

NHS Health Scotland Commentary on NICE Clinical Guideline (Public Health aspects)	
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NICE ref:	Clinical guideline 43 (CG43) <i>Note: This Health Scotland (HS) Commentary focuses only on the Public Health Recommendations and relevant Research Recommendations in the Guideline.</i>
HS ref:	NICECG43(PH)
Date issued:	December 2006
Title:	Obesity: guidance on the prevention, identification, assessment and management of obesity in adults and children

Subject area:	Obesity
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Background to this Commentary

The National Institute for Health and Clinical Excellence (NICE) in England produces two types of guidance on public health topics: Public Health Intervention Guidance (interventions being defined as involving single measures, eg GP advice to patients to be more active) and Public Health Programme Guidance (on broader activities, eg strategies for smoking cessation). In Scotland, such Guidance has no formal status but attracts interest and provides a useful source of reviewed evidence.

As part of its role in promoting and supporting evidence-informed action for health improvement in Scotland, NHS Health Scotland (HS) produces Commentaries on NICE Public Health Guidance. Each Commentary, with Comments/Conclusions on the Recommendations set out in the NICE Guidance, is produced in collaboration with an appropriately constituted specialist Reference Group with members from within and beyond HS. The process involves consideration of the evidence cited and the Recommendations presented in the NICE Guidance, in the context of policy and practice in Scotland.

In the subject area of obesity, NICE has published Guidance in the form of a Clinical Guideline containing both Public Health and Clinical Recommendations. As indicated above, this particular HS Commentary is on the Public Health aspects.

Purpose and limitations of this Commentary

By offering Comments/Conclusions on NICE Guidance, this Commentary is intended to help organisations, professionals and others make use of that Guidance in a Scottish context. It does not in itself constitute formal Guidance or Guidelines.

The scope and contents of the Commentary are limited by those of the NICE Guidance on which it is based. The Commentary should not be seen as a full action plan or full basis for a health improvement strategy on the subject area concerned, but rather as one evidence-informed contribution to such an action plan or strategy. By not only addressing the NICE Recommendations but also presenting in an accessible way the cited evidence statements on which these are based, the Commentary gives decision makers the opportunity to formulate their own action points informed by the evidence statements, combining these with evidence from other sources and taking account of other relevant considerations.

The Commentary

General HS Notes

- 1. NICECG43(PH) contains a total of 56 Recommendations for action, across 7 audiences/settings, devised by a Guidance Development Group (GDG) taking account of evidence statements resulting from number of evidence reviews. The evidence presented in support of the Recommendations is variable in amount and strength, and indeed there are 19 Recommendations for which no evidence is cited. From a purely evidence-based action point of view, the making of Recommendations on the basis of considered opinions of the Guidance Development Group is questionable. However, in such circumstances the confining of Recommendations to ones that are supported by evidence would lead to a focus on a relatively small number of actions, with skewing towards the sorts of interventions that are conducive to evaluation using particular types of study within the conventional hierarchy of study designs used in assessing the efficacy of individual-centred clinical interventions. Such an approach would run the risk of a promoting a piecemeal view of population health improvement as opposed to one that recognises complexity and the importance of multifaceted, multilevel and interacting efforts (see also Comments 1 and 2 on 'Scope'). Against this background, the approach adopted by the GDG in formulating Recommendations is supported.*
- 2. Above points notwithstanding, the still-limited coverage of NICECG43(PH) and its Recommendations (see Comments 1 and 2 on 'Scope') should be recognised. This is important in considering national and more local strategic approaches to healthy weight.*

General HS Notes, contd	3. <i>It is also important to bear in mind that effective efforts to promote healthy eating, physical activity or both will have health benefits outweigh any impact on weight.</i>
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Scope	<p><u>Groups covered by the Guideline</u></p> <ul style="list-style-type: none"> ▪ Adults and children aged ≥ 2, whether of a healthy weight, overweight or obese. ▪ The following special groups were considered where there was good evidence of effectiveness in relation to them: black and minority ethnic groups; lower socioeconomic groups; and ‘vulnerable groups, including older people and women of child-bearing age’. <p><u>Areas covered by the Guideline in relation to primary prevention of obesity</u></p> <ul style="list-style-type: none"> ▪ Approaches intended to support adults and children in maintaining a healthy weight – mainly outside the clinical setting, and including the following: <ul style="list-style-type: none"> - raising awareness of what constitutes a healthy weight range and the need to stay within such a range - identifying adults and children who should participate in prevention programmes based on their risk factors for obesity and readiness and opportunities to change their behaviour - maintaining local strategies to prevent obesity and support weight maintenance in adults and children of healthy weight focusing on multicomponent interventions including: community-based services including those to which people are referred from primary care services; broader environmental interventions in the community; interventions in workplaces; interventions in schools; interventions targeted at children aged 2-5 years; and interventions targeted at black and minority ethnic groups, at vulnerable groups and at individuals at vulnerable life stages. <p>For NICE CG43(PH) a rapid evidence review was carried out on each of the following topic areas: identification of children and adults at risk of obesity; raising awareness of weight, diet and activity; determinants of energy balance; interventions among children aged 2-5 years and families; school-based interventions; workplace-based interventions; community-based interventions led by health professionals; broader community-based interventions; interventions among black and ethnic minority groups, among vulnerable groups, and at life stages with increased risk for weight gain; and management of obesity in non-clinical settings.</p>
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Scope, contd:	<p>The primary outcome measure for NICECG43(PH) was body mass index (BMI) and/or waist measurements; other reported outcomes based on body measurements (eg skinfolds) were considered where available; dietary and physical activity outcomes which may promote to protect against obesity were considered key outcomes.</p> <p>The Public Health reviews include interventions with at least 3 months' follow-up, NICECG43 stating that such reviews 'focus on the measurement of group changes over time' and that 'these are measurable over a period as short as 3 months'.</p> <p>A Public Health health economics review was conducted to assess the state of the economic evidence, 'given that in the main searches this evidence was limited'.</p>
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HS Comments on scope:

1. *NICECG43 states: 'In terms of prevention of overweight and obesity, the guidance will contribute to the evidence base leading to subsequent recommendations in national government or European policies, including fiscal policy, food labelling policy and food advertising and promotion. The guidance is intended to support local practice, whereas national or "upstream" action will be addressed in the context of wider work...'*
2. *While a number of the Public Health Recommendations in NICECG43 are concerned with making healthy choices easier choices by promoting access to/opportunities for healthy eating and physical activity, the guidance does not address various 'bigger picture' influences that contribute to what has been termed the 'obesogenic environment'. It is important to recognise in the field of population health improvement more generally that the sorts of actions (often individual-centred) for which evidence and evidence-informed recommendations tend to be most readily available do not necessarily offer the best route to positive changes in health or in risk factors for preventable ill-health. Moreover, the 'whole system' of influences relevant to a given subject area needs to be considered, not just the evidence available on isolated component parts of that system.*
3. *In the field of physical activity promotion, broader environmental and organisational changes are the subject of future Public Health Programme Guidance being developed by NICE.*
4. *The nature of the groups covered by the guidance is supported. As regards vulnerable groups, it would have been helpful to have Recommendations relating to people with mental health problems.*

