 3% weight loss is more realistic to achieve and maintain than the 5-10% often cited (achieved in more intensive interventions). Given the expectations of commissioners, it is important that expected outcomes are realistic and achievable to ensure that the best services are commissioned locally. We recognise that greater weight loss is possible with higher baseline BMI's or more intensive interventions, but for Tier 2 services, this is less likely. We suggest in addition that there is a sliding scale of benefit associated with weight loss, so that 3% weight loss is also likely to be of clinical benefit, particularly if achieved using appropriate lifestyle and activity approaches which result in long-term positive changes which can be maintained.	Thank you for this comment. The text has been amended to more clearly communicate the points you raise. In particular, specific reference is made to DH best practice criteria for weight management services.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 5: Providing information for adults considering a lifestyle weight management programme.	9	We suggest that family and friends may be additional sources of long-term support. Sources of support should be discussed with individuals and tailored accordingly.	Thank you – the test has been amended in line with your comments.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 5: Providing information for adults considering a lifestyle weight	9	We question how realistic input from a registered dietitian, clinical psychologist and a qualified physical activity instructor into Tier 2 services is. Specialist weight management dietitians are trained in all aspects of delivering training to Tier 2 services. We suggest therefore that clinical psychologists and physical activity instructors would be	Thank you for this comment. The recommendations highlight that a multidisciplinary team – including a dietitian be involved in the development of programmes and training of

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	management programme.		best utilised in Tier 3 services, in order to maximise their specialist input and remain cost effective.	programme staff.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 6: core components of lifestyle weight management services: weight loss	10	We would like clarification added to the point about the multi-component nature of programmes (i.e. that they address diet, activity levels and behaviour change).	Thank you, the bullet has been amended in include a brief definition of multicomponent. It is also defined in the introduction and glossary.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 6: core components of lifestyle weight management services: weight loss	10	Whilst we agree that a clear energy intake or calorie reduction target, tailored to the individual, should be set, we also recognise that accuracy of calculation of BMR and calorie intakes for individuals is poor.	Thank you, wording of this recommendation has been amended to state 'ensure specific dietary targets are agree (for example, for a clear energy intake or for a specific reduction in energy intake) tailored to individual needs and goals.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 6: core components of lifestyle weight management services: weight loss	10	We would like to see a recommendation made with regard to self monitoring of weight; the importance of which should be included and emphasised in weight management services.	Thank you, self-monitoring is included within the bullet on behaviour change methods. A reference to self-monitoring has also been added to the recommendation on prevention of weight re-gain.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 6: core components of lifestyle weight management services: weight loss	10	It is unclear from the second point what time period is considered optimal for the programme.	Thank you for this comment. The evidence review were not able to indicate the optimal length of programme. The updated recommendation states that programmes should be at least 3 months and that sessions should be offered at least weekly or fortnightly and include a 'weigh in' at each session.

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Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 6: core components of lifestyle weight management services: weight loss	10	We would like to see a clear distinction made between being less sedentary and being more physically active, since both are now recognised as important for health as well as weight management.	Thank you for this comment. The recommendation states that people should be encouraged to reduce sedentary behaviour and be more physically active.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 6: core components of lifestyle weight management services: weight loss	10	To the section on behaviour-change methods, in order to maintain a coherent order we would like to suggest the following changes: '*Use a variety of behaviour-change methods. This should include: exploring and strengthening motivation; problem solving; goal setting; self-monitoring of weight or related behaviours; feedback on performance; developing plans on how to achieve desired behaviours; and planning to enlist social support or to make changes to their social environment*'.	Thank you, the text has been re-ordered.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 6: core components of lifestyle weight management services: weight loss	11	Consideration of personal preference for group or individual programmes should be given, in order to encourage maximum adherence to the programme.	Thank you, this issue is addressed within the recommendation on referral.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 7: Core components of lifestyle weight management services: maintaining weight loss	11	The impact of both healthy eating and physical activity on overall health as well as long-term weight loss maintenance should be stressed.	Thank you, the recommendation is in line with this comment.
Dietitians in Obesity Management UK (a specialist group of the	Recommendation 7: Core components of	11	With relation to maintaining weight lost, we would like the findings and recommendations of the National Weight Control Registry to be included.	Thank you for this comment. The evidence review for this guidance considered interventions for

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British Dietetic Association)	lifestyle weight management services: maintaining weight loss			maintenance rather than associations with maintenance.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 7: Core components of lifestyle weight management services: maintaining weight loss	12	We would like to see the following change made to the text: *'Provide support and advice on the challenges of ~~how to~~ maintaining their new behaviours'*.	Thank you, the wording of this recommendation has been amended.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 8: Commissioning lifestyle weight management programmes	12	To activities that address the wider determinants of health, we would like *'removing junk food from checkouts of food and non-food retailers'*, added as an additional example.	Thank you for this comment. The list provides examples and does not preclude action on eg foods at checkouts. This is covered by other NICE guidance such as obesity – working with local communities and the prevention of CVD.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 9: Referrals to lifestyle weight management programmes	13	Before point 1 we would like the following added: *'Raise the issue of weight in a timely and sensitive manner'*.	Thank you – the text has been amended in line with this comment.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 9: Referrals to lifestyle weight management programmes	13	To the first point we would like the following added: *..'whilst being aware of differential health risks faced at lower body fat levels by some population subgroups e.g. south Asians'*.	Thank you for this comment –cut offs for adults from black and minority groups is are included in the glossary definition of overweight and obesity
Dietitians in Obesity Management UK (a specialist group of the	Recommendation 9: Referrals to lifestyle weight	13	We welcome the emphasis on measuring outcomes (in relation to de-commissioning services)	Thank you for this comment.

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British Dietetic Association)	management programmes			
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 9: Referrals to lifestyle weight management programmes	14	We feel that focus should be given to all adults at or above a BMI of 25kg/m^2. In terms of health risk we recognise that the greatest health risks are generally faced by those with the highest BMI; however in terms of prevention of obesity, focusing on those at or over 25 25kg/m^2 has potential cost benefits. In addition focusing mainly on those with a BMI > 30kg/m^2 will disadvantage those population subgroups who face greater health risks at lower BMI cut off points.	Thank you for this comment. The revised recommendation states that ' 'where there is capacity, access for adults who are overweight should not be restricted'
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 9: Referrals to lifestyle weight management programmes	14	We would like self referral to programmes to be considered as an option.	Thank you for this comment. This recommendation is for health professionals making funded referrals. The guidance is applicable to all programmes, including those that have individuals who have self-referred.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 10: Improving programme uptake, adherence and outcomes. Who should take action?	14	We would like to see commissioners of lifestyle weight management services added to those who should take action. Pragmatically, commissioners are likely to be in a position to provide support to providers (internal or external) to ensure that data is shared in line with information governance and data protection requirements.	Thank you for this comment - the wording around this point has been amended for clarity and commissioners are included in the list of who should take action.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 10: Improving programme uptake, adherence and outcomes. What action should they take?	15	In terms of participant consent to send feedback on their progress to referring agents, we suggest that this is identified as an explicit expectation of participation in the programme.	Thank you for this comment. The PDG considered feedback to be important but did not consider it appropriate to make it an expectation of participation in the programme.
Dietitians in Obesity Management UK (a	Recommendation 10: Improving	15	We would like the following change made to the text, in line with working in a patient-centred manner:	Thank you - the text has been amended in line with your comments.

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specialist group of the British Dietetic Association)	programme uptake, adherence and outcomes. What action should they take?		'Explore' in place of 'Assess and discuss with participants their' (motivation to change and other issues that may affect their likelihood of benefiting from the programme. Discussions should take place at the outset and throughout the programme)	
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 10: Improving programme uptake, adherence and outcomes. What action should they take?	15	We would like to see the following changes made to the text, in line with working in a patient-centred manner: 'Use the regular weigh-in ~~as an indicator of change and motivational tool~~ to monitor and review progress'. In addition, we recognise that lack of weight change does not necessarily indicate lack of compliance to the programme, and participants may have made other significant beneficial changes to their lifestyles.	Thank you, the wording of this recommendation has been amended to 'Use the regular weigh-in as an opportunity to monitor and review progress toward individual goals'.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 11: Training, knowledge and skills: GPs and other health professionals	16	We would like to see 'Train GPs and other health professionals to assess patient motivation..' changed to 'Train GPs and other health professionals to **explore** patient motivation…', to highlight the collaborative nature of such a discussion.	Thank you the wording of this recommendation has been changed.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 11: Training, knowledge and skills: GPs and other health professionals	16	In addition to accurately measure and record height and weight to determine body mass index, we would like recognition of possible lower cut off points for different population subgroups to be also taken into account.	Thank you for this comment –cut offs for adults from black and minority groups is are included in the glossary definition of overweight and obesity
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 11: Training, knowledge and skills: GPs and other health professionals	16	With regard to those with complex needs, we would like clarification on suitable referrals into Tier 2 services especially for those with more complex dietary requirements. In addition we would like the glossary updated to include complex dietary requirements.	Thank you for this comment. The guidance does not address the additional needs of individuals with complex needs. Clarification has been added to the introduction to the guidance.

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Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 12: Training, knowledge and skills: GPs and other healthcare professionals	16	Trainers and training teams should have recognised training and expertise to deliver all aspects of a weight management programme.	Thank you for this comment. The revised recommendation states 'develop training….with qualified professionals….'
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 12: Training, knowledge and skills: programme staff	16	We welcome the recognition that programme staff should be trained to communicate effectively and work collaboratively with participants. Given the sensitive nature of weight management we feel that this point cannot be emphasised enough.	Thank you for this comment.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 13: monitoring and evaluation: programmes	18	We would like an additional bullet point as follows: 'Average and range percent weight loss from baseline to end of programme (including non-completers)', to identify a potential sliding scale of benefits.	Thank you, the wording of this recommendation has been amended to flag what data should be collected as a minimum and in line with DH best practice guidance and the standard evaluation framework.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 13: monitoring and evaluation: programmes	18	We would also like to see an additional bullet point: 'Percent of participants whose weight has not increased', in recognition of the potential health benefits of halting weight increase and maintaining current weight.	Thank you, the wording of this recommendation has been amended to flag what data should be collected as a minimum and in line with DH best practice guidance and the standard evaluation framework.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 13: monitoring and evaluation: programmes	18	Measurement of and improvement to co-morbidities should be added to outcome measures.	Thank you, the wording of this recommendation has been amended to flag what data should be collected as a minimum and in line with DH best practice guidance and the standard evaluation framework. Data on other outcomes such as improvement in health outcomes are listed as outcomes to consider collecting.

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Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 13: monitoring and evaluation: programmes	19	Other outcomes could include changes to body shape and size e.g. waist circumference. In addition indicators of wellbeing should be included.	Thank you, the wording of this recommendation has been amended to flag what data should be collected as a minimum and in line with DH best practice guidance and the standard evaluation framework. Data on other outcomes such as improvement in health outcomes or indicators of wellbeing are listed as outcomes to consider collecting.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Recommendation 13: monitoring and evaluation: programmes	19	To the third point, patient and participant satisfaction surveys could be used.	Thank you, the views of users is already included within this recommendation.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Protecting people's mental and physical wellbeing	22	3.1 We welcome the recognition from the PDG that the overarching approach to lifestyle weight management should be 'first do no harm'. We strongly agree with this, given the potential harm to mental and emotional wellbeing likely if a participant feels worse about themselves as a result of interaction with healthcare professionals.	Thank you for this comment.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Protecting people's mental and physical wellbeing	22	3.2 We are unclear about what is being actually recommended in terms of % weight loss, and the time period over which the weight should be lost in Tier 2 services. We would welcome clarification of this point.	Thank you for this comment. The recommendations on commissioning and evaluation have been amended to make reference to the pragmatic criteria outlined in the DH best practice guidance.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Protecting people's mental and physical wellbeing	24	We suggest that there is a need for recognised competencies for healthcare professionals working in weight management, whilst acknowledging the breadth of defining and agreeing such competencies. However we feel that measuring the effectiveness of training is not possible without measurement of competencies	Thank you for this comment – recognised competencies for healthcare professionals working in weight management is outside the remit of this guidance.

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			achieved as a result of training.	
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Wider context	25	We suggest that examples such as access to open spaces or affordable fruit and vegetables are more relevant to Tier 1 services, and are not obesity specific.	Thank you for this comment. The text has been amended for clarity and emphasises wider determinants of health more generally, rather than giving a specific example.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Commissioning	25	3.12 Although the PDG has spelt out the importance of support to maintain any weight loss in the long term, it is unclear who should take responsibility for this. We would welcome clarification of this point.	Thank you for this comment. The revised guidance gives more examples of on-going support. To note that the evidence on weight maintenance was limited and research recommendations have been made on this point.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Commissioning	25	The guidance emphasises the importance of weight loss at 6 months and one year, along with weight maintenance. If this is considered evidence of success, we suggest that providers, including CSG, should be expected to provide this data as evidence of success.	Thank you for this comment. The commissioning recommendation flags that monitoring responsibilities should be agreed at the outset.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Research		Studies need to include details on how competencies are measured and maintained throughout.	Thank you - this has not been included as it goes beyond the evidence considered / remit of the work.
Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	Training		Staff **competence** also needs to be measured.	Thank you – the text has been amended in line with your suggestion.
Dudley MBC	General		The whole document reflects current practice which is sound, but the evidence reviews demonstrate no significant differences between	Thank you for raising these issues. Please note that primary prevention is

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			themes or approaches, for example the time/length of intervention, supervised v/s unsupervised exercise, which basically makes the reader think, so why do people lose weight? The document also lends itself to a "if you do what you've always done you get what you've always got" belief, most areas would state that they are complying/could comply with the guidance, so why is obesity on the rise? Should the document recognise the need for health professionals to give out the lifestyle advice and recommendations contained in this guidance as a primary prevention message before people become obese? With regards to the activity message there needs to be recognition around frequency and intensity and linking this to people's position within an intervention. The message of 5x30 of moderate intensity activity is a **minimum** recommendation for the general population however obese people need to do 45-60mins, this message needs to be explicit within the guidance, and provide information on how this introduced gradually into an intervention. I would like the guidance to push the boundaries a little and investigate messages around personal responsibility and wider roles and responsibilities, I appreciate, this may be for other guidance, but this guidance needs to recognise the intricacies of weight loss.	addressed in other NICE guidance. The specific dietary or physical approaches to weight loss or maintenance were outside the remit of this guidance, which focuses on programmes.
Dudley MBC	Section 10		I support the recommendations, there are far too many gaps in the evidence leading to too many variables and contributing to a lack of impact in this area on the ground. There is a need for more research into the cost effectiveness of repeat referrals into services and the need for stronger collaboration with GP practices to provide follow up data to weight management services post programme to enable a clear understanding of programme success to be measured.	Thank you for this comment. The research recommendation on referral currently states that 'does re-referral to the same or similar programmes influence adherence, effectiveness or cost effectiveness.'
Dudley Metropolitan Borough Council	General		The whole document reflects current practice which is sound, but the evidence reviews demonstrate no significant differences between themes or approaches, eg time/length of intervention, supervised v/s unsupervised exercise, which basically makes the reader think, so	Thank you for these comments. The recommendations reflect the findings of the effectiveness reviews commissioned for this guidance. This guidance only

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			why do people lose weight? The document also lends itself to a "if you do what you've always done you get what you've always got" belief, most areas would state that they are complying/could comply with the guidance, so why is obesity on the rise? Should the document recognise the need for health professionals to give out the lifestyle advice and recommendations contained in this guidance as a primary prevention message before people become obese? With regards to the activity message there needs to be recognition around frequency and intensity and linking this to people's position within an intervention. The message of 5x30 of moderate intensity activity is a **minimum** recommendation for the general population however obese people need to do 45-60mins, this message needs to be explicit within the guidance, and provide information on how this introduced gradually into an intervention. I would like the guidance to push the boundaries a little and investigate messages around personal responsibility and wider roles and responsibilities, I appreciate, this may be for other guidance, but this guidance needs to recognise the intricacies of weight loss. I support the recommendations for additional resa	focused on lifestyle weight management programmes. NICE has produced a range of guidance that directly or indirectly impacts on obesity – see the NICE obesity pathway. Links have been made throughout to other NICE guidance.
Dudley Metropolitan Borough Council	Gaps In Evidence section 10		I support the recommendations, there are far too many gaps in the evidence leading to too many variables and contributing to a lack of impact in this area on the ground.	Thank you for this comment.
Hartlepool Borough Council	1	4	Include other cancers of the digestive system affected by obesity such as colon and stomach, not just breast and kidney	Thank you for this comment, breast and kidney are examples only.
Hartlepool Borough Council	1	5	Suggestion for further research to calculate a risk measure or score which incorporates BMI and waist circumference collectively	Thank you, identification and assessment of obesity are outside the remit of this guidance.
Hartlepool Borough Council	1	6	Under what action should they take (integrated approach), include an action around GP engagement or incorporate GP and practice staff within bullet point 3	Thank you for this comment, additional recommendations have been added on raising awareness of local services among GPs and health professionals.

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Hartlepool Borough Council	1	7	Is non-measurement of waist circumference in patients with BMI >35 standard practice and well communicated? Would this make any changes in body shape / composition difficult to measure if only BMI is considered?	Thank you for this comment, the text has been amended for clarity. To note that assessment issues per se are outside the remit of this guidance. Measuring waist circumference below BMI 35 reflects existing NICE guidance in obesity 2006 and is re-emphasising this point.
Hartlepool Borough Council	1	10	Why monitor after 12 weeks – this should be dependent on the length of the programme	Thank you for this comment, the wording of this recommendation has been amended.
Hartlepool Borough Council	1	10	Is training input from a clinical psychologist necessary at tier 2?	Thank you – this input was considered important by the PDG.
Hartlepool Borough Council	1	10	Consider motivational interviewing as a behaviour change technique (last bullet point). HBC suggests all facilitators of weight management programmes have training in MI skills	Thank you for this comment. Motivational interviewing was not explicitly mentioned in the evidence considered.
Hartlepool Borough Council	1	13	Evaluation should be aligned to the NOO standard evaluation framework (SEF) for consistency	Thank you, this is mentioned in revised recommendation 17 on monitoring and evaluation.
Hartlepool Borough Council	1	15	Consider elements of one-to-one / personalised assessments pre- and post-group to assess readiness to change, improve confidence and reduce barriers to attending a group environment	Thank you for this suggestion – this was not identified within the evidence considered.
Hartlepool Borough Council	1	17	Ensure Motivational Interviewing is referenced in staff training as an important element	Thank you for this comment. Motivational interviewing was not explicitly mentioned in the evidence considered.

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Health at Every Size UK	general – with regard to reliability of expert testimony on weight bias		Expert testimony paper 1 includes the question - *"Are there any characteristics of weight management programmes that may increase or decrease weight bias?"* The reply made no mention the growing recognition of the bias and stigma that results from the focus on weight management as a treatment. Thus, the Binge Eating Disorder Association state that: • Extensive evidence-based research has found that focusing on weight and dieting instead of health does more harm than good, resulting in an increase in eating disorders, weight gain, lower self-esteem, and bullying, for example. This is a hugely significant omission. The draft document as it stands is a mandate for oppression.	Thank you for this comment. The questions in the expert testimony were posed by the PDG and where these have not been answered the expert is either unable to answer to question or not aware of any evidence. The PDG considered all the evidence available to them, including the expert testimony, to develop recommendations. The recommendations emphasise the stigma that people who are overweight or obese may feel or experience. The considerations section highlights that the approach is to do no harm. The evidence identified for this guidance identified no adverse effects of the type you mention. However, the PDG flagged that this was not systematically reported and have made research recommendations in this light.
Health at Every Size UK	General	1	There is no definition in the paper for what counts as "overweight" and "obese" except the discredited BMI measurement. This is a fundamental weakness at the foundation of this Guideline.	Thank you for this comment. The definition of obesity reflects existing NICE guidance on obesity (2006).
Health at Every Size UK	Introduction	1	Your own expert reviews of metadata give long-term weight loss success as between 2-3 kg (6.6 lb) and 1-1.5 kg (3.3 lb) over the "long-terms" of 12-18 months and 18-24 months, respectively. 36-48 months is mentioned in your evidence statement only. There is no data for longer times, and the weight loss that you mention is insignificant. The data imply that deliberate dieting to lose weight just doesn't work and should be abandoned.	Thank you for this comment. The guidance flags that the lack of long term data is disappointing. Our conclusions however differ. The economic modelling report suggests that weight loss of as little as 1kg maintained for life are cost effective, as are actions to prevent further weight gain and weight.

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			The programme is set to take place over 12 months and is not "long-term" by the standards included here. Weight loss results would be meaningless: any programme need to be about 5 years long. Some programmes only run for 12 weeks. This is a fundamental weakness of this Guide.	
Health at Every Size UK	Recommendation 1: Background	4	The Guidance mentions reduction in risks, but should look at actual deaths, not just numbers generated by blood-tests or BP measurements. The positives of overweight (fewer cancers overall, decrease in osteoporosis etc) are not given in any depth. This means the Guidance is culturally biased, not based on Health.	Thank you for this comment. The PDG briefly discussed the available epidemiological evidence on obesity and morbidity and mortality. They are aware that there is on-going debate on the risks of overweight (for example, with Flegal et al reporting a u shaped curve compared with Willet et al showing a direct relationship). However, all show that increasing levels of obesity increase risk of morbidity and mortality.
Health at Every Size UK	Recommendation 1: Background	4	Fatness is not a "morbidity" and it's outrageous that this terminology is used in a NICE Guideline.	Thank you for this comment. NICE fundamentally disagrees with this comment. Many studies have consistently show the health risks associated with obesity, as outlined in section 2 of the draft guidance.
Health at Every Size UK	Recommendation 1: Assessment	5	BMI has been discredited…it's even been on TV.	Thank you for this comment. Identification and assessment of overweight and obesity are outside the remit of this guidance and therefore refer to existing guidance from obesity (2006). The relevant recommendations in obesity 2006 are section 2.2.1 on identification and

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				assessment (see http://publications.nice.org.uk/obesity-cg43/guidance#clinical-recommendations). The recommendations flag that BMI is not a direct measure of obesity and should be interpreted with caution. It particularly flags caution with use in very muscular adults and the need to adjust for age in children. The section in the full guideline with evidence statements is here http://guidance.nice.org.uk/CG43/Guidance/Section/2/pdf/English . The full guideline includes a discussion of different anthropometric measures and the fact that BMI is a convenient practical but indirect measure. There is also new guidance on BMI for Black and minority ethnic groups here http://publications.nice.org.uk/assessing-body-mass-index-and-waist-circumference-thresholds-for-intervening-to-prevent-ill-health-ph46/recommendations. Lower cut offs are recommended with caution and in relation to the prevention of type 2 diabetes. Consistent with the 2006 guideline, there is emphasis on also assessing co-morbidities, diet and physical activity. The existing guidance promotes a thoughtful approach whereby decisions are made on a range of information, not just BMI.
Health at Every Size UK	Recommendation 2: What Action…?	7	The Guidance asks *commissioning local lifestyle weight management services* to be aware of the health benefits of permanent loss of even a relatively small amount of weight. They should also be aware of the	Thank you for this comment. NICE does not accept that the guidance is culturally biased. The evidence reviews for this

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			very real dangers to health from trying and failing to lose weight (weight cycling) and the huge stress put on the body (particularly the heart) whilst starving/dieting. The Guidance is incomplete here, again it seems culturally biased.	guidance did not identify any adverse effects of the programmes considered. The PDG have made cautious recommendations and have recommended research on this point.
Health at Every Size UK	Recommendation 4	8	Perhaps the focus should be on health not on simple weight loss.	Thank you for this comment. The guidance makes numerous references to the wider benefits and focusing on improvements to dietary intake, reduction in sedentary behaviour and increased physical activity levels. The guidance also highlights the potential benefits of preventing any further weight gain.
Health at Every Size UK	Recommendation 4	8	5-10% of weight of someone weighing say, 16 stone, is 1.6 stone (about 21 lb). By the research included with this Guidance the maximum long-term weight gain is likely to be only 7-ish lb at the most. This sets an unrealistic, hopeless, goal that is guaranteed to fail. This will contribute to self-loathing and harden attitudes of professionals. This is deeply harmful.	Thank you for this comment. A maintained weight loss of 5-10% has been consistently shown to be associated with significant health benefits but is considered an achievable goal for many people. While the observed average weight loss in the evidence reviews was around 3%, there was a large range of loss. This recommendation is clear that there can be benefits with a range of outcomes and that these benefits are likely to be greater with losses above 5-10%.
Health at Every Size UK	Recommendation 5	12	The Guidance recommends a *healthy low-fat diet.* What approach do they suggest to support people to adopt and maintain sound nutrition habits long term given that the traditional approach based on cognitive restraint is associated with increased risk of troubled eating and body	Thank you for this comment. A healthy low fat diet is in line with population advice for heart health. To note that the wording of this recommendation has

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			dissatisfaction?	been amended for clarity and links have been added to the NHS choices website.
Health at Every Size UK	Recommendation 10	15	The Guidance recommends getting rid of non-responders. This looks as if you're building in a method to skew your data. (Non-responders won't show, therefore it looks as if the programme works!)	Thank you for this comment. The recommendation on monitoring and evaluation flags assessing outcomes for all participants.
Health at Every Size UK	Recommendation 11	16	Regarding *staff attitudes and concerns about their own weight.* These poor people could be used as a pilot study/programme if you genuinely believe in this Guidance. Only if it works here, and their health improves, should you conceive of widening its influence.	Thank you for this comment.
Health at Every Size UK	Recommendation 13	19	Exercise has been proven many times to reduce depression. NICE is in danger here of deciding that improvements to self-esteem, depression or anxiety are related to weight loss.	Thank you for this comment. The recommendation stresses the routine collection of information in bullet one and collection where possible of other outcomes, in the knowledge that such data collection can be costly and onerous. NICE promotes vigorous monitoring and evaluation in all guidance to ensure that there can be learning from practice.
Health at Every Size UK	Part 2: Public health need and practice	21	The *cost of obesity* is estimated at £16 billion. This number should be unpicked to show those who are obese as a result of their condition, and those whose obesity is irrelevant to their condition. You can bet this figure is calculated to be as high as possible…anyone who's ill will be blamed for their weight and recorded as such. However, given that the NHS national budget is £96 billion we can see that obese people aren't costing near enough money. Your figure reckons they form 24% of the population. They should be costing a	Thank you for this comment. You may be interested in the analysis here.

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			quarter of the NHS budget, that's £24 billion. You could almost say that obese people are saving us money.	
Health at Every Size UK	Part 2: Public health need and practice	21	Stigma and bullying, discrimination and deprivation: these are the real problem areas. We need a NICE Guide on how to work on these prejudices – not just trying to change the fact that weight has achieved a higher set point than in the near-past (possibly due to changes in our food, starvation dieting and other eating disorders).	Thank you for this comment. The guidance flags the importance of a respectful, non-judgemental approach throughout. The stigma that adults who are overweight or obese may feel or experience has also been flagged throughout.
Health at Every Size UK	Paragraph 3.3	22	Adverse effects of programmes such as this have been systematically purged from experiment reports. NICE should not take any evidence into account that is biased like this.	Thank you for this comment. NICE has no evidence that there has been selective reporting or that negative outcomes have been purged from respected peer reviewed studies. The PDG flagged that adverse or unintended effects had not been systematically reported and have made research recommendations in this light.
Health at Every Size UK	3.3 and general	22	We note the paragraph "Observed losses from multicomponent lifestyle weight management programmes (as identified in the evidence review) are unlikely to be associated with adverse physical effects. But the PDG noted that any adverse effects were not actively investigated or systematically reported in the majority of trials reviewed ". We also note the research recommendation for monitoring of adverse effect. We do not feel the health consequences of pursuing weight loss have been taken seriously. We feel that the PDG must further investigate risk of potential adverse effect as raised in an expert paper and that it is insufficient to rely on the fact that the studies included in the review	Thank you for this comment. Adverse effects were investigated in 9 of the included studies. A significant amount of PDG time focused on this issue. The PDG considerations on this matter are outlined in this section and a research recommendation has been made.

