Public Health Programme Guidance

Overweight and obese adults - lifestyle weight management services - Consultation on draft scope
Stakeholder Comments Table

17th January 2012 – 14th February 2012

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Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Arthritis Care	General		As well as citing heart disease, cancer, and diabetes, we recommend that the guidance resolve to draw clear links between obesity and osteoarthritis. Osteoarthritis places a huge financial burden on the NHS. Musculoskeletal disorders are the fourth highest area of spend in the NHS, consuming £4.2billion in 2008/9[1], and osteoarthritis is the most common of MSK conditions. Increasing in obesity and the ageing population means that this area of need and expenditure is set to increase substantially. There is evidence that increased services to promote lifestyle alterations would reduce the risk of developing osteoarthritis, e.g. strengthening exercises, general fitness, anti-obesity programmes and the use of supportive appliances[2]. Up to half of all knee osteoarthritis is theoretically preventable by weight reduction and up to a third is preventable by preventative advice on activities that lead to joint injury. (Ibid). Despite this, there is evidence that pharmacological interventions are being inappropriately favoured by clinicians, whilst lifestyle changes and physiotherapy are being under-promoted. Research has found that clinicians who care for patients with osteoarthritis are likely not following standard care	Thank you for raising this issue. Paragraph 3b notes that being overweight and obese leads to severe and chronic medical conditions. The conditions mentioned are intended as examples and not exhaustive.

[1] Department of Health, Programme Budgeting Data 2008-09pa http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_111236.pdf department of Health

[2] Standards of care for people with osteoarthritis, ARMA, 2005.

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			guidelines based on the most current evidence, opting for medication or surgery rather than weight loss plans or exercise programs[3].	
Arthritis Research UK Primary Care Centre, Keele University	General		We suggest that best practice should take into account an assessment of patients' suitability for such weight management programmes, based on co-morbidities.	Thank you this comment. The wording of the draft scope is being amended to clarify this issue. General issues around the participation of individuals with pre-existing conditions in lifestyle weight management will be considered in this guidance. The guidance excludes adults undergoing clinical

[3] Details of the this study are available in the January 2011 issue of Arthritis Care & Research, a journal published by Wiley-Blackwell on behalf of the American College of Rheumatology. See also:

http://www.medicalnewstoday.com/articles/212765.php , and

http://www.firstscience.com/home/news/breaking-news-all-topics/clinical-practitioners-not-adhering-to-evidence-based-guidelines-for-osteoarthritis_97861.html

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				management of obesity.
Arthritis Research UK Primary Care Centre, Keele University	4	6	Considering that up to two thirds of older adults have joint pain, there is a strong likelihood that many potential candidates for lifestyle weight management programmes will have joint pain. The subsidiary question which addresses the 'views, perceptions and beliefs of adults who use lifestyle weight management programmes' could be extended to take into account the beliefs adults with joint pain. Adults with joint pain may believe that an increase in physical activity as part of a lifestyle weight management programme may increase their joint pain and risk of further joint damage. However this is not born out in the literature and the evidence suggests otherwise.	Thank you for raising this issue. The question as it stands does not exclude consideration of any available evidence on joint pain. However, detailed, specific consideration of this issue is outside the scope of this guidance.
Arthritis Research UK Primary Care Centre, Keele University	4.3	7	Expected outcomes might include other measures which take into account changes in behaviour in relation to weight loss and beliefs about weight loss. Measuring the self efficacy of patients would provide a useful measure.	Thank you for raising this issue, the scope has been amended.
Arthritis Research UK Primary Care Centre, Keele University	4.3		It would be useful to provide some evidence for the independent and combined effects of reducing energy intake and increasing physical activity/exercise. Comparisons could be made between the evidence for diet alone, and exercise alone and for both combined to show in the guidelines the benefits of a "multi-component approach".	Thank you for this comment. Assessment of diet or exercise alone and comparison with multi-component approach is outside the scope of this guideline and is covered by existing NICE guidance on obesity (CG43).
Arthritis Research UK Primary Care Centre, Keele University	3 and 4	2 and 5	The section on need for guidance states that 85% of patients with hypertension are obese and 90% of those with type 2 diabetes are obese. However, section 4.1.2 suggests that the focus of the guidance will not include	Thank you this comment. The wording of the draft scope is being amended

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			those with other conditions which may or may not be related to their obesity. We suggest that this is unrealistic as the focus would then be on the "healthy, worried, well" people who are obese. We suggest that the guidance should not limit its focus to specific conditions as the largest proportion of obese people will have some form of co-morbidity, which in all likelihood will need to be considered in any 'best practice' weight management intervention.	to clarify this issue. General issues around the participation of individuals with pre-existing conditions in lifestyle weight management will be considered in this guidance. The guidance excludes adults undergoing clinical management of obesity.
Association for the Study of Obesity	General		The scope document is not very explicit, but there a large number of PCT 'own-brand' weight loss on prescription type services. As far as we know, they are not versions of the same, unlike Weight Watchers for example, but each is unique. There never could be nor should there be RCTs to test each one. Given that such programmes exist, it might be important to have some explicit guidance on how such programmes might be evaluated. For example, it seems entirely reasonable for the programme to have to supply data that may be compared on a like for like basis with that available from randomised trials of Weight Watchers, or Slimming World, which are available. We would have thought that producing guidance on how to evaluate whether such local schemes are effective is a key output from the guidance. It could be unrealistic for the NICE PDG to evaluate all these schemes themselves.	Thank you for a raising this issue; a question on evaluation has been added to the scope.
Association for the Study of Obesity	4.3	6	While (cost) efficacy might trap a 'summary' of benefit the difficulties lie in the definitions of efficacy. These may be weight-related, but are better defined by	Thank you for raising this issue.

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			more direct health outcomes. There are potential confounders of using an economic outcome – e.g. the infertile woman who becomes eligible for assisted conception. Definition of 'meaningful' outcomes is critical and may be hard to extract from some existing datasets which have (e.g. in the commercial sector) tended to exclude those with significant concomitant illness or disease.	
Association for the Study of Obesity	4.3	6	*Subsidiary questions* - Needs an additional point – 'How to integrate these services in a weight management pathway?'	Thank you for raising this issue, which may be considered by the PDG depending on the evidence available. The scope has not been amended.
Association for the Study of Obesity	4.3	7	*Expected outcomes, Point 1*: 'Anthropometric measures, or changes in weight or waist circumference.' – There is no point looking at change of BMI in adults as height is constant and measurement error just adds imprecision.	Thank you for raising this issue. The scope reflects the outcomes that may be identified in the evidence reviews.
Association for the Study of Obesity	4.3	7	*Expected outcomes, point 2:* Short, medium and long-term need definition.	Thank you for raising this issue. The precise definition of short, medium and long term will be an issue for the PDG to consider and is likely to be discussed in the final guidance.
Association for the Study of	4.3	7	*Expected outcomes, Point 3*: Suggest amend wording to: 'Intermediate	Thank you for this

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Obesity			measures such as changes in diet or physical activity behaviours.	comment, the scope has been amended.
Association for the Study of Obesity	4.2.2	6	We suggest that the exclusions in Para 4.2.2 be removed, there is little evidence, so will add little to the workload	Thank you this comment. The wording of the draft scope is being amended to clarify this issue. The guidance excludes adults undergoing clinical management of obesity.
Bolton NHS Foundation Trust	4.3 Re training of staff	6/7	Most healthcare professionals will not have time to be trained to any significant level in diet/weight management. Evidence around delivering brief advice should be noted here. It is likely that a high number of brief assessments and signposting interventions by frontline healthcare staff will result in a bigger uptake of support services. It is accepted that a majority of these assessments will not result in direct involvement with a more specialised weight management/dietry service. However, given the basic investment of time and training in the healthcare professional has not been large it is suggested that these interventions are likely to be cost effective. Those staff who have more reason to be more specialised in weight/dietry management can access more specialised training which can follow the brief advice training. The process being that all healthcare staff can at least deliver a basic intervention (every contact counts) and then those staff who spend more time with patients in addressing various issues can access further training and deliver more involved interventions. The second level of training can be promoted during the first brief level training.	Thank you for raising this issue. The evidence for brief intervention / advice in relation to this guidance is likely to be considered by the PDG.
Bolton NHS Foundation Trust	4.3	6/7		Thank you for this

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			"What are the best practice principles for primary care when referring people to commercial, voluntary or self-help lifestyle weight management programmes?" In relation to the above question. Although on the periphery of this consultation it is imperative that the environments in which the various weight loss/management interventions take place are considered in terms of suitability regarding the food and drink provision available. Many weight loss programmes are run in various locations in a community some of which are filled with energy dense foods. Not only does this energy dense food environment potentially undermine any weight loss activity on the day, it also undermines a more prolific message about how the environment can guide and support people to either eat an appropriate energy content diet or a high energy diet. The public health component must be considered as part of referral to or delivery of such programmes or the opportunity to normalise a lower energy value food and drink environment.	comment. Issues around the local environment and wider determinants of obesity are outside the scope of this work but are included in range of other existing NICE guidance such as guidance on the prevention of CVD (PH25), prevention of type 2 diabetes (PH35) and guidance currently being developed on working with local communities (due to be published November 2012).
British Obesity and Metabolic Surgery Society	General		We believe that lifestyle management is useful in overweight people but that in people who are morbidly obese and who fulfil the NICE criteria for surgery, this is the only useful treatment option.	Thank you for raising this issue. Evidence for effectiveness across different levels of BMI is likely to be considered during the development of this guidance. The clinical management of obesity is outside the scope for this work.

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British Obesity and Metabolic Surgery Society	General		Lifestyle changes, eg exercise, is difficult for patients with extreme obesity.	Thank you for raising this issue. As noted in section 4.3 the views of participants will be considered.
British Obesity and Metabolic Surgery Society	General		We believe that in patients who fulfil NICE criteria for surgery, spending money on attempts to change lifestyle is a waste of time and money.	Thank you for raising this issue.
British Psychological Society	General		The suggested guidance is timely and strongly welcomed by the BPS.	Thank you for this comment.
British Psychological Society	3e)	3-4	From the limited available evidence (please see SIGN, 2010; British Psychological Society, 2011; Simpson *et al*., 2012), one area of agreement in the outcome and maintenance studies examining weight management programmes is that the longer the support offered, the better the outcome (including a greater chance of weight loss being maintained, thereby improving cost-effectiveness). *References:* SIGN (2010). *Management of Obesity: A National Clinical Guideline.* Edinburgh: Scottish Intercollegiate Guidelines Network. British Psychological Society (2011). *Obesity in the UK: A psychological perspective.* Report of the Professional Practice Board's Obesity Working Group. Available online: http://www.bps.org.uk/sites/default/files/images/pat_rep95_obesity_web.pdf. Accessed February 2012. Simpson, S.A., Shaw, C. & McNamara, R. (2011) What is the Most Effect	Thank you for raising this issue and providing these references.

