NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Obesity: prevention and lifestyle weight management in children and young people.

Date of Quality Standards Advisory Committee post-consultation meeting:
4 September 2014.

2 Introduction

The draft quality standard for obesity: prevention and lifestyle weight management in children and young people was made available on the NICE website for a 4-week public consultation period between 10 July and 7 August 2014. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 34 organisations, which included service providers, national organisations, professional bodies and others.

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

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

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

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

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

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

4 General comments

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

- Clarity needed over the age ranges included in the quality standard.
- Clarity over which management strategies are excluded.
- Suggested changes to the introduction include
  - highlighting particular groups prone to being overweight.
  - non-alcoholic fatty liver disease alongside diabetes, heart disease and cancer
  - highlighting the potential role of genetics as well as lifestyle and environmental factors for children who are obese with parents who are obese.

  - Figures on the problems obesity causes such as mortality.
  - Stronger focus on the importance of the whole family approach.
  - Defining overweight and obesity in children.
- Concern about some of the subjective terminology which may affect implementation of the standard.
- Suggestion that the QS will work if supported by the obesity prevention and management lead and team with one data set and one system.
- No mention of the legal duties in the Health and Social Care Act 2012 to reduce inequalities or highlight sufficient focus of action in deprived areas.
- Promotion of plant stenols.
- Suggestions for inclusion of other evidence sources and policy context references.
- Outcomes suggested
    - increased life expectancy
    - prevention of chronic diseases for example type 2 diabetes, stroke, and IHD
    - decrease health inequalities
    - provide cash savings for NHS/ Board/ Local Authority
    - food education alongside diet
    - more examples of how it relates to the public health outcomes framework and how is it affected by the refresh.

Consultation comments on data collection

- Data collection felt to be feasible in theory.
- Suggestions to develop tighter specifications for the measures for comparison purposes.
- Concerns over local resource needed, both financial and human and the general move away from national indicators and performance management models.
- Concern over the fragmentation of settings for any national survey.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Local authorities and their partners in the community provide and promote healthier food and drink choices at local authority venues used by children and young people.

Consultation comments

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

- Suggestion to expand the statement to include
  - front of packet labelling
  - full potential of local authorities in creating opportunities for healthy eating for example influencing planning for fast food outlets, advertising, regulation, reviewing catering contracts
  - all catering including vending machines and those delivered by third parties
  - all settings used by children and young people and not just those where physical activity takes place.
  - areas in and around venues used by children and young people.
- Suggestions for stronger wording in the statement
  - actively promote
  - accessible and affordable
  - food provided meets a minimum standard as it currently implies less healthy choices will also be available.
- Definition of promotion to include free availability of water.
- Include age-appropriate portion sizes with staff awareness.
- Structure measure – suggestion to look at provision of unhealthy food.
- Concerns over implementation of statement including commercial concerns

5.2 Draft statement 2

Head teachers and chairs of governors, in collaboration with parents and pupils, assess the school environment and ensure that the school's policies encourage

children and young people to maintain a healthy weight, eat a healthy diet and be physically active.

Consultation comments

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

- Broaden statement to include early year's settings, school ethos, teaching practice and whole school action and training to empower parents.
- Further definition of school environment, should it include built and natural as well as the area around the school?
- Include a named responsible person.
- More detail suggested on what should be assessed and its evidence base and signposting to resources.
- Active travel to schools should be linked to complementary NICE guidance and are often outside the schools remit.
- Further emphasis on nutritious school food within independent and academy schools which do not have a statutory requirement to comply with Government standards.
- Implementation concerns about
  - time availability of head teachers and what can realistically be expected from schools.
  - burden of data collection and who collects it.
  - commercial pressure in relation to food choices.
  - audit template would be useful.
- Definitions – include tuck shops, breakfast clubs under catering and free availability of water as well as school lunch policy for packed lunches, nutrition and food preparation skills. Include walking and cycling.
- Measures are currently too narrow - suggested outcome on establishment of healthy habits for adult life, further measures on participation of PE lessons and minimum times for physical activity, food and drink available outside of mealtimes
- Check data sources for accuracy.

5.3 Draft statement 3

Local authorities and their partners in the community develop a coordinated local physical activity strategy to promote the benefits of physical activity, highlight the risks of sedentary behaviour and increase the opportunities for children and young people (and their families and/or carers, as appropriate) to be physically active.

Consultation comments

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

- More emphasis on importance of developing enjoyment of physical activity in early years and the role of parents in this.
- Coordination and integration of different departments for example transport, urban design, health and social care
- Further definition of physically active needed.
- Increasing opportunities should be accessible and affordable to all families e.g. cost of participating with some sports for example swimming for larger families
- More explicit about the need to reduce sedentary time and active play and how it will be measured.
- Referencing of the CMO recommendations.

5.4 Draft statement 4

Local authorities and their partners in the community raise awareness of lifestyle weight management programmes among the public, healthcare professionals and other professionals who work with children and young people.

Consultation comments

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

- Suggestion for one nationwide programme (applies to statements 4-6).
- Include healthy eating programmes for children at risk of obesity.
- Suggestions to raise awareness of other interventions e.g. healthy eating, lifestyle.
- It was highlighted that local authorities will need procedures in place to assess the suitability of programmes.
- Include children and young people after programmes to differentiate from adults.

- National campaign suggested for implementation.
- Named lead suggested for dissemination.
- Definition of programmes should not include ‘and/or’.
- Highlighted the importance of healthcare professionals in referring children and young people and top–down responsibility.
- Suggestion to ensure sufficient evidence-based programmes are commissioned and services are integrated rather seeing each other as competition.
- Role for community pharmacists for this statement.
- More focus needed on outcomes rather than process.
- Highlighted that programmes should be age-appropriate and include information that is culturally and ethnically appropriate.

5.5 Draft statement 5

Lifestyle weight management programme providers encourage family members to be involved.

Consultation comments

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

- Statement needs to be situated in the wider context of public health and social marketing so parents can recognise when their children are overweight or obese.
- Statement stricter on family involvement especially for young children e.g. cooking classes
- Acceptance of flexibility of what ‘involving the family means’ for example parents with several children may not be able to attend every session, needs to include other opportunities e.g. parent conferences, awareness days, drop in centres.
- Safeguarding procedures needed for families not engaging and guidance for workers.
- Include support for overweight adults.

Definitions:

- Suggestion to include the main core components and their accuracy.
- Suggestion to include how to cook cheap food and buy food cheaply.

- Wording of definition around if the family recognises that their child is overweight or obese.

Measures

- Outcome a) and b) remove ‘feel that’ as they either have or haven’t taken an active role/understand the aims and objectives.
- Concern that subjective outcome measures may not be collected due to lack of resources.

5.6 Draft statement 6

Commissioners and providers of lifestyle weight management programmes monitor and evaluate the programme and use the information to amend and improve it.

Consultation comments

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

- Relationship and overlap with exercise referral schemes.
- Suggestion to specify the length of the programme.
- Concerns over resources available for monitoring and evaluation.
- Commissioner audience descriptor – suggested change of audience to public health teams and other local authority commissioners.
- Reference the Standard Evaluation Framework for Weight Management Interventions.

Measures:

- Add measure on decommissioning of programmes that aren’t effective.
- Process measure a), locally the number of programmes would be small.
- Suggestion to measure children at 1 year who did not complete the programme.
- Difficulties in maintaining measures at 6 months and 1 year with a lack of funding.
- Strengthen measures to improve monitoring of inequalities in access, uptake, treatment and readmissions.
- Include outcome measures on psychological outcomes e.g. quality of life, anxiety and depression as well as BMI and physical outcomes.

6 Suggestions for additional statements

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

- Early start to obesity prevention
  - Antenatal programmes and parental obesity in pregnancy
  - Promoting breastfeeding and breastfeeding support
  - Baby-friendly/breastfeeding friendly facilities
  - Complementary feeding for infants specifically cereal based foods
  - Restricting marketing and advertising to children
  - Parenting skills and good food education especially for babies and toddlers to cover budgeting, shopping and cooking.
- Regulating food market.
- Overarching food strategy similar to the physical activity strategy in statement 3.
- Interventions for family members and carers who are overweight or obese.
- Minimum standards for physical activity in schools.
- Local authorities approving planning applications for fast food outlets especially those close to schools.
- More regular monitoring of children's weight throughout school years.
- Access to mental health services.
- Monitoring and evaluating obesity prevention initiatives.

Appendix 1: Quality standard consultation comments table

ID	Stakeholder	Statement No	Comments[1]
1	British Heart Foundation	General	The British Heart Foundation (BHF) is the nation's leading heart charity. Our vision is of a world in which no one dies prematurely of heart disease. There are over 2.3 million people in the UK living with coronary heart disease. The BHF is committed to improving heart health and tackling childhood obesity is a key part of this. Up to 30 per cent of children and young people aged 2-15 years in the UK are now classed as overweight or obese. Obese children are more likely to become obese adults, and this in turn is linked to an increased risk of serious health problems, including heart disease later in life. The BHF also raise awareness of the benefits of a healthy lifestyle, advocate for the right environment to make the healthy choice, the easy choices, and provide information and support for people at risk of living with heart disease. We also fund the British Heart Foundation National Centre for Physical Activity (BHFNC) based at Loughborough University, which is a centre of excellence for physical activity, whose primary aim is to develop, translate and disseminate research and practice-based evidence to expand and improve effective practice of physical activity promotion in the UK. Both the BHF and the BHFNC welcome the opportunity to respond to this consultation to develop a Quality Standard on this issue. If you have any queries about this response or would like more information please contact Amy Smullen, Policy Officer smullena@bhf.org.uk
2	British Heart Foundation	General	The QS does not make it clear what ages are considered within its remit. It would be useful to see the breadth of ages covered and also some guidance and consideration given to the differing techniques that different age groups would need to ensure a successful intervention or prevention of obesity. Medical, emotional and mental capacity assessment for children and young people also needs to be taken into consideration when deciding how best to prevent or intervene
3	British Heart Foundation	General	The BHF strongly agree with the requirement for all professionals involved in prevention and providing lifestyle

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

ID	Stakeholder	Statement No	Comments[1]
			management weight services to have sufficient and appropriate training. However the Quality Standard (QS) lacks detail on who will be responsible for ensuring this training is delivered and how it will be monitored and evaluated. Similarly we welcome NICE acknowledgement that a multi-disciplinary team is required, but the training offered must take into consideration the differing training requirements for providers and clinicians at each stage. This could be clearer in the QS.
4	British Heart Foundation	General	We recognise that parents and carers have an important role to play within the prevention of obesity and most importantly, within any intervention undertaken. However we believe that the QS could be stronger in enforcing the importance of a whole family approach, as this is key to the success of the intervention. For example in younger children, support of parents or carers is vital to ensure any interventional programme is adhered to and undertaken.
5	British Hypertension Society	General	The quality document is very worthy and it is difficult to argue with the 6 quality standards that are put forward as far as they go. Concerns are as follows: The quality standards are very "local" and the onus to implement and measure them falls almost exclusively on local authorities, schools and local healthcare professionals. The document has missed the opportunity to have some more "national" quality standards that could apply to eg food producers, retail outlets and supermarket chains The quality statements use terms such as "promote", "ensure", "develop", "encourage", "ensure" which are rather woolly, subjective aspirations rather than stipulating more hard and objective targets that need to be achieved As a result of the very subjective nature of the statements we fear this quality standard will result in a "tick box" excercise for most local authorities and community services, without any meaningful and substantial changes that will address the obesity problem. There is no mention about the investment and resources that will need to be allocated to achieve the desired outcomes. We therefore think that these quality statements will do very little to effect meaningful changes in the diets and levels of activity of children and young people in this country
6	Children's Liver Disease Foundation	General	When speaking about the health problems an overweight child could face as an adult, should Non-Alcoholic Fatty Liver Disease also be mentioned alongside diabetes, heart disease and cancer.
7	Department of Health	General	This does not reference the legal duties in the Health and Social Care Act 2012 on commissioning organisations to have regard to reducing health inequalities. Nor the duties to integrate services where this will reduce health inequalities. This is particularly important given the strong positive relationship which exists between deprivation and obesity prevalence for children in each age group evidenced at page 2.
8	Department of Health	General	This does not identify the need to ensure there is sufficient focus of action in deprived areas so as to address inequalities in rates of obesity. The equality and diversity considerations need to be clear about the statement