HS Comments on scope, contd:

5. *The types of outcome measures described in NICECG43(PH) are supported. In addition, it would have been helpful to have information on any psychological outcomes, whether intended or unintended (eg effects on self-esteem or self-efficacy, and including any potential negative effects eg associated with unsuccessful attempts to lose weight, or relating to eating disorders).*
6. *The desirability of being able to capture more evidence than would have been possible with a longer minimum follow-up period is recognised. Nevertheless, findings based on only 3 months' follow-up are of limited value: longer-term maintenance of effects on BMI, waist measurement and other outcomes such as health-related behaviours is of substantial importance to population health improvement.*

Study selection criteria:

NICECG43 states: 'A pragmatic approach was taken in defining the time period for searches and the included study types and outcome measures.'

In summary, reviews included: systematic reviews from 1995 and single studies (predominantly randomised controlled trials [RCTs] and non-randomised trials) from 1990; studies with outcome measures of weight, diet and/or physical activity and UK-based 'corroborative'-type evidence (such as surveys, case studies and qualitative work) to assess issues such as barriers and facilitators to implementation. See references, under 'Scope', to outcome measures and inclusion of interventions with at least 3 months' outcomes.

Studies were selected on the basis of relevance to key questions, and their quality appraised (see under 'Study appraisal methods').

NICECG43 cites a review of the grading of public health evidence and recommendations as concluding that 'gold standard' RCTs 'cannot readily be performed in public health interventions (particularly community-based programmes) for feasibility, cost and practical reasons', and states that reviews of evidence for public health interventions tend to be dominated by 'lower' levels of evidence.

NICECG43 indicates that, in relation to developing public health recommendations on obesity, it was agreed that the rapid reviews should actively incorporate 'corroborative evidence' (from observational and qualitative studies) for the feasibility and likelihood of success of an intervention if implemented in the UK.

HS Comments on study selection criteria:

1. *The ‘pragmatic approach’ adopted reflects commonly encountered difficulties in obtaining RCT-based evidence on public health interventions – and limitations to the applicability of ‘clinical treatment-type’ evidence rating to wider public health actions. Inclusion of a broad spectrum of research designs (and of studies that did not meet criteria for high quality – see under ‘Study appraisal methods’) limits the confidence with which it can be concluded that findings can be attributed to interventions, but offers the potential to capture a larger number and wider range of relevant findings. The application of study appraisal methods (see next section of this Commentary) helps assess the strength of evidence thus captured.*
2. *Taking account of 1. above, the study selection criteria are supported.*

Study appraisal methods:	<p>In the reviews for NICECG43(PH), in relation to intervention studies, research designs/sources of evidence were each categorised as one of four <u>types</u>:</p> <ol style="list-style-type: none">1 Meta-analyses; systematic reviews of randomised controlled trials (RCTs); or single RCTs2 Systematic reviews of non-RCT/case control/cohort/controlled before-and-after (CBA)/interrupted time series (ITS) studies; or single such studies3 Non-analytic studies (eg case reports, case series)4 Expert opinion, formal consensus. <p>Studies of types 1 and 2 were each <u>quality</u>-rated as ++, + or - according to the risk of potential bias/confounding or chance in their design/execution.</p> <p><u>Levels of evidence</u> accordingly ranged from 1++ (‘highest’ in the hierarchy used) through to 4.</p>
HS Comments on study appraisal methods: <ol style="list-style-type: none">1. <i>Appropriate, but recognised as subject to limitations resulting from points made in Comment 1 on the study selection criteria.</i>	

HS Notes:	<p>The next section of this Commentary presents NICECG43’s Public Health Recommendations, for a range of audiences/settings, together with the evidence statement(s) on which they are based, and presents HS Comments/Conclusions on the Recommendations. The numbering system used for audiences/settings and Recommendations was devised for this Commentary.</p> <p>The figure +/- symbol in the square brackets – [1+], [3] etc – after a given evidence statement indicates the overall level given by NICE to the reviewed evidence on which that statement is based.</p>
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Audience/setting 1 – Public	
1a. – Public: All	
Recommendation 1.1:	Everyone should aim to maintain or achieve a healthy weight, to improve their health and reduce the risk of diseases associated with overweight and obesity, such as coronary heart disease, type 2 diabetes, osteoarthritis and some cancers.
Evidence base for Recommendation 1.1:	'Opinion of the GDG' (Guidance Development Group)
HS Comments/Conclusions on Recommendation 1.1:	
1. <i>No evidence cited, but Recommendation considered appropriate and endorsed.</i>	
Recommendation 1.2:	People should follow the strategies listed in box 1 (see Appendix 2 for revised version of NICE's box 1, produced by the Reference Group involved in the development of this Commentary), which may make it easier to maintain a healthy weight by balancing 'calories in' (from food and drink) and 'calories out' (from being physically active).
Evidence base for Recommendation 1.2:	<ol style="list-style-type: none"> 1. Cohort studies suggest that children who increase calorie intake, increase fat intake, consume 'junk food', 'takeaways' and 'carbonated drinks' and/or do not eat breakfast, tend to gain weight. The evidence on 'snacking' is limited and inconsistent. [2+] 2. There is limited evidence from prospective cohort studies over at least one year for the relationship between regular meals, portion size or snacking with weight in children. [2+] 3. Cohort studies suggest that children who do not participate in sport outside school and who are the least active appear to gain more weight than their more active peers. [2+] 4. The evidence from cohort studies is inconsistent on the associations between television viewing and weight gain. Some but not all identified studies found a significant association between greater television viewing and weight gain. [2+] 5. There is a body of evidence from cohort studies that adults are more likely to maintain a healthy weight if they maintain an active lifestyle and reduce sedentary behaviours such as television viewing. [2++]