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			did not systematically record adverse effect. We contend that any potential for adverse effect of sudden death from an intervention warrants investigation and that failure to do so in this instance would be unethical and is a function of size discrimination. (From testimony: In addition, studies exploring yo yo dieting suggest that weight loss followed by weight regain may be linked with physical health consequences such as heart disease and sudden death although this research is inconclusive (Jebb et al, 1991; Kroeke et al, 2002).	
Health at Every Size UK	General and paragraph 3.7	24	The lack of research into the harmful effects of starvation dieting reflects the vested interests of the Food/Slimming Industry. There are considerable amounts of money at stake, and keeping everyone confused is helpful for the Industry. NICE is adding to this confusion with this Guide, which should be shelved until we know more.	Thank you for this comment. No representative of the slimming industry were members of the PDG and all members, experts and contractors declared their interests at the start of each meeting. NICE is aware that millions of adults use commercial or primary care led programmes each week and our aim to ensure that these programmes follow best practice based on the evidence available. Where evidence has been lacking the recommendations draw on the considerable experience of the PDG. The consultation also gave an opportunity for all stakeholders in this field to comment and suggest amends to improve this guidance.
Health at Every Size UK	Paragraph 3.13	25	Programmes *that are effective in the short term* are by definition ineffective. In fact worse than useless as they promote yo-yo dieting.	Thank you for this comment. The guidance notes the importance of providing support in the long term.
Health at Every Size UK	Cost effectiveness:	26	The programme will only be cost-effective if weight loss is maintained for life. As well as being contentious (you are talking about 1 kg) there	Thank you for this comment. The guidance includes core components for

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	Paragraph 3.17		is concern that most people regain the weight eg. SIGN guidelines, BNF. Why not focus on increasing activity levels in a safe, non-weight-related way? This might have real measurable benefits. At present the programme is going to be very cost-**in**effective, and just provide another stick to beat "larger-than-insurance table" people over the head with.	weight maintenance and emphasises throughout the importance of on-going support for weight loss maintenance. The modelling report shows that the intervention would be cost effective ***if*** the weight were to be lost for the whole of life.
Health at Every Size UK	Paragraph 3.18	27	You are saying yo-yo dieting is ok…very dangerous assumption.	Thank you for this comment. The guidance does not promote yoyo dieting. This is the outcome of the cost effectiveness model which shows benefits of weight loss even if weight is regained in 3 to 10 years among older adults.
Health at Every Size UK	Part 4: recommendations for research.	28	How about some research that starts out with the hypothesis that weight is mostly irrelevant to health? Most research is conducted by people with vested interests in the Food/Slimming Industry. They set out to prove weight is harmful because it keeps the business/money/status/career rolling along. Why not recommend some truly unbiased research?	Thank you for this comment. Research recommendation flags the importance of considering alternative approaches to weight management, such as approaches that focus on healthy living, behaviour change rather than the prevention of weight loss.
Health at Every Size UK	Key questions:	37	• Is weight actually related to health? Why is it so difficult to prove if this is true? • Does prolonged or repeated dieting cause detrimental changes in health (such as heart attacks, increases in BP)? • Is the consumption of diet drinks and sugar substitutes (taken in an attempt to diet) related to diabetes? • Are "overweight" people just part of the normal	Thank you for these suggestions. Many of these points are covered in the research recommendations. The impact of specific dietary components on weight, such as artificial sweeteners are outside the remit of this guidance. Cultural prejudice or discrimination per se is outside the remit of NICE.

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			human spectrum, and are always there, if food is not limiting? • How can NICE address the issue of prejudice towards people who are differently-sized, in adults and children? • How can NICE help put legal safety nets in place for people who may be unfairly discriminated against at work, at leisure, in the Health Service, or socially? Additional questions NICE might want to consider.	
Health at Every Size UK	Commissioned report	42	Who are the *known weight management providers* in the UK? Are they representatives of the Food/Slimming Industry, because unfortunately they're not a reliable source of research information, having vested interests.	Thank you for this comment. The known weight management providers are those known to operate in the UK. The NICE technical team searched for providers operating in the UK. NICE takes on board the views of all stakeholders. NICE had excluded those with a conflict of interest in relation to this from being a member of the PDG and so we sought to include their views through the means of a survey. The limitations of the survey were accepted and discussed by the PDG.
Health at Every Size UK	Evidence statement 1.11	52	Weight loss (and not other health parameters) was measured during these programmes, and the success or failure of the programme was related to weight loss only, not health. This is a weakness of these studies.	Thank you for this comment. The primary outcome for this guidance was weight (or other anthropometric measures) but information on other outcomes was extracted where available.

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Health at Every Size UK	Evidence statement 2.3	64	Encouragement of competition between dieters is silly; it's not a measure of success.	Thank you for this comment. This evidence statement is based on qualitative research with dieters themselves.
Health at Every Size UK	Part 10: Gaps in the evidence: point 1	72	There are no trials of 3 years or longer. NICE should drill down into these data and find out why. Our guess is that weight-loss programmes don't work in the long-term.	Thank you for this comment. The PDG were disappointed by the lack of longer term data and therefore made this a key research recommendation.
Health at Every Size UK	Part 10: Gaps in the evidence: point 3	72	Exploration of adverse effects is crucial before a general public health recommendation is made.	Thank you for this comment. NICE is aware that millions of adults use commercial or primary care led programmes each week and our aim to ensure that these programmes follow best practice based on the evidence available. Where evidence has been lacking the recommendations draw on the considerable experience of the PDG. This consultation also gives an opportunity for all stakeholders in this field to comment and suggest amends to improve this guidance. All NICE guidance is regularly reviewed and updated as new evidence becomes available.
Health at Every Size UK	Part 12: Why is this guidance being produced?	76	NICE is meant to promote good health and prevent ill health. There isn't sufficient evidence for either in this draft Guide, which should be held until more evidence is obtained.	Thank you for this comment. NICE is of the view that there is sufficient evidence to make the type of recommendations that are included in this draft guidance. It is hoped that these can be improved as more evidence becomes available .

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Health at Every Size UK	10	72	There is a lack of evidence on whether there are any adverse or unintended effects associated with long-term weight management programmes. There is also a lack of evidence on 'weight cycling' (repeated attempts to lose weight) in relation to these programmes. (Source: evidence reviews 1a, 1b and 1c; expert paper 1) The expert papers demonstrate a lack of familiarity with the evidence on adverse effect of weight management both in terms of personal health and with regard for anti-oppressive health care and size stigma.	Thank you for this comment. NICE is of the view that there is sufficient evidence to make the type of recommendations that are included in this draft guidance. It is hoped that these can be improved as more evidence becomes available .
Health at Every Size UK	general – social value		http://stigmaconference.files.wordpress.com/2013/06/jane-ogden_stigma-talk.pdf We are concerned that the committee sought testimony on weight stigma from someone who suggested positive consequences of stigma (see link). We cannot see how this can be reconciled with the PDGs statement that they have taken social value judgements into account or that it meets standards of ethical practice.	Thank you for this comment. NICE always seeks out a variety of views and engages with the full range of stakeholders for different guidance topics. The expert to whom you refer was suggested by a member of the PDG, is highly respected in the field and therefore it is valid for the PDG to consider her view.
Health Equalities Group	Section 6	10 -11	Programmes should be **'asset based' and 'solution focused'**. Ie build on the healthy aspects of the participant's lifestyles and encourages participant to identify and suggest changes for themselves	Thank you for this comment. We are of the view that the guidance as it is written reflects this approach.
Health Equalities Group		11	Top line - 'instruction on how to perform behaviour' What does this mean?	Thank you for this comment, the text has been amended for clarity.
Health Equalities Group		12	'low fat diet' – excludes the contribution sugar makes to obesity. Should be 'the wider benefit of a diet low in fat and sugar'	Thank you for this comment, the text has been amended for clarity.
Health Equalities Group		16	Train GPs and other health professionals to use the 'asset-based and solution focused' approach. This is an evidence based approach to	Thank you for this comment. We are of the view that the guidance as it is written

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			behaviour change.	reflects this approach.
Health Equalities Group		16	To make 'every contact count' all staff within the primary care setting should have the opportunity to access and be encouraged to complete nhs elearning: INSERT REF also GLASS HALF empty ref	Thank you for this comment. The revised recommendation states 'raise the issue of weight loss in a respectful and non-judgemental way. Recognise that this may have been raised on numerous occasions and respect someone's choice not to discuss it further on this occasion'.
Health Equalities Group		17	Add: Builds on healthy aspects of the participant's current lifestyles	Thank you for this comment. Updated recommendation 8 states 'Explore….any previous or ongoing strategies to manage their weight (acknowledge what the person has already achieved).
Health Equalities Group	GENERAL		There is no reference to the role that health visitors and other health professionals who work with families have in identifying/referring/encouraging adults with weight issues. Although this is guidance for adults, many will be parents and the first contact with professionals in relation to overweight and obesity may be through their children.	Thank you for this comment. The evidence reviews did not identify any specific evidence on health visitors or other professionals working with families. If they are providing information in line with the guidance then it would apply to them. To note that NICE has published a guideline on lifestyle weight management in children.
Health Equalities Group	GENERAL		Overweight and obesity amongst nhs employees. Although this is acknowledged (page 17) the guidance does not suggest any actions to mitigate the impact being overweight or obese has for a health professional whose role is to raise the subject with patients or clients. This should be specifically addressed through training for professionals and through support to address their own weight issues.	Thank you for this comment. This issue is addressed in existing NICE guidance on obesity –working with local communities (recommendation 9, http://publications.nice.org.uk/obesity-working-with-local-communities-

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				ph42/recommendations#recommendation-9-local-authorities-and-the-nhs-as-exemplars-of-good-practice)
Ki Performance Lifestyle Ltd.	Recommendations 5, 6 and 7	Pages 9 to 11	XX XXXXXXXX XXXXXX XXXX XXXX X XXXXXXXX XXXXX XXXXXXXX XXXXXXX XXX XXXXXX XXXX XXX XXXXXX XXX XXXXXX.. XX XXX XX XXXXXXXXXX XX XXXXXX XXXXX, XXXXX XXXXX-XXXXXX, XXXXX XXXXXXX XXXXX XXXXXXXX XXXX XXXX XXXXX XXX XXXXX, XXXXXXXXX, XXXX, XXXXXXXXX, XXXX XXXXXXX XXXXXXXX. XXX XXX XX XX XXXXXXXXXX XXXX XXXX XXXXXXXXXXX XX XXX XXXXXXX XXXXX XXXXXXXX, XXXXXX XXXXXXXX XXXX XXX XXXXXXX XXXX XXXXXXXXX XXXXXXXXX	REMOVED AS PROMOTIONAL INFORMATION
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LighterLife	General		LighterLife would like to thank NICE for allowing us to comment on this important piece of draft guidance.	Thank you.
LighterLife	1.1	6	Whilst LighterLife welcomes the recommendation that people should be easily referred through the different tiers of weight management services, we remain concerned about the willingness and/or ability of commissioners to do so. We understand that the Department of Health is currently working on guidance to address this issue and we look forward to the release of such guidance.	Thank you for this comment.
LighterLife	1.1	6	LighterLife strongly welcomes the recommendation that staff should be aware of the lifestyle weight management services to which patients can be referred. We also believe that an increased knowledge of the services that are available in the community is absolutely crucial for staff to be able to encourage and facilitate patient choice as well as referring patients to the most appropriate programme for them.	Thank you for this comment.
LighterLife	1.1	6	LighterLife also agrees that local weight management services should meet local needs, as identified and set out by each area's Joint Strategic Needs Assessment.	Thank you for this comment.
LighterLife	1.2	6	We agree that all organisations involved in assisting individuals with managing their weight need to be aware of the effort required from patients to both avoid further weight gain and subsequently lose weight if required. Indeed, LighterLife is particularly aware of the stigma experienced by overweight or obese adults as many of our counsellors have themselves been overweight or obese in the past, and as such are mindful of the need for non-blaming and respectful dialogue with weight loss clients, as well as across all other forms of communication	Thank you for this comment.

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			at all times. We also believe that respectful dialogue should feature more prominently during situations in which individuals need to be treated with greater sensitivity. As such, we particularly endorse this recommendation, as it seeks to tackle the issue of stigma and avoid apportioning blame. This will help patients feel supported in their efforts to manage their weight.	
LighterLife	1.3	7	We agree that awareness of lifestyle weight management services being offered by local commercial providers is absolutely essential to ensure that commissioners are able to effectively assist overweight and obese individuals. In addition to the above, LighterLife strongly believes that it is crucial that commissioners should have a broad understanding of the different approaches being offered commercially, as well as acknowledging the differences between the wide range of sub-groups within overweight and obese individuals. Furthermore, they should have due consideration for published research which provides evidence as to how best support these sub-groups, as this is central in effectively assisting overweight and obese individuals, not least through an element of patient choice.	Thank you for this comment. An additional recommendation has been added for Public health England to establish a national source of information on lifestyle weight management programmes suitable for commissioning.
LighterLife	1.3	8	LighterLife completely supports the inclusion of sources of information and advice about local lifestyle weight management services in any communications about being overweight or obese, including that which is provided by GPs, practice nurses and pharmacists. LighterLife also believes that having one independent organisation fund the collation and widespread distribution of all information on weight loss services offered by the NHS, voluntary groups and local commercial organisations would be an effective way of ensuring that it reaches a wider target audience, particularly if the information is	Thank you for this comment. Additional recommendations have been added about raising awareness of local services among (1) GPs and other health professionals and (2) the local population. Thank you for this comment. An additional recommendation has been added for Public health England to

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			provided in less traditional settings including libraries, local leisure centres, and through digital media.	establish a national source of information on lifestyle weight management programmes suitable for commissioning.
LighterLife	1.4	8	LighterLife welcomes this very sensible recommendation and strongly endorses the need to ensure that both GPs and individuals are aware as to what is to be expected and realistically achieved during any weight loss programme that an individual may undertake. In addition to this, it is also important to set realistic expectations regarding lifestyle weight management programmes; including communicating that there is not one programme that is suitable for all and, most importantly, the benefits of maintaining even a small weight loss when it is achieved.	Thank you for this comment. We are of the view that the recommendation covers these points as it stands.
LighterLife	1.5	9	LighterLife endorses this recommendation and believes that individuals should be provided with as much information as is required to make an informed choice as to whether or not they should proceed with a lifestyle weight management programme. In particular, we believe that it is crucial to ensure that there is continued support both during weight loss and subsequently during weight management. Furthermore, for adults considering a weight management programme, it should be highlighted that as well as making changes to their diet and exercise, additional long-term behavioural changes will be required and are likely to result in greater success.	Thank you for this comment.
LighterLife	1.6	10-11	LighterLife agrees with the core components set out in the draft guidance that will be required for lifestyle weight management services to be eligible for recommendation or commissioning.	Thank you for this comment.
LighterLife			XX XXXXXXXX XXXXXX XXXX XXXX X XXXXXXXX XXXXX XXXXXXXX XXXXXXX XXX XXXXXX XXXX XXX XXXXXX XXX	REMOVED AS PROMOTIONAL INFORMATOIN

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LighterLife	1.7	11-12	LighterLife agrees that weight management services should be commissioned or recommended only if they provide advice and support for the maintenance of weight loss and ultimately foster independence and self-management as a long term solution.	Thank you for this comment
LighterLife			XX XXXXXXXX XXXXXX XXXX XXXX X XXXXXXXX XXXXX XXXXXXXX XXXXXXX XXX XXXXXX XXXX XXX XXXXXX XXX XXXXXX.. XX XXX XX XXXXXXXXXX XX XXXXXX XXXXX, XXXXX XXXXX-XXXXXX, XXXXX XXXXXXX XXXXX XXXXXXXX XXXX XXXX XXXXX XXX XXXXX, XXXXXXXXX, XXXX, XXXXXXXXX, XXXX XXXXXXX XXXXXXXX. XXX XXX XX XX XXXXXXXXXX XXXX XXXX XXXXXXXXXXX XX XXX XXXXXXX XXXXX XXXXXXXX, XXXXXX XXXXXXXX XXXX XXX XXXXXXX XXXX XXXXXXXXX XXXXXXXXX	REMOVED AS PROMOTIONAL INFORMATION
LighterLife	1.8	12-13	LighterLife wholly supports this recommendation and the actions it	Thank you for this comment. An

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			sets out. However, we wish to emphasise that it is crucial that commissioners ensure that they have full knowledge of, and as such no unfounded prejudices against, locally available weight management services including commercial weight management providers with strong evidence bases and good rates of success.	additional recommendation has been added for Public health England to establish a national source of information on lifestyle weight management programmes suitable for commissioning.
LighterLife	1.9	13-14	We agree with the recommendation that people's preferences should be taken into account if possible, along with their previous experience of weight management programmes. We firmly believe that prospective patients should receive adequate information about the services available in the local community, including those offered by commercial weight management providers so that an informed patient choice can be made.	Thank you for this comment. The revised guidance includes an additional recommendation on raising awareness among the local population about available services.
LighterLife	1.10	15	LighterLife agrees that GPs who have referred patients to weight management services should be able to assess their progress on weight management programmes in order to help ensure adherence and positive outcomes. We fully accept that this should be done with the informed consent of the patient and that appropriate information governance and data protection should be strictly observed. However, at the same time, we have directly experienced the unevidenced and unfounded bias against commercial weight management services amongst GPs, which can impact on their referral decisions, and affect their assessment in instances where individuals seek out weight management services without their GPs involvement. As such, we would like to stress the element of considering and respecting patient choice when it comes to uptake and adherence to weight loss programmes.	Thank you for this comment. An additional recommendation has been added for Public health England to establish a national source of information on lifestyle weight management programmes suitable for commissioning. The updated guideline also includes an additional recommendation re awareness raising among GPs and other health professionals which states that they should be aware of the services available locally.
LighterLife	1.10	15	LighterLife agrees with this recommendation and would like to stress the importance of discussing at regular intervals, the participants' motivation to change. As outlined in previous comments, LighterLife's	Thank you for this comment.

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			weight management programmes provide group counselling sessions to facilitate discussions about participants' motivation to change which is continually assessed throughout their time on the programme.	
LighterLife	1.11	16	LighterLife agrees that the training of health professionals to identify how and when to raise the notion of weight management with a patient, including how to identify those with complex needs and refer them to appropriate services, is a very important but often overlooked step in weight management. We also agree that they should help patients make informed decisions about the best weight management option for them and that patient choice should be taken into consideration Health professionals are ideally placed to address the issue of overweight and obesity with patients and LighterLife believes that the Royal Colleges should be considering the provision of further training given the extent of the obesity epidemic and associated costs, both health and financial.	Thank you for this comment.
LighterLife	1.12	17-18	XX XXXXXXXX XXXXXX XXXX XXXX X XXXXXXXX XXXXX XXXXXXXX XXXXXXX XXX XXXXXX XXXX XXX XXXXXX XXX XXXXXX.. XX XXX XX XXXXXXXXXX XX XXXXXX XXXXX, XXXXX XXXXX-XXXXXX, XXXXX XXXXXXX XXXXX XXXXXXXX XXXX XXXX XXXXX XXX XXXXX, XXXXXXXXX, XXXX, XXXXXXXXX, XXXX XXXXXXX XXXXXXXX. XXX XXX XX XX XXXXXXXXXX XXXX XXXX XXXXXXXXXXX XX XXX XXXXXXX XXXXX XXXXXXXX, XXXXXX XXXXXXXX XXXX XXX XXXXXXX XXXX XXXXXXXXX XXXXXXXXX	REMOVED AS PROMOTIONAL INFORMATION
LighterLife	1.13	18-19	XX XXXXXXXX XXXXXX XXXX XXXX X XXXXXXXX XXXXX XXXXXXXX XXXXXXX XXX XXXXXX XXXX XXX XXXXXX XXX XXXXXX.. XX XXX XX XXXXXXXXXX XX XXXXXX XXXXX, XXXXX XXXXX-XXXXXX, XXXXX XXXXXXX XXXXX XXXXXXXX XXXX XXXX XXXXX XXX XXXXX, XXXXXXXXX, XXXX, XXXXXXXXX,	REMOVED AS PROMOTIONAL INFORMATION

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LighterLife			Finally, we also believe that provision of this data can provide evidence which could be used during specific obesity-management training for health care practitioners in this area, thus helping them to advise on programmes that may suitable for various individuals.	Thank you for this information.
LighterLife	Recommendation 14	19	LighterLife strongly endorses the need to monitor local provision. It is vital to ensure that lifestyle weight management providers are broadly in line with an accepted set of standards and we welcome assessment of this. In addition, the awareness amongst health professionals of available weight management services and potential issues arising from service provision, such as conflict over the payment of different tiers of weight management, are areas which LighterLife believe require particular monitoring.	Thank you for raising this issue. Please note that local funding decisions are outside the remit of NICE.
Living Streets	Recommendation 4	8	We welcome the recommendation that GPs and other health professionals should take action to explain to adults the importance of gradual long term changes to physical activity. In particular the role of walking as a route to increase levels of physical activity. There is also a role to highlight where such changes can take place. For example walking to work is one example of where small changes could be made to increase levels of physical activity. The impact of including workplaces in such an approach is significant. Living Streets' Walking Works project engages with adults in employment to encourage more walking to, from and at work. Funded by BIG Lottery's Health and Wellbeing Fund as part of the Travel Actively consortium, the campaign has raised awareness of the benefits of walking more to over 28,000 individuals so far, through walking pledges, regular digital campaigns and the annual Walk to	Thank you for these comments.

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			Work Week challenge. Walking Works includes a programme of more in-depth support for workplaces, including helping establish 'walking champions', running bespoke walking challenges and activities and helping workplaces to integrate walking activity with their workplace travel plan…cont…..	
Living Streets			XX XXXXXXXX XXXXXX XXXX XXXX X XXXXXXXX XXXXX XXXXXXX XXXXXXX XXX XXXXXX XXXX XXX XXXXXX XXX XXXXXX.. XX XXX XX XXXXXXXXXX XX XXXXXX XXXXX, XXXXX XXXXX-XXXXXX, XXXXX XXXXXXX XXXXX XXXXXXXX XXXX XXXX XXXXX XXX XXXXX, XXXXXXXXX, XXXX, XXXXXXXXX, XXXX XXXXXXX XXXXXXXX. XXX XXX XX XX XXXXXXXXXX XXXX XXXX XXXXXXXXXXX XX XXX XXXXXXX XXXXX XXXXXXXX, XXXXXX XXXXXXXX XXXX XXX XXXXXXX XXXX XXXXXXXXX XXXXXXXXX	REMOVED AS PROMOTIONAL INFORMATION
Living Streets	Recommendation 6	P10	We agree with the statement that lifestyle weight management services should only be recommended or commissioned if they encourage people to reduce sedentary behaviour and adopt physical activities such as walking once the intervention has ended. Interventions such as Living Streets walking works programme (highlighted above) encourages long term behaviour change by highlighting the opportunities for walking during the daily journey to work and during the working day.	Thank you for these comments.
Living Streets	Recommendation 8	12	We welcome the requirement for commissioners to ensure lifestyle weight management programmes complement activities which tackle the wider determinants of physical inactivity such as the provision of safe walking routes. This includes a range of measures including reduced speed limits such as 20mph and safe crossing points. We believe it would be useful to differentiate between local authority officers and councillors and also cabinet members for policy areas including transport, environment and housing in addition to public health.	Thank you for this comment.
Living Streets	General		We welcome the cross links made to the walking and cycling	Thank you for this comment.

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			guidance which was produced by NICE in 2012.	
Motivational Interviewing Network of Trainers (MINT)	General		We appreciate the thoughtful evaluation of the existing evidence in this document, and particularly the consideration given to the interpersonal relationship between patients and practitioners. It is refreshing to see a document which acknowledges the wider social context and challenges that face people who are struggling to maintain a healthy weight that can often affect their motivation to make and maintain changes. We are also pleased to see greater emphasis on long term, rather than short term, outcomes, particularly as the available evidence suggests that many weight loss interventions are not maintainable in the long term.	Thank you for this comment.
Motivational Interviewing Network of Trainers (MINT)	Section 1, Recommendation 4	8	Under the section 'what action should they take', the language is still quite judgmental and does not correspond to the non-blaming approach that is outlined earlier in section 1. The way this recommendation is currently written suggests a 'fix it' approach, and an implicit assumption that the patient is lacking in knowledge. Phrasing this as 'explain to adults' is quite patronising, and could lead providers to think their role is to simply give the patient information about what they need to do. This could distance and disengage people considering weight management. Most adults who are obese and overweight are aware of at least some areas that need to change, and do not need to feel they are being lectured about things they already know. It is also not necessarily a good use of clinical time to tell patients what they already know. It would be good to see more focus on eliciting from the patient what they understand about attending a lifestyle management intervention, what their own reasons for changing might be, and filling in knowledge gaps where appropriate. Additionally, drawing upon patient autonomy and knowledge by asking, rather than telling, the patient what they would find helpful may be more engaging for patients.	Thank you for this comment. The wording of this recommendation has been amended to 'Discuss with adults……'
Motivational Interviewing Network of Trainers (MINT)	Section 1 Recommendation	9	We would like to support the more person centred approach apparent in this section. It may also be beneficial to include a recommendation	Thank you for this comment. Updated recommendations 7 and 8 address

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	5		of practitioners exploring any additional perceived barriers to managing weight that the patient identifies (that may not be covered on this list).	barriers.
Motivational Interviewing Network of Trainers (MINT)	Section 1 Recommendation 6	10-11	Again, within this section, there is a lot of emphasis on what clinicians should encourage patients to do, but not much on encouraging patients to actively be involved in the process of setting their own goals/targets for change to diet, exercise etc. alongside practitioners in a collaborative manner. This could be interpreted by health professionals as the practitioner deciding what changes should be made and how they should be made. This may be counterproductive in encouraging patients to make maintainable changes in the long term. Within the bullet point of behaviour change methods, there are a lot of helpful examples of strategies that can help patients who are ready to make changes. However, there is no mention of exploring ambivalence to make changes, for those who may be less ready or perhaps unsure about how or why to change. Additionally, there needs to be the opportunity to explore what has inhibited change in the past and how this could be overcome longer term.	Thank you for this comment. The recommendations flag tailoring and personal goals. The recommendations on core components reflect the evidence on effectiveness.
Motivational Interviewing Network of Trainers (MINT)	Section 1 Recommendation 10	15	We recognise the importance in the monitoring of clinical outcomes as a means of evaluating interventions, and support this. However, although 'weigh ins' may be one indicator of change, this may not in itself be reflective of changes made and is not consistent with a patient centred approach. For example, if a patient's primary goal of losing weight is to break a cycle of emotional eating, reduce their blood pressure, to be able to do more physically etc., surely it would be better to focus upon those kinds of outcomes. Weight loss is an outcome, but it is not in itself a behaviour change. It seems that the interventions described in this document are about changing behaviour. The number on the scales is not in and of itself an 'indicator of change', and we are pleased this is also noted in section	Thank you for this comment. The updated recommendation 10 states 'monitor weight indicators of behaviour change and participant's personal goals throughout the programme'.

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			4, recommendation 2. Given the stigma attached to weight described earlier in section 1, enforced 'weigh ins' place the emphasis of the intervention on 'change in the number on the scales', rather than the upon the wider physical and mental health benefits obtained from losing weight. Emphasis placed upon this may serve as a counter-motivational rather than a 'motivational tool' as described.	
Motivational Interviewing Network of Trainers (MINT)	Section 1 Recommendation 11	16	We strongly support the idea of training GPs and health professionals to raise concern in an empathic manner. We would also recommend that emphasis is placed on both sensitivity and asking permission to raise the topic with patients, to avoid disengagement and avoidance of services.	Thank you for this comment. The updated recommendations states 'raise the issue of weight loss in a respectful and non-judgemental way. Recognise that this may have been raised on numerous occasions and respect someone's choice not to discuss it further on this occasion'.
Motivational Interviewing Network of Trainers (MINT)	Section 3 Protecting people's mental and physical wellbeing	22	There appears to be no consideration within this section for different cultural norms around healthy body-weight and image. This may be particularly relevant for practitioners working within minority and recently-arrived communities.	Thank you for raising this issue. Raising weight is discussed in training recommendation 14.
Motivational Interviewing Network of Trainers (MINT)	3.12	25	We support the concept of ongoing support, and engaging people from lower income groups in a way that is helpful to them. Change is a process, not an event, yet it seems that people are often left alone when they need support following the end of a weight management intervention. Might initiatives such as healthy workplaces, community groups/activities etc also help with this, as managing weight has links with wider life factors rather than just a health problem a person presents to their GP with.	Thank you for this comment. Links with other relevant services is flagged in recommendation 1 and links are given to existing NICE guidance on obesity, such as obesity – working with local communities.
Motivational Interviewing Network of Trainers (MINT)	3.17	26	This is interesting information, but we are unsure how this evidence has been generated. A reference/hyperlink would be helpful here.	Thank you. Information on the modelling is included in the annex and associated cost effectiveness report. This section follows a standard template.

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Motivational Interviewing Network of Trainers (MINT)	Section 4 Recommendations for research		From the practitioners among us who work within weight management, we are all familiar with the papers cited in the reference section, and appreciate the very thorough consideration given to this in the research recommendations. However, we are struck by the fact that consistently from the research studies that have been conducted, drop out and lost to follow-up rates tend to be high (around 50%). This is similar to what is seen within clinical practice in weight management services, where patients often fail to attend initial appointments, or stop attending midway through an intervention. This perhaps signals a problem in successfully engaging patients with weight management difficulties with services, and certainly warrants further research and investigation. It suggests that services perhaps need to work more actively at helping patients to engage with weight management, There is particularly a lack of qualitative research from the perspective of the patient, and from providers, about engagement. We would welcome more research in this area to help services to better address this issue.	Thank you for this comment – the research recommendations have been amended to reflect your comment.
Motivational Interviewing Network of Trainers (MINT)	Section 4 Recommendations for Research		There is very little work into the role of motivational interviewing in obesity and recommendations need to be made to encourage research into this area.	Thank you for this comment. The research recommendations flag the need for trials to consider whether named behaviour change techniques improve weight maintenance in the long term.
Motivational Interviewing Network of Trainers (MINT)	Section 4 Recommendations for research		There is little evidence to guide how best to engage diverse racial and social groups with weight management in terms of facilitating behaviour change. More research is needed in this area.	Thank you for this comment. The research recommendation 5.2 includes effectiveness and cost effectiveness of programmes for people of different ages, gender, sexuality or form different ethnic or socioeconomic groups.