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			Way to Maintain Weight Loss in Adults? *British Medical Journal*, *344*, d8042.	
British Psychological Society	3e)	4	The BPS would welcome clarification of what is meant by "brief intervention" and of the evidence that supports the provision of such interventions for overweight and obese people.	Thank you for raising this issue. Brief interventions have been considered by previous NICE public health guidance and have been generally defined as 'opportunistic advice, discussion, negotiation or encouragement. They are commonly used in many areas of health promotion and are delivered by a range of primary and community care'. The evidence and specific definition of brief intervention in relation to this guidance is likely to be considered

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				by the PDG.
British Psychological Society	Appendix B	11	The BPS recommends that "Critical elements" (6th bullet point) should include: "content of interventions in terms of behaviour change techniques used". Breaking down programmes in terms of their behaviour change techniques and change processes (as well as their overall theoretical basis) is important (Abraham & Michie, 2008) and so some attempt to look at the data using this level of detail should be included. Several recent reviews show how this can add useful information leading to recommendations about the content of lifestyle interventions – Michie *et al*., 2009; Greaves *et al*. 2011; Abraham & Michie 2008). This would be consistent with the approach taken in the recent NICE public health guidance on diabetes prevention in at-risk individuals on this topic (NICE 2011). *References:* Abraham, C. & Michie, S. (2008). A Taxonomy of Behavior Change Techniques Used in Interventions. *Health Psychology*, *27(3)*, 379-87. Greaves, C.J., Sheppard, K.E., Abraham, C., Hardeman, W., Schwarz ,P., Roden, M., *et al*. (2011). Systematic Review of Reviews of Intervention Components Associated With Increased Effectiveness in Dietary and Physical Activity Interventions. *BMC Public Health*, *11(119)*, 1-12. Michie, S., Whittington, C., Abraham, C. & McAteer, J. (2009). Effective Techniques in Healthy Eating and Physical Activity Interventions: A meta-regression. *Health Psychology*, *28(6)*, 690-701. NICE (2011). *Preventing Type 2 Diabetes - Risk Identification and Interventions for Individuals at High Risk: Draft guidance*. London: National Institute for Health and Clinical Excellence.	Thank you for raising this issue. The behaviour change techniques used in interventions that meet the inclusion criteria are likely to be considered in detail by the PDG. Please note that NICE has issued separate guidance on behaviour change (PH6) which is due to be updated.
British Psychological Society	General		The Programme Development Group will need to include sufficient expertise in behaviour change intervention. In addition, the BPS recommends that	Thank you for raising this issue. It is hoped that a

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			evidence be sought from applied psychologists/behavioural scientists working in the applied lifestyle intervention/weight loss field.	psychologist with relevant experience will be a member of the PDG.
British Psychological Society	General		The BPS recommends an updated review be commissioned on self-directed (self-help manual, web-based, DVD or computer-based or mobile-phone based) approaches to weight loss/changing diet and/or physical activity. This seems to be an important emerging technology in this area, with successful approaches now reported for smoking cessation (e.g. text2quit; Free *et al*., 2011) and managing depression with CBT (e.g. Beating the Blues; Kaltenthaler *et al*., 2006): if these substantial cognitive-behavioural challenges can be overcome with e-health technologies, then weight loss should also, in theory, be amenable to such approaches. *References:* Free, C., Knight, R., Robertson, S., Whittaker, R., Edwards, P., Zhou, W. *et al*. (2011). Smoking Cessation Support Delivered Via Mobile Phone Text Messaging (txt2stop): A single-blind, randomised trial. *The Lancet*, *378(9785)*, 49-55. Kaltenthaler, E., Brazier, J., De Nigris, E., Tumur, I., Ferriter, M., Beverley, C. *et al*. (2006). Computerised Cognitive Behaviour Therapy for Depression and Anxiety Update: A systematic review and economic evaluation. *Health Technology Assessment*, *10(33)*, 1-6.	Thank you for these comments. Self directed approaches, such as internet based programmes will be included if they meet the inclusion criteria and definition of lifestyle weight management as stated in the scope.
British Psychological Society	General		It would be useful to aim to provide exemplars of the content of intervention programmes that would meet any recommendations made. Many alternative (and often evidence-free) programmes are 'in the market', so it is important for commissioners to understand what is the minimum level/content required to ensure a reasonable likelihood of benefit.	Thank you for this suggestion.

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British Psychological Society	General		Maintenance of weight loss is a hugely important topic (House of Lords Technology Select Committee, 2011) and the BPS finds it encouraging that this is to be specifically considered. In addition to the interventions that are effective for maintenance, however, it may be worth considering whether maintenance is also influenced by the content of the initial intervention. For instance, whether or not it is more difficult to maintain weight loss if the initial means of weight loss is not sustainable; such as when this is achieved by the use of food replacements (liquid meals, etc.), weight loss pills or extreme dietary regimes (e.g. avoidance of carbohydrates). We suggest that a specific review of the evidence base for maintenance of weight loss which incorporates both these issues would be worth commissioning. *Reference:* House of Lords Technology Select Committee (2011). *Behaviour Change*. London: House of Lords.	Thank you for raising this issue. Any available longer term data for studies that meet the inclusion criteria will be considered. Maintenance of weight following weight loss per se is outside of the remit of this guidance.
British Psychological Society	General		The BPS recommends guidance be included on the appropriate assessment/screening of adults that should be carried out before any weight management intervention, in order that the aggravation of any pre-existing medical conditions and the increasing of any risk of psychological disorders (e.g. eating disorders, depression) be avoided.	Thank you for this comment. General issues around the participation of individuals with pre-existing conditions in lifestyle weight management will be considered in this guidance. The guidance excludes adults

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				undergoing clinical management of obesity. The assessment of weight is covered by existing NICE guidance on obesity (CG43). Following review in 2011, CG43 will be partially updated.
British Psychological Society	2	1-2	The BPS recommends that the NHS Health Check programme[1] be mentioned here: personal communications at the NHS Health Checks Forum in November 2011 gave strong indications that commissioners are struggling to find the best evidence-based strategies for lifestyle intervention following health checks. [1] http://www.healthcheck.nhs.uk	Thank you for this comment. Reference to the Health Check programme will be added to the scope.
British Psychological Society	4.1.2	5	The BPS would welcome a definition of "Adults who are undergoing clinical treatment for obesity" (3rd bullet point). For example, does this include people taking weight loss medications? It may be important to include in a review (as a separate group of interest) the evidence on using lifestyle programmes alongside pharmaceutical interventions. There is quite a bit of this in existence (we would be happy to provide details if this would be helpful).	Thank you for this comment. This section of the scope is being amended. The guidance excludes adults who are undergoing clinical management for obesity.
British Psychological Society	4.1.2	5	It is stated (in the 4th bullet point) that the guidance will not cover "Adults who have other conditions which may or may not be related to their obesity (such	Thank you for this comment. This section of

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			as Type 2 diabetes". It is not clear from this whether or not the scope will cover people with disabilities – a group previously identified as being at particular risk of obesity (NICE, 2006). The BPS recommends that this group be included or, if they are to be excluded because of an overlap with other guidance, that this be made explicit. *Reference:* NICE (2006). Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE clinical guideline 43. London: National Institute for Health and Clinical Excellence. Available at: www.nice.org.uk/nicemedia/live/11000/30365/30365.pdf. Accessed 7 February 2012.	the scope is being amended. The guidance excludes adults who are undergoing clinical management for obesity. The guidance does not exclude people with disabilities.
British Psychological Society	4.3	7	*Expected outcomes, 2nd bullet point:* The BPS considers it important to define what is meant here by "short, medium and long term". Some studies/authorities define long term as six months or 12 months (e.g. Simpson *et al*., 2011), but this is clearly at odds with the one to 80 year timescales over which benefits are expected to accrue. Unfortunately, the evidence base is restricted mostly to studies with follow-up of five years or less (and more usually six to 24 months). So a pragmatic choice will be needed here (e.g. short term might be defined as up to 6 months, long term as 24 months or more). However, whatever the choice made, it seems important to model and clearly present the health economic consequences of different (assumed) weight regain profiles over longer timescales. *Reference:* Simpson, S.A., Shaw, C. & McNamara, R. (2011). What is the Most Effect	Thank you for raising this issue and providing the reference. The precise definition of short, medium and long term will be an issue for the PDG to consider and is likely to be discussed in the final guidance.

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Combating Obesity		7	**Referrals** Fully trained staff understanding range of services Detailed assessment of patient need Patient provided with details to make an informed choice Type and length of support required	Thank you for these comments.
Combating Obesity		7	**Commissioners** Knowledge & awareness of Foresight Maps Acknowledgement of non-clinical, self-help interventions Appreciation for community-led services Appreciation of market segmentation – one size not fit all Commissioning of range of services Full consideration of services provided by voluntary sector organisations of all sizes Commissioning of training for staff & volunteers Ensure range of services for morbid obesity (not only surgery) Understanding of range of outcomes – (hard) weightloss, blood pressure, cholesterol, glucose control etc and (soft) engagement, sustained involvement	Thank you for these comments.

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			etc. Consideration of social returns on investment (SROI) and wider benefits. **Training** Foresight Maps Listening skills Understanding limitations of BMI Nutrition, activity, family dynamics, genetics, Social pressures / barriers to weight management Dangers of stereotyping patients Local availability of support	
Combating Obesity		7	**Expected Outcomes** Consider broader outcomes that indicate improving health. Less focus entirely on weight-loss as not realistic for many particularly morbidly obese or those with co-morbidities	Thank you for these comments. A range of outcomes will be considered, depending on the evidence available.
Combating Obesity	**General**		The draft scope is very encouraging and reasonably robust however the limitations outlined above are some of the central planks to combating obesity. The level of ignorance and stereotyping around this condition is creating negative environments where efforts are easily undermined and obstructed. Anyone commissioning or delivering weight management programmes must	Thank you for raising these issues.

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			acknowledge and understand the complexities they are facing and act appropriately. Existing training excludes or overlooks the real psychological and social implications for obese people and providers must recognise how their own actions can inadvertently contribute to increasing the difficulties obese people face. Focus must be on robust training of commissioners and providers to understand the importance of effectively engaging with obese people. There is a very real danger that poorly designed programmes will disengage the very people requiring the most support. We really do not want to still be in a position of ignorance in ten years time having wasted more valuable time and resources. I am very concerned for the very largest people as these are the hardest to reach and engage because many providers design services for the quickest and easiest returns ie those with much less weight to lose. Successful outcomes must be appropriate to the person seeking help and support. Weight management specialists services for the most obese must not be limited to academics and surgeons**.**	
Combating Obesity	4.1.2	5	Many obese and particularly morbidly obese people have one or more other	Thank you this comment.

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			conditions which impact on their ability to manage their weight; to exclude them from the guidance will severely restrict their access to opportunities to lose weight and improve their health. Equity & Excellence report 2010 focuses heavily on patients increased choice and control and excluding them goes against the aims and spirit of the report. If they are not included in the guidance commissioners will fail to provide a comprehensive range of interventions and treatment opportunities restricting patient choice and increasing health inequalities for those most in need.	The wording of the draft scope is being amended to clarify this issue. General issues around the participation of individuals with pre-existing conditions in lifestyle weight management will be considered in this guidance. The guidance excludes adults undergoing clinical management of obesity.
Combating Obesity	4.3	6	Multi component lifestyle wm programmes tend to consist of 6, 10 or 12wks of intense interventions which bear little or no resemblance to daily living. Recidivism is a major problem. Providing specialist professionals for short bursts of activities is v costly and generally fail to change life-long behaviour. Many front line professionals have little real understanding of the complexity of obesity and receive very little training on engaging patients thus repeatedly wasting valuable resources. Weight management is complex and should be reflected in the commissioning of a range of alternative approaches. The medical model doesn't work for	Thank you for raising these issues. Short, medium and longer term interventions that meet the inclusion criteria for this guidance will all be considered, depending on the evidence available.