Evidence base for Recommendation 1.2, contd:	6. There is a body of evidence from cohort studies that adults are more likely to maintain a healthy weight if they consume a low-fat diet containing less 'takeaway' foods, more fruit and vegetables, salad and fibre and little alcohol. Reducing consumption of confectionery and drinks high in sugar may also help to prevent weight gain. [2+]
HS Comments/Conclusions on Recommendation 1.2: 1. <i>Recommendation endorsed, with amendments to box 1 (see Appendix 2).</i>	
Recommendation 1.3:	All adults should be encouraged to periodically check their weight, waist measurement or a simple alternative, such as the fit of their clothes.
Evidence base for Recommendation 1.3:	1. 'Opinion of the GDG'
HS Comments/Conclusions on Recommendation 1.3: 1. <i>No evidence cited here, but see evidence statement 2 under 'Evidence base for Recommendation 1.4'.</i> 2. <i>In any case, Recommendation 1.3 is considered appropriate and endorsed</i>	
Recommendation 1.4:	People who have any queries or concerns about their – or their family's – diet, activity levels or weight should discuss these with a health professional such as a nurse, GP, pharmacist, health visitor or school nurse. They could also consult reliable sources of information.
Evidence base for Recommendation 1.4:	1. There is some evidence that considering an individual's weight history (for example, previous weight gain or loss, previous attempts at dieting) and monitoring more recent weight gain may help identify adults at risk of becoming overweight or obese in the future [3] 2. The majority of non-UK guidance and recommendation documents suggest that periodic monitoring of weight status and BMI and waist circumference measurements should be routinely undertaken [4] 3. There is some evidence from the UK that patients are likely to welcome the provision of advice despite concerns by health professionals about interference or damaging the relationship with patients. [3]

HS Comments/Conclusions on Recommendation 1.4:	
<p>1. <i>Recommendation endorsed subject to the following points. People who have queries or concerns about their/their family's diet, activity levels or weight might not necessarily choose to discuss these with a health professional in the first instance – they might usefully refer to reliable other resources of information as a first course of action. Also, it is important to consider and address appropriate health professionals' training needs to ensure that they are able to respond appropriately when patients raise these matters, and therefore to link this Recommendation with Recommendation 2.5.</i></p>	
1b. Public – Adults considering dieting to lose weight	
Recommendation 1.5:	<p>Weight loss programmes (including commercial or self-help groups, slimming books or websites) are recommended only if they:</p> <ul style="list-style-type: none"> ▪ are based on a balanced healthy diet ▪ encourage regular physical activity ▪ expect people to lose no more than 0.5–1 kg (1–2 lb) a week. <p>Programmes that do not meet these criteria are unlikely to help people maintain a healthy weight in the long term.</p> <p>People with certain medical conditions – such as type 2 diabetes, heart failure or uncontrolled hypertension or angina – should check with their general practice or hospital specialist before starting a weight loss programme.</p>
Evidence base for Recommendation 1.5:	1. 'Opinion of the GDG'
HS Comments/Conclusions on Recommendation 1.5:	
<p>1. <i>No evidence cited, but Recommendation considered appropriate and endorsed subject to adaptation as applicable to meet the needs of people with disabilities that preclude, or limit, significantly energy-expending physical activity.</i></p>	
1c – Public: Parents and carers	
Recommendation 1.6:	<p>In addition to the recommendations in box 1 (<i>see Appendix 2 to this Commentary for revised version</i>), parents and carers should consider following the advice in box 2 (<i>also shown in Appendix 2</i>) to help children establish healthy behaviours and maintain or work towards a healthy weight. These strategies may have other benefits – for example, monitoring the amount of time children spend watching television may help reduce their exposure to inappropriate programmes or advertisements.</p>

<p>Evidence base for Recommendation 1.6:</p>	<ol style="list-style-type: none"> 1. Parents are important role models for children and young people in terms of behaviours associated with the maintenance of a healthy weight. [3] 2. Cohort studies suggest that children who increase calorie intake, increase fat intake, consume 'junk food', 'takeaways' and 'carbonated drinks' and/or do not eat breakfast, tend to gain weight. The evidence on 'snacking' is limited and inconsistent. [2+] 3. There is limited evidence from prospective cohort studies over at least one year for the relationship between regular meals, portion size or snacking with weight in children. [2+] 4. Cohort studies suggest that children who do not participate in sport outside school and who are the least active appear to gain more weight than their more active peers. [2+] 5. The evidence from cohort studies is inconsistent on the associations between television viewing and weight gain. Some but not all identified studies found a significant association between greater television viewing and weight gain. [2+] 6. The provision of regular meals in a supportive environment free from distractions may improve dietary intakes. [4] 7. Interventions which involve parents in a significant way may be particularly effective and can improve parental engagement in active play with children and a child's dietary intake. [2+] 8. 2–5 years is a key time to establish good nutritional habits especially when parents are involved. [1+] 9. Interventions require some involvement of parents or carers. [1+]
<p>HS Comments/Conclusions on Recommendation 1.6:</p> <p>1. Recommendation endorsed, with amendments to box 1 (see Appendix 2).</p>	

<p>Audience/setting 2 – NHS Note: NICE CG43(PH) indicates that Recommendations in other sections may also be relevant to health professionals.</p>	
<p>2a. NHS – Overarching Recommendation</p>	
<p>Recommendation 2.1:</p>	<p>Managers and health professionals in all primary care settings should ensure that preventing and managing obesity is a priority at both strategic and delivery levels. Dedicated resources should be allocated for action.</p>
<p>Evidence base for Recommendation 2.1:</p>	<p>'Opinion of the GDG'</p>

HS Comments/Conclusions on Recommendation 2.1:

1. *No evidence cited, but Recommendation considered appropriate and endorsed with the following addition –*

Service planning, priority setting and delivery should also take account of the roles of secondary and tertiary care settings in relation to the prevention and management of obesity, within a context of integrated care.

2b. NHS – Strategy: for senior managers and budget holders

Recommendation 2.2:

In their role as employers, NHS organisations should set an example in developing public health policies to prevent and manage obesity by following existing guidance and (in England) the local obesity strategy. In particular:

- on-site catering should promote healthy food and drink choices (for example by signs, posters, pricing and positioning of products)
- there should be policies, facilities and information that promote physical activity, for example, through travel plans, by providing showers and secure cycle parking and by using signposting and improved décor to encourage stair use.

Evidence base for Recommendation 2.2:

‘Opinion of the GDG’

HS Comments/Conclusions on Recommendation 2.2:

1. *No evidence cited, but Recommendation considered appropriate and endorsed with the following Scottish contextual addition –*

Work currently underway to establish nutritional standards for NHS catering services should be completed, and NHSScotland should demonstrate exemplar practice in the provision of food and drink and in respect of food- and drink-related promotion, marketing and sponsorship activity in all its premises.

2. *Additional Scottish contextual point – In Scotland, local obesity strategies are not currently mandatory but have been developed in some areas.*

3. *See also Recommendation 6.5.*

Recommendation 2.3:

All primary care settings should ensure that systems are in place to implement the local obesity strategy. This should enable health professionals with specific training, including public health practitioners working singly and as part of multidisciplinary teams, to provide interventions to prevent and manage obesity.