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National LGB&T Partnership	General		Research on LGB&T people and weight suggests that gay and bisexual men are less likely to be obese than heterosexual men (Guasp, 2012). However, it is important to note that this may not be case for all gay and bisexual men, for example, the bear culture celebrates a larger weight body ideal, while twink culture celebrates a very thin body ideal, which could be associated with anorexia and bulimia issues and related mental health conditions. Health services must ensure that they are engaging with specific communities within communities. It must be recognised that the LGB&T community is not one homogenous group.	Thank you for raising this issue.
National LGB&T Partnership	General		However, the situation is very different for lesbian and bisexual women. One study of lesbian and bisexual women in Britain found little difference in rates of obesity between lesbian and bisexual women and the general population (Hunt and Fish, 2008). However, 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 (Aaron et al., 2001; Barnett Struble et al., 2010; Cochran et al., 2001; Conron et al., 2010; Leonard et al., 2012; Valanis et al., 2000). 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 (Yancey, 2003). This is also the focus of large-scale research currently being undertaken by Brigham and Women's Hospital in Boston, Mass. (e.g. http://cnsnews.com/news/article/feds-spend-15-million-study-why-lesbians-are-fat). Therefore lesbian and bisexual women need to be recognised as a high risk group and weight management programmes need to be appropriately targeted.	Thank you for raising this issue. We did not identify any specific evidence on this group (see evidence statement 1.7) but have added to research recommendations, such that 5.2 includes effectiveness and cost effectiveness of programmes for people of different ages, gender, sexuality or form different ethnic or socioeconomic groups.
National LGB&T Partnership	General		There is little evidence of weight among trans people. However, those who seek surgery are often told to lose weight in order to access	Thank you for this comment.

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			surgery, without receiving adequate support is poor. They are at risk of becoming victims of the imagery trap of a cisgender ideal. BMI becomes an issue for trans people as they often do not fit the standardised profile of BMI trans women automatically rise in BMI when they transition.	
National LGB&T Partnership	General		There are few specific studies on overweight and bisexuality, but anecdotally I think there are issues within bisexual communities in relation to this - amongst both men and women. Research into LGB issues often do not disaggregate by sexual orientation meaning the experiences of bisexual people can remain invisible. There is evidence of higher levels of mental health problems amongst bisexual people - compared to lesbian and gay people (see the Bisexual Report: http://www.bisexualindex.org.uk/uploads/Main/TheBisexualityReport.pdf) - and the likelihood that this puts them at more risk (whatever their gender) of overweight and obesity (reference McElroy, et al)	Thank you for this comment.
National LGB&T Partnership	Recommendation 6	11	When considering the needs of different subgroups this needs to include lesbian and bisexual women.	Thank you for raising this issue. We did not identify any specific evidence on this group (see evidence statement 1.7) but have added to research recommendations, such that 5.2 includes effectiveness and cost effectiveness of programmes for people of different ages, gender, sexuality or form different ethnic or socioeconomic groups.
National LGB&T Partnership	Recommendation 8	12	We value an integrated, holistic approach to service provision and to the reduction of health inequalities. This section could be more explicit about different public services working together proactively to address issues around cycling safety, local food offer, etc., as measures	Thank you for this comment. The issues raised are covered in existing NICE guidance such as obesity – working with local communities. A link to this

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			around this usually fall within the remit of local authority planning departments rather than health and social care.	guidance is given in the text.
National LGB&T Partnership	Recommendation 10	15	What kind of information is referred to when recommending systems to be put in place to share "any relevant information"? If this refers to monitoring of protected characteristics sexual orientation and gender identity should be monitored to ensure LGB&T people are accessing the service and are having their needs met. For more information about sexual orientation monitoring see http://www.lgf.org.uk/policy-research/SOM/, for information about gender identity monitoring see http://www.gires.org.uk/monitoring.php.	Thank you for raising this issue. We did not identify any specific evidence on this group (see evidence statement 1.7) but have added to research recommendations, such that 5.2 includes effectiveness and cost effectiveness of programmes for people of different ages, gender, sexuality or form different ethnic or socioeconomic groups.
National LGB&T Partnership	Recommendation 12	17	Training for staff should include information about the prevalence of obesity amongst lesbian and bisexual women as well as a reminder to always use non-heteronormative, inclusive language, not to assume service users are in heterosexual relationships, etc.	Thank you for raising this issue. We did not identify any specific evidence on this group (see evidence statement 1.7) but have added to research recommendations, such that 5.2 includes effectiveness and cost effectiveness of programmes for people of different ages, gender, sexuality or form different ethnic or socioeconomic groups.
National LGB&T Partnership	Recommendation 13	18	Routine monitoring should also include sexual orientation monitoring and possibly gender identity monitoring especially if the purpose is to assess the impact of health inequalities. LGB&T people face a range of health inequalities, which cannot be addressed without the necessary evidence base. This in turn cannot be developed without routinely monitoring sexual orientation (and gender identity). Of course this has to be done sensibly and within a supportive, inclusive environment. For more information about sexual orientation monitoring see http://www.lgf.org.uk/policy-research/SOM/, for information about gender identity monitoring see http://www.gires.org.uk/monitoring.php.	Thank you for raising this issue. We did not identify any specific evidence on this group (see evidence statement 1.7) but have added to research recommendations, such that 5.2 includes effectiveness and cost effectiveness of programmes for people of different ages, gender, sexuality or form different ethnic or socioeconomic groups.

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National LGB&T Partnership	Recommendations	All	All recommendations need to have a focus on the particular experiences of LGB&T people to improve knowledge of need and tailor services that will have better engagement and improved outcomes for individuals: integrate services, minimise harm and improved awareness of services.	Thank you for raising this issue. We did not identify any specific evidence on this group (see evidence statement 1.7) but have added to research recommendations, such that 5.2 includes effectiveness and cost effectiveness of programmes for people of different ages, gender, sexuality or form different ethnic or socioeconomic groups.
National LGB&T Partnership	2 Public health need and practice	20	This section makes no reference at all to the higher prevalence of obesity amongst lesbian (and bisexual) women.	Thank you for raising this issue. We did not identify any specific evidence on this group (see evidence statement 1.7) but have added to research recommendations, such that 5.2 includes effectiveness and cost effectiveness of programmes for people of different ages, gender, sexuality or form different ethnic or socioeconomic groups.
National LGB&T Partnership	2 Public health need and practice	20	Commercial, voluntary sector and self-help weight management programmes may be part of the solution – especially in terms of specialised provision for particular subgroups such as lesbian and bisexual women.	Thank you for this comment.
National LGB&T Partnership	Evidence statement 1.7		Since you point out that there is no evidence as to whether the effectiveness of BWMPs varies based on the sexual orientation of participants (and some other characteristics), it is especially important to recommend monitoring for sexual orientation in order to build an evidence base around this for the future.	Thank you for raising this issue. We did not identify any specific evidence on this group (see evidence statement 1.7) but have added to research recommendations, such that 5.2 includes effectiveness and cost effectiveness of programmes for people

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				of different ages, gender, sexuality or form different ethnic or socioeconomic groups.
National Obesity Forum	General		The National Obesity Forum welcomed the launch of the consultation on this important piece of draft guidance and would like to thank NICE for allowing us to comment on it.	Thank you.
National Obesity Forum	1.1	6	The National Obesity Forum welcome the recommendation that local authorities should take an integrated approach to the prevention and management of obesity. We agree that people should be allowed to progress easily through the local obesity pathway. However, we believe that the current situation is characterised by a certain unwillingness to refer patients through the different tiers of service, something which we believe could be tackled by reforming the Quality and Outcomes Framework (QOF). By allocating a certain number of QOF points for the appropriate screening and referral of obese and overweight patients, it would be possible to provide the necessary support and advice to help them achieve and maintain weight loss safely. We understand that the Department of Health is currently working on guidance to address this issue and we look forward to the release of such guidance.	Thank you for this comment. QOF is outside the remit of this guideline.
National Obesity Forum	1.1	6	The National Obesity Forum strongly welcome the recommendation that staff should be aware of the lifestyle weight management services that patients can be referred to. As highlighted above, we believe that a system providing incentives to GPs for referring overweight and obese patients to the services available in the community would be a very effective tool for tackling	Thank you for this comment.

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			the current obesity epidemic. Within this framework, it would be absolutely crucial for healthcare practitioners to have adequate knowledge of relevant services available in the local community.	
National Obesity Forum	1.1	6	The National Obesity Forum also agree that local weight management services should meet local needs, as identified and set out by each area's Joint Strategic Needs Assessment.	Thank you for this comment.
National Obesity Forum	1.2	6	We are acutely aware of the problems associated with stigma towards adults who are overweight or obese, and we very much agree that all organisations involved in assisting individuals manage their weight need to be aware of the effort required from patients to lose weight and avoid further weight gain.	Thank you for this comment.
National Obesity Forum	1.3	7	As mentioned above, the National Obesity Forum believe that all those involved in the commissioning of local lifestyle weight management services should be aware of the approach being offered by local commercial providers. In addition, we agree that awareness of local prevalence of overweight and obesity, and of the health benefits for overweight and obese people of permanently losing even a small amount of weight, should be substantially raised among commissioners.	Thank you for this comment.
National Obesity Forum	1.3	8	The National Obesity Forum strongly endorse the inclusion of sources of information about lifestyle weight management services in any communications about being overweight or obese from all healthcare practitioners, including information and advice provided by pharmacists. However, we are not sure whether it will be effective on its own, without providing effective incentives for referral.	Thank you for this comment.
National Obesity Forum	1.4	8	The National Obesity Forum welcome this recommendation, as the	Thank you for this comment.

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			provision of information to patients is crucial to ensure that realistic expectations are set regarding lifestyle weight management programmes.	
National Obesity Forum	1.5	9	Similarly to the point above, the National Obesity Forum endorse this recommendation and believe that individuals should always be able to make an informed choice on whether or not to proceed with a lifestyle weight management programme.	Thank you for this comment.
National Obesity Forum	1.6	10-11	The National Obesity Forum agree with the core components set out in the draft guidance that will be required for lifestyle weight management services to be eligible for recommendation or commissioning.	Thank you for this comment.
National Obesity Forum	1.7	11-12	The National Obesity Forum concur that weight management services should be commissioned or recommended only if they provide advice and support for the maintenance of weight loss or continued weight loss.	Thank you for this comment.
National Obesity Forum	1.8	12-13	The National Obesity Forum support this recommendation and the actions it sets out, but once again wish to emphasise that it is crucial commissioners have full knowledge of, and no prejudices against, locally available weight management services.	Thank you for this comment.
National Obesity Forum	1.9	13-14	We agree with the recommendation that people's preferences should be taken into account if possible, along with their previous experience of weight management programmes. We believe that to achieve this it is crucial prospective patients receive adequate information about the services available in the local community. The National Obesity Forum also believe that providing better training for GPs regarding obesity and overweight would incentivise them to	Thank you for this comment.

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			actually refer overweight and obese patients to weight management service. We would like to note that GPs should be making every contact count, by discussing patients' weight even if they have not gone to see the GP about that issue, or even if they are not attending a visit for themselves (e.g. they are accompanying their children).	
National Obesity Forum	1.10	15	The National Obesity Forum agree that GPs that have referred patients to weight management services should be able to assess their progress on weight management programmes in order to ensure adherence and positive outcomes.	Thank you for this comment.
National Obesity Forum	1.11	16	As already mentioned, the National Obesity Forum strongly agree that the training of GPs and other health professionals is a crucial element to incentivise them to refer patients to the appropriate services in all occasions. However, we also believe that coupling training with better incentives provided through the Quality and Outcomes Framework would be a much more effective solution overall..	Thank you for this comment. QOF is outside the remit of this guidance.
National Obesity Forum	1.12	17-18	The National Obesity Forum strongly endorse this recommendation, as we consider that training for lifestyle weight management staff should always be of a high standard and delivered by qualified professionals.	Thank you for this comment.
National Obesity Forum	1.13	18-19	The proposed collection of validated outcome data and of data on the views and experiences of all participants and staff referring or delivering weight management programmes is welcomed by The National Obesity Forum. We believe this information can be can be useful to outline general improvements for weight management schemes and also to highlight	Thank you for this comment.

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			those weight management services that have satisfactorily met the criteria set out in this draft guidance, and are therefore effective in helping overweight and obese adults manage their weight.	
National Obesity Forum	Recommendation 14	19	The National Obesity Forum agrees that monitoring local provision will ensure that services meet local needs and agreed standards. We also welcome the recommended monitoring of awareness among health professionals and potential users, which will be crucial to ensure that patients are adequately and timely referred, and that their choices are taken into account.	Thank you for this comment.
Newcastle University, Institute of Health and Society	General		It would be helpful if the reference or evidence statement number accompanied each of the recommendations rather than having a summary at the end, with links between evidence and recommendations, as shown on page 44 & 45.	Thank you for this comment. The guideline layout follows a standard format for all public health and clinical guidelines.
Newcastle University, Institute of Health and Society	General		The guidance may be more relevant if policy makers/commissioners and health care practitioners had separate documents. This would then make all the information relevant to whoever was reading it.	Thank you for this comment. The guideline layout follows a standard format for all public health and clinical guidelines. The Centre of Public Health produces local government briefings on public health guidelines. Recommendations on particular aspects of the prevention and management of obesity or for particular professional groups can be identified through the NICE pathway on obesity.
Newcastle University, Institute of Health and Society	General		If a study is confidential and authors are not willing for results to be publicly scrutinised then the study should not be included and should not contribute to the guidance. High levels of conflict of interests might be present and these should be openly disclosed. If the authors of the guidance decide to	Thank you for this comment. NICE has a transparent policy of handling information submitted in academic or commercial in confidence. The

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			use this information extra caution should be applied when informing recommendations based on this.	information is scrutinised by the contracted research team and PDG in the same way that published evidence is scrutinised. The impact of information submitted in confidence is clear within the evidence statements for this guidance. Please note that a study considered academic in confidence for review 2 is now in press.
Newcastle University, Institute of Health and Society	General		From the evidence (review 1c) there was a lack of high quality studies on the effectiveness of weight loss maintenance interventions. However, the area of weight maintenance research is then not included in either the research recommendations or in the section on the gaps in evidence. If this area is lacking in number of studies with high quality research, logic dictates that this should be included in the research recommendations.	Thank you for this comment. Research recommendation 1 is focused on addressing long term weight maintenance.
Newcastle University, Institute of Health and Society	General		Two studies from Neve et al's review (Neve, M., Morgan, P. J., Jones, P. R., & Collins, C. E. (2010). Effectiveness of web-based interventions in achieving weight loss and weight loss maintenance in overweight and obese adults: a systematic review with meta-analysis. *Obesity Reviews*, *11*(4), 306-321) appear to meet the inclusion criteria for the effectiveness reviews: 1. McConnon Á, Kirk SFL, Cockroft JE, Harvey EL, Greenwood DC, Thomas JD, et al. The Internet for weight control in an obese sample: Results of a randomised controlled trial. *BMC Health Services Research*. 2007;7. 2. Womble, L.G., Tadden, T.A., McGuckin, BG., Sargent, S.L., Rothman, R.A., Krauthamer-Ewing, E.S. A Randomised Controlled Trial of a commercial weight loss program. *Obesity Reviews*, 2004; 12;1011-1018. These are both internet weight loss studies that would add to the evidence base included for this guidance, which currently contains a small amount of internet based studies in comparison to face-to-face weight loss studies.	Thank you for these references.
Newcastle University, Institute of Health and	Section 1	7	In 'Recommendation 3' and under 'What action should they take?' it is stated that all those commissioning local lifestyle weight management	Thank you for this comment. The revised guideline includes a

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Society			services should be aware of local prevalence, likely health benefits and local strategic approach to prevention and treatment. However, it does not mention how they could obtain this information or who should or could provide the information to the commissioners. It would be important to give some pointers on those better placed to do so (e.g. Public Health England, researchers, or health improvement teams).	recommendation to public health England to establish a national source of information on lifestyle weight management programmes suitable for commissioning.
Newcastle University, Institute of Health and Society	Section 1	8	Recommendation 4: GPs, other health professionals and providers of lifestyle weight management services referring patients are told to explain to adults wanting to lose weight how much weight they might realistically expect to lose in total and on a weekly basis if they adhere to the programme. However, it gives no details on how, in practice, to explain this (healthcare professionals involved in these programmes may have varied skill sets and expertise). A reference to NHS Choices website and a link to it could be helpful. This web page presents a variety of resources that can be used by health professionals to facilitate the enactment of this recommendation. This suggestion, in line with others above, aims at decreasing barriers to implement the guidance emerging from this document.	Thank you for this comment. Links to NHS choices have been added to the text. Additional recommendations have been added on awareness raising with health professional and the public.
Newcastle University, Institute of Health and Society	Section 1	10	Recommendation 6: Lifestyle weight management services are only to be recommended or commissioned if they are multi-component programmes. This could be expanded on to allow clarity to readers as to what constitutes a multi-component programme. Maybe just stating that a multi-component programme consists of diet and physical activity advice, as well as behaviour change with regards to diet and physical activity.	Thank you for this comment – the text has been amended in line with your suggestion.
Newcastle University, Institute of Health and Society	Section 1	10	Recommendation 6 outlines core components of lifestyle weight management services: weight loss. One suggested component is setting a clear energy intake or calorie reduction target, tailored to individual needs. In connection with this core component it mentions that contact with a dietitian may be beneficial but is not essential. We understand that this might be trying to circumvent human resources issues, but it may be useful to add that involving a dietitian in the planning or training of other professionals deploying lifestyle weight management programmes could also be beneficial.	Thank you for this comment. The statement reflects the evidence available. Dietitians are flagged as an important member of the MDT developing programmes and training.

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Newcastle University, Institute of Health and Society	Section 1	10/11	Recommendation 6: Behaviour change methods are included in the core components of lifestyle weight management services: weight loss. This includes a list of behaviour change techniques to be incorporated into a programme. Including a reference where definitions of each technique mentioned can be found (Michie, S., Ashford, S., Sniehotta, F. F., Dombrowski, S. U., Bishop, A., & French, D. P. (2011). A refined taxonomy of behaviour change techniques to help people change their physical activity and healthy eating behaviours: The CALO-RE taxonomy. *Psychology and Health, 26*(11), 1479-1498) would allow full descriptions to be examined by professionals. Readers could also be guided to view an example of materials in Sniehotta FF, Dombrowski SU, Avenell A, Johnston M, McDonald S, Murchie P, et al. Randomised Controlled Feasibility Trial of an Evidence-Informed Behavioural Intervention for Obese Adults with Additional Risk Factors. PLoS ONE. 2011;6(8):e23040.	Thank you for this suggestion. Behaviour change techniques per se are outside the remit of this guidance but appropriate links are given to NICE guidelines on behaviour change.
Newcastle University, Institute of Health and Society	Section 1	11	Recommendation 6: The point states that monitoring weight and behaviour change is needed for at least 12 months. However it does not state what behaviour change to monitor or how often within the 12 months. Suggestions here may be beneficial such as food diaries for diet, accelerometers (monitoring) or pedometers (self-monitoring) for physical activity.	Thank you for this comment. More information on monitoring and evaluation is given in other recommendations. The revised guideline more strongly flags using validated tools and the standard evaluation framework.
Newcastle University, Institute of Health and Society	Section 1	12	Recommendation 7: On this page it states that a programme should only be commissioned if it considers the needs of different subgroups. However, the guidance concludes that the evidence is lacking in this area and more research is needed, making it difficult to draw conclusions. It may be useful to highlight the importance of including the patient in the decision process and recording the patient characteristics along with the programme option chosen to add to the knowledge base in this area.	Thank you for this comment. The updated recommendation on evaluation flags that information on participant age, gender, ethnicity and socioeconomic status should be routinely collected to assess the impact of health inequalities.
Newcastle University, Institute of Health and Society	Section 1	13	One of the actions suggested in Recommendation 8: 'commissioning lifestyle weight management programmes' is to ensure a range of local services support people who need to maintain their weight or weight loss. Service providers informing patients of possible support available, after a programme has been completed, would allow an opportunity to signpost and raise people's awareness to relevant local services and could be included in the actions.	Thank you, the recommendation has been amended in line with your comment.

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Newcastle University, Institute of Health and Society	Section 1	14, 16	Recommendation 9: referrals to lifestyle weight management services mentions ensuring that people know GPs, practice nurses or other health professionals can provide ongoing support but it is not stated what this ongoing support consists of. Later in the guidance it goes on to recommend training for all GPs and health professionals (recommendation 11, page 16). This is very positive, but we believe more information should be provided on what training is needed, and who from. Only after these professionals are fully trained will they be able to appropriately provide ongoing support for patients.	Thank you for this comment. We are of the view that the updated training recommendations are clear about the training that is required and who has responsibility for implementing the recommendations.
Newcastle University, Institute of Health and Society	Section 1	18	In this recommendation (recommendation 13) it states that information should be routinely collected for all participants at the end of the programme. However it then mentions weight loss and per cent of baseline weight loss. Therefore collecting baseline information should also be a key point and should be included in the opening sentence of collecting information: 'at least at baseline and at the end of a programme.'	Thank you for this comment. Other recommendations within the guidance make it clear that monitoring is required throughout and at baseline.
Newcastle University, Institute of Health and Society	Section 1	18	Related to the above comment, and if each lifestyle weight management programme is required to collect the same routine information, would it be appropriate to have a central resource for data storage? This would make data collection consistent between all programmes and would contribute to the accumulation of evidence, better serving practitioners and researchers.	Thank you for this comment. The revised guideline includes a recommendation to public health England to establish a national source of information on lifestyle weight management programmes suitable for commissioning.
Newcastle University, Institute of Health and Society	Section 4	30	Research recommendation 3 relates to programme components. The CONSORT statement (25 item checklist) could be mentioned for guidelines on reporting for trials (Moher D, Schulz KF, Altman DG. The CONSORT statement: revised recommendations for improving the quality of reports of parallel-group randomised trials. The Lancet. 2001;357(9263):1191-4) as well as Boutron I, Moher D, Altman DG, Schulz K, Ravaud P, for the CONSORT group. Extending the CONSORT Statement to randomized trials of nonpharmacologic treatment: explanation and elaboration Ann Intern Med. 2008:295-309. A reference to Davidson K, Goldstein M, Kaplan R, Kaufmann P, Knatterud G, Orleans C, et al. Evidence-based behavioral medicine: What is it and how do we achieve it? Annals of Behavioral Medicine. 2003;26(3):161-71 could also be included to outline what minimal	Thank you for these references.

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			intervention detail should be described in a trial report. Further detail should be given on the behaviour change techniques used (Michie, S., Ashford, S., Sniehotta, F. F., Dombrowski, S. U., Bishop, A., & French, D. P. (2011). A refined taxonomy of behaviour change techniques to help people change their physical activity and healthy eating behaviours: The CALO-RE taxonomy. *Psychology and Health, 26*(11), 1479-1498).	
Newcastle University, Institute of Health and Society	Section 6	34	In the glossary a definition is given for 'providers of lifestyle weight management programmes'. After the definition it may be helpful to include examples of health professionals likely to be involved (i.e. dietitians, nutritionists, physical activity experts, practice nurses).	Thank you for this comment. The health professionals that should be involved in developing programmes and training is dealt with in recommendations.
Newcastle University, Institute of Health and Society	Section 8	40	Query as to why people with pre-existing medical conditions were excluded. Obesity is greatly associated with a number of serious diseases (Foresight. (2007). *Tackling Obesities: Future choices - Project Report*.) Therefore evidence from studies containing participants who have co-morbidities will not have been analysed. Studies were included if they focused on prevention of signs of pre-disease measures (i.e. pre-diabetes, slightly high blood pressure). However the mean BMI for participants from the guidance evidence review was 33 and therefore co-morbid conditions may have been present even if not reported. The strain on NHS funding and availability of programmes means that lifestyle weight management services may also need to be referred and recommended for those with co-morditities when specialist tier 3 services are not accessible.	Thank you for this comment. This guidance is only one aspect of NICE work on obesity. This is a large topic and it was important that the work was achievable in the time available. The introduction to the guidance has been revised to state: The guidance does not consider the additional needs of adults with complex needs (such as those who are obese and also have alcohol or mental health problems). Clinical judgment will be needed to determine whether lifestyle weight management programmes are appropriate for people with associated conditions or complex needs.
Newcastle University, Institute of Health and Society	General		The comment above links to this comment concerning the study by Hindle (2012) which was included in Review 2 when it examined a specialist weight management program (tier 3). Should this study be included in the review if this guidance focuses on tier 2 programmes? (i.e. if co-morbidities are excluded so should specialist services).	Thank you for this comment, the review team considered this paper to meet the inclusion criteria.
Nottinghamshire Healthcare	General -		– Providing information to adults considering Lifestyle weight	Thank you for these comments.

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NHS Trust	Recommendation 5		management, in our experience most people attending weight management programmes think attending is enough, they invariably believe they will wake up the next morning at their target weight! they don't realise how hard THEY have got to work at it. A "One off session" ensuring they understand all the "pros and cons" before they undertake the programme will be extremely beneficial. For most people it is daunting to start a diet we need to be able to offer life style changes that may be small but could reduce weight. Recipes, advice on takeaways e.g tomato based curries rather than creamy masala type, make weight loss more achievable. Portion Size is becoming more and more important, most of those that have lost weight on our programme have done so by reducing their portion sizes and increasing their exercise We think getting this part right could lead to more successful weight losses, because people will be more informed before they start.	
Nottinghamshire Healthcare NHS Trust	general		We think the actual messages that they are recommending to be given fit in really well with what we are actually currently delivering, such as explaining how much motivation is required, that there isn't a 'magic' solution and the importance of gradual, long term changes to eating habits and physical activity. We think the section of what commissioners should be looking for in a service is really useful. We also liked getting GP's and health care professionals to signpost in through a variety of methods, including health checks. We think this would be very beneficial, as we I have had quite a few conversations with professionals when out on training about the current lack of routes out of the health check for those that are overweight/obese. We also agree with all the recommendations set out, especially the need for longer term evaluation, and the use of Dietitians, clinical	Thank you for these comments.

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			psychologists and physical activity advisors in the programme	
Nottinghamshire Healthcare NHS Trust	Draft recommendations	12	Note that an approach that is not costly to follow and that avoids 'banning' specific foods or food groups is preferable. We would say that this was essential	Thank you for this comment. The wording reflects the evidence available.
Nottinghamshire Healthcare NHS Trust	Draft recommendations	11	Consider the needs of different subgroups and tailor programmes accordingly. For example, provide women- or men-only sessions as necessary, provide sessions at a range of times and in venues with good transport links, and consider providing childcare for attendees. We would question how achievable this is given likely budget constraints.	Thank you for this comment. Local funding issues around the implementation of NICE guidance is outside the remit of NICE.
Nottinghamshire Healthcare NHS Trust	Draft recommendations	14	Focus mainly on adults with a BMI over 30 kg/m² (there should be no upper BMI or upper age limit for referral) A lower BMI cut off would be appropriate for some Ethnic groups.	Thank you for this comment. A link has been added to the glossary definition which notes lower BMI for some Black and minority ethnic groups.
Nottinghamshire Healthcare NHS Trust	general		Many of the comments below are informed by the 2011 publication by the British Psychological Society: **Obesity in the UK; A psychological perspective** I note that this evidence has not been used in this guidance	Thank you. The evidence reviews for this work considered peer reviewed primary studies or systematic reviews. The BPS report is a position report rather than a systematic review and would therefore have been excluded from the evidence review search. The PDG did consider expert testimony from clinical psychologists.
Nottinghamshire Healthcare NHS Trust	General And recommendation 11		Input from a Psychologist appears to be limited to training other healthcare professionals. There may be room for a more specific role for the psychologist.	Thank you for this comment. Practitioner psychologists are identified as being involved in the development of programmes and training.
Nottinghamshire Healthcare NHS Trust	general		Input from a Psychologist at Tier 2 could be beneficial	Thank you for this comment. Practitioner psychologists are identified as being involved in the development of

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				programmes and training.
Nottinghamshire Healthcare NHS Trust			• To assess need for more intensive treatment at tier 3 • At tier 2 to assess stage of change • To apply an intervention using motivational interviewing • To help with goal setting • To identify an underlying Eating Disorder	Thank you for these comments. The issues raised are addressed throughout the recommendations (particularly those on referral, improving outcomes and training). No evidence was identified on motivational interviewing.
Nottinghamshire Healthcare NHS Trust	Recommendation 9		The rationale for group therapy I would question should be made not only on cost saving, but also on therapeutic effectiveness grounds. If group therapy is not therapeutic the cost saving is nothing. There is evidence in weight loss programmes and other chronic illness group intervention to show that the power of the group has a more powerful therapeutic effect than individual therapy.	Thank you for this comment, the recommendation on referral flags that a number of factors should be considered.
Nottinghamshire Healthcare NHS Trust	Section 4		Psychologists could have a role in the design audit	Thank you for this comment. Practitioner psychologists are identified as being involved in the development of programmes and training.
Nottinghamshire Healthcare NHS Trust	general		I would have liked to see some “value based” goal setting in the guidance. People are motivated to lose weight for many reasons – the health benefits for some people may not be the main motivator – “valuing being in a long term relationship”, “being able to be the parent I would like to be for my children”, may for some lead to more person centred goals being achieved. Acceptance Commitment Therapy, used in pain management could offer this.	Thank you for this comment. Goal setting is mentioned in the core components as one of the behaviour change methods but the guidance is not prescriptive on the approach.
Nutratech Ltd	General		The draft guidance concentrates only provision of local lifestyle weight management services providing 'face to face' consultation. Although there is no doubt that group or individual consultation is successful in promoting weight loss, there are substantial merits in the promotion of online obesity treatment programmes. **Wieland *et al*** (August 2012) performed a meta-analysis of weight	Thank you for this information. The evidence reviews identified limited information on online programmes with follow up of at least 12 months. Evidence statement 1.12 covers this point. The guidance applies to all programmes.