ID	Stakeholder	Statement No	Comments[1]
			applying to all those with protected characteristics in law.
9	Department of Health	General	These statements do not identify the need to ensure there is sufficient focus of action in deprived areas so as to address inequalities in rates of obesity. The equality and diversity considerations need to be clear about the statement applying to all those with protected characteristics in law.
10	Department of Health	General	Does not mention health inequalities duties on commissioners
11	Department of Health	General	The draft Quality Standard (QS) outlines the serious inequalities in child obesity. It is therefore very disappointing that the QS does not seek to address these. If implemented, the measures as a whole may well widen inequalities in child obesity. It would be helpful if the draft Quality Statements and underpinning measures sought to address inequalities – for example by using a "proportionate universalist" approach (as advocated in Fair Society, Healthy Lives (the Marmot Review), ensuring action is proportionately targeted towards areas of high need, or groups with obesity issues. Similarly the recommended measures could take account of inequalities, for example through analysis based on area deprivation or, for schools based measures, using Free School Meals as a proxy for need/deprivation. If the QS is amended to give some focus to addressing inequalities, it would be appropriate to reflect this in the overarching measures it seeks to support (Table 1) – including PHOF overarching measure 0.2 (reducing differences in Life Expectancy and Healthy Life Expectancy between communities, through greater improvements in disadvantaged communities). All the indicators already listed in Table 1 are supposed to support achievement of overarching indicator 0.2. As it currently stands, without more focus on inequalities, the draft QS could well work against that. The Health and Social Care Act 2012 is referenced at page 4 in terms of continuous improvement in the quality of services. The health inequalities duties which fall upon the Secretary of State for Health, NHS England and CCGs are also relevant. It would be helpful if the QS was revised to incorporate action on health inequalities across all the draft Quality Statements in order to support commissioners and service providers to take action in a way which is more likely to address inequalities in child obesity. On a wider point, looking across the Quality Statements as a whole, it was surprising that the role of Local Authorities in approving planning applications for food outlets was not included – they can take account of health in considering applications and some of these would be relevant to child obesity, such as green space for physical activity and the number of chips/burgers/doughnut outlets available close to schools, particularly those in more deprived areas.
12	Dietitians in Obesity Management UK (domUK)	General	We agree that obese children are likely to have obese parents, but would like the potential role of genetics as well as lifestyle and environmental factors to be acknowledged.

ID	Stakeholder	Statement No	Comments[1]
13	Dietitians in Obesity Management UK (domUK)	General	It would be helpful to have the training needs and competencies specified.
14	Living Streets	General	This section should list *NICE public health guidance 41- Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation*.
15	Living Streets	General	This list should refer to the Cabinet Office – Cross Government Olympic and Paralympic Games legacy document – *Moving More, Living More – Olympic and Paralympic Games Legacy*
16	Nottingham City Council	General	Re: "All professionals involved in preventing overweight and obesity and providing lifestyle weight management services for children and young people should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard." It would be helpful to know how such training and competencies might be judged or evidenced – what would constitute "sufficient and appropriate"?
17	Nottingham City Council	General	"Policy context It is important that the quality standard is considered alongside current policy documents, including:" Although the policy document list is not intended to be exhaustive, it would be useful if it also referred to the School Food Plan.
18	Nottingham City Council	General	The overall tenor of the document is very much in line with what we would want, and an integrated approach is advocated by the document. However, it is unclear exactly what is conveyed by the general statement that "services should be commissioned from and coordinated across all relevant agencies". It would be useful to have a more specific account of which are the relevant agencies, and the mechanisms for ensuring such coordination, particularly when the commissioning process occurs in a piecemeal fashion.
19	Nuffield Council on Bioethics	General	These comments draw upon the conclusions and recommendations of the Nuffield Council on Bioethics' report 'Public health: ethical issues' published in 2007 (available at: www.nuffieldbioethics.org/publichealth). The report starts from the position that the state has a duty to enable everybody to lead a healthy life. It proposes a 'stewardship model' that outlines the ethical principles that should be considered by public health policy makers. Paragraph numbers in brackets refer to paragraph numbers in the report
20	Royal College of Nursing	General	Please note that there were no comments on the NICE Quality Standard Consultation for Obesity: Prevention and Lifestyle Management in Children to be submitted on behalf of the Royal College of Nursing.
21	Royal College of Paediatrics and Child Health	General	Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the Obesity: prevention and lifestyle management in children draft standard. We have not received any responses for this consultation
22	Royal College of Physicians	General	The RCP is grateful for the opportunity to comment on the draft QS. We welcome the quality standard's advocacy of coordinated care across different services in health and social care. We strongly advocate joined-up, patient-centred

ID	Stakeholder	Statement No	Comments[1]
			care.
23	Royal College of Physicians and Surgeons of Glasgow	General	Page 1 and 2. In general terms as well as quoting figures re obesity levels (and increasing rates of obesity with increasing age) it may be pertinent to describe the problems this causes. WHO claim that 6% of mortality worldwide is caused directly by obesity, whilst another 6% is directly due to physical inactivity. The economic cost to the country could be stated, as well as the burden of disease caused by obesity and physical inactivity. This could perhaps be summarised with relevant figures e.g. Action to decrease obesity will lead to longer life expectancy, a lower burden of chronic diseases for example type 2 diabetes (which costs the NHS £1Million per hour), and tangible cash savings of £XX billion to the NHS Page 3. diet and physical activity should be given equal status in their role in preventing disease. We would suggest that "Physical Activity" sits directly below "diet" rather than towards the end of the bullet points. The outcomes quoted in bullet points could be broadened, to include bullet points such as -increased life expectancy -prevention of chronic diseases for example type 2 diabetes, stroke, and IHD -decrease health inequalities -Provide cash savings for NHS/ Board/ Local Authority
24	Royal College of Physicians and Surgeons of Glasgow	General	This section talks about the need for co-ordinated action without really specifying what that involves. Specific reference that co-ordinated cross sectoral action is required at a) National Level b) Local Authority Level and c) Community level may be helpful while also specifying sectors that can have a role in obesity management Co-ordinated action is needed by those in sectors including -Health and social care -Education -Transport policy -Sport systems promoting Physical Activity for all -Community engagement -Infrastructure and urban design -Public education and mass media
25	Royal College of Physicians and Surgeons of Glasgow	General	We agree that involving the person, parents, family, community in decisions both personal and re local provision is important and helpfully stated
26	SHINE Health Academy	General	This is an essential document in relation to preventing and reducing obesity rates in children and young people. However its implementation will be an arduous task requiring a great number of professionals and organisations to apply standards consistently and simultaneously if any significant changes will take place. It also requires responsibility at all levels be it individuals, parents, extended family, schools, recreational centres, food industry, marketing and advertisements. It also requires more pressure from government in enforcing appropriate strategies

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			and policies to make this happen. After twelve years in obesity management in children and young people, we are hopeful this will really start to make a different to prevent those needing services such as ours in the future. Here are our comments.
27	SHINE Health Academy	General	Scope of document is prevention and lifestyle weight management for children and young people under 18. The earlier the prevention the better the result, but there is no reference to maternal health, pregnancy and early weaning which are some of the most influential years in establishing healthy eating patterns. Also mention of schools but may need to include nurseries and early year centres, parent groups etc and their role too. There is reference to the NCMP and this system appears to have improved over the years, but there are still only measures at Reception and Year 6. . A good prevention strategy would benefit from more regular monitoring of a child's height and weight throughout school life. Having only two measures early on is limiting. Over the past eighteen months We have conducted over 1000 measures on school children ages 12/13 with 41% overweight/obese rates. Surely yearly measures would be a good prevention strategy so that early intervention pathways can be instigated.
28	SHINE Health Academy	General	In many of the NICE obesity documents there is reference to 'professionals involved in preventing overweight and obesity and providing lifestyle weight management services should have sufficient and appropriate training and competence to deliver actions and interventions' described in the quality standard but there is never any reference as to what this is and what the minimum training should be? Who should deliver it? And how should competencies be assessed? This leads to inconsistencies and in my experience commissioning of cheaper services which are provided by youth workers or physical activity instructors rather than 'professionals' who are 'appropriately trained'. It would be helpful for training and competence levels to be described and an outline as to who should/could deliver what at each level (tier). In this instance what qualifications should a tier 1/2 person have to deliver preventative services and what competencies do they require?
29	SHINE Health Academy	General	Good plans in place. We look forward to hearing from the consultation. It is hoped that money to support preventative and early intervention strategies are appropriately funded so it does not dilute present funding for other interventions greatly needed at Tier 2 and 3 as in some organisations!
30	Weight Watchers	General	The scope of the QS as outlined in the Introduction includes 'interventions for lifestyle weight management in children and young people' but then states that is does not cover the management of obesity in children and young. It would be useful if this difference could be clarified.
31	Weight Watchers	General	"It is well recognised that children who are obese are likely to have obese parents. Many cases in which obesity runs in families may be due to environmental factors, such as poor eating habits learned during childhood, or due to relational and behavioural factors such as poor boundary setting. Therefore, family involvement in interventions is important to ensure improvements in outcomes are maintained." This section makes a very valid point but the factor offered as example of an environmental factor, eating behaviour, would not usually be described as an environmental. Perhaps an alternative example from the obsogenic environment, such as the easy availability of energy dense, low cost food from takeaways would be helpful here? In

ID	Stakeholder	Statement No	Comments[1]
			addition, the example of 'poor boundary setting' does not perhaps recognise the challenges faced by many parents who themselves struggle with their weight. Finally, it might be useful to include genetic factors here, as mentioned later in the draft QS. Therefore an alternative might be: "It is well recognised that children who are obese are likely to have obese parents. There are various reasons why this is the case, including genetic influences, the obesogenic environment and family upbringing. Genes passed through generations can mediate certain eating behaviours such having a large appetite; whilst the shared physical environment that children within families are exposed to, may include easy access to energy dense, low cost food from takeaways combined with poor physical environments that make being more active difficult or unsafe. Family upbringing is a major factor and can be the most amenable to change. Family members tend to have similar eating, lifestyle and activity habits, therefore it is vital that the whole family is involved in both helping the child achieve and then maintain a healthy weight. To ensure this is a realistic goal, other adult members of the family who are obese will need support to increase their own healthy behaviours so that they are both a role model for the child and are able to offer practical guidance."
32	Weight Watchers	General	"Quality standards recognise the important role families and carers have in supporting children and young people who are overweight or obese. If appropriate, professionals should ensure that family members and carers are involved in the decision-making process about initiatives to help children maintain a healthy weight or prevent excess weight gain and the provision of lifestyle weight management services for children and young people who are overweight or obese." Again, this section touches on an extremely important point, which perhaps could be put more explicitly, for example: "Quality standards recognise the important role families and carers have in supporting children and young people who are overweight or obese. Professionals should ensure that a family-based approach is taken. This should include making certain that family members and carers are involved in the decision-making process about initiatives to help children maintain a healthy weight or prevent excess weight gain, that the active participation of family members and carers is integral within any lifestyle weight management service that is available for the child or young person, and that family members and carers who are themselves overweight or obese are able to access evidence based weight management support, as detailed in NICE Public Health Guidance 53, Managing overweight and obesity in adults – lifestyle weight management services."
33	Wokingham Borough Council	General	We agree that a Standard is a useful tool. The prevalence stats will be key information as it refers to the intended outcomes. The document could reference more strongly the need for education on budgeting, shopping and cooking in school settings or family based interventions. There is a strong requirement on local data monitoring, is there a recommended tool for to ensure consistency?