Evidence base for Recommendation 2.3:	<ol style="list-style-type: none"> 1. Sustained health-professional-led interventions in primary care or community settings, focusing on diet and physical activity or general health counselling can support maintenance of a healthy weight. [1+] 2. Interventions which provide support and advice on physical activity and diet are more likely to be effective for weight outcomes than interventions which focus on physical activity alone. There is no reliable evidence for diet alone. [1+]
<p>HS Comments/Conclusions on Recommendation 2.3:</p> <p>1. Recommendation endorsed where local obesity strategies exist.</p>	
Recommendation 2.4:	<p>All primary care settings should:</p> <ul style="list-style-type: none"> ▪ address the training needs of staff involved in preventing and managing obesity ▪ allocate adequate time and space for staff to take action ▪ enhance opportunities for health professionals to engage with a range of organisations and to develop multidisciplinary teams.
Evidence base for Recommendation 2.4:	<ol style="list-style-type: none"> 1. The type of health professional who provides the advice is not critical as long as they have the appropriate training and experience, are enthusiastic and able to motivate, and are able to provide long-term support [3] 2. It remains unclear whether interventions are more effective when delivered by multidisciplinary teams. [Level not applicable] 3. 'Opinion of the GDG'
<p>HS Comments/Conclusions on Recommendation 2.4:</p> <p>1. Recommendation endorsed.</p>	
Recommendation 2.5:	<p>Local health agencies should identify appropriate health professionals and ensure that they receive training in:</p> <ul style="list-style-type: none"> ▪ the health benefits and the potential effectiveness of interventions to prevent obesity, increase activity levels and improve diet (and reduce energy intake) ▪ the best practice approaches in delivering such interventions, including tailoring support to meet people's needs over the long term ▪ the use of motivational and counselling techniques. <p>Training will need to address barriers to health professionals providing support and advice, particularly concerns about the effectiveness of interventions, people's receptiveness and ability to change and the impact of advice on relationships with patients.</p>

<p>Evidence base for Recommendation 2.5:</p>	<ol style="list-style-type: none"> 1. Tailoring dietary advice to address potential barriers (taste, cost, availability, views of family members, time) is key to the effectiveness of interventions and may be more important than the setting. [3] 2. The type of health professional who provides the advice is not critical as long as they have the appropriate training and experience, are enthusiastic and able to motivate, and are able to provide long-term support [3] 3. There is some evidence that primary care staff may hold negative views on the ability of patients to change behaviours, and their own ability to encourage change. [3] 4. There is some evidence from the UK that patients are likely to welcome the provision of advice despite concerns by health professionals about interference or damaging the relationship with patients. [3] 5. Tailoring physical activity advice to address potential barriers (such as lack of time, access to leisure facilities, need for social support and lack of self-belief) is key to the effectiveness of interventions. [1++]
<p>HS Comments/Conclusions on Recommendation 2.5:</p> <p>1. Recommendation endorsed with the following additional clarifying point –</p> <p>In identifying which staff are the most appropriate, consideration should be given to their attitudes, enthusiasm and opportunities to contribute in a local context, not just their jobs.</p>	
<p>2c. NHS – Delivery: for all health professionals</p>	
<p>Recommendation 2.6:</p>	<p>Interventions to increase physical activity should focus on activities that fit easily into people’s everyday life (such as walking), should be tailored to people’s individual preferences and circumstances and should aim to improve people’s belief in their ability to change (for example, by verbal persuasion, modelling exercise behaviour and discussing positive effects). Ongoing support (including appropriate written materials) should be given in person or by phone, mail or internet.</p>
<p>Evidence base for Recommendation 2.6:</p>	<ol style="list-style-type: none"> 1. Behavioural/educational interventions to increase physical activity can be moderately effective, particularly for walking and non-facility-based activities, although increases may not be sustained over time. [1++] 2. Tailoring physical activity advice to address potential barriers (such as lack of time, access to leisure facilities, need for social support and lack of self-belief) is key to the effectiveness of interventions. [1++]

HS Comments/Conclusions on Recommendation 2.6:	
1. <i>Recommendation endorsed.</i>	
Recommendation 2.7:	Interventions to improve diet (and reduce energy intake) should be multicomponent (for example, including dietary modification, targeted advice, family involvement and goal setting), be tailored to the individual and provide ongoing support.
Evidence base for Recommendation 2.7:	<ol style="list-style-type: none"> 1. Moderate- or high-intensity dietary interventions most commonly report clinically significant reductions in fat intake and an increase in fruit and vegetable intake. [1++] 2. Briefer interventions, such as brief counselling/dietary advice by GPs or other health professionals, can be effective in improving dietary intake but tend to result in smaller changes than intensive interventions. [1++] 3. Interventions with a greater number of components are more likely to be effective. [1++] 4. Tailoring dietary advice to address potential barriers (taste, cost, availability, views of family members, time) is key to the effectiveness of interventions and may be more important than the setting. [3]
HS Comments/Conclusions on Recommendation 2.7:	
1. <i>Recommendation endorsed.</i>	
Recommendation 2.8:	Interventions may include promotional, awareness-raising activities, but these should be part of a long-term, multicomponent intervention rather than one-off activities (and should be accompanied by targeted follow-up with different population groups).
Evidence base for Recommendation 2.8:	<ol style="list-style-type: none"> 1. There is limited evidence to show that a multi-component intervention including a public health media campaign, can have a beneficial effect on weight management, particularly among individuals of higher social status. [2+] 2. There is a body of evidence that promotional campaigns including media interventions can increase awareness of what constitutes a healthy diet and may subsequently improve dietary intakes. [2+] 3. Promotional campaigns including media interventions can improve knowledge, attitudes and awareness of physical activity. Levels of awareness are likely to vary according to type of medium used and the scale of the campaign. [2++] 4. 'Opinion of the GDG'
HS Comments/Conclusions on Recommendation 2.8:	
1. <i>Recommendation endorsed.</i>	