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			loss involving a total of 2537 people and found that after 6 months, people using an online programme lost more weight than those who received no / minimal intervention, although not as effective as face to face programmes. In addition there is a strong correlation between the use of food and exercise diaries and weight loss. **Johnson and Wardle** (2011) found food diary compliance to be a strong predictor of weight loss in a study of over 3600 adults in the UK. Evidence suggests that online weight management services may be an additional tool to be considered as part of the pathway for managing overweight and obesity in adults.	
Nutratech Ltd	Recommendation 4	8	The application of 'goals and progress' is important in any programme. Realistic, and manageable, goals will encourage continued adherence to the programme, and maintain interest. Discussing and setting goals with an individual will help to address the expectations of the programme. This would also apply to an online system which sets individualised goals, and records progress on a weekly basis.	Thank you – the revised draft makes more explicit mention of goals in recommendations 8 and 9.
Nutratech Ltd	Recommendation 6	10 (point 5)	Although one to one contact or advice from a registered dietitian may not be essential, the support of a team of multi-disciplinary experts can help to support an individual with their weight loss. Access to experts through an online service may provide the support that an individual requires without the time and workload falling to the Primary Care provider. Many online services work with qualified experts including Registered Nutritionists, State Registered Dietitians, GPs, Fitness Experts and others to provide appropriate and individualised advice to support weight loss.	Thank you for this comment, the wording of this recommendation has been revised.
Nutratech Ltd	Recommendation	11	Online weight loss providers can offer members all the tools and	Thank you for this comment. The wording of this recommendation has

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	7		ongoing support that they require to maintain their weight loss. The system fosters independence and self management from day one. A food diary based system teaches the importance of healthy eating and physical activity for long term weight loss maintenance. The approach educates the user on how the food they eat and the activity they do work together – providing the knowledge to understand their personal energy expenditure.	been revised to flag online resources.
Nutratech Ltd	Recommendation 8	13	Online services can provide an evenly resourced national coverage, where provision of face to face services may be limited.	Thank you for this comment
Nutratech Ltd	Recommendation 11	16	The long term goal of any weight management service is to encourage people to self-manage their weight. Web-based tools such as food and exercise diaries can help to support the transition of the individual from group/ one-to-one services to a self-managed weight maintenance approach.	Thank you for this comment.
Nutratech Ltd	3.4 Considerations	23	The real or perceived stigma of obesity requires a non-blaming approach. Providing anonymity via an online service may suit some people's desire to lose weight without the added stigma of attending group classes or weigh-ins. "It is vital patients are enabled to make informed choices about if, when and how they manage their weight" - providing many options including online services may broaden the scope of weight loss options in this case.	Thank you for this comment
Nutratech Ltd	3.17 Cost Effectiveness	26	The economic model used in the draft guidance is based on 'face-to-face' contact approaches which require ongoing input from healthcare	Thank you for this comment. This was not modelled due to a lack of evidence. The role of new technologies has been

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			professionals as weight loss is maintained. Online services could be considered as an option in cases where weight loss goals have been reached, and an individual feels comfortable using this type of system as a way of maintaining weight.	flagged in the research recommendations.
Public Health Wales	Recommendation 1	Page 6	The range of services could also refer to third sector In identifying local services – could provide more comprehensive examples of both Physical activity and food related activities	Thank you for this comment. This issue is dealt with in existing guidance on obesity – working with local communities.
Public Health Wales	Recommendation 2	Page 6 Page 7	Consideration of 'empathy' in relation to communication approaches could be included Could include an initial task to undertake a risk assessment of settings where lifestyle management groups are to be delivered to ensure suitability Respect both privacy and choice in relation to weight checks	Thank you for this comment. Empathy is addressed in the training recommendations. 'Preference' has been added to the revise text.
Public Health Wales	Recommendation 3	Page 7 Page 8	Commissioners should also be made aware of the need to ensure consistent, evidence based message and should be informed of any revision or new evidence/developments as appropriate. This could be extended to include other health professions or add in allied health professionals, occupational health nurses etc	Thank you for this comment. The revised guidance includes recommendations on raising awareness of local services among (1) GPs and other health professionals and (2) the local population.
Public Health Wales	Recommendation 4	Page 8	The first 2 bullets could be made more positive – e.g. focus on the positive impact that participation can have on health outcomes, rather than 'not guaranteed success' or 'not a magic bullet ' And focus on person centred approach to decided own realistic goals and commitment to long term behaviour change As well as past experiences to discuss previous /current barriers real or perceived	Thank you for these comments. The text has been revised reflecting your comments.
Public Health Wales	Recommendation 5	Page 9	Information on what the programme is about should make clear that it is not a prescribed dieting or fitness regime and focuses on a holistic	Thank you for this comment, it is our view that this is the approach of the

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			lifestyle management approach encouraging and supporting the maintenance of long term small behavioural changes .	guidance throughout.
Public Health Wales	Recommendation 6	Page 10	One to one contact /advice from a registered dietitian may be applicable in individual circumstances where group support is not appropriate. Reference to clear energy intake or kcal reduction target may be inappropriate – some may benefit from food based targets (with a goal to reduce energy) Physical activity should consider additional benefit of including structured supervised PA Nutrition and food behaviour led sessions should be delivered by someone with minimum levels of nutrition qualification e.g. Level 2/3 nutrition qualification, training and supervision from a registered dietitian and group facilitation skills	Thank you for this comment. This recommendation has been revised in line with your comments.
Public Health Wales	Recommendation 7	Page 11	Consideration of child care – the fact that many of these programmes will be delivered in more deprived areas means that many parents will be on low incomes and have children at home and therefore there may need to be a regular provision not just a consideration or specify joint work with other agencies May also want to consider a family based approach (refer or link to childhood obesity intervention guidance), rather than individual adults. It would be useful for the guidance to make stronger links with the importance of family change where appropriate. Maintenance of weight still requires a person centred , behavioural approach to manage and prevent lapses – not just provision of advice or support Healthy low fat diet – consider use of healthy balanced diet, based on current evidence base (link to Eat well Plate)	Thank you for this comment. No family based interventions where identified with outcomes in adults. A link has been added to NHS choices website.
Public Health Wales	Recommendation 8	Page 12	Needs further clarification on BMI's appropriate for referrals – this may vary depending on extent of co morbidities or impact on health but some criteria could be included with reference to flexibility at local level . Links to appropriate Level 3 specialist services could be included	Thank you for this comment, the revised recommendation provides additional clarification.

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			The decommissioning of programmes that fail to meet uptakes, or outcomes is a difficult area. The service provider may have done everything they can to optimise this but it may be failure on the referrers, inappropriate referrals, or lack of local support that may contribute to failure. It would need to be demonstrated that it is entirely their fault in order to decommission.	Thank you for this comment. The revised recommendation states 'amend, improve or decommission…..'
Public Health Wales	Recommendation 10	Page 15	Regular weigh ins should not be considered essential to monitor motivation as may not be an individual's choice to participate in this aspect.	Thank you for this comment. The need to respect individual choices is noted elsewhere.
Public Health Wales	Recommendation 11	Page 16	It is not clear what range of BMI and/or complex needs is being considered for these Level 2 interventions and making links to when it is appropriate to refer to Level 3 specialist services. A paragraph about the links and overlap between the different levels would be helpful Also links to NICE Guidance 27 for considerations for pre pregnancy, pregnancy and post natal	Thank you for this comment. An upper BMI was not set and the level of complex need is a clinical decision. Links with other guidance are note and this guidance will be placed within the NICE pathway on obesity.
Public Health Wales	Recommendation 12	Page 17	Training Programmes should aim to be accredited with built in quality assurance on a regular basis. It should also make reference to training the people delivering groups on group facilitation skills to maximise engagement and on-going attendance.	Thank you for this comment.
Public Health Wales	Recommendation 13	Page 18	Monitoring and evaluation – use of standardised evaluation tools to enable comparison of outcome between programmes . Include criteria for when to collect other outcome data such as dietary behaviour, PA, sedentary behaviour and use of standardised	Thank you for this comment. This recommendation has been amended in line with your comments.

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			tools	
Public Health Wales	Recommendation 14	Page 20	Service Specification should ensure monitoring and evaluation is built in	Thank you. The recommendation on commissioning flags that monitoring should be part of contracts.
Public Health Wales	General		There could be more explicit links made between the range of NICE guidance on this topic for children, adults and maternal obesity and the need to consider the requirement for family interventions which crosses over different guidance	Thank you for this comment. When the guidance is published online it will be clearer that the guidance is part of the existing NICE pathway on obesity.
Public Health Wales			The level of defined 'motivational interventions' in such programmes needs to be treated with caution as this requires a high level of skill and training. The language needs to be clear in terms of expectations on service deliverers, training requirements and competencies and skill levels – e.g the basics of active listening, developing rapport, negotiating change and supporting client centred decision making	Thank you for raising this issue.
Public Health Wales			Additional information on local public health, third sector and industry services should be included to help improve clients' options to seek additional support with weight management. Programmes should highlight the importance of discussing lifestyle goals with family and/or friends as this improves commitment to change and social support network.	Thank you for this comment – family or friends has been added as a source of support to the core components for weight maintenance.
Public Health Wales			In view of the number of emerging chronic condition pathways and pre operative requirement for weight loss – it is worth considering guidance on the range of patient groups that may benefit from weight management interventions e.g pre orthopaedic surgery, and a condition of inclusion on waiting lists evidenced based advice on these are would be helpful inclusion	Thank you for this comment. The management of chronic conditions or pre-operative requirements are outside the remit of this guidance. Whether such programmes are appropriate for such patients would be a clinical decision.
Rotherham Metropolitan Borough Council	Recommendation 4: Addressing adults' expectations of a lifestyle weight management programme	8	• *How much motivation and commitment is needed to lose weight and maintain weight loss* – this is too subjective and difficult to measure and the guidance is unclear on how it expects providers to do this or commissioners to monitor it. • *How much weight they might realistically expect to lose in total and on a weekly basis if they adhere to the programme* – this is difficult for a provider to state on first contact and	Thank you for these comments. These points are about helping to manage the expectations of users, rather than just for monitoring purposes of commissioners.

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			could raise unrealistic expectations not knowing the clients lifestyle / context of their lives	
Rotherham Metropolitan Borough Council	Recommendation 5: Providing information for adults considering a lifestyle weight management programme	9	General comments on this section: Providers may need to access additional training to help ensure they refer the right people. Providers may need to look at how they refer to other sources of support after the programme. • *What action should they take?* – this information needs proving in a service information pack and assessed using a pre intervention readiness tool as carrying out all the actions would be too time consuming or realistic for a tier 2 intervention	Thank you for these comments. Training needs are addressed in other recommendations in the guidance.
Rotherham Metropolitan Borough Council	Recommendation 6 Core components	9	General comments on this section: This was interesting as it reiterated the importance of kcal planning and also reinforced the view that not all patients need to be seen in a 1:1 clinic by a dietitian Providers would need to consider qualifications of staff in order for them to teach exercise – instructors would need to be REPS registered and insured Monitoring at 12 months is challenging although required but would need innovative approaches to keep patients engaged.	Thank you for this comment. The guidance notes that responsibilities for monitoring should be agreed at the outset and systems put in place for the sharing of information to support the collection of data at 12 months.
Rotherham Metropolitan Borough Council	Recommendation 9:	13	General comments on this section: Tier 2 services in the Rotherham Healthy Weight Framework focuses on BMI above 25kg/m2 in line with the overweight range in the BMI classification system. People with a BMI over 35kg/m2 are referred to the tier 3 services.	Thank you for this comment. BMI 30 to 40kg/m^2 is suggested as the main (but not exclusive) focus for funded referrals based on the economic modelling for this guidance. However the revised guidance also notes that adults who are overweight should not be excluded

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				where there is capacity.
Rotherham Metropolitan Borough Council	Recommendation 14: Monitoring and evaluation: local provision	19	• *What action should they take?* – This could also include reporting of KPI's to Health and Wellbeing Boards as part of any reporting framework for key priorities.	Thank you for this suggestion.
Rotherham Metropolitan Borough Council	Recommendation 2 Outcomes	29	• *What action should they take?* – It would be useful to keep these outcomes linked to the NOO SEF or bring the SEF in line with these guidelines to ensure there is consistency across all services so a clearer picture of success from lifestyle weight management services could be developed across the UK.	Thank you for this suggestion, a reference to SEF has been added to this monitoring recommendation.
Royal Bolton Hospital	Recommendation 5	Pg 9	Training should be provided by appropriately trained health professionals with experience in weight management – rather than just an dietitian/clinical psych/physical activity instructor	Thank you, the revised guideline states 'developing training….with qualified….'
Royal Bolton Hospital		Pg 79	Encourage a diet that incorporates healthy eating, a balance of food groups and a low fat/low sugar diet – low fat diets alone are not enough to achieve long term weight loss especially in the mildly active – reduced/low sugar also needs to be incorporated into the healthy eating plan.	Thank you for this comment. The wording has been amended for clarity and links given to the NHS choices website.
Royal Bolton Hospital	Recommendation 8		Allow a certain time period for services to develop and achieve desired results .	Thank you for this comment. The revised wording states 'Review programmes that do not meet agreed update, provision or outcome targets. Amend or de-commission programmes as appropriate.'
Royal Bolton Hospital	General		Guidance for promotion and recruitment and uptake into services especially for tier 2 which isn't primarily a Health professional referral service should be given to ensure services have support to achieve necessary referrals e.g. marketing and stakeholding guidelines	Thank you for this comment. The local implementation of the guidance is outside the remit of NICE.

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Royal Bolton Hospital	General		BMI is used as the main indicator for which tier service an adult is appropriate for – this should be flexible. Certain health conditions should indicate appropriateness for suitable tiered obesity service not just BMI.	Thank you for this comment. The guidance does not specify BMI cut offs for different tiers.
Royal Bolton Hospital	General		Consistent guidance on healthy eating for weight management needs to be standardised so that all services are promoting the same balanced messages for supporting adults with weight loss.	Thank you for raising this issue.
Royal Bolton Hospital	General		Weight management tier 2 service should be linked to tier 1, 3 & 4 services to ensure fluidity of referrals and access for clients to engage in other tiered servcies for long term support and success with weight maintenance	Thank you for this comment – this issue is addressed in recommendation 1.
Royal Bolton Hospital	General		Ongoing training for weight management staff in behaviour change techniques and communicating with overweight and obese adults using motivation interviewing techniques to encourage and influence successful long term behaviour change and weight maintenance techniques.	Thank you for this comment, specific training recommendations in the guidance cover communication issues. Specific evidence on motivational interviewing was not identified.
Royal College of Nursing	General		There are no comments to submit on behalf of the Royal College of Nursing to inform on the above draft guideline consultation at this present time.	Thank you
Royal College of Obstetricians and Gynaecologists	Recommendation 9 (same point applies elsewhere		Current services for this patient group are often geared to accepting referrals and rejecting non-attenders. Where such default occurs these patients are generally obliged to seek re-referral. Perhaps there should be some thought to “leaving the door open”.	Thank you for this comment. The revised guideline states that a future re-referral can be one of the options considered.
Royal College of Obstetricians and Gynaecologists	3.4	23 of 79	Stigmatisation and failing to make a positive impact is a major issue for the overweight/obese. I hear often from patients that they are upset by the subject of their weight being repeatedly raised, especially when there is no chance of a positive message and when it is being raised by people who obviously have no trouble maintaining their own	Thank you for this comment.

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			weight. A wider recognition of the need to avoid stigmatisation is to be encouraged.	
Royal College of Obstetricians and Gynaecologists	General		This is very sensitively written guidance with many references to being respectful and non-blaming	Thank you for this comment.
Royal College of Obstetricians and Gynaecologists	General		I appreciate that this is not designed to help manage co-morbidities but there is no mention of impact on fertility or pregnancy and I wondered whether it should be mentioned with a reference for specific guidance	Thank you for this comment. The NICE guidance on fertility is listed as a linked guidance and links may be more obvious once the guidance is published online and it is seen as part of the NICE pathway on obesity. A reference to fertility has been added to recommendation 1.
Royal College of Physicians	General		While it is important not to stigmatise patients who have a weight problem it is also important not to put off health care professionals who should be engaging with these patients and who may be hesitant for fear of stigmatising them. We believe that the engagement of general practitioners needs to be emphasised clearly and more often within the guidance.	Thank you for this comment. The guidance has been checked throughout to ensure that there is adequate mention of engaging GPs. Training recommendation for GPs and other health professionals addresses confidence in addressing this issue.
Royal College of Physicians	General		Appropriate weight management services. There are published data on weightwatchers and our experts feel that these should be mentioned.	Thank you for this comment. An additional recommendation has been added to the revised guidance which asks public health England to establish a national source of information on weight management programmes suitable for commissioning. The recommendation notes the UK based programmes shown to be effective in the evidence reviews for this guidance.
Royal College of Physicians	General		The engagement of GPs will be critical to any progress in this area.	Thank you for raising this issue.

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Royal College of Psychiatrists	1	7	The bullet point 'only measure the waist circumference of people with a BMI of less than 35' is unclear. Does this mean don't measure it in people over BMI 35, or just rely on waist circumference rather than BMI? It does not appear consistent with advice to GPs on P13	Thank you, the wording has been amended for clarity.
Royal College of Psychiatrists	1	10	The comment that 'an approach which avoids 'banning' particular foods is preferable' is a very helpful one	Thank you for this comment
Royal College of Psychiatrists	general		Practitioners measuring weight and BMI need robust equipment which is regularly calibrated. If patients receive different information about their weight/progress because of inaccuracies in measurement, it will not help achieve their goals. Ordinary bathroom scales are not sufficient.	Thank you for this comment. The recommendation on minimising harm emphasises that 'any new scales can accurately measure the heaviest patients….'. The monitoring recommendation has also been revised to flag that scales should be regularly calibrated.
Royal Pharmaceutical Society	General		The Royal Pharmaceutical Society welcomes evidence-based public health guidance on managing overweight and obesity in adults-lifestyle weight management services and agrees with the recommendations made. Pharmacists have a significant role in public health, raising awareness of the health risks associated with being overweight, providing advice on healthy lifestyles and also supplying medicines and nutritional products to help patients manage their weight. The RPS are currently developing professional standards for public health to help lead, support and develop pharmacists and pharmacy teams across Great Britain to enable delivery of high quality public health services.	Thank you for this comment.

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Royal Pharmaceutical Society	2	4.3	We have noted that NICE does not plan to update CG43 section 1.2.5 Pharmacological Interventions, and that the changes made to the guidance regarding sibutramine in 2010 (following the suspension of its marketing authorisation) are currently communicated in the form of notes within the original guidance. Would this be a good opportunity to reconcile this section of the guidance?	Thank you for this comment. Updated of other sections of CG43 are outside the remit of this guidance.
Royal Pharmaceutical Society	Recommendation 5	9	It could be useful to include pharmacists in the examples of sources of long-term support-- pharmacies are accessible, open long hours and present in communities across the country (including areas of deprivation). The accessible and inviting environment of pharmacies in the community, allow people to seek advice and have conversations about weight management at a time that is convenient for them, without having to make an appointment.	Thank you for this comment. The evidence reviews for this guidance did not identify any specific information on pharmacists but if they are providing information on issues covered by the guideline then the guidance would apply to them. Pharmacies have been added to recommendation 1.
Royal Pharmaceutical Society	Recommendation 9	14	Pharmacists could also be added to GPs and practice nurses as sources of ongoing support (see explanation above).	Thank you for this comment. The evidence reviews for this guidance did not identify any specific information on pharmacists but if they are providing information on issues covered by the guidance then the guideline would apply to them.
Shropshire Community Health NHS Trust	General		It should be noted that the views and opinions expressed result from my experience and evidenced evaluation of weight loss programmes in Telford and Wrekin, Shropshire, which I currently lead, and are not necessarily those of Shropshire Community Health. In addition, I have undertaken some private trials during 2013 with a small cohort of clients to evaluate an alternative approach to weight loss and these findings are also included in my comments.	Thank you

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Shropshire Community Health NHS Trust	Recommendation 3	7	The reference here that commissioners be aware of the health benefits of even a relatively small amount of weight loss or as a result of avoiding further weight gain. Locally, with commissioners, there is a push for payment by results (PBR) and therefore a real conflict. 5% weight loss at 12 weeks seems to be becoming a standard with commissioners. This does seem at odds with this guidance.	Thank you for this comment. It is hoped that commissioners will follow the NICE guidance.
Shropshire Community Health NHS Trust	Recommendation 4	8	This adds to the above confusion as providers of weight loss programmes try to explain to clients that; • 'no programme can guarantee success', (surely this is not about the programme but more about compliance in both the short and the longer term) • 'the health benefits of a 5-10% weight loss', • 'the benefits of maintaining even a small weight loss of 3%' • 'the benefits of preventing further weight gain'. This combination of messages is very confusing to clients if not getting fatter is good – why diet at all? In addition, how do you set a benchmark for how providers will get paid? Is it 5%, 3% or what?	Thank you for this comment. The wording of this recommendation has been amended for clarity.
Shropshire Community Health NHS Trust	Recommendation 6	10	The comment of a focus on long-term lifestyle change sounds great, but for most this is an impossible challenge as relapse follows relapse. You also note that approaches to weight loss should avoid banning specific foods. The reality is that the foods people eat are their foods of choice and regardless of the content of any weight loss intervention, the vast majority of people perversely return to these foods, post intervention, even though these are the foods that made them fat in the first place. The result is they regain all the weight lost and usually also gain a bit more.	Thank you for raising these issues. This guidance is for multicomponent lifestyle interventions addressing diet, activity and behaviour change. The evidence reviews for this guidance identified that such programmes can help people to successfully lose weight. The guidance flags the difficulties in weight maintenance and the recommendations suggested are based on the evidence available.

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			The greater the lifestyle change the harder it is to sustain. Therefore for people with entrenched eating habits, and I would suggest, from my experience, that this is the majority of people who are overweight, and more significantly with those who are obese or morbidly obese, maintaining changes is an unrealistic expectation. Also here there is a reference to increased physical activity. This is such a red herring. The evidence is clear that increasing physical activity has no real impact on weight loss. Research papers from experts such as Paul Gately and others attest to this. In addition, it gives clients an excuse – 'I cannot lose weight because I cannot exercise because of my health'. Removing the issue of physical activity from the weight loss equation enables clients to accept that it is what they eat that is the sole reason they are overweight. This acceptance is the key to individuals taking personal responsibility for the size they are and the reason (singular) why.	
Shropshire Community Health NHS Trust	Recommendation 7	11	The comments on fostering independence and self-management are highly pertinent. Work I have been doing with my private client cohort very much supports this and as a result I have produced a self help guide for weight loss. It combines an understanding of the reason people are overweight, because they over eat, and taking personal responsibility for weight loss. As to ongoing support, with taking personal responsibility this becomes far less necessary. Again physical activity is mentioned when the reality is that it is more	Thank you for these comments. This guideline is for multicomponent lifestyle interventions addressing diet, activity and behaviour change. The evidence reviews for this guidance identified that such programmes can help people to successfully lose weight. The guideline flags the difficulties in weight maintenance and the recommendations suggested are based on the evidence available.

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			important to understand calories and to not over eat than to be more active. I am not saying that physical activity is not important to health, it is. What I am saying is that it is more important when it comes to weight loss to remove any confusion or possible contradiction and to concentrate on the only real issue; that we are overweight because of the calories we consume and for no other reason.	
Shropshire Community Health NHS Trust	Recommendation 8	12	I heartily endorse the comment in the last bullet point.	Thank you for this comment.
Shropshire Community Health NHS Trust	Recommendation 8	13	Programme monitoring and outcomes at 12 months are a real issue as the commissioning trend is for 12 month contracts. This data is readily available with our current programmes under the old NHS provision of services but would not be under future contracting as once the contract comes to an end there is no ongoing relationship that would enable this to happen.	Thank you for raising this issue. It is hoped that commissioners follow the guidance.
Shropshire Community Health NHS Trust	Recommendation 11	16	The comment on training in raising the issue of weight for GPs and other health professionals is very important. In Shropshire we have developed a Brief Intervention training programme for exactly this and this has been delivered to a range of health professionals and others with some success. The problem remains of trying to get GPs to attend. It would appear that without an incentive, probably financial, this does not happen. In addition, I suspect that unless there is some financial incentive attached to a referral to a weight loss programme, referrals will remain low. For example, in Telford and Wrekin, GP referrals to our programmes are, on average, less than 1% of their patients although over 60% are overweight or obese.	Thank you for this comment. Local implementation of the guideline, and for example, financial incentives for referral, are outside the remit of this guidance.
Shropshire Community Health NHS Trust	Recommendation 12	17	Understanding why people have difficulty managing their weight is important. What is more important is that the Government and the food industry accept their culpability in this epidemic.	Thank you for these comments, however these issues are outside the remit of this guideline.

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			The evidence is clear that voluntary agreements do not work. They did not work with the tobacco industry and they will not work with the food industry either. Legislation is required and that includes simple traffic lights on the front of packaging. The food industry spent over a billion Euros burying traffic lights in the European Parliament for a reason. They cannot be trusted, they poison us and make us fat for profit and this has to be stopped. For every £1 that WHO spends to reduce food related risks to health the food industry spends £500 promoting unhealthy foods. Without legislation to stop this we may as well just give up now. This unhealthy and irresponsible relationship between governments and the food industry is explained to readers of my self help guide and has been significant in their making changes to the way they shop and the foods they eat.	
Shropshire Community Health NHS Trust	Recommendation 13	18/19	The issue of collecting information from participants is fine. We do pre and post programme well being questionnaires and post programme evaluation forms. These demonstrate the quality of the programmes we deliver and client satisfaction with their weight loss – at least while they are participants. Ongoing data at 6 and 12 months is more difficult as clients are resistant to attending just to be weighed. Therefore self reported weight is the best we are able to achieve for most. As to clients who did not complete the programme, we recently sent questionnaires to 240 such clients that included pre-paid reply envelopes, we had 2 responses.	Thank you for these comments. The recommendation on commissioning highlights that responsibilities for monitoring should be agreed at the outset and systems should be in place to support the collection of data at 12 months.
Shropshire Community Health NHS Trust	Public health need and practice	21	The paragraph – In many areas, the local authority,,, etc should also include NHS weight loss providers along side of commercial	Thank you, the text has been amended in line with your comment.