ID	Stakeholder	Statement No	Comments[1]
34	Children's Liver Disease Foundation	Outcomes	When listing the outcomes that the quality standard is expected to contribute too, should food education be included when diet is mentioned?
35	Dietitians in Obesity Management UK (domUK)	Outcomes	We would like to see more examples of how this QS relates to the Public Health Outcomes Framework.
36	Living Streets	Outcomes	We welcome the reference to improving physical activity levels as an outcome on page 3.
37	Wokingham Borough Council	Outcomes	Are any of these affected by the new PHOF refresh?
38	Baby Milk Action	Question 1	In addition to implementing the World Health Assembly resolutions in their entirety, the Guidance could call for implementation of the actions outlined in the EU Action Plan on Childhood Obesity 2014-2020 that was adopted at the Greek Presidential Conference in Athens on 26th February 2014. 1 The Plan lists priority actions in 'a possible toolbox of measures for consideration' respect Member States' 'roles and freedom of action in counteracting childhood obesity.' The Plan recognises the importance of breastfeeding and appropriate complementary feeding, the need to control marketing and also to ensure that there is no food and drink sponsorship in schools. The toolbox of 8 'doable' actions ● Support a healthy start in life (breastfeeding support, monitoring of marketing etc.) ● Promote healthier environments especially in schools and preschools ● Make the healthy option the easier option (no food and drink sponsorship in schools) ● Restrict marketing and advertising to children (defined as 0-18) ● Inform and empower families ● Encourage physical activity ● Monitor and evaluate ● Increase research.
39	Baby Milk Action	Question 1	Also of concern are Cereal-based foods for infants and young children that are marketed in many countries as the first complementary food for infants. The current Codex Alimentarius standard for cereal based foods Processed Cereal-Based Foods for Infants and young Children (CODEX STAN 74-1981) for infants and young children permits levels of added sugars as high as 30% of energy. In 2006 Thailand made a proposal to reduce the permitted levels of sugars in cereal based baby foods. This proposal was blocked by the US, EU and the Codex Secretariat. The marketing of complementary foods should be strictly controlled and support the principles recommended by WHO's Scientific and Technical Advisory Group (STAG) on Inappropriate Promotions of Foods for Infants and Young Children: Technical Paper on Definition of Inappropriate Promotion. (http://www.who.int/nutrition/events/2013_STAG_meeting_24to25June/en/)

ID	Stakeholder	Statement No	Comments[1]
			1. Promotion is inappropriate if it undermines the use of suitable home-prepared and/or local foods a. Products should not be marketed as a complete substitute for home-prepared and/or local foods. b. Promotion should not suggest that commercial products are inherently superior to home prepared foods. c. Promotion should not imply that home-prepared or local foods should be delayed until after commercial products are fed. 2. Promotion is inappropriate if it is misleading, confusing, or could lead to inappropriate use a. Health claims should not be allowed unless specifically approved by national or international authorities. b. Information and instructions should be clear and correct and appropriate for the language and literacy of the target population. c. Promotion should not imply that products contain more of an ingredient than they in fact do.
40	Baby Milk Action	Question 1	In addition to the above points we call for: Implementation of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA Resolutions in their entirety. Monitoring and evaluating obesity prevention initiatives to judge their cost effectiveness, and particularly to consider SES inequalities in responsiveness to interventions. Commissioners and health care providers and local authorities to recognise the importance of an early start to obesity prevention through pregnancy and infant and young child feeding: for example, provision of Baby Friendly hospital facilities, provision for staff breastfeeding facilities at onsite nurseries and crèches (local and health authority) – and breastfeeding in all local and health authority public-access spaces.
41	Baby Milk Action	Question 1	The Guidance does not address the critical importance of early child feeding in obesity prevention. The contribution of high fat, high sugar, high calorie foods alongside reduced levels of physical exercise to rising levels of obesity is well established and acknowledged. The role of optimal infant and young child feeding (exclusive breastfeeding for six months, followed by continued breastfeeding alongside appropriate complementary foods) is less well acknowledged. Evidence indicates that breastfeeding – the physiological norm – in addition to its contribution to the prevention of child mortality and mortality - provides an important window of opportunity for obesity prevention and may help in the development of taste receptors and appetite control. While obesity has more than tripled in many European countries since the 1980s, with 7% of health budgets now spent on associated diseases, evidence is mounting about the importance of very early life feeding and behaviour. The chances of children sliding into or out of obesity seem to be diminished as they grow older. (ref: N Engl J Med

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			2014;370:403-11. DOI: 10.1056/NEJMoa1309753) Obesity data from the US Centre for Disease Control (CDC) published in the February 26 2014 issue of the Journal of the American Medical Association, show a 43% decline in obesity among children aged 2 to 5 years. From nearly 14 percent in 2003-2004 to just over 8 percent in 2011-2012 – based on CDC's National Health and Nutrition Examination Survey (NHANES) data. CDC speculates that this could be due to decreased consumption of sugary drinks and increased breastfeeding rates in the United States. WHO's data on the 'Prevalence of exclusive Breastfeeding' in the EU (which unfortunately mixes 'under' or 'at '6 months of age.') shows wide variation in the region: Denmark at the top with nearly 60%; the UK 7th from the bottom with less than 2% When considering ways to tackle this problem it's important that the focus is moved away from individual 'choice' to providing an environment that supports good healthy decision making. Schemes that seek promote breastfeeding but fail to ensure that women receive adequate and consistent and objective support and advice at the time they need it and allow conflicting commercial messages to continue, are likely to back fire and create hostility. The commercial promotion of breastmilk substitutes and the host of new products that share the same branding (formulas for infants and young children and fortified foods and supplements for children and pregnant and nursing mothers) mislead health workers, mothers and carers and contribute to women's doubt about their bodies' competence to breastfeed and the nutritional quality and safety of unprocessed family foods. Such marketing remains a key obstacle to informed decision making about infant and young child feeding. If breastfeeding rates and duration are to increase, industry's efforts to interfere with policies that aim to protect and support it, must be identified, understood and addressed. Most importantly the baby food industry must not be viewed as a 'partner' in child health programmes, nor should it be involved in any way in nutrition education programmes. Its role is defined in the Global Strategy on Infant and Young Child Feeding and should be confined to producing safe products that are correctly labelled. See Protecting breastfeeding -Protecting babies fed on formula Why the UK government should fulfil its obligation to implement the International Code of Marketing of Breastmilk Substitutes and other papers: http://www.babyfeedinglawgroup.org.uk/monitoring Although the vast majority of women in the UK want to breastfeed, most are failed by the system and stop breastfeeding long before they wanted to because of problems that could have been avoided with proper support and care. Most give up long before they have to return to work. However working women face specific challenges – and even more so if they are breastfeeding so maternity protection at work needs to be translated at into strong protective labour-specific legislation. See IBFAN's Statement on Maternity Protection at work.

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42	Baby Milk Action	Question 1	The importance of regulating the baby food market Efforts to prevent non communicable diseases go against the business interests of powerful economic operators. In my view, this is one of the biggest challenges facing health promotion. As the new publication makes clear, it is not just Big Tobacco anymore. Public health must also contend with Big Food, Big Soda, and Big Alcohol. All of these industries fear regulation, and protect themselves by using the same tactics. Research has documented these tactics well. They include front groups, lobbies, promises of self-regulation, lawsuits, and industry-funded research that confuses the evidence and keeps the public in doubt. In the view of WHO, the formulation of health policies must be protected from distortion by commercial or vested interests… Tactics also include gifts, grants, and contributions to worthy causes that cast these industries as respectable corporate citizens in the eyes of politicians and the public. They include arguments that place the responsibility for harm to health on individuals, and portray government actions as interference in personal liberties and free choice." Margaret Chan, Director-General of WHO, 8th Global Conference on Health Promotion Helsinki, Finland 10 June 2013 In the human rights context, Member States, as primary duty bearers, have an obligation to protect, promote and support breastfeeding and provide the enabling environment women need to breastfeed optimally. Governments also have an obligation to ensure – through appropriate legislation - that 'marketing and advertising do not have adverse impacts on children's rights.'
43	Cheshire West and Chester Council	Question 1	Thank you for the opportunity to comment on this Quality Standard. We welcome the QS and recognition of the pivotal role local authorities can and should play in prevention and lifestyle management of children and young people. We believe that the draft Quality Standard accurately reflects the key areas for quality improvement.
44	Children's Liver Disease Foundation	Question 1	When speaking in general terms about the standard and what it should cover, should good food education be involved.
45	Food for Life Partnership	Question 1	While Statements 1 and 2 provide important guidance on promoting healthier food and drinks choices and improving the food served in schools (and we comment on both of these statements below) they fail to recommend an overarching food strategy, such as is recommended for physical activity in Statement 3 The Sustainable Food Cities programme - led by the Soil Association, Sustain and Food Matters - helps towns, cities, boroughs, districts and counties to build multi-agency, cross sector partnerships around promoting healthy, sustainable food, to maximise health and well-being, economic and environmental outcomes. Developing a joined-up food strategy lies at the heart of this approach. Participating cities/local authorities are demonstrating the efficacy of a joined-up approach. Kirklees County Council,

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			for example, has developed a Good Food Charter and a Food Strategy. The Kirklees food strategy is focussed on local health priorities; developing sustainable food systems; improving access, choice and skills in the community; and transforming the procurement of food across the county. The local authority are working with takeaway owners across Kirklees to produce healthier menu options without compromising on cost or taste, and are briefed on the planning regulations that can be used to restrict unhealthy food outlets on the school fringe. The Council's Catering Service has also been awarded the Silver Food for Life Catering Mark for providing healthy school meals using sustainably-sourced and traceable ingredients; the service holds the catering contract for 95% of the schools in Kirklees. The Council has also developed a comprehensive physical activity strategy, and the food and physical activity strategies have been aligned. This integrated approach to food, alongside physical activity, is helping to bring about whole system change in Kirklees. While NICE quality statements 1 and 2 include important guidance that will effectively support the prevention of obesity in children and young people, and over-arching joined-up strategy should be the focus. FFLP recommend that NICE should develop a quality standard that: Ø Local authorities and their partners in the community develop a coordinated local food strategy that promotes the benefits of healthy eating, and realises the pivotal role that food can play in driving positive social, economic and environmental change in the local area.
46	HENRY – Health Exercise Nutrition for the Really Young	Question 1	As this standard relates specifically to prevention we believe there should be a greater emphasis on early years. The need for intervention in babyhood is suggested by research showing that heavier babies are at increased risk of later obesity and that habits around eating and physical activity are formed in the earliest years of life. With so many children overweight or obese at age 5 a focus on early years is key. Evidence on importance of early years below. Baird J, Fisher D, Lucas P, Kleijnen J, Roberts H, Law C. Being big or growing fast: systematic review of size and growth in infancy and later obesity. BMJ. Oct 22 2005; 331 (7522):929). Whitaker RC, Wright JA, Pepe MS, Seidel KD, Dietz WH. Predicting obesity in young adulthood from childhood and parental obesity. N Engl J Med. Sep 25 1997; 337 (13): 869-873BMJ. Whitaker RC. Predicting pre-schooler obesity at birth: the role of maternal obesity in early pregnancy. Paediatrics. 2004 114(1): p. e29-36
47	HENRY – Health Exercise Nutrition for the Really Young	Question 1	We believe that the role of parenting styles and skills (and these skills in childcare settings) needs to be highlighted more vigorously than it is in the current draft of this standard. The role of school setting is rightly given attention, but children spend more time at home than at school, and for babies and toddlers (who do not attend school) their parents are the key care-givers and therefore the greatest influence on whether they become one of the almost one in four children who are overweight or obese by the time they start at school. Evidence on importance of parenting on