Recommendation 2.9:	Health professionals should discuss weight, diet and activity with people at times when weight gain is more likely, such as during and after pregnancy, the menopause and while stopping smoking.
Evidence base for Recommendation 2.9:	<ol style="list-style-type: none"> 1. On balance, smoking cessation interventions incorporating weight management may increase continuous abstinence rates but the long-term impact on weight, and the impact on diet and physical activity levels, remains unclear. [1+] 2. There is a body of evidence that exercise (walking, other aerobic training, resistance training, strength training with weights machines or combinations) can improve body composition and result in a small loss of body weight and fat in postmenopausal women. This effect seemed to be optimal when combined with a weight-reducing diet. [1++] 3. There is limited evidence that a weight management programme addressing diet and activity during the menopause can prevent excess weight gain in women during the menopause. [1++] 4. There is limited evidence to suggest that continuing a regular exercise regimen and following an appropriate, healthy diet throughout pregnancy can result in significantly less total weight gain and significantly less increases in the sum of skinfolds. [2+] 5. Among adults, there is a body of evidence from cohort studies that pregnancy, menopause and smoking cessation are key stages in the life-course associated with weight gain. The evidence on the importance of other life stages, such as marriage, divorce and a change in work patterns (for example, shift working) remains unclear. [2+] 6. There is limited evidence from cohort studies that increasing physical activity may minimise the weight gain associated with smoking cessation. [2+]
HS Comments/Conclusions on Recommendation 2.9: 1. <i>Recommendation endorsed.</i>	
Recommendation 2.10:	All actions aimed at preventing excess weight gain and improving diet (including reducing energy intake) and activity levels in children and young people should actively involve parents and carers.
Evidence base for Recommendation 2.10:	<ol style="list-style-type: none"> 1. Interventions require some involvement of parents or carers. [1+]
HS Comments/Conclusions on Recommendation 2.10: 1. <i>Recommendation endorsed.</i>	

2d. NHS – Delivery: for health professionals working in/with primary care settings	
Recommendation 2.11:	All interventions to support smoking cessation should: <ul style="list-style-type: none"> ▪ ensure people are given information on services that provide advice on prevention and management of obesity if appropriate ▪ give people who are concerned about their weight general advice on long-term weight management, in particular encouraging increased physical activity.
Evidence base for Recommendation 2.11:	<ol style="list-style-type: none"> 1. On balance, smoking cessation interventions incorporating weight management may increase continuous abstinence rates but the long-term impact on weight, and the impact on diet and physical activity levels, remains unclear. [1+] 2. There is limited evidence from cohort studies that increasing physical activity may minimise the weight gain associated with smoking cessation. [2+]
HS Comments/Conclusions on Recommendation 2.11:	
1. <i>Recommendation endorsed.</i>	
2e. NHS – Delivery: for health professionals working in/with broader community settings	
Recommendation 2.12:	All community programmes to prevent obesity, increase activity levels and improve diet (including reducing energy intake) should address the concerns of local people from the outset. Concerns might include the availability of services and the cost of changing behaviour, the expectation that healthier foods do not taste as good, dangers associated with walking and cycling and confusion over mixed messages in the media about weight, diet and activity.
Evidence base for Recommendation 2.12:	<ol style="list-style-type: none"> 1. Tailoring dietary advice to address potential barriers (taste, cost, availability, views of family members, time) is key to the effectiveness of interventions and may be more important than the setting. [3] 2. Tailoring physical activity advice to address potential barriers (such as lack of time, access to leisure facilities, need for social support and lack of self-belief) is key to the effectiveness of interventions. [1++] 3. Barriers may vary by age, gender and social status. [3] 4. Interventions may be ineffective unless fundamental issues are addressed, such as individual confidence to change behaviour, cost and availability; pre-existing concerns such as poorer taste of healthier foods and confusion over mixed messages; the perceived 'irrelevance' of healthier eating to young people; and the potential risks (including perception of risk) associated with walking and cycling. [3]

Evidence base for Recommendation 2.12, contd:	5. Additional barriers for black and minority ethnic groups and vulnerable groups include cost, child care, cultural codes of conduct, language, racism and religious discrimination. [3+]
HS Comments/Conclusions on Recommendation 2.12: 1. <i>Recommendation endorsed.</i>	
Recommendation 2.13:	Health professionals should work with shops, supermarkets, restaurants, cafes and voluntary community services to promote healthy eating choices that are consistent with existing good practice guidance and to provide supporting information.
Evidence base for Recommendation 2.13:	1. Point of purchase schemes in shops, supermarkets, restaurants and cafes can be effective in improving dietary intakes at least in the short term, particularly if accompanied by supporting education, information and promotion. There is some evidence that longer-term, multi-component interventions may show greater effects. [2++]
HS Comments/Conclusions on Recommendation 2.13: 1. <i>This Recommendation, for which the cited evidence is very limited in respect of the role of health professionals, is not endorsed in a Scottish context. In Scotland, national level agencies and programmes are engaged in developing point of sale schemes supported by education, information and promotion, namely the healthliving award (for caterers) and the Scottish Grocers Federation (SGF) Healthy Living Programme (for retailers). While health professionals may have parts to play within this overall picture, it is considered that implementation of Recommendation 2.13 as worded might run the risk of over-extending their role at the expense of other, more effective contributions within the overall picture of local multicomponent interventions and partnerships.</i> 2. <i>Taking account of the above, <u>the following Conclusion is offered as an alternative to Recommendation 2.13</u> –</i> Consideration should be given to possible roles for health professionals in working with local partners to promote healthy eating choices, consistent with existing good practice guidance, and to provide supporting information – taking account of relevant national and local schemes. However, any such involvement should be considered in the wider context of how health professionals can best contribute to the overall picture of local multicomponent efforts and partnerships.	
Recommendation 2.14:	Health professionals should support and promote community schemes and facilities that improve access to physical activity, such as walking or cycling routes, combined with tailored information, based on an audit of local needs.

<p>Evidence base for Recommendation 2.14:</p>	<ol style="list-style-type: none"> 1. There is a body of evidence that creation of, or enhanced access to space for physical activity (such as walking or cycling routes), combined with supportive information/promotion, is effective in increasing physical activity levels. [2++] 2. Targeted behavioural change programmes with tailored advice appear to change travel behaviour of motivated groups. Associated actions such as subsidies for commuters may also be effective. [1++]
<p>HS Comments/Conclusions on Recommendation 2.14:</p> <p>1. <i>Recommendation endorsed, subject to the clarifying points that such efforts should be based on an audit or assessment of local needs <u>where available</u>, and such audit/assessments will not necessarily be conducted by health professionals.</i></p>	
<p>Recommendation 2.15:</p>	<p>Health professionals should support and promote behavioural change programmes along with tailored advice to help people who are motivated to change become more active, for example by walking or cycling instead of driving or taking the bus.</p>
<p>Evidence base for Recommendation 2.15:</p>	<ol style="list-style-type: none"> 1. The general promotion of active travel (for example, publicity campaigns) does not appear to be effective in increasing physical activity levels. [1++] 2. Targeted behavioural change programmes with tailored advice appear to change travel behaviour of motivated groups. Associated actions such as subsidies for commuters may also be effective. [1++]
<p>HS Comments/Conclusions on Recommendation 2.15:</p> <p>1. <i>Recommendation endorsed.</i></p>	
<p>Recommendation 2.16:</p>	<p>Families of children and young people identified as being at high risk of obesity – such as children with at least one obese parent – should be offered ongoing support from an appropriately trained health professional. Individual as well as family-based interventions should be considered, depending on the age and maturity of the child.</p>
<p>Evidence base for Recommendation 2.16:</p>	<ol style="list-style-type: none"> 1. Children at risk of becoming overweight or obese may be identified from opportunistic monitoring using growth charts after 2 years of age [3] 2. There is some evidence that children at risk of overweight or obesity may be identified by assessing measures of habitual activity levels and diet [3] 3. There is a body of evidence which suggests that the offspring of overweight and obese parent(s) are at increased risk of themselves becoming overweight or obese in childhood or adulthood. [2+] 4. Family-based interventions that target improved weight