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			everyone and must be acknowledged as one in a range of approaches.	
Counterweight Ltd.	3e	4	The Counterweight Programme for adults has also been delivered in a broader community based setting increasing the reach of the programme. (Family Practice April 1st 2012, 184 general practices, 16 pharmacies (pharmacy assistants) and community based setting (healthcare assistants)). Outcomes by practitioner type not presented but can provide the data to support the aggregated outcomes in the publication). The Counterweight Programme for adults is currently being implemented in a broad range of occupational health settings with full evaluation in place. Although the intervention can be delivered as part of routine care it would not be described as a brief intervention. Health care professionals are trained and mentored until competent and confident to deliver the programme.	Thank you for providing this information.
Counterweight Ltd.	3e	4	A manuscript is being prepared on Counterweight Programme implementation in pharmacy.	Thank you for alerting us to this publication.
Counterweight Ltd.	3d	3	The Counterweight Project Team developed the Counterweight Programme in the period 2000-2002 and conducted initial evaluation in general practice 2002-2005. There have been a number of publications reporting Counterweight outcomes. The Counterweight Project Team. A new evidence-based model for weight management in primary care: the Counterweight Programme. J Hum Nutr Dietet 2004; **17**: 191–208. The Counterweight Project Team. Empowering Primary Care to tackle the obesity epidemic: The Counterweight Programme. Eur J Clin Nutr 2005; **59**: Supplement 1, S93-101.	Thank you for providing these references.

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			Counterweight Project Team. Evaluation of the Counterweight Programme for obesity management in primary care: a starting point for continuous improvement. Brit J Gen Pract. August 2008; **58**: 548-554.	
Counterweight Ltd.	3d	3	A paper reporting Counterweight outcomes in areas of high social deprivation in Scotland will be published in Family Practice April 1st 2012. Loss to follow up was higher in populations not routinely engaging with general practice but weight change in those attending was higher than previously published outcomes. Data from 184 general practices, 16 pharmacies and one community-based service. The pharmacy data is being prepared for separate publication.	Thank you for alerting us to this publication.
Counterweight Ltd.	3d	3	Cost effectiveness of the Counterweight Programme was assessed and the programme was found to be cost dominant. Counterweight Project Team and Trueman P. Long-Term Cost Effectiveness of Weight Management in Primary Care. Int J Clin Practice. 2010; **64**(6): 775-783.	Thank you for this reference.
Counterweight Ltd.	3d	3	We have evaluated the Counterweight Low Energy Liquid Diet Programme in primary care. This abstract reviews outcomes over a 12 week intervention with 810kcal liquid diet. Lean MEJ, Brosnahan N, Mackenzie M, McLoone P, Morrison D, Sloan M, McCombie L. Delivery of low energy liquid diets, by counterweight, within routine UK primary care: a feasibility study. HTP.021 Obesity Reviews 12 (Suppl 1) (2011) 276-277. Visit: http://onlinelibrary.wiley.com/doi/10.1111/j.1467-789X.2011.00889.x/pdf. P214 of 217 labelled as pages 276-277	Thank you for this reference.

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			A manuscript is being prepared at present which will present 12 month outcomes with Counterweight Low Energy Liquid Diet programme and an abstract about the 12 month outcomes will be presented at ECO 2012.	
Counterweight Ltd.	3f	4	Frequency of attendance required to achieve the desired treatment outcome should be considered. The Counterweight Programme is offered in 9 appointments and the outcomes of this intervention are known. Some interventions can achieve attractive weight change but frequent attendance (>30 sessions) is required which is acceptable and possible for some individuals but not for the health service. The health service may purchase a block of sessions but not necessarily an amount of attendance which relates to evidence of satisfactory outcome. Counterweight Project Team. Evaluation of the Counterweight Programme for obesity management in primary care: a starting point for continuous improvement. Brit J Gen Pract. August 2008; **58**: 548-554. Counterweight Project Team and Trueman P. Long-Term Cost Effectiveness of Weight Management in Primary Care. Int J Clin Practice. 2010; **64**(6): 775-783.	Thank you for this reference.
Counterweight Ltd.	3f	4	New evidence on how to commission weight management services would be welcomed as effectiveness appears to have little to do with outcomes of commissioning at present. We are advised it just comes down to funding and sometimes referring the problem out rather than up-skilling internally when there are insufficient payments for weight management delivery. In addition the tendering process frequently sets unrealistic timescales which cannot be met which leaves groups which are tendering losing money. We have reserved staff to be available for a number of contracts won to find out that the PCT needs to incur a delay of x months but cannot pay to assist us with the	Thank you for providing this information.

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			delay.	
Counterweight Ltd.	4.2.1	5	The Counterweight Programme for adults in now available in primary care where staff are trained to implement the programme within routine care. Counterweight is also available in pharmacy, leisure services, occupational health companies, workplaces and in private healthcare. Wider programme implementation will be fully evaluated with the same dataset collected as within the health setting.	Thank you for providing this information.
Counterweight Ltd.	4.3	6	The Counterweight Programme has been found to be highly cost effective when evaluated in a primary care setting. Counterweight Project Team and Trueman P. Long-Term Cost Effectiveness of Weight Management in Primary Care. Int J Clin Practice. 2010; **64**(6): 775-783.	Thank you for this reference.
Counterweight Ltd.	4.3	6	Lifestyle change and weight loss can be sustained once the weight management programme has ended if the programme was aimed at addressing underlying factors which contributed to overweight and obesity and strategies to assist long term behaviour change were addressed. The Counterweight Programme is aimed at setting realistic goals for change and empowering overweight and obese individuals to make long term changes to enable them to live as a thinner person. It is delivered in 9 appointments over 12 months during which time the individual is supported by a Counterweight Practitioner to develop skills necessary for long term change. Counterweight differs from other programmes in that the ultimate goal for weight change is realistic, achievable and brings well documented health benefits. Additionally factors which may have contributed to weight gain are assessed and the individual is supported in selecting methods to achieve weight loss and weight loss maintenance. In comparison some diets have a more didactic approach which can only be followed for a few months and do	Thank you for providing this information and references.

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			not address how the individual can amend their lifestyle to make it less obesogenic. This cannot result in long term changes to weight and results in dependence on cyclical short term diets and yo-yo weight change. The Counterweight Project Team. A new evidence-based model for weight management in primary care: the Counterweight Programme. J Hum Nutr Dietet 2004; **17**: 191–208. The Counterweight Project Team. Empowering Primary Care to tackle the obesity epidemic: The Counterweight Programme. Eur J Clin Nutr 2005; **59**: Supplement 1, S93-101. Counterweight Project Team. Evaluation of the Counterweight Programme for obesity management in primary care: a starting point for continuous improvement. Brit J Gen Pract. August 2008; **58**: 548-554.	
Counterweight Ltd.	4.3	6	Views, perceptions and beliefs of adults - see The Counterweight Project Team. Engaging patients, clinicians and health funders in weight management: the Counterweight Programme**.** Fam Pract. 2008; **25(S1**):179-186. Data on prevalence of obesity clearly shows that deprivation has a significant impact on overweight and obesity particularly in women. Interventions therefore need to be appropriate for the whole target population. Counterweight has demonstrated outcomes in populations from the top 15% areas of deprivation in Scotland. Data presented for any potential programmes tendering for activity should consider populations baseline characteristics. This is true not just in relation to socio-economic status but also BMI, presence of disease, exclusions etc.	Thank you for providing this reference.
Counterweight Ltd.	4.3	6	Counterweight Programme evidence has been gathered in a wide range of	Thank you for raising this

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			settings in primary care with a number of practitioners – practice nurses, healthcare assistants, pharmacy assistants, pharmacists, physical activity advisors. Practitioners with no medical background have equally effective outcomes in their clinics. Publications involve data from all clinics but unpublished data can be shared if helpful to demonstrate this.	issue. Please note that a call for evidence will be issued once the scope is finalised; we would welcome seeing unpublished data in confidence.
Counterweight Ltd.	4.3	6	Best practice principles must involve a full review of evidence and cost effectiveness. If services are to be referred out of primary care there needs to be a review of number of appointments which primary care will pay for and how this equates in terms of demonstrated outcomes at this time point .i.e. if 10 sessions paid then should review whether to commission a programme which requires 40 sessions to be effective. There should also be due consideration given to cost/resource to PCT versus value to the 'end user'. There is a tendency within the NHS to focus on 'in year' costs rather than viewing the value the already paid for staff produce for patients seeking weight management. Much NHS time potentially being spent carrying out needs assessments and developing new programmes rather than have resource focusing on direct delivery of weight management interventions.	Thank you for raising this issue.
Counterweight Ltd.	4.3	6	Commissioners need to set realistic targets for outcomes when tendering services. If completely unrealistic levels are set for attendance and weight change the tender will be unsuccessful. Perhaps PCTs should all follow exactly the same structure when doing different types of tender to improve the quality of this process.	Thank you for raising this issue.
Counterweight Ltd.	4.3	6	Counterweight Programme evidence indicates that training and mentoring are required to enable practitioners delivering weight management to be effective.	Thank you for providing these references.

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			The Counterweight Project Team. A new evidence-based model for weight management in primary care: the Counterweight Programme. J Hum Nutr Dietet 2004; **17**: 191–208. The Counterweight Project Team. Empowering Primary Care to tackle the obesity epidemic: The Counterweight Programme. Eur J Clin Nutr 2005; **59**: Supplement 1, S93-101. The bio-Project which previously assessed training in relation to weight management demonstrated that training alone with no mentoring achieved a change in practitioner knowledge, attitudes and beliefs but not in the patient outcomes. Moore, H., Summerbell, C.D., Greenwood, D.C., Tovey, P., Griffiths, J., Henderson, M., Hesketh, K., Woolgar, S. & Adamson, A.J. (2003) Improving the management of obesity in primary care: cluster randomised trial. BMJ 327, 1085–1088. The Counterweight Project are evaluating online training and mentoring at present with nurses in Canada. Previously all training and mentoring was face to face.	
Counterweight Ltd.	4.3	8	Return on investment calculations would be welcomed as this will assist commissioners in primary care. At present cost effectiveness evidence is of limited value when short term benefits are seeked. We find GPs are very interested in our cost effectiveness evidence but not commissioners as they find themselves having to look at short term budgetary priorities. Counterweight Project Team and Trueman P. Long-Term Cost Effectiveness of Weight Management in Primary Care. Int J Clin Practice. 2010; **64**(6): 775-783.	Thank you for raising this issue and for the reference provided.