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			child obesity below. Gerards SM, Sleddens EF, Dagnelie PC, de Vries NK, Kremers SP. Interventions addressing general parenting to prevent or treat childhood obesity. Int J Pediatr Obes. 2011 Jun;6(2-2):e28-45. Epub 2011 Jun 10; Sleddens EF, Gerards SM, Thijs C, de Vries NK, Kremers SP. General parenting, childhood overweight and obesity-inducing behaviors: a review. Int J Pediatr Obes. 2011 Jun 9; Epub 2011 Jun 9. Available at http://www.ncbi.nlm.nih.gov/pubmed/21657834; Barlow J,Whitlock S, Hanson S, Davis H, Hunt C,Kirkpatrick S, Rudolf M. Preventing obesity at weaning: parental views about the EMPOWER programme. Child: care, health and development, April 2010 Golan M, Weizman A, Apter A, Fainaru M. Parents as the Exclusive Agents of Change in the Treatment of Childhood Obesity. American J Clinical Nutrition 67(6):1130-1135. June 98 Rudolf M. Tackling Obesity through the Healthy Child Programme: A Framework for Action, noo.org.uk Also, national evaluation of Let's Get Healthy with HENRY course for parents, Dr T. Willis, University of Leeds, in preparation.
48	Living Streets	Question 1	We particularly welcome quality statements 2 and 3 on page 5 regarding physical activity.
49	Nottingham City Council	Question 1	With respect to the areas of prevention and intervention dealt with by the standard, it might be that the prevention aspect could be strengthened, particularly with respect to ensuring prevention occurs at the earliest possible (and perhaps most effective) stage in the life course – antenatal programmes are not covered, for example, and integrated pre-school lifestyle approaches to deal with nutritional programming, for example.
50	Royal College of General Practitioners	Question 1	This is a thoughtful document and covers all the areas of importance. The care of the child prone to obesity needs to be addressed in the context of the Health School and in particular: 1.Identifying children already overweight or at risk 2.Working with them at school and home and using peer educators in the schools to run "weight-watcher" type programmes 3.To ensure that the sports/ exercise facility can cater for different tastes and abilities, . The Private/Public schools have learned this for the idea is to give young men and women interesting skills and activities for life 4. In particular dancing is often much more attractive to girls than say hockey or netball. It can also be a useful social skill 5.As children continue to grow taller the aim is for them to not increase body weight rather than lose weight. This is a much more hopeful approach. 6 The armed forces set minimal targets for fitness and where this is not achieved provide extra help and coaching e.g to be able to run 1.5miles in 12 minutes. It may be possible to design some similar standards for schoolchildren at different ages and make their achievement on par with academic targets
51	Royal College of Physicians and Surgeons of Glasgow	Question 1	Useful set of statements. Would be useful to include more direct measures. When should this quality be achieved? How much improvement do we seek? If we appreciate that levels of physical activity and levels of healthy eating directly relate to rates of obesity (and consequences of) it may be helpful to include measures of a) physical activity b)

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			sedentary behaviour c) salt consumption d) healthy eating
52	Royal College of Psychiatrists	Question 1	There is a significant interaction between obesity in childhood and mental health in a number of ways. For children with morbid obesity, there is an increased risk of mental health problems which can complicate and interfere with the management of the young person's obesity. Equally there are often significant levels of psychosocial adversity amongst family members, with or without increased incidence of mental health problems in parents. This requires a closer liaison between community and paediatric services and child and adolescent mental health services. For children and young people with all forms of obesity, and their parents/families, difficulties in motivating children and young people to change their lifestyle is a major challenge. Approaches such as Motivational Interviewing, again often used in CAMHS settings, particularly in alcohol and substance misuse services, should be made available to staff working with obese children and young people and family systemic approaches should be made available to families where there is a marked resistance to change in lifestyle.
53	Slimming World	Question 1	The local authority could also be involved in promoting breastfeeding and targeting the population groups where both initiation and rates at 6 weeks are low.
54	Staffordshire and Stoke on Trent Partnership NHS Trust	Question 1	The quality standard for most part is accurate and addresses the key areas for improvement. To help further strengthen the standard, a quality statement that urges an overarching integrated childhood obesity strategy for delivery would perhaps help achieve a more co-ordinated approach to tackling childhood obesity. An integrated childhood obesity strategy for delivery which is co-developed, produced and owned by all partners who play a key role in the agenda, supported with a delivery plan with clear objectives would drive consistent and effective communication across all key partners to help realise key objectives / outcomes.
55	The Royal College of Pathologists	Question 1	Yes – this draft quality standard appears to capture the key areas of importance. It is particularly encouraging to see Quality statement 6 emphasising the importance of evaluation of lifestyle weight management programmes, and also Quality statement 5 emphasising the importance of family involvement in lifestyle weight management programmes.
56	Weight Watchers	Question 1	We would suggest that, based on the evidence, and previous recognition in the QS that family members and carers of overweight and obese children are often themselves overweight/obese, that the treatment of the adults should go hand in hand with the treatment of the child, and that therefore it should be explicitly stated as an additional statement. For example by adding the following: Statement 7 Adult family members and carers who are themselves overweight or obese are supported in managing their own weight through evidence based approaches such as referral to lifestyle interventions, as recommended in NICE Public Health Guidance 53, Managing overweight and obesity in adults – lifestyle weight management services."
57	World Obesity Federation	Question 1	**Commissioners and health care providers and local authorities** There is a need to recognise the importance of an early start to obesity prevention through pregnancy and infant feeding: for example, provision of Baby Friendly hospital facilities, provision for staff breastfeeding facilities at onsite nurseries and creches (local and health authority), encouragement for breastfeeding in all local and health authority public-access spaces.

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58	World Obesity Federation	Question 1	**Monitoring and evaluating prevention initiatives** This appears to be missing from the standard. An attempt needs to be made to properly evaluate initiatives to prevent obesity, and to judge their cost effectiveness, and particularly to consider SES inequalities in responsiveness to interventions.
59	Cheshire West and Chester Council	Question 2	With regard to the question of whether it would be possible to collect the local data for the proposed quality measures, it may be feasible in theory; however, in practice, collecting the local data would require considerable local resource (financial and human) which may not be available to the Local Authority or its partners.
60	Cheshire West and Chester Council	Question 2	Any national survey would have to recognise the fragmentation of schools and the number of Academies, therefore making it potentially difficult to collect data systematically.
61	Nottingham City Council	Question 2	It ought to be possible to collect the data, should the necessary systems and structures be in place. However, given the current constraints with respect to public sector budgets, this seems a difficult condition to satisfy. Furthermore, with the general move away from national indicators and performance management models, it might be difficult both financially and culturally to reinstitute such data collection at a local level. A number of the quality statements suggest that local data collection be used. Without a very tight specification for such local data, this may prove insufficient to be able to monitor the implementation of this quality standard in a meaningful way, or in a way that permits comparison between different places.
62	The Royal College of Pathologists	Question 2	The proposed quality measures appear reasonable, and if sufficient resources are made available it should be possible for the necessary data to be collected.
63	The Vegan Society	Question 2	Give details about the specific, measurable, time-bound objectives for each quality standard.
64	Mytime Active	Question 3	Currently there are programmes that target overweight and obese children across all age groups, including MytimeActive. Those external organisations are able to feed into the database all measurements in order to provide wider picture of excess weight prevalence in children, not only those measured via the NCMP. Creation of a national platform that would aim to host, audit, analyse and disseminate data would help to ensure quality and opportunities for progress in reducing childhood obesity.
65	Nottingham City Council	Question 3	One potential barrier might be the fact that public health is still bedding into its new location within local authorities. Associated with this is a lack of familiarity amongst local authority officers with how NICE operates, and how its standards should fit into the wider legislative and regulatory landscape within which local authorities discharge their diverse responsibilities. NICE standards specifically designed for public health are one important way of addressing this. However, if such standards are not well known, and if they are viewed as being purely advisory, it may well be insufficient to compete with other statutory requirements of local authorities or with other competing local priorities. The document does usefully refer to the fact that the Health and Social Care Act states that the care system should consider NICE quality standards. In this context, “must” would probably be preferable to “should”. Furthermore, it

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			would be helpful to have set down what would constitute sufficient consideration of the standards in this context; and in cases where they are not followed, how this might be justified. This might be helped by some sort of audit process for the use of quality standards, or some coordination with existing audit and judgement organisations and processes. For example, if Ofsted or equivalent were to look for evidence of consideration of/adherence to NICE quality statements when inspecting local government children's services, this would be likely to help.
66	The Vegan Society	Question 3	Strong leadership by example from policy-makers as well as in the community will be key to significant improvement. Financial measures which make physically active leisure pursuits significantly cheaper than sendentary, and lightly processed plant-strong foods (vegetables, grains, legumes, fruits, nuts seeds) significantly cheaper other foods, are also vital.
67	Association of Paediatric Chartered Physiotherapists	Quality Statement 1	This will work if there is an Obesity Prevention and Management Lead (OPML) to ensure an integrated whole system commissioning approach. All agencies have to buy into the ethos and we must follow one system not have loads of different ones.
68	British Heart Foundation	Quality Statement 1	We welcome NICE's acknowledgement that the obesigenic environment in which children and young people live has an impact on their consumption behaviour. We think that this section could be strengthened by recommending local authorities encourage an assist retailers, restaurants and caterers in their local authority area to introduce the Government's voluntary recommended front-of-pack labelling to empower their populations with the information to make quick, heart healthy informed food choices at the point of purchase.
69	Dietitians in Obesity Management UK (domUK)	Quality Statement 1	We would like the wording slightly altered to: 'Local authorities and their partners in the community provide and actively promote….'
70	Dietitians in Obesity Management UK (domUK)	Quality Statement 1	We feel that the following (or similar) should be inserted into the rationale: 'The movement of Public Health into Local Authorities places greater responsibility on to Local Authorities in this regard'.
71	Dietitians in Obesity Management UK (domUK)	Quality Statement 1	We would like the full potential of the local Authority to be recognised in this standard, including their role in creating opportunities for healthy eating in the wider community (such as influencing planning, advertising, planning and regulations as well as active promotion of breastfeeding and breastfeeding-friendly initiatives).
72	Dietitians in Obesity Management UK (domUK)	Quality Statement 1	We would like this to include all catering, including vending machines.
73	Dietitians in Obesity Management UK (domUK)	Quality Statement 1	'Promotion' also includes readily available healthier food and drink options. We would like free availability of fresh drinking water specifically highlighted.
74	Food for Life Partnership	Quality Statement 1	Many local authority and NHS Trust procurement teams are being driven by budget-cutting pressures to give ever greater weighting to cost, relative to quality, when awarding contracts for food provision in schools, hospitals, children's centres and leisure centres. However, the Public Services (Social Value) Act requires public authorities -

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			including local authorities and the NHS - to have regard to economic, social and environmental well-being in connection with public services contracts. The authority must consider (a) how what is proposed to be procured might improve the economic, social and environmental well-being of the relevant area, and (b) how, in conducting the process of procurement, it might act with a view to securing that improvement. The Soil Association's Food for Life Catering Mark scheme allows local authorities or NHS Trusts to adopt or specify quality standards for catering in schools, children's centres, hospitals, leisure centres and other settings, and the scheme already certifies over 170 million meals a year. Bronze, Silver and Gold standards cover nutrition (monitoring compliance with national best practice or statutory nutrition standards for each sector), freshness, quality, provenance and sustainability, and the scheme is backed by annual inspection. For every £1 invested in a Catering Mark menu there is a local social return on that investment of more than £3, mostly in the form of increased opportunities for local food businesses , in line with the aims of the Public Service (Social Value) Act. FFLP recommend that NICE quality standard 1 should: Ø Reference the Public Service (Social Value) Act as a lever for raising the quality of local food provision. Ø Recommend that local authorities review that status of all their catering and vending contracts for venues used by children and young people, with a view to specifying quality standards once those contracts are up for review. Ø Recommend that local authorities seek out independent verification of the quality of food provided in venues used by children and young people, such as is provided by the Food for Life Catering Mark.
75	HENRY – Health Exercise Nutrition for the Really Young	Quality Statement 1	This should include age-appropriate portion sizes so that staff have awareness and understanding of suitable portion sizes of different food groups for children of different ages.
76	Nottingham City Council	Quality Statement 1	"Local authorities and their partners in the community provide and promote healthier food and drink choices at local authority venues used by children and young people." Perhaps a semantic point, but by seeking the provision of healthier choices, the standard implies that less healthy choices will also be available. A stronger standard would be that all food provided meets a minimum requirement for healthful eating, or that certain food items are proscribed. Effectively, we would wish to see the choices offered being between healthy food A or healthy food B, rather than between healthy or unhealthy.
77	Nottingham City Council	Quality Statement 1	"…especially those at which children and young people can take part in physical activity" It is difficult to see why healthy food choices should be particularly provided where physical activity is undertaken, rather than being a universal requirement. Such a targeted approach might be counterproductive, when it is the whole system that needs to change?