<p>Evidence base for Recommendation 2.16, contd:</p>	<p>maintenance in children and adults, focusing on diet and activity, can be effective, at least for the duration of the intervention. [1++]</p> <ol style="list-style-type: none"> 5. The effectiveness of interventions tends to be positively associated with the number of behaviour change techniques taught to both parents and children. [1++] 6. It remains unclear whether the age of the child influences the effectiveness of family-based interventions compared with individual interventions. [Level not applicable] 7. Interventions should be tailored as appropriate for lower-income groups [1+]
<p>HS Comments/Conclusions on Recommendation 2.16:</p> <ol style="list-style-type: none"> 1. <i>Recommendation endorsed with the following additional point. It is important to take account of health professionals' training needs (including in respect of what are appropriate interventions at different ages), and thus to link with Recommendation 2.5.</i> 	
<p>2f. NHS – Delivery: for health professionals working in/with preschool, childcare and family settings</p>	
<p>Recommendation 2.17:</p>	<p>Any programme to prevent obesity in preschool, childcare or family settings should incorporate a range of components (rather than focusing on parental education alone), such as:</p> <ul style="list-style-type: none"> ▪ diet – interactive cookery demonstrations, videos and group discussions on practical issues such as meal planning and shopping for food and drink ▪ physical activity – interactive demonstrations, videos and group discussions on practical issues such as ideas for activities, opportunities for active play, safety and local facilities.
<p>Evidence base for Recommendation 2.17:</p>	<ol style="list-style-type: none"> 1. The effectiveness of interventions tends to be positively associated with the number of behaviour change techniques taught to both parents and children. [1++] 2. There is evidence for small but important beneficial effects of interventions that aim to improve dietary intake (such as videos, interactive demonstrations, and changing food provision at nursery school) so long as these interventions are not solely focused on nutrition education alone. [2+] 3. Interventions which involve parents in a significant way may be particularly effective and can improve parental engagement in active play with children and a child's dietary intake. [2+] 4. 'Opinion of the GDG'
<p>HS Comments/Conclusions on Recommendation 2.17:</p> <ol style="list-style-type: none"> 1. <i>Recommendation endorsed.</i> 	

Recommendation 2.18:	Family programmes to prevent obesity, improve diet (and reduce energy intake) and/or increase physical activity levels should provide ongoing, tailored support and incorporate a range of behaviour change techniques (see Clinical Recommendations, Lifestyle interventions). Programmes should have a clear aim to improve weight management.
Evidence base for Recommendation 2.18:	<ol style="list-style-type: none"> 1. Family-based interventions that target improved weight maintenance in children and adults, focusing on diet and activity, can be effective, at least for the duration of the intervention. [1++] 2. The effectiveness of interventions tends to be positively associated with the number of behaviour change techniques taught to both parents and children. [1++] 3. There is some evidence that interventions which do not focus on preventing obesity, but aim to bring about modest changes in dietary and physical activity behaviour, are unlikely to demonstrate an impact on body weight. However, there is evidence from cohort studies that people who habitually eat healthy diets and are physically active are more likely to maintain their weight over the long term. [2+] 4. Interventions should be tailored as appropriate for lower-income groups [1+] 5. Interventions require some involvement of parents or carers. [1+]
<p>HS Comments/Conclusions on Recommendation 2.18:</p> <p>1. Recommendation endorsed.</p>	
<p>2g. NHS – Delivery: for health professionals working in/with workplace settings</p>	
Recommendation 2.19:	Health professionals such as occupational health staff and public health practitioners should establish partnerships with local businesses and support the implementation of workplace programmes to prevent and manage obesity.
Evidence base for Recommendation 2.19:	1. 'Opinion of the GDG'

HS Comments/Conclusions on Recommendation 2.19:

1. *Scottish contextual points – In Scotland, the potential contributions of health professionals in this regard should be considered in the context of local partnership work linking with the activities of the Scottish Centre for Healthy Working Lives (including the Healthy Working Lives Award scheme), and with due regard to appropriateness of involvement and the need to avoid over-extending roles at the expense of other, more effective contributions within the overall picture of local multicomponent interventions and partnerships.*
2. *Taking account of the above, **the following Conclusion is offered as an alternative to Recommendation 2.19** –*

Consideration should be given to possible roles for certain health professionals in supporting the establishment of partnerships involving local businesses, and in supporting the implementation of workplace programmes for the promotion of healthy weight management – taking account of relevant national and local schemes. However, any such involvement should be considered in the wider context of how health professionals can best contribute to the overall picture of local multicomponent efforts and partnerships.

**Audience/setting 3 – Local authorities (LAs)
and partners in the local community**

3a. LAs & partners – Overarching Recommendation

Recommendation 3.1:	As part of their roles in regulation, enforcement and promoting wellbeing, local authorities, primary care trusts (PCTs) or local health boards and local strategic partnerships should ensure that preventing and managing obesity is a priority for action – at both strategic and delivery levels – through community interventions, policies and objectives. Dedicated resources should be allocated for action.
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Evidence base for Recommendation 3.1:	1. 'Opinion of the GDG'
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HS Comments/Conclusions on Recommendation 3.1:

1. *Recommendation endorsed subject to adaptation to fit the context of community planning in Scotland and the structure and working relationships of the NHS in Scotland.*