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			Return on investment consideration is key to future activity and best use of public expenditure. Systems should be put in place to ensure that best return of investment is achieved. As mentioned above, there remains an issue around funding versus the clinical outcomes related to funding: Counterweight is unique in that the programme includes the opportunity to not only to carry out robust monitoring of patient numbers but also clinical outcomes in terms of weight change. This allows commissioners to be 100% aware the impact any funding has on the actual target activity i.e. providing interventions for people aiming to manage their weight	
Deparment of Health	General		I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Noted.
Dietitians in Obesity Management UK (domUK)	General		We welcome this draft scope and the clarity it may shed on this complex area of care.	Noted.
Dietitians in Obesity Management UK (domUK)	General		Whilst we recognise that the scope of this work is multi-component programmes, we would welcome broad scope for the individual components of the multi-component programme. For example with regard to dietary components, we would welcome consideration of the use of meal replacement products for both weight loss and maintenance of lower body weight, within the context of a multi-component approach (meal replacement products were not considered in the NICE Obesity Guidelines, 2006).	Thank you for these comments. Consideration of the individual components of multi-component programmes or comparison between eg diet alone and multi-component programme is outside the scope of this work and is covered by existing NICE guidance on obesity

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				(CG43). Please note that following review in 2011, CG43 is being partially updated.
Dietitians in Obesity Management UK (domUK)	General		Within the context of dietary approaches we would like to see a correction of the definition of Very Low Calorie Diets in line with Codex Alimentarius (CODEX STAN 181-1991) and SCOOP VLCD Working Group. This was incorrectly stated as <1000kcals in the NICE (2006) Obesity Guidelines.	Thank you for raising this issue. The definition of VLCD is outside the remit for this guidance. The definition of VLCD in CG43 was based on the evidence considered in the development of the guideline. Please note that following review in 2011, CG43 is being partially updated.
Dietitians in Obesity Management UK (domUK)	General		We would welcome consideration of modes of delivery, including group versus individual delivery, and use of novel approaches e.g. new technologies such as evidence-based web programmes both for weight loss and long term support.	Thank you for raising this issue, the scope does not exclude consideration of modes of delivery or new technologies that meet the inclusion criteria for this guidance.
Dietitians in Obesity Management UK (domUK)	General		We would welcome clear recognition that community lifestyle weight management programmes are offered at the lower tiers of a defined care pathway for overweight and obesity, and that the needs of more complex patients may be best met through clinical management e.g. dietetic and/or	Thank you for raising this issue. Evidence for effectiveness across different levels of BMI is

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			bariatric care.	likely to be considered during the development of this guidance. The clinical management of obesity is outside the scope for this work.
Dietitians in Obesity Management UK (domUK)	4.1.2	5	We have concerns that a cut off point of BMI < 25 will exclude groups potentially at increased health risks at lower BMI. We would welcome use of the WHO (2004) public health cut-off points of 23.5 and 27 kg/m2 respectively for increased and very increased risk (e.g. South Asians) or SIGN (2010) cut-off points of >23 or 27.5kg/m2 respectively for increased and very increased risk (e.g. South Asians, Chinese & Japanese). We recognise that this issue is currently under investigation by NICE and would welcome alignment of the two guidance sets.	Thank you for raising this issue. The cut off of 25 kg/m2 is based on existing NICE recommendations on the assessment of overweight and obesity (CG43). However, NICE is also currently developing new guidance on BMI and waist circumference in BME groups (see http://guidance.nice.org.uk/PHG/Wave0/596).
Dietitians in Obesity Management UK (domUK)	4.1.2	5	We would welcome clarity around the definition of 'clinical treatment of obesity'.	Thank you for this comment. The guidance has been amended to include examples of clinical treatment (eg pharmacological or surgical treatment).

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				NICE has already produced guidance on the prevention and management of obesity (CG43). It is important that the guidance being produced does not unnecessarily reproduce the existing guidance.
Dietitians in Obesity Management UK (domUK)	4.3	6	To subsidiary question 2, we would like the addition of 'and in what format' to be added to 'who might best deliver these'	Noted, thank you.
Dietitians in Obesity Management UK (domUK)	4.3	6	With regard to subsidiary question 2, we would like a wider exploration of effectiveness, to include diet and physical activity in addition to psychological components (with regard to both cost-effectiveness & consideration of who is best to deliver those components).	Noted thank you. Please note that evidence for diet or activity components per se are covered in CG43.
Dietitians in Obesity Management UK (domUK)	4.3	6	Subsidiary question 3: We welcome the inclusion of adherence to programmes and factors affecting adherence, given its relationship to successful outcomes	Noted
Dietitians in Obesity Management UK (domUK)	4.3	6	Subsidiary question 3: We would like to see the addition of 'diverse' to this question i.e. how can a more diverse population of overweight & obese adults be encouraged to join and adhere to the programmes.	Thank you for this comment, the scope has been amended.
Dietitians in Obesity Management UK (domUK)	4.3	6	Subsidiary question 4: We welcome the inclusion of sustaining change, maintenance of lower body weight achieved, and factors affecting that.	Noted
Dietitians in Obesity Management UK (domUK)	4.3	7	Subsidiary question 5: We would like the addition of 'including short and long term monitoring' to the subsidiary question relating to best practice principles for primary care referrals	Thank you for this comment. A separate bullet on monitoring and evaluation has been

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				added to this section.
Dietitians in Obesity Management UK (domUK)	4.2.2	6	We would welcome clarity about what is included in 'clinical management of adults who are overweight or obese'	Thank you – see answer above.
Forest Heath District Council	general		This guidance will help the Council to understand best practice to help adults taking part in weight management activities.	Thank you for this comment.
Forest Heath District Council	general		The scope appears to cover everything and that it will produce some interesting results.	Thank you for this comment.
Forest Heath District Council	3 (e)	3	It would be interesting to know if offers for weight management and physical activity have been coupled together to encourage more use of both at the same time.	Thank you for raising this issue.
Forest Heath District Council	3 (f)	4	The guidance should detail the effectiveness of behavioural interventions in a non-clinical setting.	The guidance will consider the behavioural components of weight management programmes in non clinical settings if the evidence is available.
Forest Heath District Council	4.3	7	The call for evidence should be submitted to Local Authorities and leisure providers.	Noted.
Institute of Health and Society, Newcastle University			There is a general focus on multi-component interventions. Whilst it may be the case that multi-component interventions are the most effective, we suggest that the evidence should guide such an assertion. For example, there are good examples of simple uni-component interventions that are highly effective in promoting increased physical activity. We recommend not necessarily emphasising the multi-component nature of interventions until the evidence is reviewed to make such a claim.	Thank you for these comments. Consideration of the individual components of multi-component programmes or comparison between eg diet alone and multi-component programme

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				is outside the scope of this work and is covered by existing NICE guidance on obesity (CG43). Please note that following review in 2011, CG43 is being partially updated.
Institute of Health and Society, Newcastle University	4.1.2 Groups that will not be covered	5	It is somewhat surprising that the guidance excludes individuals with other conditions. There might be at least two reasons for re-considering this exclusion: 1. A large proportion of obese adults will carry additional obesity related risk factors and current criteria exclude large parts of the obese population for whom this guidance might be beneficial. In addition, much of the evidence gathered for the effectiveness of interventions has been conducted in individuals carrying additional risk factors and a mix of individuals with and without additional disease. Large sections of high quality, relevant evidence would be excluded based on the current inclusion criteria. We recommend that scope be extended to include adults with additional obesity related risk factors. 2. To our knowledge, there is no evidence that obese adults with other conditions need different interventions for weight loss compared to obese individuals without additional conditions. Obese individuals with other conditions might need additional service input for these conditions, but the evidence for the effectiveness to lose weight is similar regardless of additional disease status. This is true for both, the targets for change (i.e. lifestyle behaviours healthy eating and physical activity) as well as the strategies employed to changes these	Thank you this comment. The wording of the draft scope is being amended to clarify this issue. General issues around the participation of individuals with pre-existing conditions in lifestyle weight management will be considered in this guidance. The guidance excludes adults undergoing clinical management of obesity.

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			(i.e. intervention components offered by weight management treatments). We recommend that the guidance provide an indication of the potential and/or evidenced generalisability of the recommendations to different sub-populations of obese adults.	
Institute of Health and Society, Newcastle University	4.3 Key questions and outcomes	6	**Subsidiary questions, bullet 2.** Did you mean: effective and cost effective (not only cost effective)?	Yes; this section will be amended for clarity.
Institute of Health and Society, Newcastle University	4.3 Key questions and outcomes	6	**Subsidiary questions, bullet 3** Why does bullet 3 include 2 questions when all other bullets include only one? We recommend splitting them into two separate bullet points.	Thank you for raising this issue; the section will be amended for clarity.
Institute of Health and Society, Newcastle University	4.3 Key questions and outcomes	6	**Subsidiary questions, bullet 4** Why does a programme need to have ended before assessing sustaining of weight loss? Weight loss maintenance might already be a feature of the programme and indeed be a target for ongoing programmes.	Thank you for raising this issue.
Institute of Health and Society, Newcastle University	4.3 Key questions and outcomes	7	**Subsidiary questions, bullet 7** Whilst we are glad to see a mention of training those who deliver interventions, we feel that this should be expanded to more broadly cover the implementation of lifestyle weight management programmes. The science of implementation is advancing at a rapid pace and extends well beyond only training of health professionals; indeed, there are trials focusing on how the specific strategies that can be used to help health professionals effectively integrate lifestyle interventions into their routine practice, and barriers and facilitators to such implementation and provide them with the skills and competence to effectively deliver these interventions. We strongly recommend adding a section on training and implementation in clinical contexts to the	Noted, thank you. The scope as it stands does not rule out consideration of this issue.