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			companies. Or are we a thing of the past?	
Shropshire Community Health NHS Trust		22	XX XXXXXXXX XXXXXX XXXX XXXX X XXXXXXXX XXXXX XXXXXXXX XXXXXXX XXX XXXXXX XXXX XXX XXXXXX XXX XXXXXX.. XX XXX XX XXXXXXXXXX XX XXXXXX XXXXX, XXXXX XXXXX-XXXXXX, XXXXX XXXXXXX XXXXX XXXXXXXX XXXX XXXX XXXXX XXX XXXXX, XXXXXXXXX, XXXX, XXXXXXXXX, XXXX XXXXXXX XXXXXXXX. XXX XXX XX XX XXXXXXXXXX XXXX XXXX XXXXXXXXXXX XX XXX XXXXXXX XXXXX XXXXXXXX, XXXXXX XXXXXXXX XXXX XXX XXXXXXX XXXX XXXXXXXXX XXXXXXXXX	REMOVED AS PROMOTIONAL INFORMATION
Shropshire Community Health NHS Trust	Evidence	24	XX XXXXXXXX XXXXXX XXXX XXXX X XXXXXXXX XXXXX XXXXXXXX XXXXXXX XXX XXXXXX XXXX XXX XXXXXX XXX XXXXXX.. XX XXX XX XXXXXXXXXX XX XXXXXX XXXXX, XXXXX XXXXX-XXXXXX, XXXXX XXXXXXX XXXXX XXXXXXXX XXXX XXXX XXXXX XXX XXXXX, XXXXXXXXX, XXXX, XXXXXXXXX, XXXX XXXXXXX XXXXXXXX. XXX XXX XX XX XXXXXXXXXX XXXX XXXX XXXXXXXXXXX XX XXX XXXXXXX XXXXX XXXXXXXX, XXXXXX XXXXXXXX XXXX XXX XXXXXXX XXXX XXXXXXXXX XXXXXXXXX	REMOVED AS PROMOTIONAL INFORMATION.
Shropshire Community Health NHS Trust	Commissioning	25	The issue of lower income families accessing weight programmes commissioned from commercial providers is indeed a concern. The likelihood of health inequalities widening still further should concern us all.	Thank you for this comment.
Shropshire Community Health NHS Trust	Cost effectiveness	26/27	It would appear from the economic modelling of cost effectiveness that weight loss interventions are a waste of money as even the nominal amounts of weight loss required have to be maintained for life. This very much confirms the reports of the British Dietetic Association when they evaluated the top 10 diets. The diet industry is a fraud and dieting to lose weight only works in the short term. Ultimately the	Thank you for this comment. The question is the length of time that weight loss has to be maintained. The modelling shows that if weight loss is very small, it has to be kept off for a long time for it to be cost effective. However, for older people, it would seem that reasonably small (not very small) weight

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			majority of dieters end up heavier not lighter. A recent audit of Weight Watchers services to the NHS concluded that the NHS keeps paying for the same pound of fat lost over and over again. Reading this draft guidance has reinforced for me the rationale for my guide and the positive impact it can have on people's ability to lose weight and keep it off.	losses for several years or more might be cost effective. The aim is now to look for interventions and approaches that can maintain weight loss for longer than a year or two. Please see the modelling report for more information.
Shropshire Council	Recommendation 1	p.6	Integrated approach – 'systems should be in place to allow people to progress easily through the local obesity care pathway' – many areas do not have fully functioning and complete obesity care pathways in place due to funding constraints/transition issues -there is currently a lack of clarity over commissioning responsibilities for Tiers, especially Tiers 3 and 4 which, though mutually dependent, are likely to be commissioned by two different organisations -fragmentation of commissioning responsibilities (LA/CCG/NHS England) has the potential to hamper implementation of integrated approach without effective communication and collaboration between organisations -integration of Public Health lifestyle risk management services through integrated commissioning approaches/arrangements is needed to reverse the trend in organisational and cross-organisational silo working	Thank you for highlighting these issues.
Shropshire Council	Recommendation 6	p.10	Core components of lifestyle weight management services – weight loss -focus on long term lifestyle change is very welcome, there is a need for consistency in relation to commissioning of weight management services that focus on maintenance of weight loss and not merely short term weight loss to 12 weeks	Thank you for this comment.
Shropshire Council	Recommendation 6	p.10	'achievable goals for weight loss including within first few weeks, after 12 weeks and at 1 year' -further, more detailed guidance on outcome indicators/ success measures is needed to help commissioners to define success e.g. a	Thank you for these comments. The revised commissioning recommendation includes DH pragmatic best practice criteria for weight

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			'basket of outcomes' that taken collectively can equate to a successful outcome/s for participants	management programmes.
Shropshire Council	Recommendation 6	p.10	-Interested to see inclusion of 'MDT including clinical psychologist', this is more usually seen in reference to Tier 3 and management of complex obesity. Tier 2 services are behaviour change focused but on the ground we are facing increasing pressure (in absence of Tier 3 provision) to manage patients with more complex obesity, including psychological issues -would welcome further guidance to qualify psychological support – i.e. nature and level/s of training required (on a par with those stated in relation to physical activity)	Thank you for these comments. Reference to MDT is in relation to the development of programmes and training. Management of complex needs outside the remit of this guidance.
Shropshire Council	Recommendation 6	p.11	Welcome recommendation 'to monitor weight and measures of behaviour change for at least 12 months' -would welcome additional detailed guidance on measurement tools	Thank you for this comment – monitoring and evaluation is discussed in detail in a separate recommendation. The recommendation discusses the importance of using validated tools such as the standard evaluation framework.
Shropshire Council	Recommendation 7	p.11	Welcome recognition of 'importance of self-management' -but would like more detail on 'how to facilitate this' effectively	Thank you for this comment. The evidence on this issue was limited and research recommendations have been added.
Shropshire Council	Recommendation 8	p.12	Welcome recognition of wider determinants work e.g. SPG development -but commissioners would value additional detailed guidance on facilitating these (often policy-led) changes	Thank you, NICE has existing guidance addressing wider determinants, links are shown through the NICE pathway on obesity.
Shropshire Council	Recommendation 8	p.12	Welcome routine evaluation built into contracts (we already include this as a given) -but would welcome further guidance on this very important area to avoid different commissioners measuring 'apples and pears'	Thank you for this comment – monitoring and evaluation is discussed in detail in recommendations 16, 17 and 18. The recommendations discuss the

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			-further guidance would recognise the importance of this aspect of commissioning weight management services and would help facilitate the beginning of a consistent approach to evaluating effectiveness of service provision in England	importance of using validated tools and the standard evaluation framework.
Shropshire Council	Recommendation 9	p.14	'there should be no upper BMI… for referral' -this is okay only if pathway is complete (with sufficient Tier 3 and 4 provision) – otherwise, unrestricted BMI/comorbidity can lead to confusion amongst health professionals/referring agencies and places pressure on behaviour change (Tier 2) services whose predominant focus is behaviour change support	Thank you for this comment. The provision of tier 3 and 4 services is outside remit of this guidance.
Shropshire Council	Recommendation 9	p.14	'ensure people understand that GPs, PNs or other health professionals can provide on-going support, whether or not they are referred to a LWMP' -this is a workforce development issue	Thank you for this comment. Training is addressed in separate recommendations.
Shropshire Council	Recommendation 10	p.14	'improving programme uptake, adherence and outcomes' -welcome recognition of this important aspect, would very much welcome additional guidance on this -importance of ensuring MECC (making every contact count) principles are built into all lifestyle risk management service specifications	Thank you for this comment. Revised recommendation 6 states 'Raise the issue of weight loss in a respectful and non-judgemental way. Recognise that this may have been raised on numerous occasions and respect someone's choice not to discuss it further on this occasion.'
Shropshire Council	Recommendation 10	p.16	'train GPs and other health professionals to identify people with more complex needs and how to refer them to appropriate services' -important to note that GPs and other health professionals will be reluctant to raise issue if there are no/limited weight management services available to refer patients/clients into -where services are available, communication plans are essential to ensure that key stakeholders are aware of services and how to access them	Thank you for this comment. The revised guideline includes recommendations on raising awareness among health professionals and the public.

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Shropshire Council	Recommendation 12	p.16	'training, knowledge and skills: programme staff' -there is a need for standard/recognisable qualification/s to support commissioners when constructing service specifications and minimum standards, on a par with those for physical activity/exercise practitioners	Thank you for these comments. Specifics of qualifications is outside the remit of the guideline.
Shropshire Council	Recommendation 13	p.18	'monitoring and evaluation: programmes' -would welcome additional guidance on this, SEF is a useful framework but more detail would assist commissioners and providers alike	Thank you for this comment. More specific guidance on this issue is beyond the remit of the work.
Shropshire Council	Recommendation 14	p. 19	'monitoring and evaluation: local provision' -would welcome more information on cost of interventions based on 'number needed to treat' model, to support commissioners in setting tariffs locally, in absence of a national tariff	Thank you for this comment. A local costing report will be published alongside this guidance to support implementation.
Shropshire Council	General		Would welcome further guidance on delivery models – i.e. examples of high reach, low cost interventions V low reach, high cost to support commissioners -would welcome further guidance on use of related approaches e.g. social marketing, market segmentation models -need additional guidance in relation to adults with specific needs e.g. learning difficulties	Thank you for this comment. How the guideline is implemented in relation to reaching particular population groups is beyond the remit of the guidance.
Shropshire Council	General		Welcome research recommendations in relation to 'programme components' – this is a particular area of concern/need for commissioners of adult weight management services - Investing time, energy and resources in new and emerging evidence will help support a consistent approach to commissioning of services, increase opportunities to optimise service delivery and drive future investment in this crucial public health area	Thank you for this comment.
Slimming World	General		We welcome the development of this important guidance and the opportunity to comment on the draft.	Thank you.

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Slimming World		2	It would be useful to define what age this guidance covers. It mentions that children are not included, could it state what age the cut off is e.g. 16 or 18?	Thank you, the guidance has been amended in line with your comments.
Slimming World	1	4	It states that this guidance does not consider the additional needs of adults with complex needs e.g. mental health problems. This potentially rules out a very large group of people all with varying degrees of mental health. We suggest more clarity is added to ensure that people are not excluded from this guidance inappropriately. In addition to this the fact that the Obesity guidance (43) which is currently being reviewed in terms of bariatric surgery and VLCDs specifically includes people with learning difficulties as a target group seems contradictory and should be included in this guidance also.	Thank you for this comment. The evidence based considered for the development of this guidance did not actively look for studies on populations with additional or complex needs. The guidance does flag where referral may be appropriate and training for providers to identify where an individual may have complex needs. Whether such programmes are appropriate for an individual will be a clinical decision.
Slimming World	2	6/7	First bullet point. We welcome this recommendation and the acknowledgment that awareness of how someone may be feeling as well as communicating in a respectful and non-blaming way is key. We would also suggest that this goes further and is extended to include the importance of being supportive, non-judgemental and realistic in communications.	Thank you, the term 'respectful and non-judgemental' is used throughout
Slimming World	2	6/7	In the second bullet point it is highlighted that equipment needs to be considered to ensure it is suitable for the majority of patients. We would suggest that some other examples are added in which are more widely used in clinics, waiting rooms and in group sessions yet often not considered. For example the type of chair that a service provides is really important, it is essential that chairs are a suitable size and not provided with arms which might result in a patient being uncomfortable or embarrassed that the chair is not large enough for them.	Thank you, the text has been amended in line with your comments.
Slimming World	2	6/7	In the third bullet point where is says only measure waist circumference of	Thank you for this comment. The

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			people with a BMI<35, we would suggest that it is made clear that this should not single out those with a BMI>35. i.e. if waist is being measured in a group setting, they shouldn't make those with BMI>35 feel uncomfortable by obviously not measuring them.	wording of this recommendation has been revised for clarity.
Slimming World	4	8	It is specified in the guidance that 'making too many changes at once may be difficult to sustain and increase risk of relapse'. What is the evidence base for this and can more clarity be added? This could be interpreted as it not being sensible to undertake 2 changes to diet at the same time, is this what is meant? If it means that people shouldn't try and change 2 different behaviours such as address diet and stopping smoking at the same time, again, what is the evidence base for this? Many people are deterred from quitting smoking for the fear of putting on weight and would welcome support to prevent weight gain at the same time as support to stop smoking.	Thank you for these comments, the wording of this recommendation has been revised.
Slimming World	4	8	The health benefits of 5-10% and 3% weight loss are highlighted. We feel it is worth acknowledging that the health benefits will be very dependent on starting BMI and those with higher BMIs will most likely need to lose more weight to gain the health benefits. Whilst we want to be encouraging it is important not to deceive people of benefits which they may not see. We would also suggest adding in the wider benefits rather than just health benefits that a patient can relate to – patients may not be able to relate to health benefits such as reduced blood pressure or cholesterol but be more likely to relate to practical benefits such as improved mobility, feeling less breathless, being able to keep up with their family and inclusion in family activities etc. This section should emphasise the importance of discussion with the patient to find out personal motivators and expectations and not make assumptions, then the discussion can be related to the individual.	Thank you for these comments, the wording of this recommendation has been revised.
Slimming World	5	9	The guidance suggests that health professionals advising or referring patients should discuss financial costs after the referral period has finished (this assumes everyone will have been referred yet the recommendation is	Thank you, the guidance has been amended in line with your comments.

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			for advising or referring patients). Suggest rewording to read 'any financial costs of the programme (including costs following a referral period if appropriate)'.	
Slimming World	6	10	Third bullet point. It states that staff should be trained by a qualified physical activity instructor. We would suggest that 'where appropriate i.e. only if activity is undertaken within the programme' is added in here. If the programme includes behaviour change to encourage increases in physical activity then training should be from a behaviour change expert rather than a physical activity instructor.	Thank you for this comment. The wording has been revised to 'Ensure any supervised physical activity sessions are led by an appropriately qualified physical activity instructor…'
Slimming World	6	10	The recommendation reads 'set a clear energy intake or calorie reduction target'. There is now lots of evidence to support an approach which focuses on energy density and the satiety value of foods to reach a balance and reduction in calories without the need to religiously calorie count. We suggest this is reworded to say 'People trying to lose weight should be encouraged to make better food choices with emphasis on foods with a lower energy density, higher satiety value and better overall nutritional profile. The older 'method' of calorie restriction could be used to set a clear…'	Thank you for this comment. The wording of this recommendation has been revised to 'Ensure specific dietary targets are agreed (for example, for a clear energy intake or a specific reduction in energy intake) tailored to individual needs and goals.'
Slimming World	6	10/11	In the variety of behaviour change methods bullet point which bridges page 10 and 11 we would suggest that 'instruction on how to perform behaviour change' is changed to 'guidance on how to….'	Thank you, the wording of this recommendation has been amended for clarity.
Slimming World	6	11	Who should take action has changed to LA commissioners. We suggest this is changed to 'Commissioners of lifestyle weight management services' to be consistent with other recommendations.	Thank you, the guidance has been amended for consistency.
Slimming World	6	11	The guidance suggests that weight and measures of behaviour change should be monitored for at least 12 months. This is only generally possible if the person is still engaged in the programme and otherwise follow up may need to sit with the referrers. It would be useful for this point to be clearer as it is in recommendation 13 where it is stated that this is a joint	Thank you, a link is given to the monitoring recommendation to avoid repetition.

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			responsibility to be planned and agreed upon between provider and commissioner.	
Slimming World	7	11	Second bullet point. Suggest change to 'If the programme operates within a set time frame, provide information or opportunities for ongoing…'	Thank you, the wording of this recommendation has been amended for clarity.
Slimming World	8	12	Who should take action. We would suggest that GP commissioners are included in this section.	Thank you, this has been amended to include all relevant local commissioners.
Slimming World	9	14	While we agree that people's preferences should be taken into consideration there is evidence to suggest that even if someone's preferred approach was individual support, people do better in the group environment and we would suggest this is acknowledged in the guidance (Renjilian et al, 2001 'individual versus group therapy for obesity: effects of matching participants to their treatment preferences' Journal of Consulting and Clinical Psychology 69 (4) 717-721).	Thank you for this comment. This evidence was not identified within the evidence reviews for this guidance. The evidence review identified that some people would prefer not to attend a group session and NICE is of the view that this should be respected.
Slimming World	11	16	First bullet point. Suggest change to read 'Train GPs and other health professionals to identify when and how to positively and effectively raise weight management…'	Thank you, the bullet has not been amended due to concern that the addition detracted from the key point.
Slimming World	12	17	The guidance suggests that staff should be trained to accurately measure waist circumference. In some settings e.g. a group setting measuring someone's waist would not be appropriate as the process could make individuals feel very uncomfortable in front of others or even having waist measured by another individual. This would seem to go against the general focus of the guidance in terms of being aware of the feelings of the overweight patient. Suggest change wording to 'and to accurately measure waist circumference where appropriate, relevant and practical to do so bearing in mind feelings of individual'	Thank you for raising this issue, the guidance has been amended in line with your comment.

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Slimming World	13	18	We would suggest that referrers are added to the 'who should take action' as they may be required to be involved in some of the data collection for example socioeconomic status, ethnicity, height.	Thank you for raising this issue, the guidance has been amended in line with your comment.
Slimming World	13	18	Suggest change 'weight loss' to 'weight change'	Thank you for raising this issue, the guidance has been amended in line with your comment.
Slimming World	13	19	Is it necessary to record views and experience of 'all' participants or would a sample be acceptable and more realistic. Would it be cost effective for a programme to collect views of all participants?	Thank you for this comment, the guidance has been amended to 'participants' rather than 'all participants'.
The Natural Ketosis Company	Section 1; Recommendation	8	Although we recognise the importance of physical activity for building and maintaining muscle as well as for metabolic rate, there is **NO** scientific evidence that engaging in physical activity contributes to weight loss. This recommendation is based on 'common sense'. However it is important to note that correlation is not the same as causation. Physical activity levels appear to be correlated to developing obesity yet there is no evidence to point out that lack of physical activity causes obesity. Wanner, M., et al., Active Transport, Physical Activity, and Body Weight in Adults: A Systematic Review. *American Journal of Preventive Medicine,* 2012. 42(5): p. 493-502.	Thank you for this comment. This guidance focuses on multicomponent programmes that address diet, activity and behaviour change. This is supported by evidence statement 1.11 that there is strong evidence from trials that programmes that address diet and physical activity lead to greater weight loss over 12 to 18 months than those that involve diet or physical activity alone.
The Natural Ketosis Company	Section 1; Recommendation	8	When discussing average weight loss, there needs to be clarity on which diet programme they are being referred to, whether it is from a low-calorie or a ketogenic diet programme.	Thank you for this comment. This guidance focused on the effectiveness of lifestyle weight management programmes per se rather than specific dietary approaches.
	Section 1;	8		Thank you for raising this issue. This

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The Natural Ketosis Company	Recommendation 4		The benefits of weight loss (even as low as 5%) are well recognised. Yet the individual is never told about the importance of maintaining such weight loss to ensure health benefits. What is in fact happening is that adults are being turned into professional dieters as they are consistently being advised to lose weight, but nothing is ever mentioned about the importance of maintenance. Gardner C.D., Kiazand A., Alhassan S., Kim S., Stafford R.S., Balise R.R., Kraemer H.C. & King A.C. 2007. Comparison of the Atkins, Zone, Ornish, and LEARN diets for change in weight and related risk factors among overweight premenopausal women: the A TO Z Weight Loss Study: a randomized trial. *The Journal of the American Medical Association.* 297 (7): 969-977.	recommendation does flag the benefits of not gaining any further weight.
The Natural Ketosis Company	Section 1; Recommendation 5	9	When considering the appropriate weight loss programme for individuals it is important to understand the reason for failure on previously advised diet programmes. Again individuals are trying a variety of weight loss methods, yet the majority of them seem to be unable to maintain the weight loss achieved. The reasons behind these failures need to be fully addressed before advising any further weight loss intervention programmes. Otherwise the weight loss system is setting people up to fail at every intervention they try. Eileen Vincent, *Dieters Need Flexibility and Professional Support to Succeed,* Journal of the American Dietetic Association, Volume 108, Issue 4, April 2008, Pages 647-648,	Thank you for this comment. This recommendation as it stands does explore the issues you raise.
The Natural Ketosis Company	Section 1; Recommendation 5	9	There is once again focus on the individual being more active. This puts pressure on the individual as lifestyle may not allow engaging in the required amount of physical activity to see weight loss.	Thank you for this comment. This guidance focuses on multicomponent programmes that address diet, activity and behaviour change. This is supported by evidence statement 1.11 that there is strong evidence from trials that programmes that address diet and

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				physical activity lead to greater weight loss over 12 to 18 months than those that involve diet or physical activity alone.
The Natural Ketosis Company	Section 1; Recommendation 5	9	Adopting a "healthier diet": please advise as to what this means in real terms for individuals. There is mounting scientific evidence that the current 'EatWell Plate' (used to illustrate a healthy diet) is in fact contributing to the current obesity epidemic. This is because it insists on meals being composed of 50% carbohydrates as well as consumption of items known to cause obesity eg: sugary drinks and confectionary.	Thank you for this comment. The wording for this recommendation has been amended but a link to the NHS choices website has been added to relevant sections of the guidance.
The Natural Ketosis Company	Section 1; Recommendation 6	10	"Focus on long-term lifestyle change" – the majority of the lifestyle weight management programmes recommended do not put enough focus on long-term change. They run for 12-24 weeks and do not put enough emphasis on developing skills needed to navigate the current food culture lived in by participants.	Thank you for these comments.
The Natural Ketosis Company	Section 1; Recommendation 6	10	Please advise how can a weight management service prove that it focuses on long-term lifestyle management versus short-term management?	Thank you for these comments. The PDG considered the collection of outcomes at 12 months as an important first step in assessing action on long term maintenance.
The Natural Ketosis Company	Section 1; Recommendation 6	10	A multidisciplinary team is mentioned to train staff, yet there is no mention of a qualified nutritionist on the team.	Thank you for this comment, the recommendation does flag that a registered dietitian should be involved.
The Natural Ketosis Company	Section 1; Recommendation 6	10	Please advise what is the evidence of requiring a qualified physical activity instructor on a multidisciplinary team to train staff involved in weight management programmes?	Thank you for this comment. The PDG discussed the importance of staff involved in teams or in training having

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				the appropriate skills and qualifications. This guidance focuses on multicomponent programmes that address diet, activity and behaviour change. This is supported by evidence statement 1.11 that there is strong evidence from trials that programmes that address diet and physical activity lead to greater weight loss over 12 to 18 months than those that involve diet or physical activity alone.
The Natural Ketosis Company	Section 1; Recommendation 6	10	"Ensures programmes are multi-component" – What does this mean? Please expand on this issue.	Thank you for this comment. Multicomponent is defined at the start of the guidance and in the glossary but additional clarification has been added here.
The Natural Ketosis Company	Section 1; Recommendation 6	10	A weight loss approach that "avoids 'banning' specific foods or food groups" – Where is the evidence to support this statement? There is mounting scientific evidence from all areas of health that are indicating the importance of re-addressing macronutrient issues. J.W. Krieger, H.S. Sitren, M.J Daniels &B.Langkamp-Henken Effects of variation in protein and carbohydrate intake on body mass and composition during energy restriction: a meta-regression *Am J Clin Nutr* February 2006 83: 2 260-274	Thank you for this comment, the statement is based on evidence statement 2.6 that there is strong evidence that users and potential users of programmes prefer diets with a simple message that do not ban particular foods.
The Natural Ketosis Company	Section 1; Recommendation 6	10	Advice to reduce "sedentary behaviour" is of very little importance with regards to weight loss. Studies have continuously shown that physical activity is not the answer in addressing maintained weight loss.	Thank you for this comment. This guidance focuses on multicomponent programmes that address diet, activity and behaviour change. This is supported by evidence statement 1.11 that there is strong evidence from trials that programmes that address diet and

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				physical activity lead to greater weight loss over 12 to 18 months than those that involve diet or physical activity alone. ES 1.23 also shows that there is some evidence (though weak) that programmes that address diet and activity are better at maintaining weight loss than those that address diet alone.
The Natural Ketosis Company	Section 1; Recommendation 6	11	"Monitor and review participants' goals" – What are these goals? Should they reflect only weight loss, health gains or other personal views on weight & appearance?	Thank you – participant goals are likely to be tailored and personal.
The Natural Ketosis Company	Section 1; Recommendation 6	11	"measures of behaviour change" – Please expand on how behaviour changes are intended to be measured.	Thank you for this comment, a link is given to the recommendation on monitoring and evaluation, which provides more information.
The Natural Ketosis Company	Section 1; Recommendation 7	11	There is again emphasis on "healthy eating" however there is no mention anywhere within section 1 on what this means and how this notion is backed from scientific research.	Thank you for this comment, have been added throughout to existing guidance and the NHS choices website.
The Natural Ketosis Company	Section 1; Recommendation 7	12	"wider benefits of eating a healthy, low-fat diet" – Please advise on the scientific research that points to this conclusion.	Thank you for this comment, this recommendation has been amended for clarity.
	Section 1;	12	"wider benefits of eating a healthy, low-fat diet" – This is the first time	Thank you for this comment, this

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The Natural Ketosis Company	Recommendation 7		in the entire document that reference is made to this way of eating. Previously the diet that had been advised to be followed was referred to "healthy" – Please advise on why the discrepancy in guidance?	recommendation has been amended for clarity.
The Natural Ketosis Company	Section 1; Recommendation 7	12	"wider benefits of eating a healthy, low-fat diet" - There is mounting scientific evidence from all areas of health that are indicating the importance of re-addressing macronutrient issues by lowering total carbohydrate intakes and increasing protein and fat intake. Research has shown that individuals following a high-protein, moderate-fat, low-carbohydrate diet have achieved better health results both in the short- and long-term. References: Boden G, Sargrad K, Homko C, Mozzoli M, Stein TP. 2005. Effect of a low-carbohydrate diet on appetite, blood glucose levels, and insulin resistance in obese patients with type 2 diabetes. *Annals of Internal Medicine*. 142: 403–411 Daly M.E, Paisey R, Millward B.A *et al*. 2006. Short-term effects of severe dietary carbohydrate-restriction advice in type 2 diabetes-a randomized controlled trial. *Diabetic Medicine*. 23: 15-20. Dyson P.A., Beatty S., & Matthews D.R. 2007. A low-carbohydrate diet is more effective in reducing body weight than healthy eating in both diabetic and non-diabetic subjects. *Diabetic Medicine*. 24: 1430-1435.	Thank you for this comment. This guidance considered the effectiveness of lifestyle weight management programmes rather than particular dietary approaches per se. Thank you for these references
The Natural Ketosis Company	Section 1; Recommendation 7 Cont…	12	Gardner C.D., Kiazand A., Alhassan S., Kim S., Stafford R.S., Balise R.R., Kraemer H.C. & King A.C. 2007. Comparison of the Atkins, Zone, Ornish, and LEARN diets for change in weight and related risk factors among overweight premenopausal women: the A TO Z Weight Loss Study: a randomized trial. *The Journal of the American Medical Association.* 297 (7): 969-977. Halton T.L. & Hu F.B. 2004. The Effects of High Protein Diets on Thermogenesis, Satiety and Weight Loss: A Critical Review. *Journal of the American College of Nutrition*. 23 (5): 373-385. Halton T.L, Walter Sc.D., Willett C., Simin Liu P.H., Manson J.E.,	Thank you for these references

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			Albert C.M, Rexrode K., Hu F.B. 2006. Low-Carbohydrate-Diet Score and the Risk of Coronary Heart Disease in Women. *The New England Medical Journal*. 355: 1991-2002. Hession M., Rolland C., Kulkarni U., Wise A. & Broom J. 2008. Systematic review of randomized controlled trials of low-carbohydrate vs. low-fat/low-calorie diets in the management of obesity and its comorbidities. *Obesity Reviews*. 10 (1): 36-50	
The Natural Ketosis Company	Section 1; Recommendation 7 Cont…	12	Rossi M., Turati F., Lagiou P., Thrichopoulos D., Augustin L.S., La Vecchia C. & Trichopoupou A. 2013. Mediterranean diet and glycaemic load in relation to incidence of type 2 diabetes: results from the Greek cohort of the population-based European Perspective Investigation into Cancer and Nutrition (EPIC). *Diabetologia*. [online] Available at: http://link.springer.com. [Accessed 25 Sept 2013]. Thomas D. E., Elliott E. J., and Baur L. 2007. Low glycaemic index or low glycaemic load diets for overweight and obesity. *Cochrane Database of Systematic Reviews*. no. 3, Article ID CD005105 Weigle D.S., Breen P.A., Matthys C.C., Callahan H.S., Meeuws K.E., Burden V.R. & Purnell J.Q. 2005. A high-protein diet induces sustained reductions in appetite, ad libitum caloric intake, and body weight despite compensatory changes in diurnal plasma leptin and ghrelin concentrations. *The American Journal of Clinical Nutrition*. 82: 41-8. Westerterp-Plantenga M.S., Lemmens S.G. & Westerterp K.R. 2012. Dietary protein – its role in satiety, energetics, weight loss and health. *British Journal of Nutrition*. 108: S105-S112. Yancy Jr WS, Olsen MK, Guyton JR, Bakst RP, Westman EC. 2004. A low-carbohydrate, ketogenic diet versus a low-fat diet to treat obesity and hyperlipidemia: a randomized, controlled trial. *Annals of Internal Medicine.* 140: 769–777.	Thank you for these references
The Natural Ketosis Company	Section 1; Recommendation 9	14	Mention is made to “cost-effectiveness” of the weight loss programme individuals are referred to – How is this cost-effectiveness measured? Is it in sterling pounds (£) run for pounds (lbs) lost? Please clarify what this statement refers to.	Thank you for this comment; the modelling report (also posted on the website) describes this comprehensively. Some information is

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				also provided in section 9 of the annex to the guidance.
The Natural Ketosis Company	Section 1; Recommendation 9	14	GPs, practice nurses & other health professionals cannot provide on-going weight loss support as they are **not trained in nutrition**. The importance of nutrition training is to provide understanding of the human metabolic process and how macro-nutrient ratio changes affects weight loss & health overall.	Thank you for this comment. The wording of these recommendations have been revised to flag awareness of the practical skills and behaviours that can help an individual lose or maintain weight
The Natural Ketosis Company	Section 1; Recommendation 10	15	A weigh-in is used as an indicator of change. Why is inch loss and behaviour change not included? We are not aware of any scientific research indicating that weigh-ins is an effective indicator of change.	Thank you for this comment, this statement is based on information from the evidence review (see evidence statement 2.4).
The Natural Ketosis Company	Section 1; Recommendation 11	15	Please advise how Professional Bodies can be responsible for setting competences with regards to developing suitable training to address patient's weight loss? Shall these programmes be run by the Association for Nutrition and/or British Dietetic Association?	Thank you for this comment. How professional bodies implement the guidance is outside the remit of the work.
The Natural Ketosis Company	Section 1; Recommendation 11	16	We agree about the importance of GPs & health professionals to know how to accurately measure BMI and waist circumference. These are important markers to accurately follow individual's progress.	Thank you for this comment.
The Natural Ketosis Company	Section 1; Recommendation 11	16	We agree about the importance of GPs and health professionals to be able to advise individuals about what the best option to lose weight.	Thank you for this comment.

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The Natural Ketosis Company	Section 1; Recommendation 12	17	When discussing the professions involved in staff training, nutritionists are not included. Please expand as to why the Nutritionist profession is not being included in staff training?	Thank you for this comment. In relation to the provision of individual dietary advice, dietitian would be the most appropriate person to be involved in training.
The Natural Ketosis Company	Section 1; Recommendation 12	17	We agree about the importance of training staff and addressing their own weight issues.	Thank you for this comment.
The Natural Ketosis Company	Section 3.7	24	We agree with the PDG about the importance of giving people "as many opportunities as possible to lose weight". We are however very aware that currently people are only given two options: eat less and move more. We feel there needs to be more done to acknowledge the fact that there are other scientifically proven methods available to lose weight.	Thank you for raising this issue.
The Natural Ketosis Company	Section 3.17	26	Cost-effectiveness of programmes – please expand on how this has been calculated. Is it in sterling pounds (£) run for pounds (lbs) lost? _____ Community based weight loss interventions run by NHS Professionals cost **£29.40** per Kg lost on this programme. *This does not include the cost of food.* A General Practice weight loss intervention costs **£66.32** per Kg lost on this programme. *This does not include the cost of food.* A Pharmacy run weight loss intervention costs **£42.86** per Kg lost on this programme. *This does not include the cost of food.* A Weight Watchers weight loss intervention costs **£12.40** per Kg lost on this programme. *This does not include the cost of food*. A Low-Carbohydrate weight loss intervention costs **£15.82** per Kg lost on this programme. *This DOES include cost of food.* Information based on*:* ***Jolly K. et al. 2011. Comparison of range of***	Thank you for this comment; the modelling report (posted on the NICE website) describes this comprehensively. Some information is also provided in section 9 of the annex to the guidance.