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78	Nottingham City Council	Quality Statement 1	"Evidence that local authorities and their partners in the community provide and promote healthier food and drink choices at local authority venues used by children and young people." In line with the comment above, it might be a more useful measure to look for how many unhealthy foods are being provided, or actually to look at relative consumption of healthy versus unhealthy in such venues.
79	Nottingham City Council	Quality Statement 1	"Local authorities should consider appointing an obesity prevention and management lead to ensure an integrated, whole-system commissioning approach." In order to optimise the opportunities for such a role to be properly coordinated with all relevant agencies and related measures, it is likely that such a role would fall with the Public Health function of the local authority. It would be helpful if the standard were to suggest or recommend this.
80	Public Health England	Quality Statement 1	Local authorities and their partners in the community provide and promote healthier food and drink choices at local authority venues used by children and young people'. – should this be 'in and around' rather than 'at' local authority venues? - to encourage local authorities to take action in shaping the wider food environment eg. by using planning legislation to restrict proliferation of fast food outlets (as in the GLAs Takeaway Toolkit) and by incentivising said food outlets and retailers to provide healthier options (as in the Tower Hamlets Food for Health Awards) We encourage including reference to Healthier and More Sustainable Catering Guidance https://www.gov.uk/government/publications/healthier-and-more-sustainable-catering-a-toolkit-for-serving-food-to-adults and PHE briefing on Obesity and the Environment regulating the growth of fast food outlets https://www.gov.uk/government/publications/obesity-and-the-environment-briefing-regulating-the-growth-of-fast-food-outlets
81	Royal College of Physicians	Quality Statement 1	This should also incorporate venues run by or for services which are delivered by third party providers on behalf of local authorities (ie where services have been commissioned and an external provider has been procured). In these instances, the promotion of healthier food and drink choices, through measures such as lower prices for healthier options, should be incorporated into contracts and contract monitoring procedures.
82	SHINE Health Academy	Quality Statement 1	We have been pioneering for these changes in sports and leisure centres for the past three years with no effect. We have taken suggestions and ideas to the local council run board and while it has been 'investigated' there has been no action to promote healthier foods and drinks at these venues. It is reported to us that if they did prices of sports activities would rise as vending machines provide a good income that help employ more staff. This was the same argument offered when vending machines were being banned in schools but this was not an option. The government need to take the same approach and prevent unhealthy products being available in venues which children and young people regularly attend. In relation to personal responsibility, where we run our groups parents are equipped with a wrath of unhealthy products which they promptly hand out to children once their activities are completed i.e.

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			swimming, dance, trampolining. Need to educate parents/carers who attend with children about intake/output expenditure.
83	Slimming World	Quality Statement 1	The statement uses the terms 'provide and promote'. Given the strong positive relationship which exists between deprivation and childhood obesity prevalence it would be good to see more emphasis on making healthier foods and drinks both more accessible and more affordable. For example drinking water should be freely available in all leisure centres. The local authority also has a role to play in food and drink availability outside their venues given their lead on planning, transport so for example can influence the number of fast food outlets, and their accessibility, in any given locality.
84	The Royal College of Pathologists	Quality Statement 1	The key is to encourage prominent and attractive display of, and access to, healthier food and drink choices. The barrier is the commercial pressure also to provide less healthy options to minimise the risk of customers going elsewhere to obtain preferred, less healthy, options.
85	The Vegan Society	Quality Statement 1	Great extra health and equality benefits to explicitly promote plant-strong foods especially a rainbow of vegetables and fruits. Sample supporting evidence: Plant-centred diets are proven protective against obesity in children as well as adults, with vegans having the lowest BMI (e.g. Sabaté and Wien 2010, http://ajcn.nutrition.org/content/91/5/1525S.full). Vegetables and fruits, particularly brightly coloured and lightly processed, enjoyed in seven or more portions per day can cut early death by 40% (Oyebode et al. 2014 http://jech.bmj.com/content/early/2014/03/03/jech-2013-203500.short). Vegan-friendly catering is also very inclusive: Which? has shown that around 50% of families are concerned about the use of animals in food production, as animal-lovers, being eco-conscious, for medical reasons, or for religious or vegan beliefs, for example.
86	World Obesity Federation	Quality Statement 1	**Local authority venues** This should be expanded to include all venues for which local authorities bear some responsibility through licensing and inspection, for example: registered nurseries, playgroup and child-minding facilities; leisure and sports facilities; institutions for children in care.
87	Wokingham Borough Council	Quality Statement 1	Strongly agree with this aspiration and what about to Planning influencing the High Streets near schools as happened in London. The vast majority of venues used by children and young people will have Drinks/Snacks Machines which will contain unhealthy items such as fizzy drinks, salty snacks, sweets, chocolate, etc. These often bring in revenue and although we agree with this approach the sea-change required will be significant.

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88	Association of Paediatric Chartered Physiotherapists	Quality Statement 2	You can have as many assessments and policies as you like however you need an OPML and team who will support the schools to achieve this and not just for one year- a 5-10 year plan. Headteachers are busy with literacy and numeracy so how do they find time to do this? Leadership is needed and that does not necessary come from headteachers.
89	Association of School and College Leaders	Quality Statement 2	ASCL would not disagree with the aim of this section, but there are a number of concerns about how it is stated. The general point is that schools have a great many other issues to deal with in educating their students, and there is a presumption in the way this is expressed that it can be a significant and explicit feature of school life. In general that will not be possible. It would be helpful if there was a recognition that while schools can, should and do address this important issue there is a limit on how much they can be expected to do, and on the impact that can be expected from what is only one element of a child's life. There is such recognition in other NICE documents. Some more specific points follow.
90	Association of School and College Leaders	Quality Statement 2	The rationale and general approach is reasonable, but there is no analysis of any evidence there may be of what types of behaviour on the part of schools has a beneficial effect in this regard to their former students' habits and health in later life, correctly identified as the significant areas of potential positive outcome. That means that schools are being invited to "assess" their behaviour, but on the basis of no research. They can and do make such assessments (generally informally) but can only do so on the basis of 'common sense', which may mean that they are making wrong choices. Some effort to share outcomes of proper research and point schools towards effective patterns of behaviour would be helpful, though it is not clear who should do this.
91	Association of School and College Leaders	Quality Statement 2	Quality measures: These are mostly expected to be collected by 'local data collection'; it is not clear by whom. In the past when local authorities have been tasked to collect such data it has often been unreliable, intrusive, and burdensome on schools. Now many schools no longer belong to local authorities, what agency can make such local data collection?
92	Association of School and College Leaders	Quality Statement 2	To the extent that the establishment of healthy habits for adult life is a significant aim the outcomes stated are not outcomes.
93	British Heart Foundation	Quality Statement 2	We welcome Statement 2 and would encourage NICE to use this as an opportunity to emphasise the importance of nutritious school food within Independent and Academy schools which do not have a statutory requirement to comply with Government school food standards. Previously, via the National Healthy Schools Programme, schools were encouraged to have physical activity and healthy eating policies in place. We believe that schools should be encouraged to have both these policies in place, promoting an active school. Evaluation and evidence collection that these policies are being implemented successfully should form part of this promotion.

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			The definitions and outcome measures for this QS are very narrow. Just measuring participation in PE lessons is not sufficient and will not incentivise providers to see promoting physical activity and a healthy lifestyle as a key component of all activities within a school. For example, a school could promote active play times, amounting to a significant amount of exercise for a child but this would not be included in evaluation. Similarly the QS remains unclear on whether the data that is collected will measure the amount of PE offered or drill down deeper to rates of participation. As PE is a compulsory subject, the amount offered may present a very different figure to participation rates. Similarly in terms of active travel to schools, the head teachers and Governors are limited by the local environment in which their school is located. It is therefore important that this QS is linked to complementary NICE guidance on promotion of physical activity and the environment and promotion of walking and cycling. This Statement focuses mainly on schools. We believe that early years settings also need to be considered to reflect the importance of physical activity and a healthy balanced diet from a young age.
94	Cheshire West and Chester Council	Quality Statement 2	Annual survey of take-up of school lunches in England from School Food Trust - this is now the Children's Food Trust
95	Department for Education	Quality Statement 2	Title - The statement and associated commentary refers to the 'schools' policies'. That's fine per se, but it may be better to be a little more specific here. It's not just the schools' policies but also its overall ethos, and its teaching practice. Is the curriculum for physical education reflective of the importance of physical activity, for example? On the 'outcomes' section 'c' – I'd go further than just participation in PE lessons. What else does the school provide? Are there after-school activities available, or lunch-time clubs? Also you may consider using data from the 'active people' and 'taking part' surveys to supplement this.
96	Department for Education	Quality Statement 2	The data source for the 'Uptake of school meals that adhere to the national standards' cannot be the 'Annual survey of take-up of school lunches' will not work. The School Food Trust no longer run an annual survey; we have undertaken a survey using a different provider we are awaiting the survey report and have yet to make decisions about future surveys. The survey has shown that schools and LAs can access data on meal take-up, but we have yet to see the ease with which they can produce this. The school food standards do not apply to academies set up between 2010 and June 2014. It is right that the quality standard encourages schools/ caterers etc. to monitor school meal take-up, and that that is linked to the national school food standards. Suggest replacing the Data source with 'Local data collection'.
97	Department of Health	Quality Statement 2	Under Outcome (a) Number of Children and Young People walking and cycling to school. It says that HSE be the data source. Can someone check for accuracy as I don't think HSE collects that data on a regular basis. The National Travel Survey might be a better source.

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98	Department of Health	Quality Statement 2	Under Definitions of terms used, policies. The last bullet point on school travel plans and provision for cycling – can walking be included too please.
99	Dietitians in Obesity Management UK (domUK)	Quality Statement 2	We would like this quality statement broadened to include the early years settings, as well as schools.
100	Dietitians in Obesity Management UK (domUK)	Quality Statement 2	We would like 'tuck shops' added to examples of catering. We would also like the role of schools in actively signing up to school meal standards highlighted, including freely available drinking water at all times.
101	Dietitians in Obesity Management UK (domUK)	Quality Statement 2	We would like to see School lunch policy added, for those children who bring lunches to school. We also feel that the responsibility for such policies needs to reside with a named person who has protected time in order to ensure that the polies exist, that staff, parents and students are involved in their development, and that they are being implemented. We would like to see this added to the quality statement.
102	Dietitians in Obesity Management UK (domUK)	Quality Statement 2	We would like 'and should be culturally and age appropriate' added.
103	Fit For Sport	Quality Statement 2	Every week there's a new headline about the lack of children's participation in sport. Recently, we had a report from UKactive, encouraging parents and schools to build a 'physical literacy' among children, even setting PE as homework. Children today are far less active than their parents were at the same age. In the 60s and 70s, walking to school, meeting your friends at the park and riding your bike everywhere, were considered the norm. Now children have increasing amounts of homework and would rather be 'active' on a PlayStation or Xbox in their spare time. More importance is placed on social media and uploading selfies, than being active and playing sport for pure enjoyment. Report after report is released giving us guidelines; telling us to get our young people active and hanging on in vain to the 'Inspire a Generation' promise of the London 2012 Olympics. Yet not a lot is changing, and I firmly believe the Olympic legacy has yet to come to any sort of fruition or to deliver on the promises made. The problem, in my mind, is that we're all too focused on 'sport': competition, excellence, elite sport, going for gold, living the dream.