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			guidance.	
Institute of Health and Society, Newcastle University	4.3 Key questions and outcomes	7	**Expected outcomes, bullet 4** Process measures should include psychological effects of the intervention in terms of factors relevant for behaviour change such as motivation, confidence, planning, self-regulation etc. Note that satisfaction should not only be in relation to the service, but also towards the personal achievement through attending the service. However, note that there is limited evidence suggesting that satisfaction of weight loss is related to weight loss maintenance. (e.g. Jeffery, R. W., J. A. Linde, et al. (2006). "A satisfaction enhancement intervention for long-term weight loss." Obesity **14**(5): 863-869.)	Thank you for this comment, the scope has been amended.
Institute of Health and Society, Newcastle University	4.3 Key questions and outcomes	7	Under the heading "Economic outcomes:" it states that "A systematic review will be undertaken to address the overarching question. The subsidiary questions will be addressed by evidence identified in the systematic review, focused searches and expert testimony. (A call for evidence will be issued once development of the guidance has commenced.)" This bullet has nothing to do with Economic outcomes. In addition, there is a plethora of review evidence already available in the obesity literature. It might be better to initially conduct a review of reviews to maximise the use of high quality review evidence already available.	Thank you for raising this issue. This section has been amended for clarity.
Institute of Health and Society, Newcastle University	4.2.2 Activities/measures that will not	6	It states that "*Prevention or management of medical conditions associated with being overweight or obese (such as cardiovascular disease)*." If this exclusion criterion is to be used then this guidance might miss crucial	Thank you this comment. The wording of the draft scope is being amended

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	be covered		evidence for effectiveness. Strategies for managing obesity in those with a cardiovascular disease are not necessarily specific to that condition and may indeed provide important evidence that would be generalisable. If an intervention targets lifestyle behaviour change for weight and includes obese adults it should be considered, regardless of whether or not it states the aim of preventing a condition. The reason for exclusion of studies should not be the goal of a treatment (e.g. the goal to prevent CVD) but the content of the treatment itself (e.g. if the intervention focuses on disease specifics irrelevant for the wider obese population).	to clarify this issue. General issues around the participation of individuals with pre-existing conditions in lifestyle weight management will be considered in this guidance. The guidance excludes adults undergoing clinical management of obesity.
Jenny Craig	3e	3	The key unique way in which the Jenny Craig programme works is that it offers weekly 1:1 telephone consultations. Weight-loss program participants who had a brief, monthly personal contact intervention - most often a 10-15 minute phone conversation - regained less weight than participants who were in a Web-based intervention or self-directed program, according to a study in the March 12 issue of JAMA, the Journal of the American Medical Association. JAMA. *2008;299[10]:1139-1148*. Unlike most other commercial weight loss organisations we do not operate groups as we realise that not all people like the group setting. However we do tick all the boxes for the suggested way that such organisations should work such as using behaviour change, encouraging physical activity and a focus on maintenance	Thank you for providing this information.
Jenny Craig	3f	4	The reason why commercial weight loss organisations like Jenny Craig should be valued as contributors to fight against obesity is that there is now growing evidence that they work and the NHS alone cannot cope with the sheer number of people who would benefit from weight loss. Not all individuals	Thank you for providing this information and reference.

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			respond in the same way to specific weight loss programmes so the variety of options offered by such commercial companies can complement the NHS. The reference by Rock et al. *in JAMA (JAMA. 2010;304(16):(doi:10.1001/jama.2010.1503)* showed that compared with usual care, the Jenny Craig structured weight loss program resulted in greater weight loss over 2 years which demonstrates the long term effectiveness of this style of programme	
Jenny Craig	4.3 Subsidiary questions	6	With regards to Maintenance, the Jenny Craig programme realises that in order to prevent weight re-gain after the end of a dieting period, clients still need to continue with behaviour change practices and physical activity. Further, it has a system in place which helps to control excessive intake such as continuing to watch portion sizes and monitoring intake and being mindful of what is in the food they are eating.	Thank you for providing this information.
Jenny Craig	4.3 general	6	The Jenny Craig menu features a variety of prepared meals and snacks which are convenient models for nutritional balance. Research has shown that portion-controlled pre-packaged meals can be more effective in helping people lose weight and reduce heart disease risk compared to people preparing their own meals on a conventional weight loss plan. *Hannum SM, Carson L, Evans EM, et al. Use of portion-controlled meals enhances weight loss in women. Obesity Res. 2004;12:538-546*	Thank you for providing this information and reference.
Jenny Craig	4.3 Subsidiary questions	6,7	NICE should encourage commissioners to appreciate that smaller scale reductions in weight than the 5-10% level can have significant public health benefits. NICE may need to show evidence of what smaller outcome measures actually mean to public health gain on a population level.	Thank you for this comment.
MEND	General		Please be aware that the health and fitness industry is very well positioned to be a channel for the delivery of community based adult lifestyle weight management interventions.	Thank you for providing this information. Please note that we will be

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			• 89% of the UK population live within 2 miles of one of the 6,500 health and fitness facilities in the UK • There are nearly 30,000 Registered Exercise Professional on the REPs register • Evidence shows us that exercise plays an important role in weight management but is ineffective on its own. Up skilling current exercise instructors to deliver effective evidence base programme provides a huge opportunity to help people learn in an "active" environment with activity options being easily accessible • There is also an opportunity to use these up skilled staff to then provide outreach activities in their local communities Please could you consider including the health and fitness sector as a potential valuable channel for the delivery of adult lifestyle weight management interventions. MEND has been commissioned by the NHS to deliver our multicomponent adult weight management programme in the health and fitness sector. We are happy to provide further information on request.	issuing a call for evidence once the scope has been finalised.
National Obesity Observatory	4.2	6	The term 'lifestyle' should be used carefully – some people think it has limited resonance with people from lower socio-economic groups	Thank you for raising this issue.
National Obesity Observatory	4.3	6	A key question (which is in here but a little buried) is how to maximise attendance and retention in such programmes. Many programmes are well designed and attract the right people, but if the attendance rate drops dramatically then they are deemed to be ineffective.	Thank you for this comment. This section has been amended for clarity.
National Obesity Observatory	4.3	6	It would be of interest to compare the relative effectiveness and cost effectiveness of commercial and non-commercial programmes.	Thank you for this comment.

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NHS Bolton	4.1	5	Groups covered:- Adults who are overweight or obese Will this include adults with physical disabilities or learning difficulties as these adults are more at risk of becoming overweight or obese? Guidance which includes these two groups is much needed.	Thank you for this comment. Obese adults with physical disabilities or learning difficulties are not excluded from this guidance and evidence will be considered for these groups as available.
NHS Bolton	4.3	6/7	Most healthcare professionals will not have time to be trained to any significant level in diet/weight management. Evidence around delivering brief advice should be noted here. It is likely that a high number of brief assessments and signposting interventions by frontline healthcare staff will result in a bigger uptake of support services. It is accepted that a majority of these assessments will not result in direct involvement with a more specialised weight management/dietry service. However, given the basic investment of time and training in the healthcare professional has not been large it is suggested that these interventions are likely to be cost effective. Those staff who have more reason to be more specialised in weight/dietry management can access more specialised training which can follow the brief advice training. The process being that all healthcare staff can at least deliver a basic intervention (every contact counts) and then those staff who spend more time with patients in addressing various issues can access further training and deliver more involved interventions. The second level of training can be promoted during the first brief level training.	Thank you for this comment. This guidance is specifically about multi-component lifestyle weight management. Brief interventions on diet, weight or physical activity per se are outside the remit of this guidance but are covered in existing NICE guidance on obesity (CG43) and behaviour change (PH6, currently being updated).
NHS Bolton	4.3	6/7	"What are the best practice principles for primary care when referring people to commercial, voluntary or self-help lifestyle weight management	Thank you for this comment. Issues around the local environment

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			programmes?" In relation to the above question. Although on the periphery of this consultation it is imperative that the environments in which the various weight loss/management interventions take place are considered in terms of suitability regarding the food and drink provision available. Many weight loss programmes are run in various locations in a community some of which are filled with energy dense foods. Not only does this energy dense food environment potentially undermine any weight loss activity on the day, it also undermines a more prolific message about how the environment can guide and support people to either eat an appropriate energy content diet or a high energy diet. The public health component must be considered as part of referral to or delivery of such programmes or the opportunity to normalise a lower energy value food and drink environment.	and wider determinants of obesity are outside the scope of this work but are included in range of other existing NICE guidance such as guidance on the prevention of CVD (PH25), prevention of type 2 diabetes (PH35) and guidance currently being developed on working with local communities (due to be published November 2012).
NHS Bolton	4.3	6/7	"How can more overweight and obese adults be encouraged to join, and adhere to, these programmes?" A key opportunity is through the National Child Measurement Programme and feeding back results to parents. Through programmes such as MEND (Mend Exercise Nutrition Do It) parents/carers are encouraged to reflect on their on dietary and physical activity levels and to make changes. This is an opportunity to tackle weight in the context of the whole family. "What are the best practice principles for primary care when referring people to commercial, voluntary or self-help lifestyle weight management?"	Thank you for raising this issue. Please note that parallel guidance is being developed on lifestyle weight management programmes for children.

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			To refer to programmes that follow the NICE Guidelines but ultimately there should be a range of programmes on offer giving the patient/client choice. Adherence to a programme is more likely to be successful if the patient chooses a programme which best meets their needs.	
NHS Derbyshire County	General		A weight management programme must be multi-component to avoid weight cycling or yo-yo dieting (which some commercial programmes provide). Lifestyle behaviour change in the long term is the goal. In Derbyshire we have introduced a model which integrates weight management programmes into local leisure services and have encouraged local providers to offer activities that will engage a wider audience, some being non-traditional for leisure services. The idea is that people will become engaged to change behaviour by accessing activities that will always be available, not just during a 12 week programme, therefore making it sustainable. Educational support is given regarding nutrition, energy expenditure, label reading etc. Follow up support is available for up to a year or beyond as the client accesses leisure services on an on-going basis.	Thank you for providing this information.
NHS Derbyshire County	General		The absence of sustainable physical activity through motivation support or access in commercial programmes is a major flaw	Thank you for raising this issue.
NHS Derbyshire County	4.3 Subsidiary questions – sustained change	6	Lifestyle changes and weight loss can only be sustained through linking into existing local models (such as leisure centres for access to physical activity and locally pertinent information regarding healthy eating). Access to support resources such as online support groups, local meetings, reinforcing information. A Utopian approach is often developed whereas realistic expectations of behaviour change should be recognised based upon the individual and where they live.	Thank you for raising this issue.
NHS Derbyshire County	4.3 Subsidiary	7	Cost effectiveness is difficult to present. Outcome based measures such as	Thank you for raising this

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	questions – Best practice principles for commissioners		throughput and completers of a 12 week course are not necessarily indicative of success. Long term success such as maintaining 5% weight loss at 1 and 2 years or lifestyle indicators such as physical activity or nutrition could be considered more indicative of success.	issue.
NHS Derbyshire County	4.3 Subsidiary questions – Primary Care	7	Best practice principles for primary care when referring are assessment of motivation, document baseline measures, information about the programme, providing consistent information and following up to document a clinical outcome achieved through the referral.	Thank you for these comments.
NHS Derbyshire County	4.3 Subsidiary questions - Training	7	Training needed for professionals directly involved with lifestyle weight management programmes for adults: Multidisciplinary – weight management, physical activity, nutrition, motivational interviewing, solution focused. Knowledge of local amenities, services, support groups, and access to physical activity is essential.	Thank you for these comments.
NHS Doncaster	4.3	6	As well as seeking the views of those engaged in programmes it would be important to identify views of those who don't engage and why. It would also be interesting to identify the impact of the weight status of those who are delivering information or sessions on the outcomes of those engaged in the programme.	Thank you for this comment, the scope has been amended.
NHS East Riding of Yorkshire	4.2.2	6	Bullet point 4 states that complementary therapies will not be covered. We feel it would be helpful to give examples as the draft scope for overweight and obese children and young people, lifestyle weight management services does.	Thank you for this comment. Complementary therapies include, for example, acupuncture, aromatherapy, hypnosis, herbal