3b. LAs & partners – Strategy: for senior managers and budget holders	
Recommendation 3.2:	Local authorities should set an example in developing policies to prevent obesity in their role as employers, by following existing guidance and (in England) the local obesity strategy. <ul style="list-style-type: none"> ▪ On-site catering should promote healthy food and drink choices (for example by signs, posters, pricing and positioning of products). ▪ Physical activity should be promoted, for example through travel plans, by providing showers and secure cycle parking and using signposting and improved décor to encourage stair use.
Evidence base for Recommendation 3.2:	1. 'Opinion of the GDG'
HS Comments/Conclusions on Recommendation 3.2:	
<p>1. <i>Recommendation endorsed, and should be extended to other community planning partners.</i></p> <p>2. <i>Scottish contextual points – In Scotland, local obesity strategies are not currently mandatory but have been developed in some areas. The Healthy Working Lives (HWL) Award Programme provides an important context for local authorities and other organisations to contribute to improving health through action relating to the workplace.</i></p>	
Recommendation 3.3:	Local authorities (including planning, transport and leisure services) should engage with the local community, to identify environmental barriers to physical activity and healthy eating. This should involve: <ul style="list-style-type: none"> ▪ an audit, with the full range of partners including PCTs or local health boards, residents, businesses and institutions ▪ assessing (ideally by doing a health impact assessment) the effect of their policies on the ability of their communities to be physically active and eat a healthy diet; the needs of subgroups should be considered because barriers may vary by, for example, age, gender, social status, ethnicity, religion and whether an individual has a disability. <p>Barriers identified in this way should be addressed.</p>
Evidence base for Recommendation 3.3:	<ol style="list-style-type: none"> 1. Barriers may vary by age, gender and social status. [3] 2. Auditing the needs of all local users can help engage all potential local partners and establish local ownership. [3] 3. Interventions may be ineffective unless fundamental issues are addressed, such as individual confidence to change behaviour, cost and availability; pre-existing concerns such as poorer taste of healthier foods and confusion over mixed messages; the perceived 'irrelevance' of healthier eating to young people; and the

<p>Evidence base for Recommendation 3.3, contd:</p>	<p>potential risks (including perception of risk) associated with walking and cycling. [3]</p> <ol style="list-style-type: none"> 4. Addressing safety concerns in relation to walking and cycling may be particularly important for females and children and young people and their parents. [3] 5. Changes to city-wide transport, which make it easier and safer to walk, cycle and use public transport – such as the congestion charging scheme in the City of London and Safer Route to School schemes, have the potential to make active transport more appealing to local users. [3] 6. Additional barriers for BMEGs and vulnerable groups include cost, child care, cultural codes of conduct, language, racism and religious discrimination. [3+]
<p>HS Comments/Conclusions on Recommendation 3.3:</p> <ol style="list-style-type: none"> 1. <i>Recommendation endorsed in principle, subject to adaptation to fit the context of community planning in Scotland, the structure and working relationships of the NHS in Scotland, and other Scottish contextual considerations in relation to community audits and health impact assessment.</i> 	
<p>Recommendation 3.4:</p>	<p>Local authorities should work with local partners, such as industry and voluntary organisations, to create and manage more safe spaces for incidental and planned physical activity, addressing as a priority any concerns about safety, crime and inclusion, by:</p> <ul style="list-style-type: none"> ▪ providing facilities such as cycling and walking routes, cycle parking, area maps and safe play areas ▪ making streets cleaner and safer, through measures such as traffic calming, congestion charging, pedestrian crossings, cycle routes, lighting and walking schemes ▪ ensuring buildings and spaces are designed to encourage people to be more physically active (for example, through positioning and signing of stairs, entrances and walkways) ▪ considering in particular people who require tailored information and support, especially inactive, vulnerable groups.
<p>Evidence base for Recommendation 3.4:</p>	<ol style="list-style-type: none"> 1. There is a body of evidence that creation of, or enhanced access to space for physical activity (such as walking or cycling routes), combined with supportive information/promotion, is effective in increasing physical activity levels. [2++] 2. Targeted behavioural change programmes with tailored advice appear to change travel behaviour of motivated groups. Associated actions such as subsidies for commuters may also be effective. [1++] 3. Point of decision prompts or educational materials such as posters and banners have a weak positive effect on stair walking. [2+] 4. Auditing the needs of all local users can help engage all potential local partners and establish local ownership. [3]

<p>Evidence base for Recommendation 3.4, contd:</p>	<p>5. Environmental improvements in stairwells, such as decoration, motivational signs and music may increase stair use. Posters alone may be ineffective or effective only while the posters are in place. [2+/++]</p> <p>6. 'Opinion of the GDG'</p>
<p>HS Comments/Conclusions on Recommendation 3.4:</p> <p>1. Recommendation endorsed subject to adaptation to fit the context of community planning in Scotland.</p> <p>2. Additional Scottish contextual point – Action of these sorts by community planning partnerships is already encouraged by the National Physical Activity Strategy Let's Make Scotland More Active (Physical Activity Task Force, 2003).</p>	
<p>Recommendation 3.5:</p>	<p>Local authorities should facilitate links between health professionals and other organisations to ensure that local public policies improve access to healthy foods and opportunities for physical activity.</p>
<p>Evidence base for Recommendation 3.5:</p>	<p>1. Point of purchase schemes in shops, supermarkets, restaurants and cafes can be effective in improving dietary intakes at least in the short term, particularly if accompanied by supporting education, information and promotion. There is some evidence that longer-term, multi-component interventions may show greater effects. [2++]</p>
<p>HS Comments/Conclusions on Recommendation 3.5:</p> <p>1. Taking account of considerations reflected in point 1 in Comments/Conclusions on Recommendation 2.13 and of the Scottish community planning context, <u>the following Conclusion is offered as an alternative to Recommendation 3.5</u> –</p> <p>Community planning partnerships and partners should aim to enhance local access and opportunities for healthy eating and physical activity.</p>	
<p>3c. LAs & partners – Delivery: specific interventions</p>	
<p>Recommendation 3.6:</p>	<p>Local authorities and transport authorities should provide tailored advice such as personalised travel plans to increase active travel among people who are motivated to change.</p>
<p>Evidence base for Recommendation 3.6:</p>	<p>1. The general promotion of active travel (for example, publicity campaigns) does not appear to be effective in increasing physical activity levels. [1++]</p> <p>2. Targeted behavioural change programmes with tailored advice appear to change travel behaviour of motivated groups. Associated actions such as subsidies for commuters may also be effective. [1++]</p>

HS Comments/Conclusions on Recommendation 3.6:

1. *The provision of advice tailored to the specific commuting/travel circumstances of individuals and communities is supported. Personalised travel plans are but one approach, and their possible use and targeting should be considered as part of the bigger picture of how best to help people shift modes of travel and live more actively as a result. Taking account of these points, **the following Conclusion is offered as an alternative to Recommendation 3.6** –*

Community planning partnerships and strategic transport bodies should consider how best to make tailored advice about more active travel available to those who would wish it.