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			commercial or primary care led weight reduction programmes with minimal intervention control for weight loss in obesity: Lighten up randomised controlled trial. BMJ. Nov 3:343.	
The Natural Ketosis Company	Section 4; Recommendation 1	28	More research needs to be done into alternative weight management approaches. There is plenty of on-going scientific research into weight management programmes. Examples as low-carbohydrate ketogenic diets need to be included for an open discussion for effective long-term weight loss.	Thank you for this comment, alternative approaches are flagged in the research recommendations.
Thinking Slimmer Ltd	Recommendation 10	15	"Use the regular weigh-in as an indicator of change and motivational tool." The feedback we receive from many of the 10,000 people currently using our behavioural change products is that regular use of the scales as a guide to their progress can be highly demotivational. For many people on a weight loss programme, even the smallest gain or a temporary standstill can demoralise them so much that they give up. They do not appreciate that water retention and the menstrual cycle have an effect on weight and that the scales are not a reliable indicator. In our experience, when people enjoy a lifestyle change that incorporates increased exercise, then the added density of toned muscle which gradually replaces fat can have an adverse effect on their weight. This presents them with a mental contradiction: "I'm eating less and doing more, my clothes feel looser, I feel better in myself and yet the scales tell me I'm not losing weight." Because of this we actively tell people to scrap the scales.	Thank you for this comment. This statement is based on information from the evidence review that there is strong evidence that a regular weight in by a group leader or health professional is seen by users a strong motivator (ES 2.4). Elsewhere in the guideline is clear that a tailored person centred approach is needed.
Thinking Slimmer Ltd	Recommendation 11	Page 16	"Train GPs and other health professionals to assess patient motivation to change and likelihood of benefiting from a lifestyle weight management programme." While we totally accept the benefits of health professionals being trained to assess patient motivation, this in itself will not bring about the patient being motivated to undergo a permanent lifestyle change.	Thank you for this comment. The guidance also found that lifestyle weight management programmes are only cost effective if the weight is kept and therefore considerable emphasis is placed on maintenance of weight following weight loss.

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			Prescribing a dietary regime to reduce calorie intake and/or an exercise regime will almost certainly have an effect on the patient's weight and wellbeing however all the evidence is that in most cases the benefits are temporary because they rely on willpower and do not create a lasting lifestyle change (See for example the NHS Choices assessment of Weight Watchers randomised clinical trials in which the drop out rate of participants was as high as 50% http://www.nhs.uk/news/2011/09September/Pages/weight-watchers-weight-loss-trialled.aspx See also a 2007 study by Weight Watchers, published in the British Journal of Nutrition [http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=1789920] which looked at the success of their programme over five years. Dr Carl Heneghan, director of the Centre for Evidence-based Medicine at Oxford University, has analysed these figures. "What it shows is that [after] two years… about 20% of them maintain their goal weight. By five years that goes down to 16%," says Heneghan. "So basically you pick the best people, the lifelong members and actually even they struggle, with the majority of people not obtaining their long-term goal weight. After 40 years of them when are people going to wake up and say this is not the answer?" See also an analysis of 1.2million people who undertook a Slimming World programme; only 72,000 completed the 12-month programme [http://www.slimmingworld.com/press-articles/ECO-2013.aspx] It is clear then that diets and exercise programmes, while undoubtedly producing short-term health benefits, do not in themselves produce a lasting lifestyle change. If health professionals are to be able to prescribe interventions which can make lasting changes then they will have to understand more fully what has caused the behaviour that has led to weight gain.	

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			A patient with an emotional attachment to food, for example, has issues within the unconscious mind which no amount of effort through dieting (ie conscious action) will solve.	
Thinking Slimmer Ltd	Recommendation 12	17	"Develop training for lifestyle weight management programme staff with qualified professionals such as clinical psychologists, registered dietitians and qualified physical activity specialists." We welcome this recommendation and would strongly urge that qualified and registered cognitive hypnotherapists (not to be confused with cognitive behavioural therapists) should be included in the professionals who will be asked to advise on the training. Our views about mindset are stated in our points on Recommendation 11 above. Nuffield Health is equipping its Health Mentors in some of its Fitness and Wellbeing Centres across the UK with Neuro-linguistic Programming training. This will enable them to spot potential problems and use cognitive coaching to have effective conversations about an individual's wellbeing and how to make small changes in behaviour that can bring about big improvements.	Thank you for this comment. The scope for this work highlighted that complementary therapies to reduce or manage overweight or obesity (for example, acupuncture or hypnotherapy) were excluded.
Thinking Slimmer Ltd	Recommendation 13	Page 18	Our submission is that measurements collected on participants in weight management programmes should not be restricted to weight and BMI since this data alone does not necessarily reflect an accurate picture of the participants progress. As we set out in our response to Recommendation 10, it is important to record changes in body shape and dimensions. Clothes can feel looser because body dimensions are reducing without any significant reduction in weight or change in BMI.	Thank you for this comment. Waist circumference is also flagged for people with a BMI under 35kg/m^2 (see recommendation 2).
Thinking Slimmer Ltd	Recommendation 13	Page 19	We welcome the recognition that changes in eating behaviours, self-esteem and anxiety states are an important part of the success of a	Thank you for this comment. Greater links between recommendations in this

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			weight management intervention. We have long felt that the emphasis on weekly weigh-ins at the heart of diet programmes used in the NHS does not fully take account of other important factors and in some cases can actually diminish self-esteem and cause deeper anxiety. We would draw your attention to the earlier points we made about Recommendation 10.	guideline and other NICE guidelines have been included in the final guidance.
Thinking Slimmer Ltd	2 Public health need and practice	21/22	The evidence published since 2006 (for example Loveman 2011) indicates that there could be benefits from a redefinition, refinement and clarification of what constitutes best practice in the approach to weight management. We would welcome a broad discussion on ways in which the range of interventions can be widened so that the emphasis is not just on diet and exercise.	Thank you for this comment – this issue is picked up in the research recommendation. To note that the evidence reviews for this guidance updated Loveman 2011.
Thinking Slimmer Ltd	3 Considerations	22/23	We note the PDG comments in 3.2 and 3.5 about the difficulty of maintaining weight loss in the long term and the PDG's understanding that short-term outcomes, such as those brought about by dieting, can be mis-leading. We would repeat our previously stated view that these short-term dietary outcomes are in most cases only temporary because they rely on willpower and do not create a lasting lifestyle change (see previously quoted evidence from various sources). If the problem of managing obesity and overweight issues is tackled at the level of behaviour and mindset then the long-term changes in lifestyle pattern are likely to produce more favourable results.	Thank you for these comments.
Thinking Slimmer Ltd	3.6	23	"The PDG concluded that multicomponent lifestyle weight management programmes that address eating behaviours, physical activity and behaviour change are effective in helping adults lose weight, at least in the short term. However, it was difficult to draw conclusions about why some programmes were more effective than others…" Our experience in this field shows that any behavioural change programme which relies solely on conscious effort, that is to say	Thank you for these comments. Links have been added throughout to existing NICE guidelines on behaviour change.

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			willpower, rarely succeeds in the long term. To be fully effective and achieve lasting changes, the programme must address behaviour at an unconscious level. The work of the Behavioural Insights Unit at the Cabinet Office has demonstrated graphically the benefits of this approach in many areas in which public behaviour has been successfully influenced. Their team at the Department of Health has been supportive in the setting up of our clinical trials into the use of unconscious persuasion to encourage and support people to make better lifestyle choices for themselves.	
Thinking Slimmer Ltd	3.7	24	We share the PDG's concern that "research is needed to confirm that repeated dieting poses no long-term health risks and does not result in a higher weight than baseline." We also share the worry that the short- and long- term impact (both positive and negative) on the psychological or physical health of obese adults repeatedly trying to lose weight remains unclear. Since the principle interventions prescribed by the NHS are centred almost exclusively on the reduction of calorie intake, the implications of the PDG's statement in 3.7 are clear and worrying. We welcome the recognition of the importance of psychological implications; in our work in our Harley Street practices we constantly see the psychological effects of repeated dieting manifesting themselves in many ways including low self-esteem, anxiety and even weight gain.	Thank you for this comment.
Thinking Slimmer Ltd	3.12	25	"The PDG was concerned that people who have attended weight management services often appear to be left to their own devices when it comes to maintaining any weight loss." We fully share this concern. For example, according to Jayne Hume, AnteNatal Fitness Provider for Birmingham Health, speaking at conference in April 2013 said obese pregnant women in Birmingham are prescribed a 12-week weight management course with Slimming World during their pregnancy but there is no active follow-up once the	Thank you for this comment. Please note that pregnancy is outside the remit of this guidance but NICE has a separate guideline on weight before during and after pregnancy.

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			baby is born.	
Thinking Slimmer Ltd	3.17	26	We are surprised that the economic model used for weight management interventions which cost £100 considers that a weight loss of as little as 1kg which is not regained within two years is cost effective for the taxpayer. We are even more surprised that the NHS is prepared to spend £1,000 to produce a shirt term weight loss of 3kg and considers this to be cost effective. The variable which influences cost effectiveness is stated to be the speed with which weight lost is subsequently regained, indicating that it is accepted the intervention will not work on average in anything other than the short term. We know that broadening the range of interventions made available through health professionals would considerably reduce the cost to the NHS and would in our view increase the time period over which weight loss is maintained, because interventions which address mindset and behaviour can produce lasting changes.	Thank you for these comments. The key issue from the economic model is that programmes are only cost effective if weight loss is maintained. Individual goals are obviously likely to be much greater than those identified in the model. See the modelling report for more information.
Thinking Slimmer Ltd	Recommendation One for Research and evaluation	28	We whole-heartedly welcome the recommendation that there should be longer-term evaluation comparing UK lifestyle management programmes. All alternative interventions should be evaluated because it surely cannot be said that the present programmes based around diet and exercise are achieving significant success for a population in which obesity is increasing so rapidly.	Thank you for this comment.
Thinking Slimmer Ltd	Recommendation 2 Outcomes	29	We whole-heartedly support the recommendation of an evaluation of programmes that collects information on important factors other than weight loss or change in BMI, such as behavioural changes to eating patterns and choices, physical activity level and sedentary behaviour, wider lifestyle factors such as sleeping patterns or stress management, psychological issues such as body confidence or attitude, depression, anxiety or self-esteem and last, but not least, that very important factor to the patient - quality of life. In our view it is time to take a more holistic approach that recognises that weight loss, though valuable and to be encouraged, should not of itself be the	Thank you for this comment.

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			prime aim of public health policy. The target should be to influence lasting beneficial lifestyle changes that cascade health benefits down the generations as parents' behaviour nudges their children towards better choices.	
Thinking Slimmer Ltd	Recommendation 3 Programme components	Page 30	We whole-heartedly support this recommendation for full evaluation trials of both individual components and combinations of components for weight loss management programmes. Our experience has shown that a diet or exercise programme can be made more effective in many cases when combined with an intervention that uses unconscious persuasion to motivate and sustain an individual's action.	Thank you for this comment.
UK Society for Behavioural Medicine	General		We would prefer the term 'behavioural' to 'lifestyle' weight management.	Thank you for this comment. Lifestyle reflects the referral for this guidance, common usage of the term and is easily understood by a broad range of stakeholders. The glossary definition highlights that is addresses modifiable behaviours.
UK Society for Behavioural Medicine	General		The guidance does not make clear which interventions or type of interventions are known to be effective. To be of maximum value to commissioners it would be helpful to be explicit, rather than just relying on general comments about multicomponent programmes, since not all are effective.	Thank you for this comment. An additional recommendation has been added to the revised guideline which asks public health England to establish a national source of information on weight management programmes suitable for commissioning. The recommendation notes the UK based programmes shown to be effective in the evidence reviews for this guidance.
UK Society for Behavioural Medicine	General		We are concerned that the overarching tone of the report is excessively anxious and critical of professional practice. There is undoubtedly considerable stigma that people with weight	Thank you for this comment. The guidance has been checked throughout to check that the tone of the guidance is

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			problems face. However, offering them support to lose weight and providing that help is not reinforcing stigma, it is simply supportive. There is evidence that people welcome this support and do not find it intrusive and they do find an appropriate offer of help sensitive. Our fear is that the current tone of the report reinforces health professionals fears that this is a difficult subject to address. It offends those who are trying to tackle obesity sensitively and discourages others from becoming involved. The media headlines following the publication of the consultation along the lines of 'GPs told to be nice to fat people' is at best patronising to professionals and will not foster engagement.	balanced to ensure that a sensitive approach is taken but also encourages commissioning. The training recommendations address health professional confidence in raising this issue.
UK Society for Behavioural Medicine	General		Throughout, there is an issue with use of 'short term' and 'long term' and a lack of definitions for what this refers to (in most cases not defined, and where defined appears variable).	Thank you for this comment, the wording of recommendations have been amended throughout to give a clearer indication of timescales.
UK Society for Behavioural Medicine	General		A minimum definition of a programme (based on number of sessions or contact frequency) should be included by NICE.	Thank you for this comment. The evidence review were not able to identify the optimal number of sessions or programme length but the revised guideline states that programmes should last at least 3 months and that sessions be offered at least weekly or fortnightly.
UK Society for Behavioural Medicine	General		Free resources that can help commissioners, health professionals and providers of lifestyle weight management carry out the suggest recommendations include material from the Change4Life campaign. Why is there no mention of this?	Thank you for these comments. This is an implementation issue, outside the remit of the work. However, it is covered by existing NICE guidance on obesity – working with local communities for which links are given throughout.
UK Society for Behavioural Medicine	General		There is no mention of the current physical activity guidelines (see Chief Medical Office's recommendations here https://www.	Thank you for this comment. Links are given to the NHS choices website in the revised guideline.

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UK Society for Behavioural Medicine	General		Has the PDG considered the life course concept as per the Behaviour Change NICE public health guidance no 6? There may be specific life events which may influence individuals' motivation to lose weight such as before pregnancy (obesity is associated with infertility for both men and women and an increased motivation for behaviour change; see Homan et al, 2012. Hum. Reprod. 27 (8):2396-2404) and after pregnancy for women (postpartum weight retention is associated with future obesity). These life events could be used to recruit participants to weight loss programmes.	Thank you for this comment. This issue is covered by existing NICE guidance such as it is covered by existing NICE guidance on obesity –working with local communities. Links are also given to other relevant NICE guidance such as that on behaviour change.
UK Society for Behavioural Medicine	What is this guidance about	2	It may be helpful to clarify that this guidance does not cover pregnant women.	Thank you for this comment, this information is included in the section 'about this guideline'.
UK Society for Behavioural Medicine	Who is this guidance for	2	Based on the fact that the guidance includes recommendations for research, maybe 'researchers' should be included in this section.	Thank you for this comment. The recommendations are not directed at researchers but research recommendations in section 4 are directed at researchers.
UK Society for Behavioural Medicine	Background – para 1	4	Reducing risk has much more benefit too.	Thank you for this comment.
UK Society for Behavioural Medicine	Assessing Adults who are overweight or obese	5	(line under table) Or use other more specific measures of adiposity.	Thank you for this comment.
UK Society for Behavioural Medicine	Recommendation 1 (point 2)	6	Somewhat unclear how this relates to what local authorities/CCGs/health and wellbeing boards should do in relation to lifestyle weight management services. This seems out of scope - if in scope, a bit more information may be useful on how this fits in with lifestyle weight management services?	Thank you for this comment. We consider this issue to be within scope.

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UK Society for Behavioural Medicine	Recommendation 2 (What action should they take? Point 1)	6	It may be helpful to provide guidance on what to do rather than what not to do (or at least both) - for example, if the guidance is going to say to be respectful and non-blaming, what would this mean in terms of the actual referral to a BWMP? And how is the GP/healthcare professional (HCP) to know what the preferences of an individual may be for terminology to describe obesity? Without concrete guidance on what to do, this may risk discouraging GPs/HCPs from bringing this up in consultation because they worry they may do it badly.	Thank you for this comment. The recommendations on training address raising this issue with confidence. Please note that the recommendations on referral have been amended.
UK Society for Behavioural Medicine	Recommendation 4	8	To manage participants' expectations of the programme, we suggest that programme specifics and how much support individuals can expect is also addressed.	Thank you for this comment. The text has been amended in line with your comment.
UK Society for Behavioural Medicine	Recommendation 4 (What action should they take? Point 3)	8	Is there evidence to support the assertion that making too many changes at once may increase risk of relapse? 'Too many' seems a subjective term - how would an individual gauge if they were making too many changes? And how to phrase this so that it doesn't discourage people from making changes that may actually be beneficial?	Thank you for this comment. The wording of this recommendation has been amended.
UK Society for Behavioural Medicine	Recommendation 4 (What action should they take? Point 4)	8	This over simplifies a very complex issue. More accurately, this suggests using complete case data to let participants know what they could lose. However, simple, total wt loss divided by number of weeks is not a sufficient approach. It would underestimate initial wt loss and over-estimate rates later on as weight change is dynamic. Guidance on where to get or where to find more accurate information on would surely be useful.	Thank you for this comment. The wording of this recommendation has been revised, but the PDG were of the view that it was important to give participants an indication of how much weight they may lose to manage their expectations.
UK Society for Behavioural Medicine	Recommendation 3 (What action should they take? Point 1)	8	Is there evidence that motivation and confidence predict outcome?	Thank you for this comment. The wording of this recommendation has been revised.

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UK Society for Behavioural Medicine	Recommendation 3 (What action should they take? Point 2)	8	This is true of most treatments for most things. Seems excessive.	Thank you for this comment.
UK Society for Behavioural Medicine	Recommendation 3 (What action should they take? Point 3)	8	Evidence?	Thank you for this comment. The wording of this recommendation has been revised
UK Society for Behavioural Medicine	Recommendation 3 (What action should they take? Point 4)	8	This is difficult to do for individual.	Thank you for this comment. The wording of this recommendation has been revised, but the PDG were of the view that it was important to give participants and indication of how much weight they may lose to manage their expectations.
UK Society for Behavioural Medicine	Recommendation 4 (What action should they take? Point 1)	8	The guidance in 4 appears to describe what people who refer eg GPs, might do and say and what a behavioural weight loss programme might do in the opening session. The problem with mixing the two is that any GP or other frontline professional will be put off from referring if they feel that they have to explain all or most of this to people they might consider referring. Please separate the guidance into that which applies to a programme, which should explain most of this, and that which applies to the referrer, who could not explain all this. This is compounded by recommendation 5.	Thank you, the guideline has been amended in line with your comments.
UK Society for Behavioural Medicine	Recommendation 4 (What action should they take? Point 2)	8	This makes it sound like the programme is to blame for failure. No programme will work if a person doesn't stick to it, but if they do, then they are most likely to see effects. Consider rephrasing.	Thank you for this comment. The wording of this recommendation and the following recommendation have been revised for clarity.

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UK Society for Behavioural Medicine	Recommendation 5 (What action should they take? Line 1-2)	9	See comments on recommendation 4. This is absolutely fine for the opening hour of a weight management course but not at all realistic for the referrer. The referrer should offer referral and discuss this as appropriate and that is sufficient guidance. Furthermore, the evidence review showed no evidence that anything the referrer did or said led to a better outcome.	Thank you for this comment. The separation of responsibilities for referrers and providers for these recommendations has been amended in the revised guideline.
UK Society for Behavioural Medicine	Recommendation 5 (What action should they take? Point 2)	9	We are not aware of evidence to suggest this is helpful.	Thank you for this comment.
UK Society for Behavioural Medicine	Recommendation 6	10	What is the evidence supporting the inclusion of a clinical psychologist instead of a health psychologist or behaviour change and obesity expert?	Thank you for this comment. The term practitioner psychologist is used throughout.
UK Society for Behavioural Medicine	Recommendation 6 (What action should they take? Point 1)	10	Long-term is important and the aim, but there are benefits of short term weight loss. This sounds as though nothing other than long term loss is worthwhile. (for example, evidence from DPP)	Thank you for this comment. The economic modelling for this guidance showed that programmes were only cost effective if weight loss was maintained. The PDG were also concerned that repeated, failed attempts to lose weight could be considered an adverse effect.
UK Society for Behavioural Medicine	Point 2	10	Why these specific time points? Also, does this imply programmes should be a minimum of 1 year in length?	Thank you for this comment. The wording of this recommendation has been revised.
UK Society for Behavioural Medicine	Point 3	10	'Ensure' – stray word. This maybe excessive and only have evidence that a dietitian finds value.	Thank you for this comment.
UK Society for Behavioural	Point 4	10	Define multicomponent here	Thank you, the text has been amended

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Medicine				to briefly define multicomponent, though it is also defined in the introduction and glossary.
UK Society for Behavioural Medicine	Point 5 – line 3	10	Need to specify what such an approach might look like. Is this statement about one-to-one contact with a dietitian, or one-to-one contact generally? Unclear what evidence the statement re: one-to-one contact is based on? Suspect wording could be improved to make this clearer.	Thank you for this comment, the text has been amended to state 'individual advice'.
UK Society for Behavioural Medicine	(point 8)	10	'and' instead of 'or'? (self-monitoring of weight or related behaviours)	Thank you for this comment, the text has been amended as suggested.
UK Society for Behavioural Medicine	(point 11)	11	A requirement for providers to collect 12 month data is likely to be costly and probably impractical to secure robust data	Thank you for this comment, the commissioning recommendation notes that responsibilities for monitoring should be agreed at the outset and that systems should be in place to support the sharing of data between referrers and providers for data collection at 12 months.
UK Society for Behavioural Medicine	(point 12)	11	Adopt a respectful, non-blaming approach (see recommendation 2). This is part of good professional practice. To be useful in this guidance it needs some explicit information on how to achieve this in the context of weight management consultations	Thank you for this comment. This is addressed in training and is also an issue for implementation.
UK Society for Behavioural Medicine	Recommendation 6	11	A recent review found that the most promising BCT for encouraging obese adults to engage in physical activity was 'teach to use prompts/cues' (Olander et al, 2013, *Intl J Beh Nutr Phys Activity, 10,* 29), you may want to include this BCT. It is also important to acknowledge, that the BCT's relevant to healthy eating and physical activity may be different.	Thank you for this information. Links to existing NICE guidance on behaviour change are given throughout.
UK Society for Behavioural	Recommendation	11	It needs to be acknowledged that certain locations such as gyms	Thank you for this comment. The

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Medicine	6		can act as barriers for some individuals and thus will stop them from attending a programme.	guideline notes the importance of tailoring and also of activities that can be continued once the programme has ended.
UK Society for Behavioural Medicine	Recommendation 6	11	In addition to measuring behaviour change for 12 months, it may also be important to provide support for this amount of time. This may in turn help collecting this data.	Thank you for this comment, the commissioning recommendation notes that responsibilities for monitoring should be agreed at the outset and that systems should be in place to support the sharing of data between referrers and providers for data collection at 12 months.
UK Society for Behavioural Medicine	Recommendation 7	11	This recommendation may be important for health professionals as well such as GP's.	Thank you for this comment.
UK Society for Behavioural Medicine	Recommendation 7	12	Examples of these 'wider benefits' may be helpful.	Thank you, the wording of this recommendation has been amended
UK Society for Behavioural Medicine	Recommendation 7 (what action should they take? Point 6)	12	It is not clear what the core components are or what support needs to be provided	Thank you for this comment. The core components were developed from the review of the evidence of effectiveness. The commissioning recommendation states that programmes should only be commissioned if they meet the core components.
UK Society for Behavioural Medicine	Recommendation 7 (what action should they take? Point 8)	12	This seems like it does not fit in this list - this has been covered previously and doesn't seem specific to weight loss maintenance?	Thank you for this comment. The wording of this recommendation has been revised.
UK Society for Behavioural	Recommendation	12	This needs to more clearly say you need to commission a range	Thank you for this comment, the text

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Medicine	8 (what action should they take? Point 2)		of services to meet the needs of different subgroups.	has been amended in line with your comments.
UK Society for Behavioural Medicine	Recommendation 8	13	Whilst it is important to de-commission programmes that do not meet agreed uptake, it needs to be acknowledged that new programmes take time to embed into referral pathways and the community.	Thank you for this comment.
UK Society for Behavioural Medicine	Recommendation 8 (what action should they take? Point 7)	13	Further detail might be useful as to what this might involve	Thank you for this comment.
UK Society for Behavioural Medicine	Recommendation 9 (Who should take action?)	13	What about allowing self referrals?	Thank you for this comment, the guidance covers both funded referrals and self-referrals, as noted in the introduction.
UK Society for Behavioural Medicine	Recommendation 9 (what action should they take? Point 1)	13	BMI is the only measure specified here which therefore brings up the issue of if it is the most appropriate measure (for an individual)?	Thank you for this comment. Specific issues around the identification of obesity are outside the remit of this guidance.
UK Society for Behavioural Medicine	Recommendation 9	14	An example of the ongoing support from GP's etc. can include weight monitoring.	Thank you for this comment.
UK Society for Behavioural Medicine	Recommendation 9	14	When referring individuals to programmes it is also important to understand individuals' perceived barriers and reasons for not losing weight and have arguments to counteract these reasons in a sensitive manner.	Thank you for this comment. These issues are addressed in the revised recommendations on 7 and 8.
UK Society for Behavioural Medicine	Recommendation 9	14	'This point would be clearer if it was rephrased as follows. Referral for behavioural weight management programmes should	Thank you for this comment. The wording of this recommendation has

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	(what action should they take? Point 2)		be considered for people with a BMI of 30 or more or a BMI of 25 or more with comorbidities or particularly high risk of vascular disease. (People are not identified as at high risk of vascular disease solely in health checks). In our experience, the cut-off for referral is often higher, say 28, in line with the cut-off orlistat. Furthermore, it might be worth cross-referring to the guidance on BMI in people of minority ethnic groups for corresponding cutoffs for such groups.	been revised for clarity. It is also noted that where there is capacity, referral of overweight adults should not be restricted. Links are given to the definition of overweight and obesity which include information on the lower cut offs for adults from black and minority ethnic groups.
UK Society for Behavioural Medicine	Recommendation 10	15	To improve programme uptake it is also important to understand why some participants drop out of services and use this knowledge to improve services.	Thank you for this comment – this issue is covered in the recommendation on monitoring and evaluation.
UK Society for Behavioural Medicine	Recommendation 10 (Who should take action – point 2)	15	Suggest that service providers also be included in 'who should take action'	Thank you for this comment, providers are included.
UK Society for Behavioural Medicine	Recommendation 10 (what action should they take? Point 1)	15	Is this repetitive given that (as per page 14, bullet point 6) the GP has already taken informed consent?	Thank you for this comment. The repetition has been removed in the revised guidance.
UK Society for Behavioural Medicine	Recommendation 10 (what action should they take? Point 2)	15	The points about consent are far too strongly emphasised. Of course everything that happens to a person should be with their consent. However, it is taken as read by most patients who are referred to services that information about them relevant to that service will pass back and forth between the referrer and the service. All of this contributes to the unhelpful tone throughout the document that this is a very problematic issue for patients and extremely sensitive, whereas in our experience it is usually not	Thank you for this comment. The repetition has been removed in the revised guidance. However, the PDG were of the view that (1) a patient centred approach is important and (2) the sharing of information may support monitoring and encourage long term support.
UK Society for Behavioural	Recommendation	15	'This seems an unnecessary process. People who are not	Thank you for this comment. The

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Medicine	10 (what action should they take? Point 4)		motivated to attend, are not changing their behaviour, and are not losing weight do not continue attending. Putting processes in place to assess whether people who are still attending are sufficiently motivated or changing their behaviour sufficiently with a view to excluding such participants seems likely to act as a barrier. We suggest omitting this point	wording of this recommendation has been revised. However, the PDG were minded to the fact that there is large variation in outcomes in trials of effectiveness. They were aware that a sizeable percentage of participants in weight management programmes lose minimal amounts of weight or have poor adherence, either dropping out or attending inconsistently.
UK Society for Behavioural Medicine	Recommendation 10 (what action should they take? Point 5)	15	It doesn't say anywhere that there should be a regular weigh in – is the assumption that this is so obvious it doesn't need stating? Also, the weigh in will not be motivational if they are losing weight. Not very well phrased. Consider changing to 'review progress and goals' or something alike. Suggest making clear if this is aimed at providers or at GPs/HCPs as well. If regular weigh-in with a GP or practice nurse this is an addition to a programme and uncosted in the economic modelling? Suggest instead the guidance suggests BWMPs must include a regular weigh-in.	Thank you for this comment. The text has been revised to 'Use the regular weigh-in as an opportunity to monitor and review progress toward individual goals' .
UK Society for Behavioural Medicine	Recommendation 11 (Who should take action?)	15	The second bullet point envisages GPs being trained in how to weigh people and how to assess their height. This may irritate GPs and may cause them to devalue the guidance. The guidance seems to verge on patronising when it suggests that GPs need training in how to provide support and encouragement. GP courses include quite advanced training in communication skills.	Thank you for this comment. This recommendation is directed at a range of health professionals not just GPs.
UK Society for Behavioural Medicine	Recommendation 11 (what action should they	16	These are not mutually exclusive.	Thank you for this comment.