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				products, homeopathic medicines, and Chinese medicines. The scope has been amended to give some examples.
NHS Gloucestershire	Appendix B	11	Useful to include in subsidiary questions a question that differentiates which interventions are most acceptable and effective by different degrees of obesity – e.g. assuming limited capacity of clinical services, which lifestyle interventions are most effective for those with BMI < 35 vs those with BMI > 35	Thank you for raising this issue. The scope as it stands does not preclude the PDG for considering this issue, depending on the evidence available.
NHS Gloucestershire	4.3	7	Under expected outcomes would be helpful to look at self-efficacy	Thank you, the scope has been amended.
NHS Gloucestershire	4.3	7	Under expected outcomes would be helpful to look at weight loss and maintenance of weight loss against baseline weight and against gradual weight gain, which would be expected to occur over time without intervening	Thank you for this comment. Any evidence available on longer term outcomes for programmes which meet the inclusion criteria will be considered. Weight maintenance per se is outside the remit of this guidance.
NHS North Somerset	4.12	5	Clarify that 'clinical treatment for obesity' includes prescribing orlistat.	Thank you for this comment. The scope

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				has been amended to give examples of clinical treatment (eg pharmacological or surgical treatment). Orlistat is therefore outside the remit of this guidance.
NHS North Somerset	4.3	6	A question should be added about the effectiveness and cost effectiveness of different programmes for different population groups, (including men, BME, low income, age groups etc) including what behavioural or psychological components work for different groups.	Thank you for this comment – the scope has been updated.
NHS North Somerset	4.3	6	What are the barriers and facilitators in encouraging different population groups to attend (and adhere to) lifestyle weight management programmes? For example, in our area NHS referral to commercial weight management organisations has been shown to deliver clinically significant weight loss for almost half those attending 1 or more session. However, only 14% of those who engaged with the scheme were men and the mean age of attendees was 47. This is a typical pattern for commercial 'slimming clubs'.	Thank you for this comment. The scope as it stands does not preclude consideration of this issue. Adherence is noted in this section.
NHS North Somerset	4.3	6	Add footnote to clarify what multi-component services need to include	Thank you for this comment. Multi-component lifestyle weight management is defined in section 4.2.1
NHS North Somerset	4.3	6	Separate out the second part of bullet point 2 of the subsidiary questions (*and who might best deliver theses*).	Thank you for this comment.
NHS North Somerset	4.3	6	Add a question about how outcomes vary be setting	Thank you – this issue is raised in appendix B,

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				potential considerations.
NHS North Somerset	4.3	6	Add a question about how outcomes vary by dose (frequency and duration)	Thank you – this issue is raised in appendix B, potential considerations.
NHS North Somerset	4.3	6	Bullet point 3. Add how views differ by subgroups (men, women, BME, socioeconomic status and age)	Thank you – this issue is raised in appendix B, potential considerations.
NHS North Somerset	4.3	7	Add economic modelling by sub-group (men, women, BME, socioeconomic status and age)	Thank you – this issue is raised in appendix B, potential considerations.
NHS North Somerset	4.2.2	6	Add 'diabetes' to 'such as cardiovascular disease'	Thank you for this comment, this section has been amended for clarity.
NHS South East Coast	4.1	5	Groups that will not be covered - Adults who are undergoing clinical treatment for obesity. 'Clinical treatment' needs to be defined somewhere. Does it refer to Orlistat and/or bariatric surgery?	Thank you for this comment. The scope has been amended to give examples of clinical treatment (eg pharmacological or surgical treatment). Orlistat and surgery are therefore outside the remit of this guidance.
Novo Nordisk	4.2.2	5	The draft scope states that adults who have other conditions which may or may not be related to their obesity will not be covered by this guideline. Patients with type 2 diabetes are cited as an example of such a group. In section 3 however the scope points out that 90% of patients with type 2	Thank you this comment. The wording of the draft scope is being amended to clarify this issue.

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			diabetes have a BMI>23 kg/m^2. There is a clear link between obesity and type 2 diabetes and therefore it is disappointing that a group of patients who are likely to receive significant benefits from lifestyle weight management services have been excluded from the scope of this guidance.	General issues around the participation of individuals with pre-existing conditions in lifestyle weight management will be considered in this guidance. The guidance excludes adults undergoing clinical management of obesity.
Royal College of Nursing	General		The Royal College of Nursing welcomes proposals to develop this guidance. It is timely. The draft scope seems comprehensive.	Thank you for these comments.
Royal College of Physicians (RCP)	4.1	5	'Other conditions which may or may not be related to their obesity' This excludes the vast majority of the overweight and obese population. Research (eg Counterweight – Br J Gen Practice 2005) has shown that prescribing costs are much higher in the obese and that 86% of obese individuals are on at least one drug treatment, mostly for obesity-related conditions. It is very doubtful that any of the published data will have excluded such individuals, so the evidence base for interventions in the group who have no illnesses is likely to be very small, and perhaps non-existent. This undermines the whole purpose of the guidance and again emphasises the point that it is impossible to separate 'lifestyle interventions' from 'clinical treatment' as they are completely interdependent.	Thank you this comment. The wording of the draft scope is being amended to clarify this issue. General issues around the participation of individuals with pre-existing conditions in lifestyle weight management will be considered in this guidance. The guidance excludes adults undergoing clinical

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				management of obesity.
Royal College of Physicians (RCP)	4.2.1	5	Pharmacological treatment is always part of a multi-component intervention and it is unsound not to include this (see above).	Thank you for this comment. The pharmacological treatment of obesity is covered by existing NICE guidance on obesity (CG43).
Royal College of Physicians (RCP)	4.3	6	While (cost) efficacy might trap a 'summary' of benefit the difficulties lie in the definitions of efficacy. These may be weight-related, but are better defined by more direct health outcomes. There are potential confounders of using an economic outcome – eg the infertile woman who becomes eligible for assisted conception. Definition of 'meaningful' outcomes is critical and may be hard to extract from some existing datasets which have (eg in the commercial sector) tended to exclude those with significant concomitant illness or disease.	Thank you for raising these issues, which may be debated by the PDG depending on the evidence available.
Royal College of Physicians (RCP)	4.3	7	Short, medium and long-term need to be defined to give meaning.	Thank you for raising this issue. The precise definition of short, medium and long term will be an issue for the PDG to consider and is likely to be discussed in the final guidance.
Slimming World			Slimming World welcomes the development of this public health guidance	Noted.
Slimming World	3, d	3	The details given here on Slimming World are not up to date. Please correct and update as following. Slimming World states that 400,000 members attend	Thank you for this clarification. The scope

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			their 7,750 weekly groups in the UK and Ireland. Their Slimming World on Referral service has run with over 70 NHS Trusts in England (Reference, Slimming World website http://www.slimmingworld.com/press/press-about.aspx)	has not been amended as the figures for UK only are probably more applicable to NICE public health guidance which is for England only.
Slimming World	4.1.2	5	We are concerned that 'adults who have other conditions which may or may not be related to their obesity (such as type 2 diabetes)' is a group that will not be covered by this guidance. In reality many people who access weight management programmes have other conditions and should not be excluded from this guidance. In fact many people improve their symptoms or management of the condition through managing their weight. There is a risk that through the guidance excluding this group, health professionals may not offer patients this type of support as a result. While the management of these conditions may not be covered in this guidance, support for weight management should not be excluded.	Thank you this comment. The wording of the draft scope is being amended to clarify this issue. General issues around the participation of individuals with pre-existing conditions in lifestyle weight management will be considered in this guidance. The guidance excludes adults undergoing clinical management of obesity.
Slimming World	4.3	6	Subsidiary questions. What are the views, perceptions and beliefs of adults who use weight management programmes? We have some published data from our initial feasibility work looking at both patient and health professional views. Some of the findings feature in the published paper (Lavin et al, 2006, Public Health) but we also have further findings which are written up in a report which is available on request.	Thank you for these comments and reference – the scope as it stands does not preclude consideration of these issues.

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Slimming World	4.3	7	Expected outcomes. Alongside changes to diet and activity and resulting weight loss, positive changes to mental wellbeing and self esteem can also be seen from attending weight management programmes and should be considered as an expected outcome in the same way that it has been identified in the scope for the children and young people's guidance.	Thank you for these comments, the scope has been amended.
Weight Concern	Appendix **B**	11	We strongly agree with the need to consider outcomes of lifestyle weight management programmes in subsections of the population-for example, ethnic minority groups, older adults, men and adults with learning disabilities, where obesity prevalences are higher than the general population and appropriate services may be lacking. Highlighting known barriers to the implementation of lifestyle weight management programmes in these groups could still be useful for healthcare providers, even if evidence is insufficient at this stage to provide specific guidance.	Thank you for these comments.
Weight Concern	**4.1.2**	5	Guidance on lifestyle weight management services may also be relevant and beneficial for those receiving clinical treatment for obesity, or those with related conditions-perhaps this group should not be excluded in this document, as practitioners will find it increasingly difficult to know where to find the most appropriate guidance for their patients.	Thank you this comment. The wording of the draft scope is being amended to clarify this issue. General issues around the participation of individuals with pre-existing conditions in lifestyle weight management will be considered in this guidance. The guidance excludes adults

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				undergoing clinical management of obesity.
Weight Concern	4.3	6	Guidance for health professionals in how to raise the issue of weight with their patients and best practice in weight-related terminology is also needed. There is a growing body of research in this area, considering patient experiences and the impact of patient –healthcare provider interactions on future behavioural intentions. Weight related discrimination is common, even in healthcare settings and can create a barrier in health-promoting activities. For example, see: *Volger et al. Patient's preferred terms for describing their excess weight: Discussing Obesity in clinical practice. Obesity (2012); **20** 1, 147–150.* *Lewis et al. How do obese individuals perceive and respond to the different types of obesity stigma that they encounter in their daily lives? A qualitative study. Soc Sci Med, 2011; 73(9):1349-1356.*	Thank you for raising this issue and the references provides.
Weight Concern	4.3	6	It is important to define weight loss maintenance and the principles that could support adults to maintain their weight. Studies tend to report mixed results for weight loss and weight loss maintenance. This issue needs to be addressed and the guidelines for weight loss maintenance should be clearly separated from weight loss guidelines – it is essential to define weight loss maintenance when developing the guidelines and searching the evidence reported from studies.	Thank you for these comments. The PDG are likely to discuss maintenance in some detail and to clearly define. Longer term studies that meet the inclusion criteria and

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				allow consideration of maintenance are likely to be considered. Weight maintenance per se is outside the remit of this guidance.
Weight Concern	4.3	7	There is an urgent need to explore how the aims of commercial weight management programmes differ from those provided in the NHS or voluntary sector. Greater scrutiny should be applied to compare the long term physical and psychological outcomes of commercial and non-commercial programmes, including the ability of participants to self-manage their condition, without repeated re-entry into lifestyle programmes.	Thank you for raising this issue. Commercial considerations will be taken into account.
Weight Concern	4.3	7	Where possible, changes in diet and physical activity should be supported by objective measures rather than self-report alone.	Thank you for this comment.
Weight Management Centre Ltd	General		**The need for evidence** The evidence base relating to (Community Weight management programmes (CWMP's) is far from complete with little robust data on programme design and content, other than perhaps guidance on duration of programme. Efficacy of programmes differs widely from programme to programme, and using this information better could prove invaluable. Such data does exist (albeit not in the form of the RCT) but in the form of independently verified results. Where programmes operate, commissioners may have to satisfy themselves that the efficacy of the programme can be verified by reliable sources other than RCT's. Currently this should be (and is) achievable as PCT's commissioning such programmes independently review and verify data, which should provide	Thank you for raising these issues.