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			That's exciting for children who have a liking or talent for sport, but what about those that don't want to be Olympic athletes or professional footballers? What about the children who just want to enjoy sport and have fun with their friends? If I asked you how many children you knew who liked sport, you'd be able to think of a few, I imagine. But if I asked you how many children you knew who liked to play – well, that's everyone isn't it? We should tap into 'play' and give young children the chance to play games and have fun: this way they'll be physically active and enjoy the benefits of exercise without even realising they doing it. The journey to sport is just as important – if not more important – for children than the sport they end up playing. Of course, parents have a responsibility to encourage their children to run around outdoors, head to the park or take their bikes out. Active families often lead to active children. But, in reality, children should be active for at least 60 minutes a day. And where are they most days? School. And that's where the opportunity lies. I'm not talking about more PE lessons – there's enough pressure on teachers to fit the curriculum into the teaching timetable as it is. I'm talking about playtime: we need to put the 'play' back into playground. At Fit For Sport, we developed a programme last year for Sport England called Engage to Compete, which focuses on training support staff, teaching assistants and even dinner ladies to deliver playground activities. The schools reported some very interesting results. Not only were the children getting active, but playground behaviour improved dramatically. The children worked better together in the classroom, building that vital team ethic at a young age. A whole school ethos brought different year groups together: in one school they even had Years 5 and 6 running the activities for Years 1 and 2. The older children gained fantastic organisational skills and leadership responsibilities. Being physically active is as important for four and five-year-olds as learning to read and write. Children don't quibble with teachers about the need to read books and learn their times tables, and they are unlikely to question teachers about the need to be active either.

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			Primary schools have a superb opportunity to help young children be more active, but I believe we must change the way they deliver the notion of sport. We should view it as a journey to sport. It starts with Years 1 and 2 children doing fun activities and games. It progresses to introducing competition in Years 3 and 4. Then, by Years 5 and 6, children should be competent enough to try new sports. First we need to build a nation of healthy youngsters through active play. And I believe the school playground is the place to start.
104	Food for Life Partnership	Quality Statement 2	Child obesity prevalence rises as household income falls, with prevalence amongst the most deprived more than double that of the least deprived (11.7% among the least deprived increasing to 24.3% among the most). Increasing the uptake of free school meals is a crucial intervention to alleviate the diet inequalities that underpin these health inequalities. By ensuring that the most vulnerable children receive at least one hot, nutritious meal a day, schools can help bridge health and attainment gaps. Independent evaluation of the Food for Life Partnership has demonstrated a 13 percentage point increase in free school meal take-up (20 percentage points in secondary schools) at a time when free school meal take-up nationally was static. This was achieved through a 'whole school approach' that uses food as a way to improve the whole school experience, making lunchtime a more positive feature of the day and enriching classroom learning with farm visits, practical cook¬ing and growing. FFLP recommend that NICE quality statement 2 should: Ø Highlight to head teachers and governors the importance of addressing health inequalities through increasing free school meal take-up, while emphasising that there must be no compromise on quality. Ø Reference the 'departmental advice on school food' published by the Department for Education in June 2014 , which states that governors should seek "evidence of compliance" with the school food standards, and which strongly encourages governing bodies to work with the senior leadership team to develop a "whole school food policy". The Food for Life Partnership has a strong track record of improving food quality in schools and of increasing school meal take-up, and has already been commis¬sioned by public health teams in 15 local authorities to help tackle child¬hood obesity. Integral to FFLP's impact has been its 'whole school approach', which was endorsed by the recent Government-backed School Food Plan. The engagement of cooks and caterers lies at the heart of this approach, and these key parties are omitted from the quality statement FFLP recommend that NICE quality statement 2 should:

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			Ø Recognise the important role cooks and caterers play in ensuring that the school's policies encourage children and young people to maintain a healthy weight and eat a healthy diet. E.g. "A school's approach to assessing the environment and developing its policies will be more effective if the whole school community is involved, for example, by encouraging collaboration between head teachers, governors, school council members, cooks and caterers, pupils and parents
105	Living Streets	Quality Statement 2	The phrase "school environment" is very broad and it is slightly unclear whether this refers to the built or natural school environment such as playing fields or whether it includes the environment around the school such as local streets. We would like to see the wider definition adopted as from working with schools across the country using School Route Audits we know that increasing the number of children walking to school is predicated on a range of improvements to school routes including lower vehicle speeds and the presence of good quality paths and crossings.
106	Living Streets	Quality Statement 2	There is little in the way of sign posting for head teachers and chair of governors to assess the whole school environment – we use a School Route Audit approach which is a way of assessing the quality of the streets around a school to make sure that they are safe, accessible and welcoming and encourage walking to school. They are a school based version of Living Streets' Community Street Audit which provides a way of involving local people to identify improvements to the walking environment. We have successfully used the School Route Audit process in the schools we work with through the Local Sustainable Transport Fund. The process provides a clear framework for engaging with children, parents, teachers and the local community and involves Living Streets staff leading children on a walk around the area surrounding the school, identifying opportunities for improving the walk to school through improvements such as the installation of footpaths and crossings through to establishing park and stride sites. Other such tools may exist to assess school grounds or school facilities by other organisations and consideration should be given to how to signpost head teachers and chairs of governors to such resources.
107	Living Streets	Quality Statement 2	Building on the point above unless "school environment" is defined and school signposted to opportunities to assess the school environment local measures will be difficult to undertake.
108	Living Streets	Quality Statement 2	Where possible we recommend separating walking and cycling as forms of active travel due to the differences in each mode
109	Living Streets	Quality Statement 2	Bullet point 4 refers to only cycling and the section does not make any reference to *NICE public health guidance 41- Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation*. Recommendation 8 - Schools – provides guidance as to how schools can foster a culture that supports physically active travel for journeys to school (for all staff, parents and students) and during the school day. We would strongly suggest this guidance is referred to within this list of policies and should also be cited as source guidance.
110	Nottingham City Council	Quality Statement 2	"Head teachers and chairs of governors, in collaboration with parents and pupils, assess the school environment and ensure that the school's policies encourage children and young people to maintain a healthy weight, eat a healthy diet and be physically active." In order to be better coordinated, the quality statement for schools could make mention of existing standards that some schools have attained or are aspiring to, such as 'Healthy Schools' or 'Food for Life Catering Marks', which are

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			themselves good evidence of achieving the standard set out in this statement. Whether it is in this quality statement (in respect of schools), or in the next one (in respect of physical activity), it would also be helpful for the NICE standard to say something about minimum time allocated within the curriculum for physical activity.
111	Nottingham City Council	Quality Statement 2	"Proportion of schools that have assessed the school environment and school policies…... ….Denominator – the number of schools." It's not clear at what geographical level this process measure is intended to operate at. Whatever the level, the denominator presumably should include all schools within that locality, i.e. including Academies, independent schools, free schools, special schools, etc. It would be helpful if this were made clear in the quality statement.
112	Nottingham City Council	Quality Statement 2	"Data source: Annual survey of take-up of school lunches in England from School Food Trust." For information: the School Food Trust is now renamed as the Children's Food Trust.
113	Nottingham City Council	Quality Statement 2	"Amount of physical activity undertaken by children and young people." For this outcome measure (and for the following one on sedentary activity), I think it is important to define the terms, so that it is clearly understood what is being measured. This would be useful for comparison purposes, but is also important given that the evidence in favour of a general increase in physical activity is good, but the evidence for formal recreation and engagement in sport (which is how this is often interpreted) is less robust.
114	Nottingham City Council	Quality Statement 2	"local transport and school travel plans are coordinated so that all local journeys can be carried out using a physically active mode of travel." It would be helpful if the standards for a physical activity strategy also referred to the need for school admissions policies to be included within the strategy. Such policies have not always had the walk to school as a paramount consideration - a significant barrier to regular physical activity is likely to be attendance at a school that is not within easy walking distance.
115	Nuffield Council on Bioethics	Quality Statement 2	Much attention has been focused on the role of schools in addressing childhood obesity, as education plays a central role in providing individuals with the capacity to choose healthy behaviours. It is unreasonable to expect interventions in schools alone to be sufficient to reduce the prevalence of obesity, given the vast array of other influences experienced by children. However, school communities do provide an important means of influencing many of the socio-cultural factors that have a lasting impact on both food choices and exercise habits. They have a prominent role in the community, are a source of support for parents and families, and can produce community change in environments, knowledge and behaviour. For these reasons, it is appropriate for schools to seek to influence positively the food and exercise habits of children (paragraph 5.35).

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			The stewardship model's emphasis on circumstances that help people to lead healthy lives, especially if they are in vulnerable positions (paragraphs 2.41–2.44), leads to an ethical justification for the state to intervene in schools to achieve a more positive culture towards food, cooking and physical activity. As in many other areas of public health policy, the only way of establishing whether a new policy is likely to lead to improved health is by trialling it. The Council recommended that UK Government departments responsible for food, health and education should develop long-term strategies for schools with the aim of preventing obesity, and changing food and exercise culture, accompanied by monitoring and follow up (paragraph 5.36). Whilst we therefore welcome the proposal for schools to assess their environments to develop policies, we would wish to emphasise that the policies should monitored in the long term and assessed for impact in improving health, in order that optimisations or amendments can be made as appropriate.
116	Public Health England	Quality Statement 2	'Assessing school environment' and 'developing school policies'- we suggest that reference is made to Schools taking a 'whole school' approach to encouraging children and young people to maintain a healthy weight, eat a healthy diet and be physically active, with dedicated time within the taught curriculum, a supportive school culture and environment and effective engagement with families and local communities: We suggest the Quality statement is reworded to: Head teachers and chairs of governors, in collaboration with parents and pupils, ensure whole school action is taken through the curriculum, school ethos and physical environment, and through partnership working with parents/carers and local communities to encourage children and young people to maintain a healthy weight, eat a healthy diet and be physically active. This change will need to be reflected in the quality measures too. In addition, we suggest the statement includes text about the school collecting appropriate local-level data in order to allow them to monitor their own progress against the statement (as the data sources that are quoted - HSE and School Meals Survey - don't provide school-level data).
117	Public Health England	Quality Statement 2	Policies should cover 'the taught curriculum (including PE). Should there also be a specific reference to nutrition and food preparation skills as examples of things that should be included in the curriculum? Suggest including reference to the British Nutrition Foundations, in collaboration with PHE, Core Food Competencies for children aged 5-16 years. A link to the draft follows. Afinal version shall be published shortly http://www.nutrition.org.uk/index.php?option=com_content&view=article&id=723&Itemid=214078
118	Royal College of General	Quality	The school's policies and curriculum need to include how pupils and their families can manage their resources well

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	Practitioners	Statement 2	(such as using home-grown produce or locally available seasonal fruit and veg through community programmes). They need to include managing their expenditure to prioritise healthy food. They should give time for physical activity within their curriculum with adequate changing and toilet facilities. They need to include how NMP results will be shared with public health and GPs and disseminated in an educative way to parents and families. (These are measureable).
119	Royal College of Physicians	Quality Statement 2	Measurement of success should monitor the impact of PE lessons (the outcome), not just levels of participation (the output). How will academies and free schools be encouraged to participate and collect and share data on this quality statement?
120	Royal College of Physicians and Surgeons of Glasgow	Quality Statement 2	Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement? Yes Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? Yes Question 3 For each quality statement what do you think could be done to support improvement and help overcome barriers This is a useful statement with realistic measurements. It may be useful to include that a range of physical activities are to be included and also specific outcome measures ie "participation in PE could assess % of primary school children getting 2 hours of PE, and % of secondary age kids getting 2 periods of PE. (These are standards reviewed by the Scottish Government and its 32 Local Authorities)
121	SHINE Health Academy	Quality Statement 2	Children and young people spend over a 1/3rd of their day in a school environment and these can be very influential. In our experiences primary schools appear to be taking a lot more responsibility that secondary schools in providing healthy eating habits. Many of the secondary schools we visit still have unhealthy 'tuck shops' and breakfast clubs and healthier options in canteens are often much more costly than unhealthier options i.e. cookies 60p bag of fruit £1.20. Again requires some governance as no consistencies across schools. Also there is a market of children selling goods 'banned' from schools such as energy drinks and chocolate. It's a hard one to tackle. Perhaps there could be a checkpoint to include health eating in Ofsted reports. Walking and cycling to school initiatives really good. Curriculum could greatly influence and could be used to a greater advantage to increase awareness and bringing home made cooking back instead of fast food such as pizzas and cakes/biscuits. How to cook healthy nutritional meals on a budget lifelong skills etc. There is now an acceptance that other psychosocial elements can lead to obesity such as low self esteem, anxiety, depression which can lead to emotional eating. Eating disorders such as anorexia and bulimia and covered in the school curriculum but obesity and healthy weight management needs to be in there too, alongside self esteem and confidence building and body confidence classes as part of the preventative plan to increase awareness.
122	Slimming World	Quality Statement 2	This statement focuses on the school setting and ignores the early years which are formative in establishing healthy eating and drinking habits.