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	take? Point 3)			
UK Society for Behavioural Medicine	Recommendation 11 (what action should they take? Point 3)	16	How would they assess likelihood of benefiting from a lifestyle weight management programme? The guidance needs to be clearer about what is effective.	Thank you for this comment, the information reflects the evidence available.
UK Society for Behavioural Medicine	Recommendation 11 (what action should they take? Point 5)	16	Unclear about who is responsible for long term weight maintenance. Is it the BWMPs, GPs and patients responsibility? Needs to be more clearly defined what is expected of each (after weight-loss).	Thank you for this comment. A range of sources of long term support are included in the revised guidance.
UK Society for Behavioural Medicine	Recommendation 12	17	A clinical psychologist may not always be best suited; a person with behaviour change and obesity expertise may be more appropriate.	Thank you for this comment. The term practitioner psychologist is used throughout.
UK Society for Behavioural Medicine	Recommendation 12	17	This training needs to explain the *complexity* of behaviour change and obesity, and weight loss/maintenance.	Thank you for this comment. We are of the view that this is reflected in the revised training recommendations
UK Society for Behavioural Medicine	Recommendation 12	17	Delivering behaviour change techniques may not be enough; staff also needs to understand how these techniques work or why they may not work.	Thank you for this comment.
UK Society for Behavioural Medicine	Recommendation 12 (what action should they take? Point 4.3)	17	Is it worth the effort to systematically collect data on changes in eating and physical activity for the sole purpose of supporting programme monitoring? How would this data be used and what would it add beyond the data on weight change? Are these secondary outcomes used to evaluate services? There should be a how or a what i.e. indication of the level of detail required. 'eating and physical activity behaviours to support…' – why? This seems to go beyond routine service delivery.	Thank you for this comment. The revised guidance makes clearer the distinction between outcomes that should be collected as a minimum for routine evaluation and other outcomes to be considered for collection where possible

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UK Society for Behavioural Medicine	Recommendation 13 (what action should they take? Point 1.3)	18	Definition of health inequalities in this context would be useful Defined as?	Thank you for this comment.
UK Society for Behavioural Medicine	(what action should be taken? Point 2.1)	19	As per comment above re: value of collecting this data If you are asking people to collect it you should tell them why or how to use the information	Thank you for this comment.
UK Society for Behavioural Medicine	(what action should be taken? Point 4)	19	1) 'longer term outcomes' - define better 2) How does this fit alongside asking service providers to provide long term support? 'Consider at the outset how this can best be achieved with minimal cost' – How?	Thank you for these comments. The guideline has been revised throughout to be clearer on specific timeframes. To note that the wording of these recommendations has been revised.
UK Society for Behavioural Medicine	(what action should be taken? Point 6)	19	This is an example of the wording we would like to see in other recommendations regarding data collection, i.e. Collect xxx and use it to xxx.	Thank you for this comment.
UK Society for Behavioural Medicine	3.10	25	It would be useful to have a simple diagram to highlight how these two documents overlap and should be used together. Many aspects of old guidance should be superseeded by evidence in this review.	Thank you for this comment. The links with other guidance will be clearer when this guidance is published in the NICE pathway on obesity. This guideline replaces section 1.1.7 of CG43
UK Society for Behavioural Medicine	3.11 – line 3	25	Define local strategic approach	Thank you for this comment, a link is given to exiting NICE guidance on obesity – working with local communities.
UK Society for Behavioural Medicine	3.12	25	Question as to what evidence this is based on. 'Left to their own devices' seems quite pejorative and we do not think this is based on information from the evidence or update reviews. This statement pulls in weight maintenance as a responsibility of weight-loss services. The two likely require different approaches - therefore, training needs, type of contact, who contact is with etc	Thank you for this comment. The wording of this section has been revised. However, limited evidence on weight maintenance was identified and the available evidence suggests many people regain weight following the active

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			should be redefined for this new context. There are no recommendations beyond 'support and advice'	component of programmes.
UK Society for Behavioural Medicine	3.13	25	The use of 'short term' here is problematic. What about 'at least at one year', or something more specific? Otherwise could be interpreted to mean at 12 weeks, etc. The wording regarding programme types is very vague. It doesn't appear in the recommendations so we question it appearing here. It appears to imply a hierarchy of services that should be commissioned but skirts around the edges of the issue, which seems out of place considering it is not addressed in the recommendations.	Thank you for this comment, the text has been amended to 12 to 18 months reflecting the evidence identified.
UK Society for Behavioural Medicine	Cost effectiveness	26	Whilst the information on the cost-effectiveness is useful, there is a concern that this may affect commissioning priorities, focusing on value for money rather than health benefits.	Thank you for this comment. The cost effectiveness refers to the cheapest ways of gaining a unit of health benefits. More information is provided in the modelling report.
UK Society for Behavioural Medicine	Research Recommendation 1	28	There is also a lack of research regarding what type of support may be acceptable to individuals to help them keep their weight off.	Thank you for this comment. User adherence and satisfaction are addressed in the research recommendation.
UK Society for Behavioural Medicine	Recommendation 1 (what action should be taken? Point 1.1)	28	Brief or short not 'short-term' as this infers something about outcomes	Thank you for this comment. The guideline has been revised throughout to be clearer about timeframes.
UK Society for Behavioural Medicine	Related NICE Guidance	31	Would be helpful to provide more context to this list, e.g. how they are related and when you should not look at the recommendations in this guidance and instead turn to another.	Thank you for this comment. The links with other guidance will be clearer when this guidance is published in the NICE pathway on obesity.

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UK Society for Behavioural Medicine	Glossary – Behaviour change	33	I think in the context of our review, at least, 'behaviour change' also had a more general meaning - i.e. as per Loveman et al to be multicomponent, programmes had to involve diet, exercise, and 'behaviour change', and behaviour change wasn't defined on the basis of using behavioural change techniques but rather on the basis of providing counselling of any type.	Thank you for this comment. The definition of multicomponent reflects the scope for this work.
UK Society for Behavioural Medicine	Glossary – behaviour change	33	Under the definition of 'behaviour change' the Theory of Planned Behaviour is mentioned. This theory is limited in terms of predicting behaviour change and it has recently been suggested that this theory is 'retired' (Sniehotta et al, 2013. Health Psychology Review, 1-8. doi: 10.1080/17437199.2013.869710), thus we suggest this theory is not used as an example.	Thank you for this comment, the definition has been revised.
UK Society for Behavioural Medicine	Eating behaviours	33	NICE recommend this data is collected with validated tools - considering this definition, which includes so much, this is going to be a complex, resource intensive exercise. Question the purpose and usefulness.	Thank you for this comment.
UK Society for Behavioural Medicine	Glossary – Weight loss maintenance	35 – line 1	Is this an official definition? If not, 'any' could be omitted - otherwise seems quite stark (if you lose 8 kg and regain 0.5kg over the course of the following year, it could be argued you have still achieved some degree of weight loss maintenance). The following sentences in this paragraph seem to suggest a broader definition that contradicts 'any.' Maybe NICE need to consider talking about rates of change rather than absolute amounts as this is also a more realistic aim.	Thank you for this comment. The revised guideline includes definitions of weight loss, weight maintenance, weight regain and weight trajectory.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	General		We prefer the term 'behavioural weight management' to the term 'lifestyle weight management.' We are concerned that the term 'lifestyle weight management' trivialises a complex process. The term 'behavioural weight management' better encompasses the scientific approach focused on the modifiable behaviours which underpin weight control and we suggest that throughout it replace 'lifestyle weight management'.	Thank you for this comment. Lifestyle reflects the referral for this guideline, the common usage of the term. The term is easily understood by a broad range of stakeholders. The glossary definition highlights that it addresses modifiable behaviours.

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Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	General		We were extremely disappointed to see that the guidance does not deal with the single most important finding of the reviews presented to the PDG. The finding is that some but not all weight loss programmes are effective. In particular, there is clear evidence from randomised controlled trials that programmes delivered by primary care staff are ineffective or at best only minimally effective. There is no evidence that weight loss programmes delivered by NHS provided group programmes are effective. There is clear evidence that programmes provided by commercial group based programmes are effective. (comments continued on next row)	Thank you for this comment. An additional recommendation has been added to the revised guidance which asks public health England to establish a national source of information on weight management programmes suitable for commissioning. The recommendation notes the UK based programmes shown to be effective in the evidence reviews for this guidance.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK			(continued from row above) Almost all other programmes in our review are not available to the English public. A person cannot be referred to or attend the Diabetes Prevention Program, for example. Most of the programmes evaluated in the review existed only for the life of the trial and then were closed down as they were provided by research teams or specialist practitioners. Only the programmes described above have generalizable relevance to England. As it stands, the guidance offers no direct help to commissioners in choosing an effective programme over an ineffective one. Moreover it is not possible to signpost a service 'likely to be effective' since, the reviews showed, it is not easy to identify the 'active ingredients' of effective programmes.	See above.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK			This makes it all the more important that the guidance should be explicit about the available evidence. Encouraging disinvestment from interventions that are not proven to be effective is equally important as encouraging investment in those that are. It would be a big missed opportunity if this distinction was not specifically addressed in the guidance.	Thank you for this comment. The guideline is clear that interventions that do not meet agreed outcomes should not be re-commissioned.
Department of Primary Care Health Sciences, University	General		The guidance is riven with references to stigma, sensitivity, and negative experiences of weight loss programmes. We do not doubt	Thank you for this comment. The committee recognised the benefits that

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of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK			the importance of stigma and discrimination but we doubt its relevance to weight loss programmes. We presented evidence to the committee. Two systematic reviews we supplied show that people who attend weight management programmes have improvements in their psychological health and their self-esteem and the psychological health benefits occur independently of weight loss achieved on a programme. Such evidence as was available in the studies we reviewed is congruent with this.	can be gained from attending lifestyle weight management programmes and that is why they have made recommendations about referral and commissioning of such programmes. However, the evidence review shows that the mean hides a broad range of outcomes for participants. Not everyone does well on programmes and many people drop out. The PDG heard testimony about stigma from different viewpoints. They were aware that weight issues are often not dealt with well, particularly at the identification and referral stage (ie before someone reaches a programmes). Therefore, the PDG felt that this was an important issue to flag throughout the guidance. However, the tone of the revised guidance has been checked to ensure that there is balance on this issue and it does not inhibit commissioning. To note that the phrase used throughout has been revised to 'respectful and non-judgemental'
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	General		Many recommendations deal with data collection and monitoring, but few of these then go on to detail how this data should be used, and we question the evidence base behind collecting certain types of data at certain points (specific examples highlighted in comments below). We view this as problematic as the collection of such data is likely to be very resource intensive, and therefore should have a clear and justifiable use if being collected.	Thank you for this comment. The revised guidance spells out more clearly what measures should be collected on a routine basis (weight outcomes) and other measures which do not need to be collected routinely.

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Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	General		The guidance emphasises assessing motivation, which we found surprising in view of the evidence presented. We cannot remember any of these weight loss programmes seeking to assess motivation prior to referral or during the programme. Despite simply offering referral to those who wanted it, weight loss was significant in most of the programmes evaluated in the update reviews. Later in this response we present evidence from a parallel field that assessing motivation reduces the uptake of behavioural support. Furthermore, emphasising assessing motivation may act to discourage GPs, for example, from tackling referral to behavioural weight management programmes because they may be concerned they lack specific skills or techniques for assessing motivation. In line with the evidence presented, we suggest that it would be sufficient to simply describe the programme and ask people if they wanted to be referred to it or not, much as is the case in other areas of behaviour change and clinical practice.	Thank you for this comment, references to motivation have been revised throughout.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Recommendation 5 (What action should they take? Point 1 and 2)	9	There is no evidence to suggest this is helpful. It could undermine motivation and takes time away from supporting weight loss strategies.	Thank you for this comment. To note that the wording of this recommendation has been revised but the PDG were clear that a patient centred approach should be the priority.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Recommendation 6 (What action should they take? Point 1)	10	This recommendation seems to imply that there are behavioural weight loss programmes that focus on short-term weight loss and that lead to rapid loss then regain. The evidence review found no evidence at all of this. There was no evidence that rapid weight loss was associated with more rapid weight regain. As a consequence, programmes that led to rapid and more profound weight loss were associated with better weight loss in the longer term.	Thank you for this comment. The text has been revised for clarity.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical	Recommendation 6 (What action	10	The evidence review showed indirect evidence that programmes in which participants were given energy (calorie) targets were associated with greater weight loss than programmes that did not do	Thank you for this comment. The text has been revised to 'Ensure specific dietary targets are agreed (for example,

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Research Council Human Nutrition Research, University of Cambridge, UK	should they take? Point 5)		so. However, in the UK there is direct evidence that a commonly available programme that does not give participants energy targets (Slimming World) is non-inferior and may be superior to one that does (Weight Watchers). As it currently stands, this stipulation may encourage commissioners to contract with Weight Watchers rather than Slimming World. The evidence for calorie counting is too weak to justify such an approach. (Madigan C, Daley A, Lewis A, Jolly K, Aveyard P. Which weight loss programmes are as effective as Weight Watchers: non-inferiority analysis. British Journal General Practice, in press).	for a clear energy intake or for a specific reduction in energy intake) tailored to individual needs and goals.'
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Recommendation 6 (What action should they take? Point 11)	11	Here and elsewhere the guidance emphasises the importance of 12 month follow-up. This is not supported by the update or evidence reviews. The review showed that weight regain after programme end was unrelated to the characteristics of the preceding weight loss programme. Thus, weight at 12 months can be predicted from weight loss achieved during the programme. Assessing weight at 12 months is neither simple nor cheap if follow-up is to be reasonably complete. Therefore, 12 month follow-up will divert resources from supporting weight loss to follow-up. If weight at 12 months is simply a function of weight at programme end, as evidence shows, then this is an unnecessary suggestion which lowers the population impact of the guidance. This problem is compounded by the suggestion that behaviour change should be monitored at 12 months. Presumably this means diet and physical activity, which is especially difficult to measure.	Thank you for this comment. The monitoring recommendations have been revised and reflect the DH best practice guideline for weight management services and the standard evaluation framework. The revised guideline is clear about what data should be collected as a minimum and what additional data could be considered for collection. Recommendation 16 flags that systems should be in place to improve information sharing between referrers and providers to support monitoring and evaluation.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Recommendation 7 (what action should they take? Point 4)	12	We did not specifically review evidence on diet composition and therefore are not sure that you can justify specific emphasis on low fat as the single most important dietary regimen.	Thank you for this comment. The wording of this recommendation has been revised.

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Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Recommendation 8 (what action should they take? Point 5)	13	Again here we are concerned with the recommendation to collect follow-up data at 12 months. See comment above re: Recommendation 6>What action should they take? >Point 11.	Thank you for this comment. The monitoring recommendations have been revised and reflect the DH best practice guideline for weight management services and the standard evaluation framework. The revised guideline is clear about what data should be collected as a minimum and what additional data could be considered for collection. Recommendation 16 flags that systems should be in place to improve information sharing between referrers and providers to support monitoring and evaluation.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Recommendation 8 (what action should they take? Point 9)	13	We suggest adding at the beginning, 'Review and de-commission programmes…'	Thank you for this comment, the text has been amended to 'review programmes that do not meet agreed uptake, provision or outcome targets. Amend or de-commission programmes as appropriate.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Recommendation 9 (what action should they take? Point 3)	14	The recommendation to take into account people's preferences is directly contradicted by available evidence and also is likely to lead to people being referred to ineffective services. We therefore suggest it be removed. Three trials have investigated the effect of choice. Two show no benefit for people who choose over people who are allocated, and one shows a clear and statistically significant benefit from being referred to a weight loss service that one did not choose over one that met one's preferences. Furthermore, two of the trials showed that because people sometimes preferred one-to-one services, which were less effective than group services, the effect of choice was to	Thank you for this comment. We disagree with this comment. The evidence review 2 identified that some individuals would not like to attend a group programme. NICE and PDG were of the view that it is important to respect individual preference, particularly when adherence to weight management programmes is so poor.

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			reduce the amount of weight lost. This is particularly important in England where the only widely available programme in primary care is provided directly by primary care teams, who are ineffective. (continued on next row)	
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK			See: *Burke LE, Warziski M, Styn MA, Music E, Hudson AG, Sereika SM. A randomized clinical trial of a standard versus vegetarian diet for weight loss: the impact of treatment preference. Int J Obes 2008; 32:166-176.*	Thank you for this reference
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK			*Renjilian DA, Perri MG, Nezu AM, McKelvey WF, Shermer RL, Anton SD. Individual versus group therapy for obesity: effects of matching participants to their treatment preferences. J Consult Clin Psychol 2001; 69(4):717-721.* *Jolly K, Lewis A, Denley J, Beach J, Adab P, Deeks J, Daley A, Aveyard P. A randomised controlled trial to compare a range of commercial or primary care led weight reduction programmes with a minimal intervention control for weight loss in obesity: the Lighten Up trial. BMJ 2011;343:d6500 doi: 10.1136/bmj.d6500.*	Thank you for this reference
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Recommendation 9 (what action should they take? Point 4)	14	This implies the bullet point above (re: taking people's preferences into account) was referring to preference for particular programme characteristics, as opposed to preferences for particular programmes. If this is the case, which programme characteristics should patients have a choice over? There could be many programme characteristics over which patients have a preference, so this needs greater clarity. We would also recommend adding a similar recommendation under	Thank you for this comment. We disagree with this comment. The evidence review 2 identified that some individuals would not like to attend a group programme. NICE and PDG were of the view that it is important to respect individual preference, particularly when adherence to weight management programmes is so poor.

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			this one, but with reference to commercial programmes, e.g. "Refer people who have no preference to a commercial programme because, on average, these tend to be more effective."	
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Recommendation 10 (what action should they take? Point 3)	15	As per general comment above, we are concerned that this guidance stresses assessing motivation to change throughout. The evidence review showed no evidence that motivational assessment was helpful. Furthermore, in our experience this is unhelpful, demotivating, and not in line with some current understanding of behaviour change. It is certainly time-consuming and we are concerned it will act as a barrier to engaging GPs and other referrers.	Thank you for this comment. References to motivation have been revised throughout.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Recommendation 11 (What action should they take? Point 3)	16	There was no evidence that asking GPs to assess motivation to change was helpful. At least some behaviour change theory suggests it is unhelpful. Parallel evidence in the field of smoking cessation shows that assessing motivation to stop smoking means that people who would have taken up referral for support do not do so and this recommendation seems likely to reduce the uptake of behavioural weight management programmes. We suggest that unless, it can be justified, recommendations to assess motivation to change as part of the referral process should be removed. See: *Aveyard P, Begh R, Parsons A, West R. Brief opportunistic smoking cessation interventions: a systematic review and meta-analysis to compare advice to quit and offer of assistance. Addiction 2012:107:1066–1073*	Thank you for this comment. This recommendation has been revised in the updated guidance. More of the recommendations in relation to discussions at the outset and improving outcomes are with providers. References to motivation have been revised throughout.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Recommendation 13 (what action should they take? Point 1)	18	Recommendation 13 is particularly important in that it provides another opportunity to give guidance on what separates effective programmes from ineffective ones. We believe the guidance could be written much more tightly here to ensure that only effective programmes are commissioned. (comment continued in next row)	Thank you for this comment. An additional recommendation has been added to the revised guidance which asks public health England to establish a national source of information on weight management programmes

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				suitable for commissioning. The recommendation notes the UK based programmes shown to be effective in the evidence reviews for this guidance.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK			(continued from row above) In the evidence reviews we looked closely at the DH guidance. There was evidence that the standards proposed clearly differentiated effective from ineffective programmes. We urge strongly that guidance here conform much more closely to that guidance. In particular, the recommendations for defining how attendance is measured and how weight loss is assessed will provide a common standard across the country. As it stands, the NICE guidance will not. The evidence from the NHS Stop Smoking Service is that having clear monitoring standards that were very tightly defined gave comparable data and has been used as a quality improvement tool. It would be a missed opportunity here if NICE were not to suggest a similarly strong monitoring framework with careful rules about how things were assessed. Given the evidence review, it seems a real shame not to reiterate those clear standards here.	Thank you for this comment. The revised guidance makes explicit reference to the pragmatic best practice criteria as outlined in the DH best practice guidance.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	(what action should be taken? Point 5)	19	We question if the collection of views and experiences of all participants is realistic in practice. We searched literature and found very little on this in an academic setting, let alone a real-world one. If collected, further clarity should also be provided on how such data would be used, especially considering their collection and analysis is likely to be time intensive.	Thank you for this comment. The recommendation has been amended to 'participants' rather than 'all participants'
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Recommendation 14	19-20	Recommendation 14 strikes us as unnecessarily complicated, suggesting lots of monitoring which comes at the expense of providing service. We wonder if the following might be helpful: "Assess the uptake of the service and weight loss by geographical location, social status, and ethnic group. Take action to address	Thank you for this comment. The wording of this recommendation has been revised. However, the PDG were of the view that specific information was required to ensure implementation of the recommendation.

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			inequalities in uptake or outcome where these threaten to widen existing inequalities in health."	
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Public Health needs and practise – paragraph 9	21	Regarding the wording "Commercial, voluntary sector and self-help weight management programmes may be part of the solution.": We feel this underplays the robustness of the evidence we found, which showed that BWMPs can (and do, in most cases) lead to significant weight loss. This sentence also might be more convincing were some supporting evidence provided.	Thank you for this comment. This wording reflects scope for the work and the rationale on which the guidance was referred to NICE.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Public Health needs and practise – paragraph 11	21	Re: sentence: "Local policies vary, but generally, these lifestyle weight management programmes are grouped within tier 2 services – and they usually run for around 12 weeks." Given we know these programmes run for 12 weeks on average, can we make the recommendations more specific when it comes to time-lines?	Thank you for this comment. The guidance applies to all programmes and not just to funded referrals. The wording throughout aims to apply to all.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	3.4 – line 9	23	We question the use of 'if' ("informed choices about if, when and how they manage their weight"). We think it is important that the guidance makes clear that healthcare professionals should be advocating the patient loses weight (unless reason not too, e.g. not appropriate), and the use of 'if' in this context may underplay the importance of advocating weight loss in a healthcare context.	Thank you for this comment. NICE and the PDG are supportive of a patient centred approach.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	3.5	23	As this paragraph reads now, it sounds as if we do not know if the effect persists at 3 to 5 years, whereas in reality we have evidence that it does. In particular, DPP had data extracted from graphs at 10-years. In our review, pooled results from seven trials showed strong, significant evidence that the effect persisted at 18 to 24 months and at 36 to 48 months. Seven studies with data >3 years is enough to make some stronger conclusions than is suggested here. We suggest this entire paragraph be reworded.	Thank you for this comment. As identified in the reviews, limited long term UK based evidence is available, particularly in relation to the 12 week referrals as addressed in this guideline.
Department of Primary Care	3.5 – line 7	23	We question the use of "problematic" in this context. Calling the	Thank you for this comment.

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Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK			longer term evidence of effectiveness problematic diminishes the strength of the evidence and diminishes the fact that people need to lose weight and any weight loss is better than none. We would strongly urge you to consider re-wording this point.	
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	3.6	23	We think it is important to define 'short term' here. We are worried this could be misconstrued to mean 3 or 6 months, whereas our data showed these programmes were effective at 12 months and at 3-5 years, which some people in the field would not call 'short term.'	Thank you for this comment. The revised guideline provides more specific timeframes.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Recommendation 1 (what action should be taken? Point 1.1)	28	We suggest changing 'short term' to 'brief' or 'short.' 'Short-term' infers something about outcomes, whereas this point is only referring to programme length, not duration of weight loss.	Thank you for this comment. The revised guideline provides more specific timeframes.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Recommendation 1 (what action should be taken? Point 1.4)	28	The inclusion of this point might be fine, but if it is based on evidence from our review, we would question it as we were specifically asked to exclude these studies, so our review is not well-placed to identify such a gap. Our review found that most studies in the 'general population' didn't report on effectiveness by subgroup (including people with depression, for example), but our review didn't look at studies which were conducted exclusively in people with depression, for example, so would be unable to identify gaps in this area.	Thank you for this comment.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research,	Glossary > Weight loss maintenance	35	Re statement: "Weight loss maintenance means not regaining any of the weight that was lost during a lifestyle weight management programme." We would question this definition (particularly the use of the word	Thank you for this comment. Glossary definitions have been revised to include definitions for weight loss, weight maintenance, weight regain and weight trajectory. The definition of weight regain

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University of Cambridge, UK			'any'). Some regain might happen, but if it were minimal and weight loss was still significant when compared to baseline weight, we still might consider this "weight loss maintenance." We suggest rewording this definition.	reflects your comments.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Glossary > Weight loss maintenance	35	Re statement: "Generally during adulthood, people put on weight." This might not be true for obese people and hence this may be too strong a statement in this context. We suggest changing. For example, a collaborative analysis of 57 prospective cohort studies found that, although participants who were classified as overweight (BMI ≥ 25 and < 30 kg/m^2) at baseline gained 0.9 kg after 10 or more years, participants with baseline BMIs of 30 to 50 kg/m^2 lost an average of -0.4 kg over the same period. See: *Whitlock G, Lewington S, Sherliker P, Clarke R, Emberson J, et al. Body-mass index and cause-specific mortality in 900 000 adults: collaborative analyses of 57 prospective studies. Lancet. 2009;373(9669):1083-96.*	Thank you for this comment, we are of the view that this is a valid statement and tallies with the economic model for this work.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Reviewing the evidence – selection criteria> exclusion criteria	40	Re: point "included people with a pre-existing medical condition…" We suggest changing this wording as it is misleading. Many of our studies included people with pre-existing conditions (e.g. hypertension, type 2 diabetes, etc.).We excluded studies which *only* included people with a *specific* pre-existing condition (for example, type 2 diabetes only and excluded any people without that condition), but this is much narrower than the way this criterion is currently described.	Thank you for this comment, the wording has been amended as suggested.
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human	Selection criteria	40 – point 3	Re: point "were published in the UK" This is not the case. Change "published" to "undertaken".	Thank you for this comment, the wording has been amended as suggested.

Public Health Guidance

Overweight and Obese Adults – lifestyle weight management - Consultation on Draft Guidance
Stakeholder response Table

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Nutrition Research, University of Cambridge, UK				
Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	Selection criteria	40 – points 4-8	Re: point "included people with a pre-existing medical condition…" Please reword this. As per comment above, it is misleading as we only excluded those studies where having a specific pre-existing condition was a criterion of inclusion.	Thank you for this comment, the wording has been amended as suggested.
Weight Concern	Recommendation 1	6	Will there be subsequent guidance on how to create an obesity pathway in more detail? This appears to be a crucial problem in obesity management at present.	Thank you for this comment. Strategic approach is addressed in existing guidance on obesity – working with local communities. A care pathway is also provided in existing guidance on obesity (CG43).
Weight Concern	Recom. 2		Re. non-stigmatizing point – will NICE point/sign-post people to appropriate training or suggest there should be space allocated in budgets for this? Rudd centre has extensive information on obesity stigma including an image gallery for images.	Thank you for this comment. Training is addressed in recommendations 14 and 15. Funding for the implementation of NICE guidance is outside the remit of NICE.
Weight Concern	Recom. 3	7	Will efforts be made to make commissioners aware of the realistic targets for weight loss in 8-12 week programmes, i.e. 3% versus 5%? If commissioners demand 5% then providers promise this as an outcome to win contracts then underhanded measures are used when evaluating programme outcomes to ensure it looks as though patients are reaching 5% weight loss. This perpetuates bad practice.	Thank you for this comment. Pragmatic criteria, based on the DH best practice guidance, have been added to the commissioning recommendation.
Weight Concern	Recom. 4	8	Commissioners and service providers should also be made aware of this.	Thank you, this recommendation has been revised.
Weight Concern	Recom. 6	10	MDT point – are you stating that an MDT needs to deliver tier 2 programmes or that they should have training to deliver a programme by an MDT? This should be made clearer as it seems unrealistic to	Thank you, the involvement of MDT is for the development of programmes and staff training.