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			sufficiently robust information upon which to commission. Certainly this is the case for all seven programmes that we provide to PCT's were the outcome data and client results is rigorously scrutinised, and independent sampling of client results is routine. All of this is published on our web site for anyone to read and the commissioning PCT's to challenge if they disagree. Building the evidence base for CWMP's may have to forgo the rigour of the RCT in favour of a national data bank of verifiable (by each PCT) programme efficacy. All organisations providing such services should be required to publish their (independently verified) data via their web site in order that any commissioner, prospective client or other interested party could determine if this programme was suitable for them. Perhaps NOO could offer a light touch data and client sampling inspection service that providers could buy into in order to publish on line results. Such as system would also allow the development of a sub-prime data base that would also provide realistic expected outcomes rather than the aspirational outcomes that are often found in many tender specification documents. This then should be a requirement for all commissioned services. If providers are not willing to make public their results, then this should exclude them from the process.	
Weight Watchers (UK)Ltd	d	3	Please note: Weight Watchers is not one word. In order to give you the most up to date figures of scale and coverage of Weight Watchers please see below: Weight Watchers is the world's leading provider of weight management services. On any given week, approximately 1.3 million members attend over 50,000 meetings in 30 countries. Providing comprehensive weight	Thank you for this clarification (the scope has been amended) and background information.

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			management services to the British public for over 45 years. With 1,800 passionate, expert Leaders, each of whom has lost weight with the Weight Watchers programme; in 2011 they hosted over 1.9 million member visits, at meetings throughout the week in over 5,000 different locations around Britain. Since 2005 Weight Watchers have provided weight loss services to over 100 Primary Care Organisations and Local Authorities in England with over 2,000 GP practices making patient referrals into their programme, with research sites in Scotland and Wales. *(Note to NICE team: Please note that these figures are correct as of December 2011 and will be subject to change. To ensure up to date figures, I will formally respond to the draft guidance with associated updates).*	
Weight Watchers (UK)Ltd	e	4	Suggested addition to the following sentence: *However, it remains unclear whether such strategies are as effective in a non-clinical setting,* or indeed what outcomes (either weight loss or behavioural outcomes) a commissioner should expect to reasonably achieve when referring patients to providers of lifestyle based weight management services'. Presently there is no national guidance on realistic outcomes which commissioners of health services for local populations should specify from adult weight loss programmes that meet NICE Best Practice Guidance. It is recommended that the guidance which NICE is preparing to formulate should extend its scope to include consideration of this issue of outcomes. The current lack of clear guidance to commissioners is translating to a lack of realism in desired outcomes: Commissioners often ask for outcomes which are not realistic when you consider the best available evidence. For example; outcomes focused on unrealistic 'intention to treat' (ITT) completion rates and	Thank you for raising this point, which has been noted. The scope as it stands does not preclude consideration of this issue.

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			proportions of referrals who achieve a 5% weight loss. This can prevent effective providers from tendering for contracts and ultimately sets up the strategy to fail. Research into weight management interventions has tested a range of interventions of different length and intensity which deliver different outcomes. Commissioners need to consider their desired outcomes and then match the best intervention length and intensity. For example some commissioners are asking for better and better outcomes from the same intervention; not necessarily acknowledging that (or indeed being able to fund) the intervention length or intensity needs to be adapted in order to realistically deliver the outcomes they are demanding..	
Weight Watchers (UK)Ltd			(cont'd) Under the section associated with expected outcomes, please see references below which relate to the outcomes from the Weight Watchers weight loss programme in general: ▪ A Review of an Evidenced-Based Weight-Loss Solution in France. S Rost, K Miller-Kovach. *Obesity Reviews* 2011 12(Suppl.1):234. ▪ A Review of an Evidenced-Based Commercial Weight-Loss Solution in Germany. S Mickelat, U Gerwig, K Miller-Kovach. *Obesity Facts* 2010; 3 (Suppl 1):S53. ▪ Greater improvements in diet quality in participants randomised to a commercial weight loss programme compared with standard care delivered in GP Practices. M. I. Eberhard and A. D. Olson and G. L. Ambrosini and A. L. Ahern and I. Caterson and H. Hauner and S. A. Jebb. Proceedings of the Nutrition Society, Volume 70, Issue OCE4, January 2011, pp E252. doi: 10.1017/S002966511100303X,	Thank you for providing these references.

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			Published online by Cambridge University Press 14 Oct 2011 ▪ Changes in Dietary Energy Density With Participation in a 12-Week Weight Loss Trial Using a Commercial Format. P O'Neil, G Cronan, T Turner, L Nance, R Malcolm, S Pechon, S Rost, K Miller-Kovach. *Obesity* 2010; 18 (Suppl 2):S96. ▪ Nutritional Correlates of Energy Density Before and During a 12-Week Weight Loss Trial. P O'Neil, G Cronan, T Turner, L Nance, R Malcolm, S Pechon, S Rost, K Miller-Kovach. *Obesity* 2010; 18 (Suppl 2):S96 ▪ Changes in Cardiovascular Risk Factors with Participation in a 12-week Weight Loss Trial Using a Commercial Format. V Milsom, R Malcolm, G Cronan, S Pechon, K Miller-Kovach, S Rost, PM O'Neil. *Obesity Reviews* 2010; 11 (Suppl 1):S244. ▪ Early Results of a Commercial Weight-Loss Service in China. K Miller-Kovach, S Jin. *Obesity Reviews* 2010; 11 (Suppl 1):S406. ▪ Outcomes of Providing a Scalable Weight-Loss Service in Spain. Z Hellman, K Miller-Kovach. *Obesity Reviews* 2010; 11 (Suppl 1):S249 ▪ Evaluation of Weight-loss Diets on Glycemic Index, Glycemic Load, Body Mass Index and Insulin Resistance. V Nguyen, L Zukley, J Brosnahan, A Summers, J Lowndes, T J Angelopoulos, JM Rippe. *The FASEB Journal* 2007; 21(5):A694. ▪ Reducing the Risk of Diabetes: The Effects of a Commercial Lifestyle Modification Weight-loss Program on Glucose Tolerance and Insulin Sensitivity. J Lowndes, L Zukley, P Lopez, M Paul, T Angelopoulos, J Rippe. *FASEB* 2006; 20(4):A585.	
Weight Watchers (UK)Ltd	General		When considering the cost effectiveness of community based weight management interventions it may be useful for future commissioners to have	Thank you for raising this issue.

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			comparative figures with lifestyle weight management interventions delivered via the traditional medical model (those interventions developed and delivered by healthcare professionals within the healthcare setting). *For example; A 12 community based meetings course supported by 16 weeks of online tools from Weight Watchers (which on average achieves a BMI drop in all referrals of 1.7 BMI units at 12 month follow up) costs the NHS £48.50 per patient. A single individual 12 minute consultation with a GP costs £36 and with a practice nurse £10 (Curtis, 2009).*	
Weight Watchers (UK)Ltd	General		Weight Watchers strongly supports the development of insights, with clear and concise data on return on investment from adult lifestyle weight management programmes. This is something that would inform not only commissioning decisions, but budget assignment at a high level for lifestyle weight management and which is currently lacking; contributing to the wide scale issue of a significant lack of funding in weight management across the country.	Thank you for this comment.
Weight Watchers (UK)Ltd	General		In order to help this guidance to better promote equality of opportunity relating to age, gender, ethnicity and socio-economic status it is recommended that the scope include analysis of how effective providers of lifestyle based weight management services are for different groups. It is often a mis-perception for example that Weight Watchers is not as effective for men as it is for women; creating an unsubstantiated drive to develop or commission alternative services from other providers that may not be as effective for the patient.	Thank you for this comment. These issues are flagged in appendix B, potential considerations
Weight Watchers (UK)Ltd	General		Weight Watchers philosophy is to provide a weight loss system including all	Thank you for providing this background

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			the tools, support, motivation and inspiration to help people lose weight and keep it off. Research indicates that continued support is a vital component of effective weight maintenance and this is why Weight Watchers has a 'Gold Member' policy. When members reach a healthy weight (BMI 20-25) or the Special Goal Weight agreed with their qualified health professional, their Weight Watchers membership is free of charge for the rest of their lives as long as they maintain a weight within 5lbs of their Goal. This membership is offered to all members regardless of whether they self funded or were referred by the NHS or Local Authority. Based on Weight Watchers commissioning experience the PDG will need to address the strategic tensions around the purpose of weight management interventions. In other words, commissioners will be faced with numerous questions. Should commissioners target those at high risk of ill health and commission interventions that deliver medically significant weight loss by programme end to achieve the greatest immediate ROI? Or, should commissioners target all those who have an unhealthy weight and commission interventions that support them to achieve and then maintain a healthy weight? Or, anything in-between these polar opposites. There are models of Weight Watchers being commissioned for both across Britain.	information.
Weight Watchers (UK)Ltd	General		It is acknowledged that, with 61.3% of the English adult population overweight or obese, it is recommended that the scalability of interventions need to be considered when evaluating options available to the NHS and Local Authorities. Locality wide, accessible services are desired. Do interventions have evidence of how they deliver to desired outcomes when applied in routine practice at scale? Do interventions lose effectiveness if they are scaled	Thank you for raising this issue. The scope as it stands does not preclude consideration of this point.

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			up to meet the needs of a locality?	
Weight Watchers (UK)Ltd	4.2.1	5	Note to NICE team: Weight Watchers primary services are delivered within the community setting; with 5,000 different community locations around Britain with meeting times every day of the week and throughout the day. However Weight Watchers also deliver services within the workplace and within primary care settings (for example within a GP practice or health centre). The package which is currently offered to the NHS and Local Authorities is a package of 12 group meetings supported by 16 weeks of access to their online platform; providing instant, round the clock access to weight management tools, advice, information and inspiration and mobile apps**.**	Thank you for providing this background information.
Weight Watchers (UK)Ltd	4.3	6	Please note: The following published, peer reviewed evidence demonstrates the (cost) effectiveness of Weight Watchers 12 week intervention for the NHS: ▪ Brown, M and McPherson, K (2009) Computer modelling the health and economic consequences of the Weight Watchers GP referral scheme. Obesity Facts, 2, (Supp 12) ▪ Trueman, P and Flack, S. Economic evaluation of Weight Watchers in the prevention and management of obesity 2006: Poster presentation at the Conference of the National Institute of Health and Clinical Excellence ▪ Jolly et al (2011) Comparison of range of commercial or primary care led weight reduction programmes with minimal intervention control for weight loss in obesity: Lighten up randomized controlled trial. *BMJ.* 2011 Nov 3;343.	Thank you for providing these references.