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			The length of the school day may be influential on diet and physical activity behaviours. Healthy breakfast clubs may also be considered in this statement. Where healthy diet is mentioned this should refer to both foods and drink.
123	Staffordshire and Stoke on Trent Partnership NHS Trust	Quality Statement 2	There is real opportunity through training and workshops to inform and empower parents, increasing their knowledge, skills and confidence to help sustain improvements. Involving parents and pupils are key requirements in sustaining any meaningful change.
124	The Royal College of Pathologists	Quality Statement 2	As with quality statement 1, the key is to encourage prominent and attractive display of, and access to, healthier food and drink choices. The barrier is the commercial pressure also to provide less healthy options to minimise the risk of pupils (especially in secondary school, where they are more likely to be free to leave the school grounds at lunchtime) going elsewhere to purchase lunch.
125	Wokingham Borough Council	Quality Statement 2	Would be useful to have a template that schools could use for this type of audit. Schools don't always have much control over the number of children and young people walking to school. Walking buses are popular but are often resourced by volunteers and interest wains when those volunteers move on, e.g. they go back to work or their children move to secondary school. Local Authority transport and planning departments need to be involved with this so that healthy and safe transport options are available for families and their children. There could be an opportunity for School Nurses to be used to support this and escalate failing schools to the Public Health team.
126	Association of Paediatric Chartered Physiotherapists	Quality Statement 3	This is possible with an OPML and team and financial support Having one programme that is used nationwide would be easier than loads of different ones. One common data set and all speaking the same language
127	British Heart Foundation	Quality Statement 3	We feel that a greater definition of what constitutes being physically active is needed as this can be open to interpretation by service providers and the public. It will also influence what data is collected to evaluate this QS. Linking into our above comment regarding the Healthy Schools Programme, Statement 3 could be more explicit about promotion of active schools, where physical activity is prioritised before, during and after the school day. We strongly support this QS in promotion of greater opportunities at a local level for children and young people to be physically active, but the quality of opportunities must also be monitored and evaluated. Alongside the commitment to increase physical activity this QS could be more explicit about the need to also reduce sedentary time. This is because someone can be physically active (i.e. meet the Chief Medical Officer's recommendations) but also spend the majority of their day sedentary, which can impact negatively on their health. Sustained public awareness raising of what the CMO recommendations are for all children and young people is crucial to the success of the prevention strand of this QS.

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			In terms of data collection to measure this QS the BHF would like to know whether this will include the CMO recommendations and what data source is going to be used, given the differing collection methodology currently used. It is also imperative that the data collected can be used to evaluate the new opportunities offered in the QS, therefore measuring performance and value of interventions.
128	Department of Health	Quality Statement 3	It may be useful to be clear that local authorities and their partners are measuring against the Chief Medical Officer's physical activity guidelines of 180 minutes a day for children aged 0-5, and 60 minutes a day for young people aged 5-17.
129	Dietitians in Obesity Management UK (domUK)	Quality Statement 3	The final sentence of the rationale is confusing. We would like: ' and increase the proportion who maintain a healthy weight' added for clarification.
130	Dietitians in Obesity Management UK (domUK)	Quality Statement 3	We would like to see 'and highlighting the risks of sedentary behaviour' added for clarification.
131	HENRY – Health Exercise Nutrition for the Really Young	Quality Statement 3	There should be more emphasis on the importance of developing enjoyment of (and habit of engaging in) physical activity in the early years and the vital role of parents/carers in this. Parents should be encouraged and enabled to engage in 'active play' with babies and toddlers to help develop healthy habits right from the start of life. This can be achieved through healthy lifestyle programmes for parents of babies and young children.
132	Living Streets	Quality Statement 3	Bullet point 6 refers to only cycling and the section does not make any reference to *NICE public health guidance 41-Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation*. The guidance provides a number of recommendations relevant to local authorities which also supports this draft guidance. We would strongly suggest this guidance is referred to within this list of policies and should also be cited as source guidance.
133	Nuffield Council on Bioethics	Quality Statement 3	The Council concluded that more could be done in the design of urban environments and buildings to reduce the obesogenic nature of the environment and increase the opportunities for people to increase their energy expenditure with ease. We endorse the statement based on our recommendation that planning decisions by central and local government should include the objective of encouraging people to be physically active. This may entail some restrictions of people's freedoms, for instance to drive anywhere they wish to, but these restrictions would be justified in terms of public health benefits (paragraph 5.32).
134	Public Health England	Quality Statement 3	We suggest this statement includes specific mention of active play and active travel as important ways for children to be physically active? And as with QS2, if we are expecting this to be monitored through 'local data collection' then perhaps there needs to be something in the statement stipulating that LAs need to include ways of measuring physical activity and sedentary activity as part of their strategy. The statement states "Local authorities and their partners in the community develop a coordinated local physical

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			activity strategy, suggest that “and NHS” are added after “community”, as it is important that local strategies integrate across public health and the NHS/primary care. Does there need to be specific reference to engaging the most deprived communities?
135	Royal College of General Practitioners	Quality Statement 3	Partners in the community should include health and well-being boards (HWB) so there is input into health. (measureable) and opportunity from health to refer in? (Good communication between all services so those ready to change can get a place).
136	Royal College of Physicians and Surgeons of Glasgow	Quality Statement 3	Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement? To an extent. It identifies it is important but does not offer sufficient clarity in its guidance as to what is required and what is good practice. Suggest include “bright spots” of good practice, or a synopsis of what works See “7 Investments that work for Physical Activity” http://www.globalpa.org.uk/investments/download.php Local Authority Level and Community level action is required as this is not happening in a co-ordinated and optimal fashion at present. Request Co-ordinated action by those with policy responsibility for sectors including -Health and social care -Education -Transport policy -Sport systems promoting Physical Activity for all -Community engagement -Infrastructure and urban design -Public education and mass media Increasing physical activity is of particular importance and it is right to be included in the quality statements. Aside from its importance in preventing obesity and treating obesity as an independent risk factor it accounts for 6% of unfractionated mortality globally (the Lancet, WHO), and costs the NHS £8.4 Bn per year (BHF data). Regular exercise can decrease the risk of developing over 40 chronic diseases. The importance of regular activity is perhaps undersold in this NICE guideline. Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? -Yes collecting data on physical activity and sedentary behaviour can be done at a local authority level (done in

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			British Columbia, Western Australia and parts of Scotland well) as can process measures for example proportion of school students given 2 hrs of PE or more per week Question 3 For each quality statement what do you think could be done to support improvement and help overcome barriers. -offer examples of good practice from other local authorities or a framework that can inform local policy like http://www.globalpa.org.uk/investments/download.php Provide expertise not only on this policy area but also on the process of improvement
137	SHINE Health Academy	Quality Statement 3	As stated on page 2 there is a strong correlation between obesity and deprivation and one of the biggest barriers we find to physical activity is costs. In local sports and leisure centres families have to pay on block for a full term for an event i.e. 10 swimming classes. 6 trampolining classes upfront. For families with several children this is not affordable. There should be concessional rates and wider opportunities. More sports within the community like street play available. Shorter sessions should be available for smaller children as their attention span in shorted i.e. 20 minutes or 30 minute sessions rather than hour classes.
138	Slimming World	Quality Statement 3	Again 'increasing the opportunities' should emphasise the need for activities to be accessible and affordable to all families. There is evidence to suggest that getting parents to be more active improves the activity levels of their children. So more emphasis on a family approach.
139	Wokingham Borough Council	Quality Statement 3	This should also make reference to the Planning and Transport departments too. This statement should be supported by a national campaign, e.g. Change 4 Life How will time spent doing sedentary activities be measured? We would welcome a template/guidance on good practice for the development of a local Physical Activity Strategy
140	Association of Paediatric Chartered Physiotherapists	Quality Statement 4	Having one programme that is used nationwide would be easier than loads of different ones. One common data set and all speaking the same language
141	British Heart Foundation	Quality Statement 4	When collecting the data it would be helpful to monitor drop out and completion rates of interventions to inform other weight management services.
142	Dietitians in Obesity Management UK (domUK)	Quality Statement 4	We would like to add 'increase awareness of healthy eating'.
143	Dietitians in Obesity Management UK (domUK)	Quality Statement 4	We would like the evidence of local arrangements to include a named lead with responsibility for dissemination.

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144	Dietitians in Obesity Management UK (domUK)	Quality Statement 4	We would like 'and/or' removed from the definition of lifestyle programmes, since all evidence based programmes should be multi-component ie include diet, activity AND behaviour change. Behaviour change is fundamental, not optional.
145	Dietitians in Obesity Management UK (domUK)	Quality Statement 4	We would like to see 'Programmes should be age appropriate, and include information that is culturally and ethnically appropriate' added.
146	HENRY – Health Exercise Nutrition for the Really Young	Quality Statement 4	For the early years (see above for important thereof) this should include families with children identified as being at risk of obesity based on e.g. maternal weight status, weight status of older children in family, Health Visitor (or other professional) concerns about lifestyle healthiness etc. For early years it may be useful to present programmes as 'Healthy Lifestyle' or 'Healthy Start' programmes as children may not yet be overweight/obese but may be at risk of obesity (see above), so parents may not feel a 'Weight Management' programme is needed whereas they may be more willing to engage with the idea of giving their child a healthy start.
147	Mytime Active	Quality Statement 4	This is a key issue to be addressed as part of this consultation to ensure that ALL health professionals, within a region that has a community Tier1/2/3 children & young persons weight management programme, is encouraged to actively refer children and young people that they see in their professional roles into the local service. It may be necessary for certain health professionals to be targeted to make referrals into a weight management programme even if the targets are financially incentivised. A suggestion for health professionals that could have more of a priority to raise the services to the children, young people and their parents are: • GP's • School Nurses • Health Visitors • Dieticians • Paediatricians To support improvement of this quality issue, there needs to be a top down reinforcement of the responsibility for all health professionals to refer into local child weight management services. I know Mytime Active teams spend a lot of time actively promoting our services to local health professionals/offering training on raising the issue/attending events/building links and networking all with a good level of success. However, this needs to be improved which may need to come from further reinforcement outside of the weight management providers responsibility.
148	Public Health England	Quality Statement 4	Should this include the basic standard of ensuring that sufficient evidence-based weight management programmes are commissioned to meet need / demand? eg. based on the number of children who are identified and informed of overweight / obesity through NCMP, and assuming a certain level of uptake, there should be adequate capacity for these children to be referred to an evidence based programme.
149	Royal College of General	Quality	Raise awareness of nutritional advice (including vitamin D), money, lifestyle and nutritional management. Perhaps