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			imagine an MDT delivering tier 2 services when we struggle with this at tier 3 level. Should there be some suggestions on budget allocation for training staff to deliver a tier 2 programme? Can NICE signpost to the Obesity Learning Centre for example?	Budget allocation is a local issue outside the remit of NICE.
Weight Concern		11	Lapse/relapse prevention seems to be missing?	Thank you for this comment. The behaviours listed are those areas identified in the evidence review.
Weight Concern	General point		What about benefits of daily weighing for weight loss and weight maintenance? This seems overlooked and it seems to me there is an evidence base for it. References can be provided if requested.	Thank you for this comment. The evidence reviews for this guidance did not identify information on daily weighing. References to self-monitoring have been added to the revised text.
Weight Concern	Recom. 9	14	Why at tier 2 should they focus on BMI > 30? Is this due to there being a lack of evidence of effectiveness at BMI between 25-30 and the possible health benefits etc. or is this suggestion as a result of the evidence of a lesser impact at this BMI range? It seems we are creating further problems by waiting until this BMI> 30 suggestion when habits become further ingrained.	Thank you for this comment. The revised guideline states that referral of people who are overweight should not be restricted where there is capacity.
Weight Concern	Recom. 11	15	Will NICE sign-post again?	Thank you for this comment. NICE identified the type of training that is required for referrers and programme staff but is not able to identify specific programmes.
Weight Concern	Recom. 12	17	Again – training is available eg via Obesity Learning Centre and SCOPE	Thank you for this comment. NICE identified the type of training that is required for referrers and programme staff but is not able to identify specific

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				programmes.
Weight Concern	RECOM 13	19	Can NICE advice more clearly on appropriate validated measures, e.g. Rosenberg self-esteem, HADS, PHQ-9, etc.	Thank you for this comment. The revised guidance makes stronger reference to validated tools and the Standard Evaluation Framework. However, it is beyond the remit of this guidance to identify specific tools.
Weight Watchers	General		Weight Watchers welcomes NICE's draft public health guidance on lifestyle weight management for adults. The presence of such a guidance represents a sea change in help available to those involved in commissioning and providing multicomponent lifestyle weight management services. Once final, it could be an immense help to those working in the field and provide guidance in an area where, too often, knowledge and skills in obesity management are being eroded. As the programme development team know, Weight Watchers has a depth of experience in developing, operating, evaluating and improving behavioural weight management programmes for the public sector. There is strong acknowledgement of the availability and efficacy of service providers such as Weight Watchers. Previous submissions to NICE have detailed the evidence underpinning this experience.	Thank you for this comment.
Weight Watchers	General		Currently NICE lumps all 'commercial programmes' together, for example on page 25, paragraph 3.13. In reality this is a very broad category of programmes and providers which differ in the methods they use, the type of training they provide to their facilitators, the materials they provide for their participants, the level and types of behavioural interventions, target audiences, whether physical activity is incorporated into delivery of the intervention, governance and QA in place, evidence of efficacy and effectiveness, costs and cost effectiveness etc. Most fundamental is the difference in the amount	Thank you for this comment. The recommendations in the guideline apply to all programmes. An additional recommendation has been added to the revised guidance which asks public health England to establish a national source of

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			and quality of studies underpinning the effectiveness of different programmes. Some programmes, such as Weight Watchers, have good quality data on self-referring / self-funding participants and those referred via health professionals and / or services, derived from RCTs published in high impact peer reviewed journals such as the BMJ and the Lancet. Others have none. Data on the effectiveness and cost effectiveness of Weight Watchers programmes can not and should not simply be translated across to other programmes and providers (such as Rosemary Conley or Jenny Craig for example). Each and every programme needs to be assessed in their own right and not lumped into to one 'commercial programme' pot. We recommend that NICE should make the point about programme diversity and variability and that decision makers must be helped to look into the data underpinning individual programmes within this guidance. At the very least we recommend amending page 25 (however the entire guidance needs to be considered in this comment); **Evidence suggests that the following commercial programmes are likely to be effective (Weight Watchers, xxxx insert any others that have been deemed to be effective by the NICE team's review of the evidence); the effectiveness of GP or practice nurse led services is less clear**'.	information on weight management programmes suitable for commissioning. The recommendation notes the UK based programmes shown to be effective in the evidence reviews for this guidance.
Weight Watchers	General		Whilst we absolutely understand that NICE seem to be challenged by the premise of citing specific programmes within the category, we find it an almost impossible concept not to do so. Each and every programme is a specific intervention in its own right. Those specific programmes that have been proven to be effective should be clearly cited within this guidance, as would any other specific intervention, device or medication that NICE are requested to evaluate for health service and public health commissioning. We believe that the omission of any kind of specificity regarding programmes is a significant issue and reduces the impact of this guidance considerably. In its current form, the guidance is process focused, it omits reflecting fully the evidence used in its development	Thank you for this comment. The recommendations in the guideline apply to all programmes. An additional recommendation has been added to the revised guideline which asks public health England to establish a central source of information on weight management programmes suitable for commissioning. The recommendation notes the UK based programmes shown to be effective in the evidence reviews for this guideline

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			and without major changes will have limited value. The evidence base has grown and we are no longer in the 'dark ages' having nothing to guide us as to what works for lifestyle weight management –the guidance needs to reflect that. There needs to be specific recommendations for the commissioning of specific lifestyle weight management programmes (to be clear we recommend specific naming of programmes from providers) that have evidence of meeting the best practice guidance and are proven to be effective. This is only fair and transparent and ultimately in the best interests of patients.	
Weight Watchers	General		There are gaps in raising awareness within draft guidance**.** Whilst Weight Watchers applauds recommendation 3 on raising awareness of lifestyle weight management services among commissioners, there remains a long standing gap in awareness of publicly funded lifestyle weight management services amongst local communities. From Weight Watchers experience of running weight management services in local communities, there is a huge tranche of overweight/obese adults who know that they should do something about their weight – but have not reached the motivational epiphany in order to take action. However, the discovery of locally available services, which are funded by the NHS or Local Authority, often galvanises many into action. There is a need for Local Authorities and the NHS to communicate clearly to their local communities what services are available, and how to access these services. At present this is often a significant gap; both on the ground and within this draft guidance. Raising awareness is crucial in the implementation of effective pathways.	Thank you for this comment. The revised guideline includes additional recommendations on raising awareness of local services among (1) GPs and other health professionals and (2) the local population. Links are also given to existing guidance on obesity – working with local communities which discusses communication and partnership issues in more detail.
Weight Watchers	General		How does this new PH guidance link with Obesity G43? Specifically in section 1.1.7.1 (page 32). This new PH guidance covers some of the best practices outlined in the clinical guidance, but not all. It is currently unclear whether users should be following both these	Thank you for this comment. The new guidance will replace the existing recommendations in section 1.1.1.7 of CG43.

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			documents, or using this new one to supersede G43. The G43 best practices are; • helping people assess their weight and decide on a realistic healthy target weight (people should usually aim to lose 5–10% of their original weight) – *covered in new PH guidance* • aiming for a maximum weekly weight loss of 0.5–1 kg . This is not directly covered in new PH guidance and needs to be if this supersedes G43. Suggest adding to actions to take in recommendation 6, spelling out what a healthy rate of weight loss is; '**Are designed to support people to achieve a healthy rate of weight loss of 05-1kg per week'**. • focusing on long-term lifestyle changes rather than a short-term, quick-fix approach - *covered in new PH guidance* • being multicomponent, addressing both diet and activity, and offering a variety of approaches - only part covered in new PH guidance, but actions around programmes being multicomponent could be strengthen / expanded if this supersedes G43; **'Ensure programmes are multi-component addressing both diet and activity and providing support to change behaviours'.** • the following best practices are also not directly covered in new PH guidance and need to be if this supersedes G43. • using a balanced, healthy-eating approach ; '**Adopt a healthy, balanced approach to eating'** • recommending and/or providing ongoing support. (as per addition suggested above)	
Weight Watchers	General		Generally, Weight Watchers feels that there could be more explicit acknowledgement that referral to multicomponent lifestyle weight management programmes could be provided by a range of providers, including commercial programmes with proven effective outcomes. Whilst this is specifically pointed out on page 21, this important theme is lost throughout the rest of the text. Where relevant it needs to be threaded and reiterated in the body of the text to ensure it is a	Thank you for this comment. The introduction to the guidance states that the guidance applies to all programmes and providers. An additional recommendation has been added to the revised guidance which

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			recommendation that is used. There is currently a seemingly purposeful avoidance of acknowledging which multicomponent lifestyle weight management programmes have been proven to be effective and as such reducing the impact of this guidance upon release. Unless the guidance reflects the evidence base of what works, it is likely to be of minimal value; simply focusing on process and avoiding offering any guidance that supports effective outcomes. We believe that the team have missed a real opportunity in producing guidance that will support effective and consistent patient outcomes.	asks public health England to establish a national source of information on weight management programmes suitable for commissioning. The recommendation notes the UK based programmes shown to be effective in the evidence reviews for this guidance.
Weight Watchers	General		There should be clear and consistent delineation between qualitative and quantitative evidence throughout the draft guidance. These types of evidence are very different in their methodology and ethos and NICE should be very clear when they are basing statements on qualitative evidence and when they are based on quantitative evidence. Currently this is done in some places but not others. Specific examples are on pages 63, 64. 65. 66 and 67. For example the statement on page 63 should read 'There is moderate qualitative evidence that people in BWMPs are largely motivated to lose weight for reasons of health and appearance'. Similarly, the statement on page 64 should read: '**There is strong qualitative evidence that many service users believe the ability to have male-oriented conversations is a benefit to men who choose to attend men-only weight loss services'**.	Thank you for this comment, evidence statements 2.x are noted as all being from review 2 which is a review of qualitative evidence. However, for clarity, 'qualitative' has been added to the statements as appropriate.
Weight Watchers	Recommendation 3	7	In the advice 'the likely health benefits for overweight or obese adults who permanently lose even'…..we have concerns over the use of the word 'permanent'. Firstly, even transitory weight loss have been shown to have beneficial impacts on health risk and as such a focus on only permanent weight loss in this guidance may be contrary to evidence based advice. Secondly this is the only mention of the word	Thank you for this comment. The importance of long term maintenance of weight loss is in line with the economic modelling. The wording has been amended to 'long term', consistent with other recommendations.

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			permanent, whilst other recommendations talk about 'long term'. In this piece of advice we suggest the guidance qualifies the 'small amount of weight' also, in order to add more clarity. Suggest amending this to; '**the likely health benefits for overweight or obese adults who lose even a relativity small amount of weight (5-10% of initial weight) or avoid further weight gain'.** Suggest adding about element to bullet 1 '**the evidence base which demonstrates outcomes from local lifestyle weight management programmes, which meet xx best practices'** *(either G43 or these recommendations based on use intentions of different guidance).*	
Weight Watchers	Recommendation 4	8	Suggest an addition around the benefits of setting achievable goals and taking steps towards an ultimate goal: **That their aspirations on weight change are important for motivation, but that focusing on achievable, short term goals and taking things step by step, is important in the journey of effective behaviour changes. Breaking their goals into small achievable steps will help them get to their ultimate goal'**.	Thank you for this comment. The wording of this recommendation has been revised.
Weight Watchers	Recommendation 5	9	Suggest addition around the evidence that 'self-help' tactics are not as effective as structure lifestyle weight management programmes. This is a vital piece of advice when providing information for adults considering a lifestyle weight management programme. Consumer insights suggest that 'self-help' is the primary and predominant route that people choose when they are taking action to make lifestyle changes to lose weight. It is important for this guidance to provide recommendations so that adults are advised using the best available evidence of what works – and this includes providing them with advice about what is not as effective. We suggest the addition' **the benefits of engaging with a structured lifestyle weight management programmes versus 'self-help' and trying to manage their weight on their own** Another addition is also recommended in this section, associated with	Thank you for this comment. The evidence reviews for this guideline either directly compared effectiveness of different programmes or considered the effectiveness of programmes with usual care. A specific search for 'self-help' was not undertaken. Therefore it is not possible to make this statement. Thank you for this comment – the

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			the evidence that increased engagement / attendance is correlated to weight loss outcome success; '**the benefits that making a commitment and engaging regularly in services can have on weight loss outcomes (a dose response relationship)'**	evidence reviews did not find any association with attendance sessions. The revised guidance notes the minimum number of sessions.
Weight Watchers	Recommendation 5 con't	9	Suggest an addition here to ensure that adults can be given all the information they need to make an informed choice – at present the effectiveness of programme are not covered here, and this is a vital element to informed decision making. Suggest adding: **The evidence of effectiveness of different lifestyle weight management programmes (that meet NICE G43 best practices), that may be available to them.**	Thank you for this comment. The revised guidance includes an additional recommendation on awareness raising among local population on available services. An additional recommendation has been added to the revised guidance which asks public health England to establish a national source of information on weight management programmes suitable for commissioning. The recommendation notes the UK based programmes shown to be effective in the evidence reviews for this guidance.
Weight Watchers	Recommendation 6	10-11	First bullet of action to take – the phrase 'over the long term' is used. What this means needs to be clarified either in the recommendations or in the glossary. These guidance will be used to screen for eligible providers of lifestyle weight management services, and in order to add practical value to the use of them, being clearer about how long 'longer term' is, would be very useful. The SEF seems to currently view 'long term' as 1 year. Providing a clearer direction on this will help commissioners and providers align and work to develop programmes and demonstrate impact over time. 2th bullet of action to take – suggest amend to '**Set achievable, healthy weight loss over**….' 3rd bullet of action to take – suggest amend in order to be consistent	Thank you for this comment. The revised guideline provides more specific timeframes. The revised guideline is consistent with SEF and identified the data that should be collected as a minimum (see recommendations 16 to 18). Consistency has been checked throughout. Please note that this guideline replaces section 1.1.7 of CG43.

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			with recommendation 12 (page 17) '**Ensure staff are trained to deliver the lifestyle weight management programme, with training having been developed with qualified professionals such as a registered dietitian, clinical psychologist and qualified physical activity instructors.** It will be vital to be clear on this recommendation and currently the 2 (6&12) are not consistent. Many providers of lifestyle weight management programmes, which have been used in evidence reviews and development of this guidance, are built on using training programmes for staff that are delivered by training professionals, with the training programme developed in collaboration and stewarded by credentialed health professionals. They are not delivered directly by these credentialed health professionals and the evidence seems to demonstrate that they do not need to be. 4th bullet of action to take – suggest amend (*depending on intention on use of these multiple guidance documents*) to '**Ensure programmes are multicomponent and meet NICE G43 best practices (see G43, page 32, 1.1.7.1)'.**	
Weight Watchers	Recommendation 6 con't		5th bullet of action to take – in order to ensure that this action is really clear and usable to interpret, we recommend amending to '**Set a clear energy intake or calorie reduction target, which is tailored to individual needs for a healthy rate of weight loss (this requires tailoring using a person's height, weight, age and gender in order to calculate the safe and appropriate energy deficit)**'. The current wording lacks clarity and amends would really help with practical value and ease of use. 10th bullet of action to take – suggest amending to '**Consider the needs of different subgroups and tailor service delivery accordingly**'. This makes it clearer that new and different programmes may not be needed for subgroups, yet how, when, where programmes are delivered may need to be adapted in order to	Thank you for this comment, the recommendation has been amended for clarity. Re monitoring, this is addressed in more detail elsewhere in the guidance and the PDG were of the view that this should be a core component of programmes and addressed at the outset in commissioning. The revised guideline is clearer on the data that should be collected as a minimum and is consistent with SEF.

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			engage these people. The examples you given in this recommendation relate to 'service delivery' and not 'programme' per se. 12th bullet of action to take –there is currently an ongoing, important debate as to who provides this element of follow up and whether is it in fact a waste of valuable investment. We strongly recommend that this element is not presented in this guidance as a core component of a lifestyle weight management programme, but may be included in recommendation 8 around commissioning of progammes. This element is not a core component of a weight loss programme, but if anything, a core component of data collection for weight loss services and a core component for commissioners. Collecting follow up data may not necessarily be the responsibility of weight management programme providers and needs to be part of partnerships and agreements locally. At present the action recommendation is very direct, and given the on-going debate with the SEF and PHE around realistic, valid and valuable measures of behaviour change (apart from using weight change as a marker), at the very minimum if this action is not deleted and moved into recommendation 8, it should be re-worded to '**Consider monitoring weight and measures of behavioural change (if considered valuable investment and using validated tools) for at least 12 months'.** Note – there is a valid debate around the value of monitoring outcomes at 12 months. We would question where the evidence base is in terms of the impact and value of this follow up.	Revised recommendation 16 emphasises the important of information sharing between referrers and providers to support monitoring and evaluation.
Weight Watchers	Recommendation 6 con't		An additional action is recommended; '**can demonstrate effective outcomes** through robust peer reviewed and published evaluations and research'. ** Using the standards defined by the DoH guidance to help identify interventions that are more likely to be effective.** Advice needs to be in place in order to help in the interpretation of 'robust evidence' and effective outcomes. Evidence of service	Thank you for this comment. An additional recommendation has been added to the revised guidance which asks public health England to establish a national source of information on weight management programmes suitable for commissioning. The

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			outcomes could be: 1. published and / or 2. peer reviewed and / or 3. impartially collected / analysed and / or 4. internally produced 5. Non-existence – with services simply called 'evidence – based'. When assessing suitability of services in line with this guidance, it is important to consider whether they have past experience of meeting the recommendations and the extent to which they can produce evidence which demonstrates their achievement. The current best practice guidance (G43) is often used as a tick box exercise to select providers of lifestyle weight management programmes. The best practices outline what a lifestyle weight management programme should *provide*, but does not extend to help decision makers and commissioners understand what *outcomes* an effective lifestyle weight management service should deliver, reducing the real world value of the guidance. Within the evidence reviews, there is the following conclusion regarding the commissioning guidance issued by the DoH in 2013 (page 70); 'This suggests that the standards defined by the guidance are able to help identify interventions that are more likely to be effective'. This guidance needs to be highlighted within recommendation 6 in order to help the guidance focus not only on process, but on outcomes too. We now have the evidence base in order to make more helpful recommendations about effective outcomes for lifestyle weight management services, recommendations that will help to guide Public Health, the NHS and society to make progress on tackling the unhealthy weight of our nation in an achievable way – so we must use it and not bury it in evidence statements. If this action is not added, there is a real danger that this guidance is only process focused and not outcome focused. *Note – this comment is <u>in addition</u> to general comments about the need for citing the specific programmes that have been proven to be effective.*	recommendation notes the UK based programmes shown to be effective in the evidence reviews for this guidance. The commissioning recommendation in the revised guidance makes stronger reference to the DH best practice guidance and the pragmatic targets suggested.

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Weight Watchers	Recommendation 7	11	Suggest adapting to help reduce potential confusion; '**Lifestyle weight management services should be commissioned or recommended for the maintenance of weight loss, only if they provide the following advice and support. They should:**'. At present the guidance is confusing. Confusing weight loss services, with services that are distinct to deliver 'weight loss maintenance' and 'weight maintenance'. It is unclear what outcomes are expected for these 3 different services – as they are all currently seemingly 3 distinct services with different components and outcomes. For example, if a local authority commissioner was looking for a service that provided outcomes of weight loss, they should look at recommendation 6. If they were looking for a service that provided outcomes of maintenance of weight loss they would look at recommendation 7. If a commissioner wants a service that achieves weight loss that is sustained, they should still be looking at recommendation 6 not 7. The current copy, which includes; 'or continued weight loss as appropriate), is highly confusing. See Weight Watchers general point about consolidating recommendation 6&7 or re-writing to be much clearer. If unchanged from the draft, the guidance could foster ineffective and confusing commissioning practices.	Thank you for this comment. The PDG were of the view that considerations around weight maintenance should be an integral part of a service and not viewed as an entirely separate service.
Weight Watchers	Recommendation 8	12	In Weight Watchers view, there is still not enough emphasis within this particular recommendation on commissioning services based on outcomes. At present, there is some reference to selecting services based on outcomes, but this fundamental point is lost within the text. The bottom line is that commissioners need to commission services with established outcomes i.e. those services which are tried and tested rather than those which might are be effective, often using the phrase 'evidence-based'. Being 'evidence based' is vital, but services also need to be proven to work in practice. There is not enough funding within the public sector to invest in services which 'could be effective', with ineffective service provision perpetuating the mis-perceptions that 'nothing work' for weight management and wasting	Thank you for this comment. An additional recommendation has been added to the revised guidance which asks public health England to establish a national source of information on weight management programmes suitable for commissioning. The recommendation notes the UK based programmes shown to be effective in the evidence reviews for this guidance. The commissioning recommendation in the revised guidance makes stronger

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			health investments. The point on basing commissioning decisions on established outcomes must be strengthened.	reference to the DH best practice guidance and the pragmatic targets suggested.
Weight Watchers	Recommendation 8 con't	12	Suggest an additional bullet; '**Commission lifestyle weight management programmes to match scale of need of local populations, avoiding inequities of access. Consider the added value of working across boundaries to seek economies of scale'**.	Thank you for this comment. Commissioning in line with JSNA is addressed in recommendation 1.
Weight Watchers	Recommendation 8 cont'd	12	Weight Watchers suggests that there should be stronger recommendation that commissioners should use the recent guidance issued by DH on commissioning lifestyle weight management services (Department of Health, Obesity and Food Policy Branch (2013). Developing a specification for lifestyle weight management services. Best practice guidance for tier 2 services). This is the most up to date guidance based on experience and realistic outcomes and is now 'owned' by PHE. NICE's own appraisal of the evidence shows that the standards for weight loss and attendance cited in DH's 2013 guidance are indicative of effectiveness and therefore validity. In this complex and complicated public health landscape, commissioners need clear pointers on what they should do and more 'up front' recommendation of this tool from DH is a straight forward way of doing this.	Thank you for this comment. More specific reference to this best practice guidance. However, to note that as an unreferenced piece of work with a lack of clarity on the development process, the PDG were limited in their ability to assess the guidance. References to the DH criteria in the revised NICE guidance are based on evidence statement 2.13.
Weight Watchers	Recommendation 9	14	Suggest amending 1st bullet action point to;'..**and other locally agreed risk factors. This may be via opportunistic interactions and / or planned outreach tactics'**. Adding this last point may help referrers think about how they may engage more with screening for eligible patients. The recommendation that referrals to lifestyle weight management programmes should focus mainly on adults with a BMI over 30kg/m² needs qualifying here. Weight Watchers acknowledges that this is based on evidence of effectiveness presented subsequently within the guidance. However, in public health terms, to encourage commissioners to ignore a tranche of overweight adults, some of	Thank you for this comment. The revised guidance states that referrals for overweight adults should not be restricted where there is capacity.

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			whom will be very ready to change their behaviour, has strong equity of access and ethical implications.	
Weight Watchers	Recommendation 9 con't	13	Last paragraph – What action should they take? Weight Watchers would also suggest that eligibility for referral should not only be based on BMI, but also on 'readiness to change' which could be assessed formally or informally by those who are referring individuals on to services (e.g. GPs, practice nurses, NHS Health Check professionals, referral screening hubs, Health Trainers) Additional action point as bullet 5 recommended; '**raise the issue and impact of unhealthy weight and the potential benefits of moderate (5-10% of initial weight) weight loss on their health and wellbeing. Aim to motivate and encourage people to engage in referred services'**. The draft guidance currently 'misses a trick' in outlining the importance of referring GPs and other health professionals on people's motivation to engage and take action. Additional action point as bullet 6; '**ensure people understand the efficacy benefits of engaging with a structured lifestyle weight management programmes versus 'self-help' and trying to manage their weight on their own**' – *see related feedback on recommendation 5.*	Thank you for this comment. The wording of this recommendation has been revised for clarity. References to motivation have been amended throughout.
Weight Watchers	Recommendation 10	15	Suggest an amend; '**Providers should ask for / seek the consent**….'. Current wording of 'get' does not capture fact that participants could opt out.	Thank you, the text has been amended in line with your comments.
Weight Watchers	Recommendation 12	17	Suggest amend; '**and to accurately measure waist circumference (where appropriate)'.**	Thank you for this comment. The text has not been amended to minimise repetition.
Weight Watchers	Recommendation 13	18	The current recommendation has huge implications that make implementation unlikely. The recommendation currently asks for	Thank you for this comment. The wording of this recommendation has

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			routine collection of information for all participants as the end of a programme (including those who have not completed it). Collecting follow up data from dis-engaged participants / lapsed participants as a routine data collection requirement is not currently asked for or actioned across the country. The level of additional service and investment of following up this cohort would impact on the ability to use the finite investment envelope on services for people, diverting into follow up data collection. In addition, the information collected needs to be expanded and specified a little more to ensure valued measurements and reports are enabled and to help promote consistency across the country. At present the data domains seem confusing and potentially unhelpful. We believe a more realistic and value for money recommendation would look like (and which is seen as best practice currently): **Routinely collect the following information for participants analysed in 2 ways (for completers classified as participants attending at least 1 of the last 3 sessions of the intervention and for all participants using baseline observations carried forward).** • **Weight at start and programme end, absolute weight change at programme end (kilograms)** • **BMI at start and programme end, absolute BMI change at programme end** • **Weight change as a per cent of initial weight at programme end** • **Per cent adherence to the programme, measured using number of available sessions attended** • **Participant age…**etc (as currently stated)	been revised.

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Weight Watchers	Recommendation 13 cont'd	18	The routine collection of additional outcome measures places extra burden on participants who are focusing on making changes to their lifestyles and managing their weight, the impact of which we don't yet know. Participants routinely being asked to complete validated measuring tools is not currently routine practice and the evidence based used for the development of this guidance is largely on service models that don't include this approach. In addition, in cases where this individual level data may be collected, the interpretation and use of the data is minimal, putting into question the value of this practice on an individual level. Lifestyle weight management services should only be commissioned if they meet the recommendation 6, so must approach weight changes using dietary and activity changes. And, programmes should provide evidence of efficacy in these areas; evidence at a programme level and not an individual level should therefore be able to be provided as a matter of course. In fact PHE are reviewing the SEF and items 43&44 are being considered to be moved to desirable not essential given the complexities and questionable value of individual level outcome measurements. It is highly recommended that this action point be amended. Suggest amends to bullet 2; '**If agreed locally to be a valid investment of additional data collection, analysis and interpretation and a valid burden on participants (it is not recommended to be undertaken as a matter of course), consider collecting other outcomes (using validated measuring tools). Consider who is best to attempt to collect follow up data, (it may be the lifestyle weight management service provider or other local services). Discuss options for overcoming potential problems and additional costs. For example…..**'	Thank you for this comment. NICE is aware of the update on SEF.
Weight Watchers	Recommendation 13 cont'd	19	Suggest adding to bullet 5…**'consider who is best to collect the views and experiences of participants, as it may be more appropriate for the referrer or commissioners to seek this feedback rather than asking service providers to do so'**.	Thank you for this comment.
Weight Watchers	Evidence	69	Should the second reference read 'Royal College of Physicians	Thank you, the text has been amended.

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	Statement 2.12 Commissioning		2013'?	

Document processed	Stakeholder organisation	Number of comments extracted	Comments
5 Boroughs Partnership NHS Foundation Trust.doc	Specialist Weight Management Service (5 Boroughs Partnership NHS Foundation Trust).	7	
Association for Improvements in the Maternity Services.doc	Association for Improvements in the Maternity Services	8	
Association for the study of obesity.doc	Association for the study of obesity	21	
British Cardiovascular Society.doc	British Cardiovascular Society	29	
British Heart Foundation.doc	British Heart Foundation	14	
British Nutrition Foundation.doc	British Nutrition Foundation	6	
British Psychology Society.doc	British Psychology Society	42	
Cambridge Weight Plan.doc	Cambridge Weight Plan	21	
Department of Health.doc	Department of Health	1	
Diabetes Management & Education Group.doc	Diabetes Management & Education Group	12	
Dietitians in Obesity Management UK.doc	Dietitians in Obesity Management UK (a specialist group of the British Dietetic Association)	44	

Dudley MBC.doc	Dudley MBC	2	
Dudley Metropolitan Borough Council.docx	Dudley Metropolitan Borough Council	2	
Hartlepool Borough Council.doc	Hartlepool Borough Council	10	
Health at Every Size UK.doc	Health at Every Size UK	31	
Health Equalities Group.doc	Health Equalities Group	8	
Ki Performance Lifestyle Ltd.docx	Ki Performance Lifestyle Ltd.	3	
LighterLife.docx	LighterLife	22	
Living Streets.doc	Living Streets	5	
Motivational Interviewing Network of Trainers (MINT).doc	Motivational Interviewing Network of Trainers (MINT)	12	
National LGB&T Partnership.doc	National LGB&T Partnership	13	
National Obesity Forum.doc	National Obesity Forum	18	
Newcastle University.docx	Newcastle University, Institute of Health and Society	20	
Nottinghamshire Healthcare NHS Trust.doc	Nottinghamshire Healthcare NHS Trust	12	
Nutratech Ltd.doc	Nutratech Ltd	8	
Public Health Wales.doc	Public Health Wales	18	
Rotherham Metropolitan Borough Council.doc	Rotherham Metropolitan Borough Council	6	
Royal Bolton Hospital.doc	Royal Bolton Hospital	8	
Royal College of Nursing.doc	Royal College of Nursing	1	
Royal College of Obstetricians and Gynaecologists.doc	Royal College of Obstetricians and Gynaecologists	4	
Royal College of Physicians.doc	Royal College of Physicians	3	
Royal College of Psychiatrists.doc	Royal College of Psychiatrists	3	

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Royal Pharmaceutical Society.docx	Royal Pharmaceutical Society	4	
Shropshire Community Health NHS Trust.doc	Shropshire Community Health NHS Trust	15	
Shropshire Council.doc	Shropshire Council	17	
Slimming World.doc	Slimming World	22	
The Natural Ketosis Company.doc	The Natural Ketosis Company	32	
Thinking Slimmer Ltd.doc	Thinking Slimmer Ltd	14	
UK Society for Behavioural Medicine.doc	UK Society for Behavioural Medicine	79	
University of Oxford.doc	Department of Primary Care Health Sciences, University of Oxford, UK; Medical Research Council Human Nutrition Research, University of Cambridge, UK	37	
Weight Concern.doc	Weight Concern	11	
Weight Watchers.doc	Weight Watchers	26	