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Weight Watchers (UK)Ltd	4.3	6	In response to the question regarding who might be best to deliver lifestyle weight management programmes: Weight Watchers methodology is based on peer-peer group support. All Weight Watchers Leaders have lost weight with the programme and therefore are strong role models. Weight Watchers Leaders are trained as 'change agents' to deliver the Weight Watchers programme. This programme is centrally developed and stewarded by credentialed scientists and qualified health professionals registered with the Health Professions Council (HPC). All Leaders have an internal central support system to keep them up to date and help them address any technical issues which arise. As part of this they have direct access to a health professional registered with the HPC. All Weight Watchers Leaders have a programme of ongoing CPD, with regular training throughout the year and a system of performance management. Weight Watchers have strict approvals processes, to ensure everything they do and say is credible, healthy and based on peer reviewed published evidence. All materials which are released by the company, be it weight management programmes, training programmes for Leaders, magazine content, online and retail platforms and any marketing or press activity, is first approved by a qualified health professional registered with the HPC. In addition strict policies and procedures are in place to protect the health and safety of all members, with specific controls in place around level and rate of healthy weight loss and to restrict access by high-risk groups, including children and pregnant women.	Thank you for providing this information.
Weight Watchers (UK)Ltd	4.3	6	There is a wealth of published data which documents the perceptions, views and beliefs adult users of Weight Watchers services. Some of these studies	Thank you for providing these references.

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			provide insight into ways of improving recruitment and adherence: ▪ Early Results of a Commercial Weight-Loss Service in China. K Miller-Kovach, S Jin. *Obesity Reviews* 2010; 11 (Suppl 1):S406. ▪ Outcomes of Providing a Scalable Weight-Loss Service in Spain. Z Hellman, K Miller-Kovach. *Obesity Reviews* 2010; 11 (Suppl 1):S249. ▪ Patient Weight Counseling Choices and Outcomes Following a Primary Care and Community Collaborative Intervention. DB Wilson, RE Johnson, RM Jones, AH Krist, SH Woolf, SK Flores. *Patient Educ Counseling* 2010; 79(3): 338-343. ▪ Patient Costs as a Barrier to Intensive Health Behavior Counseling. AH Krist, SH Woolf, RE Johnson, SF Rothemich, TD Cunningham, RM Jones, DB Wilson, KJ Devers. *Am J Prev Med* 2010; 38(3):344-348. ▪ An Electronic Linkage System for Health Behavior Counseling. Effect on Delivery of the 5A'. AH Krist, SH Woolf, CO Frazier, RE Johnson, SF Rothemich, DB Wilson, KJ Devers, W Kerns. *Am J Prev Med* 2008; 35(Suppl 5):S350-S358. ▪ Using Online Tools in Conjunction with a Comprehensive, Group-Based Weight Loss Plan Enhances Outcomes. V Nguyen, A Summers, J Brosnahan, L Zukley, J Lowndes, T Angelopoulos, J Rippe. *Obesity* 2007; 15 (Suppl 9):A221. ▪ Regular Meeting Attendance as Part of a Comprehensive Weight-	

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			Loss Program Decreases Insulin Resistance and Body Weight. L Zukley, V Nguyen, A Summers, M Paul, J Brosnahan, R Alvarado, J Lowndes, N Meade, D Knapp, TJ Angelopoulos, JM Rippe. *Obesity* 2006; 14 (Suppl):A252. ▪ Regular Attendance Enhances Results in a Comprehensive Weight-Loss Program. L Zukley, J Lowndes, V Nguyen, T Angelopoulos, J Rippe. *Diabetes* 2006; 55(Suppl 1):A518.	
Weight Watchers (UK)Ltd	4.3	6	Please note the following pieces of evidence to demonstrate how changes in behaviour are sustained after a Weight Watchers programme has ended: ▪ Comparison of range of commercial or primary care led weight reduction programmes with minimal intervention control for weight loss in obesity: Lighten up randomized controlled trial. K Jolly, A Lewis J Beach, J Denley, P Adab, JJ Deeks, A Daley, P Aveyard. *BMJ.* 2011 Nov 3;343. ▪ Weight-Loss Maintenance 1, 2 and 5 Years after Successful Completion of a Weight-Loss Programme. MR Lowe, TVE Kral, K Miller Kovach. *British Journal of Nutrition* 2008; Apr;99(4): 925-930. ▪ Long-Term Follow-Up Assessment of Successful Dieters in a Commercial Weight-Loss Program. MR Lowe, J Thaw, K Miller-Kovach. *International Journal of Obesity* 2004; 28 (Suppl 1):S29.	Thank you for providing these references.
Weight Watchers (UK)Ltd	4.3	7	In relation to the question: What are the best practice principles for primary care when referring people to commercial, voluntary or self-help lifestyle weight management programmes? Weight Watchers would encourage NICE to undertake outreach to establish case studies of models that work in primary	Thank you for this comment. NICE will seek expert testimony for this guidance, based on PDG

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			care: Seeking expert testimony. There is perhaps little published evidence at present to demonstrate best practice principles, yet there are certainly many commissioners and health professionals across the country who are working on the ground and delivering excellent services to their patients. Best practices may include considerations such as: ▪ How to make commissioning decisions for adult lifestyle weight management services ▪ What outcomes should a commissioner reasonably expect to achieve in their target populations ▪ What should referring health professionals do to maximise adherence to weight management interventions ▪ How health professionals should raise the issue of weight and create motivations to change ▪ How should health professionals assess readiness to change ▪ How to target recruitment from areas of greatest deprivation to tackle health inequalities. ▪ How much service choice should patients be offered at tier 1 and tier 2 based on the risk of offering interventions that deliver poorer outcomes for the patient ▪ The best and most efficient processes for referral into providers (Recommendations to a provider, facilitated referrals or signposting to a 'hub' centre for assessment and personalised recommendations for available providers) ▪ How to work in partnership with providers to ensure ongoing development of services and effective and safe patient communications to support each patient in a seemly way. ▪ Inclusion / exclusion criteria ▪ Referral pathway options	discussion and evidence gaps identified by the commissioned evidence reviews. NICE will also undertake a call for evidence once the scope has been finalised.

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			▪ What service assurances needs to be in place, such as health and safety and Information governance requirements ▪ The most useful and efficient evaluation processes: How and when to evaluate to ensure ongoing development of services ▪ How often should health professionals follow up patients after referral to weight management interventions It is recommended throughout this that it is very clear what are the reasonable responsibilities of the provider of adult lifestyle weight management services and what are the responsibilities of the local health environment and the commissioner. Recommended evidence to examine one type of service model: ▪ Comparison of range of commercial or primary care led weight reduction programmes with minimal intervention control for weight loss in obesity: Lighten up randomized controlled trial. K Jolly, A Lewis J Beach, J Denley, P Adab, JJ Deeks, A Daley, P Aveyard. *BMJ.* 2011 Nov 3;343.	
Weight Watchers (UK)Ltd	4.3	7	In consideration of the question: What are the best practice principles for commissioners of lifestyle weight management services for adults? Please refer to the work currently underway by the DH Obesity team in this area, which aims to establish 'off the shelf 'service specifications, guidance and quality indicators to help commissioners to understand the complexities of weight management, establishing a bar for good quality providers and establishing, on the best available evidence; what outcomes (completion rates, weight loss levels and % of all referrals that may achieve ≥5% of initial	Thank you for highlighting this issue.

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			weight loss) commissioners can reasonably and realistically expect from adult lifestyle weight management programmes of a certain length and intensity. Weight Watchers would encourage commissioners of adult lifestyle weight management services to focus on the demonstrable outcomes that potential providers deliver. There is a difference between a programme being 'evidence based' and meeting NICE Best Practice Standards and a programme having good quality data of its demonstrable outcomes when delivered within a community at scale. Commissioners should demand evidence of how providers deliver to desired outcomes before commissioning the programme.	
Weight Watchers (UK)Ltd	4.3	7	Under the section associated with expected outcomes, it is encouraged that this guidance recognise that there are different levels of outcomes which adult lifestyle weight management programmes may be commissioned for and with this it's likely that there is a need for different levels of intervention length or intensity. Outcomes may include but are not exclusive to: ▪ Immediate risk reduction: A medically significant level of 5-10% weight loss at programme end (e.g. 12 weeks) ▪ Sustained risk reduction: Sustaining a medically significant level of 5-10% weight loss at the 12 months follow up ▪ Supporting prevention of type 2 diabetes ▪ BMI change from obese to overweight to a healthy weight ▪ Cost per kg lost ▪ Cost per success (i.e. cost per 5% weight loss) It is recommended that this new guidance should be very clear on the outcomes which interventions are aimed to achieve, as each question and assessment is made on it. Under the section associated with expected outcomes, please see references	Thank you for raising this issue and the references provided. Section 4.3 flags that a broad range of outcomes will be considered and this is likely to be a topic of discussion for the PDG, depending on the evidence available.

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			below which relate to the outcomes from Weight Watchers working together with healthcare professionals: ▪ Comparison of range of commercial or primary care led weight reduction programmes with minimal intervention control for weight loss in obesity: Lighten up randomized controlled trial. K Jolly, A Lewis J Beach, J Denley, P Adab, JJ Deeks, A Daley, P Aveyard. *BMJ.* 2011 Nov 3;343 ▪ Primary care referral to a commercial provider for weight loss treatment versus standard care: a randomised controlled trial. SA Jebb, AL Ahern, AD Olson, LM Aston, C Holzapfel, J Stoll, U Amann-Gassner, AE Simpson, N Fuller, S Pearson, NS Lau, AP Mander, H Hauner, I Caterson. *Lancet*. 2011. September 7. ▪ Weight Watchers on Prescription: An Observational Study of Weight Change among Adults Referred to Weight Watchers by the NHS. AL Ahern, AD Olson, LM Aston, SA Jebb. *BMC Public Health* 2011, 11:434. ▪ Weight Reduction for Overweight Patients Improves if a Commercial Weight Reduction Program is Recommended by the Patient's General Practitioner. C Holzapfel, J Stoll, AL Ahern, AD Olson, LM Aston, A Simpson, S Pearson, N Fuller, I Caterson, SA Jebb, U Amann-Gassner, H Hauner. *Obesity Facts* 2010; 3 (Suppl 1):S26. ▪ Dixon K et al (2011) Evaluation of weight loss outcomes for obese adults referred to a choice of three commercial weight management providers. South West Public Health Scientific Conference.	
Weight Watchers (UK)Ltd	4.3	7	Defining the 'Maintenance of weight loss in the short, medium and long term' in terms of time would be useful. 'Long term' is currently classed as 12 months, but there is often a disconnect between this and the aspirations of health improvement commissioners who are thinking about 5, 10 years down	Thank you for raising these issues. Short, medium and longer term interventions that meet

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			the line, which is absolutely valid but at odds with the current advice of 'long term weight maintenance' as being measured at 12 months. Across the country some commissioners are asking for short term interventions that have been developed to deliver medically significant levels of weight loss in order to reduce health risks, to deliver weight loss which is maintained over very long periods of time, such as 5 years. The current literature demonstrates that obesity is a chronic issue; with continued support delivering continued weight management benefits, whilst commissioners are wanting to achieve this very long term sustained weight loss in perhaps very short interventions. What is the length of time that commissioners can expect different levels of weight loss to be maintained in the absence of a continued weight management programme?	the inclusion criteria for this guidance are likely to be considered, depending on the evidence available. The precise definition of short, medium and long term will be an issue for the PDG to consider and is likely to be discussed in the final guidance.