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	Practitioners	Statement 4	foodbanks could be further enabled to give nutritionally sound children packs.
150	Royal College of Physicians	Quality Statement 4	This quality statement appears to be very process-focused and it could be significantly strengthened through a stronger focus on outcomes.
151	Royal College of Physicians and Surgeons of Glasgow	Quality Statement 4	a) Whilst it is important to evaluate programs that have been initiated, these are potentially of less importance than other quality measures. These programs reach a modest proportion of those affected by obesity whilst NHS Scotland (NHS Health Scotland) have shown that particularly in relation to physical inactivity Brief Advice and Brief Intervention is much more effective at £20-£440 per QALY than Exercise referral (£20,000 per QALY- which is still cost effective). A single quality statement looking at lifestyle intervention programs (incorporating family buy-in) and a further quality statement for asking about diet and physical activity a part of what we do as health care professionals would be cost-effective. We should ensure we integrate dietary advice and advice about physical activity into Primary care (currently smoking worth 70 points in QOF, Physical Activity worth none) Secondary care (currently smoking/ alcohol asked about in clerking documents less so diet and PA) Medical education (less than half of universities teach PA guidelines, and less than 15% GP's know PA guidelines compared to 97% for alcohol(Dunlop, Murray)
152	Royal Pharmaceutical Society	Quality Statement 4	Community pharmacies, through their accessibility to patients, are in a position to raise awareness of these programmes to the public. Local authorities should consider engaging them as partners in the community who can signpost to these services. This could involve including them in the list of partner organisation to whom they disseminate the list of local evidence - based lifestyle weight management programmes and publicity materials.
153	SHINE Health Academy	Quality Statement 4	There needs to be more integrated services as what is often the case is that if there are a variety of lifestyle weight management programmes available but there is a culture of competitiveness rather than cohesion. Services should be available depending on a child's individual need. There needs to be an established pathway for individuals to gain access to a range of services with cross referrals. This would prevent fragmentation of services
154	The Royal College of Pathologists	Quality Statement 4	The key to raising awareness of lifestyle weight management programmes and encouraging participation is active in-school promotion of approved programmes. As mentioned in the quality statement, local authorities will need to have procedures in place to assess suitability of local programmes for publicity/endorsement.
155	Weight Watchers	Quality Statement 4	For clarity, it would be helpful if Statement 4 could be more explicit that the lifestyle weight management programmes mentioned here are aimed at weight management for children and young people
156	Weight Watchers	Quality Statement 4	We would suggest adding 'children and young people' after 'lifestyle weight management programmes' to differentiate from programmes for adults.
157	Weight Watchers	Quality statement 4	The description of lifestyle weight management programmes defines them as "focus[ing] on diet, physical activity **and/or** behaviour change." A key component of all lifestyle weight management programmes is they include behaviour change strategies, therefore the 'or' is this description should be removed.
158	Wokingham Borough	Quality	We feel this should be supported by a national campaign.

ID	Stakeholder	Statement No	Comments[1]
	Council	Statement 4	
159	The Vegan Society	Quality Statement 4-6	Explicitly promote plant-strong foods especially a rainbow of vegetables and fruits.
160	Association of Paediatric Chartered Physiotherapists	Quality Statement 5	An OPML and team to ensure this happens and one programme nationwide so all agencies work together to support family and children
161	British Heart Foundation	Quality Statement 5	The BHF welcome this QS but feel it should be stronger as outlined above; the importance of support and involvement of the family and carers cannot and should not be under estimated. This is especially important when the child is younger as they will not have the tools to take the rights steps to reduce their weight, for example purchase power, cooking skills, or the ability or confidence to communicate with healthcare providers. Therefore the QS could be stricter in requiring parent or carer involvement for this aged group, as 'encouragement' is not enough. Again the involvement of parents and carers also needs to be considered on an individual basis when the child or young person is disabled or has other medical needs that impact on their ability to reduce their weight.
162	Dietitians in Obesity Management UK (domUK)	Quality Statement 5	We would like the core components of family involvement specified, and feel that the main priority is to actively engage with the main caregiver; written information may be more appropriate for those less actively involved in the child's day-to-day care.
163	Dietitians in Obesity Management UK (domUK)	Quality Statement 5	We would like 'feel that' removed, as family members either have or have not taken an active role.
164	Dietitians in Obesity Management UK (domUK)	Quality Statement 5	We would like 'feel that' removed, as family members either understand the aims and objectives, or do not.
165	Dietitians in Obesity Management UK (domUK)	Quality Statement 5	We feel that the following sentence is misplaced: 'they should also find out whether the family recognises that their child is overweight or obese' and should be replaced by 'they should explore the family's understanding of overweight and obese and how to relates to their child/ren'. This is because we feel that families who do not recognise that their child is overweight or obese are unlikely to be attending weight management programmes.
166	Nottingham City Council	Quality Statement 5	"Family members feel they have taken an active role in their children's lifestyle weight management programme." Any new subjective measures that are required to be collected, whilst important, are likely to create a new burden either for provider or commissioner, and so may struggle to survive budgetary pressures.
167	Royal College of General Practitioners	Quality Statement 5	Family members, especially those from black, ethnic minority and migrant groups. (The introductory info omits the evidence that these groups are particularly prone to overweight). The interventions should include how to cook cheap food and buy food cheaply, as well as eating behaviours including weight management and physical exercise.

ID	Stakeholder	Statement No	Comments[1]
			(Migrant and targeted groups are measureable).
168	Royal College of Physicians	Quality Statement 5	With obesity, there are the dual challenges of social stigma, where obese people can encounter prejudice due to social perceptions and judgement about their weight, and social normalisation, whereby the increasing prevalence of overweight and obesity has meant that we collective struggle to correctly identify unhealthy levels of overweight. Indeed, a substantial proportion of parents whose children were identified as overweight or obese through the National Child Measurement Programme have refuted the findings. As such, this quality statement needs to be situated within a wider context of public health and social marketing interventions to support the wider population, and this specific patient population and their families, to understand what healthy weight is, without stigmatising people who are obese.
169	SHINE Health Academy	Quality Statement 5	Needs to be an acceptance of more flexibility of what 'involving the family' means. Parents with several children may not be able to attend every session with their child. There needs more variation in what can be offered to parents/carers rather than traditionally attendance on courses, for example parent conferences, awareness days and drop in centres – need safeguarding procedures clarified for families identified with a 'high risk child' but who are not engaging or doing anything about it, clearer guidelines for workers.
170	Slimming World	Quality Statement 5	Family members should be involved in any programme supporting the younger child to manage their weight. Without family involvement the programme is not likely to be effective. There is some evidence which would suggest that the intervention/programme might just involve the parents. The parent is the gate-keeper of the foods which are provided at home
171	Weight Watchers	Quality Statement 5	Referring back to the previous acknowledgement that obesity and overweight co-occur in family units, this section would offer an effective opportunity to reinforce that adult carers are likely to have their own support needs, and for them to be best able to support their child, adult family members would benefit from adult interventions to support their own weight issues.
172	Association of Paediatric Chartered Physiotherapists	Quality Statement 6	Use one programme nationwide so we all speak the same language and ensure the people running the programme are supported by the OPML and team
173	British Heart Foundation	Quality Statement 6	The BHF would welcome guidance on how exercise referral schemes fit into weight management programmes for children given NICE's recent guidance on exercise referral schemes for adults.
174	Dietitians in Obesity Management UK (domUK)	Quality Statement 6	We would like the optimal length of programmes to be specified, rather than solely specifying points for data collection.
175	Dietitians in Obesity Management UK (domUK)	Quality Statement 6	We would like to see 'Programmes shown to be ineffective should be de-commissioned' added.
176	Nottingham City Council	Quality	"Proportion of lifestyle weight management programmes that are monitored and evaluated."

ID	Stakeholder	Statement No	Comments[1]
		Statement 6	If measured locally, the number programmes that constitute the denominator of this measure is likely to be prohibitively small. Furthermore, applying a meaningful definition to the assessment of whether a programme is monitored and evaluated may be problematic, and could result in a "tick-box" approach to fulfil the standard.
177	Nottingham City Council	Quality Statement 6	"Commissioners (including directors of public health, public health teams and local authority commissioners) ensure that sufficient resources are dedicated to monitoring and evaluation" In the current financial climate Public Health teams may well struggle to provide the resources for evaluation. However, relying on the provider to carry out evaluation may risk a conflict of interest. Some advice on best practice to ensure monitoring and evaluation is included as part of the commissioning process might help. A further comment: "public health teams and other local authority commissioners" may be a preferred phrase, since public health teams generally contain commissioners and are now within local authorities
178	Public Health England	Quality Statement 6	We suggest the statement includes targeting weight management services at children and young people in the most deprived communities and includes reference to the Standard Evaluation Framework for Weight Management Interventions http://www.noo.org.uk/core/frameworks/SEF
179	Royal College of Physicians	Quality Statement 6	This needs to have strong emphasis on how programme uptake and efficacy is monitored and improved in relation of equality and diversity characteristics. This is fundamentally important in the management of obesity as both its prevalence and the uptake of obesity management services is linked to gender, ethnicity and socioeconomic status (for the latter, this correlation is particularly strong amongst children). Therefore it is fundamental that services are tailored to meet the needs and preferences of different patient groups – particularly different cultural groups. Meaningful monitoring of uptake and outcomes according to equality characteristics is central to this. Monitoring and evaluation must also be robustly outcomes- rather than output-focused. Service performance should not, for example, be measured by patient throughput, but by outcome measures such as sustained weight loss, improved management of related co-morbidities, or improved mental wellbeing.
180	SHINE Health Academy	Quality Statement 6	As always main emphasis on BMI and physical outcomes need to include more about psychosocial outcome measures such quality of life, anxiety and depression measures, emotional eating measures – now included in programmes so need to evaluate Difficulty in maintaining measure at 6 months and one year – strategies as to how to keep families involved for that length of time with lack of funding to support programmes of this length
181	The Royal College of Pathologists	Quality Statement 6	As stated in the quality statement, the key is to have procedures in place to measure outcomes not just at completion of a programme, but also up to 1 year after completion. Ideally, it would also be good to have outcome data on those who do not complete a programme, but this may be difficult to obtain in practice.
182	World Obesity Federation	Quality	**Monitoring and evaluating weight management programmes** This needs to be strengthened to improve the

ID	Stakeholder	Statement No	Comments[1]
		Statement 6	monitoring of inequalities in access to referrals, uptake of referrals, prejudicial treatment by staff, adherence to treatment, re-admissions. There is a small but growing body of evidence that obese people in different social group seek help and respond to treatment differently, get treated differently by the health staff, and show different drop-out rates, according to their income/education status.

Stakeholders who submitted comments at consultation

- Association of Paediatric Chartered Physiotherapists
- Association of School and College Leaders
- Baby Milk Action
- British Heart Foundation
- British Hypertension Society
- Cheshire West and Chester Council
- Children's Liver Disease Foundation
- Department for Education
- Department of Health
- Dieticians in Obesity Management UK (domUK)
- Fit for Sport
- Food for Life Partnership
- HENRY – Health Exercise Nutrition for the Really Young
- Living Streets
- Mytime Active
- Public Health England
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Paediatrics and Child Health
- Royal College of Pathologists
- Royal College of Physicians
- Royal College of Physicians and Surgeons of Glasgow
- Royal College of Psychiatrists
- Royal Pharmaceutical Society
- SHINE Health Academy
- Slimming World
- Staffordshire and Stoke on Trent Partnership NHS Trust
- The Vegan Society
- Weightwatchers
- Wokingham Borough Council

- Nottingham City Council
- Nuffield Council on Bioethics
- World Obesity Federation