Recommendation 3.7:

Local authorities, through local strategic partnerships, should encourage all local shops, supermarkets and caterers to promote healthy food and drink, for example by signs, posters, pricing and positioning of products, in line with existing guidance and (in England) with the local obesity strategy.

Evidence base for Recommendation 3.7:

1. Point of purchase schemes in shops, supermarkets, restaurants and cafes can be effective in improving dietary intakes at least in the short term, particularly if accompanied by supporting education, information and promotion. There is some evidence that longer-term, multi-component interventions may show greater effects. [2++]

HS Comments/Conclusions on Recommendation 3.7:

1. *Scottish contextual points – In Scotland, national level agencies and programmes are engaged in developing point of sale schemes supported by education, information and promotion, namely the healthliving award (for caterers) and the Scottish Grocers Federation (SGF) Healthy Living Programme (for retailers). The potential role of local authorities in this area of effort should be considered in the context of how they can best contribute to local multicomponent interventions and partnerships.*
2. *Recommendation endorsed subject to adaptation to fit the above context and that of community planning in Scotland.*

Recommendation 3.8:

All community programmes to prevent obesity, increase activity levels and improve diet (and reduce energy intake) should address the concerns of local people. Concerns might include the availability of services and the cost of changing behaviour, the expectation that healthier foods do not taste as good, dangers associated with walking and cycling and confusion over mixed messages in the media about weight, diet and activity.

Evidence base for Recommendation 3.8:

1. Interventions may be ineffective unless fundamental issues are addressed, such as individual confidence to change behaviour, cost and availability; pre-existing concerns such as poorer taste of healthier foods and

Evidence base for Recommendation 3.8, contd:	confusion over mixed messages; the perceived 'irrelevance' of healthier eating to young people; and the potential risks (including perception of risk) associated with walking and cycling. [3]
HS Comments/Conclusions on Recommendation 3.8:	
1. <i>Recommendation endorsed.</i>	
Recommendation 3.9:	Community-based interventions should include awareness-raising promotional activities, but these should be part of a longer-term, multicomponent intervention rather than one-off activities.
Evidence base for Recommendation 3.9:	<ol style="list-style-type: none"> 1. There is limited evidence to show that a multi-component intervention including a public health media campaign, can have a beneficial effect on weight management, particularly among individuals of higher social status. [2+] 2. The effectiveness of promotional campaigns focusing on education alone remains unclear. [1+] 3. There is a body of evidence that promotional campaigns including media interventions can increase awareness of what constitutes a healthy diet and may subsequently improve dietary intakes. [2+] 4. Promotional campaigns including media interventions can improve knowledge, attitudes and awareness of physical activity. Levels of awareness are likely to vary according to type of medium used and the scale of the campaign. [2++]
HS Comments/Conclusions on Recommendation 3.9:	
1. <i>Recommendation endorsed.</i>	

Audience/setting 4 – Early years settings	
Recommendation 4.1:	All nurseries and childcare facilities should ensure that preventing excess weight gain and improving children's diet and activity levels are priorities.
Evidence base for Recommendation 4.1:	1. 'Opinion of the GDG'
HS Comments/Conclusions on Recommendation 4.1:	
1. <i>No evidence cited, but Recommendation considered appropriate and endorsed subject to widening of 'childcare facilities' to 'childcare providers', thereby covering eg childcare provided by registered childminders in domestic environments as well as care in more formal facilities.</i>	

Recommendation 4.2:	All action aimed at preventing excess weight gain, improving diet (and reducing energy intake) and increasing activity levels in children should involve parents and carers.
Evidence base for Recommendation 4.2:	1. Interventions require some involvement of parents or carers. [1+]
HS Comments/Conclusions on Recommendation 4.2: 1. Recommendation endorsed.	
Recommendation 4.3:	Nurseries and other childcare facilities should: <ul style="list-style-type: none"> ▪ minimise sedentary activities during play time, and provide regular opportunities for enjoyable active play and structured physical activity sessions ▪ implement Department for Education and Skills, Food Standards Agency and Caroline Walker Trust guidance on food procurement and healthy catering.
Evidence base for Recommendation 4.3:	<ol style="list-style-type: none"> 1. Interventions which do not identify favourable changes in weight outcomes may identify favourable changes in diet and/or activity outcomes (where recorded). The reasons for this are unclear. [1+] 2. There is evidence for small but important beneficial effects of interventions that aim to improve dietary intake (such as videos, interactive demonstrations, and changing food provision at nursery school) so long as these interventions are not solely focused on nutrition education alone. [2+] 3. There is limited evidence that structured physical activity programmes within nurseries can increase physical activity levels. [Grade pending] 4. Interventions which involve parents in a significant way may be particularly effective and can improve parental engagement in active play with children and a child's dietary intake. [2+] 5. There is limited evidence that interventions to increase opportunities for children to be active can be incorporated into nurseries and implemented by nursery staff. [Grade pending]

HS Comments/Conclusions on Recommendation 4.3:

1. *Recommendation endorsed subject to: widening of ‘childcare facilities’ to ‘childcare providers’, thereby covering eg childcare provided by registered childminders in domestic environments as well as care in more formal facilities; and adaptation to fit the following Scottish context. In Scotland, Nutritional Guidance for Early Years applies to all early years childcare providers. It provides information and guidance on the provision of healthy meals and snacks for children from 1 to 5 years of age, as well as emphasising the importance of physical activity and attention to dental/oral health. Training has been supported across Scotland to facilitate its implementation.*

Recommendation 4.4:

Staff should ensure that children eat regular, healthy meals in a pleasant, sociable environment free from other distractions (such as television). Children should be supervised at mealtimes and, if possible, staff should eat with children.

Evidence base for Recommendation 4.4:

1. ‘Opinion of the GDG’

HS Comments/Conclusions on Recommendation 4.4:

1. *No evidence cited, but Recommendation considered appropriate and endorsed subject to adaptation to fit the following Scottish context. In Scotland, Nutritional Guidance for Early Years recommends that children be offered regular, healthy meals and snacks in a pleasant sociable environment with adequate supervision and staff involvement in meal times whenever possible.*

Audience/setting 5 – Schools

5a. Schools – Overarching Recommendation

Recommendation 5.1:

All schools should ensure that improving the diet and activity levels of children and young people is a priority for action to help prevent excess weight gain. A whole-school approach should be used to develop life-long healthy eating and physical activity practices.

Evidence base for Recommendation 5.1:

1. ‘Opinion of the GDG’

HS Comments/Conclusions on Recommendation 5.1:

1. *No evidence cited, but Recommendation considered appropriate and endorsed.*
2. *Scottish contextual points – In Scotland, action consistent with this Recommendation and others will be promoted by the Schools (Health Promotion and Nutrition) (Scotland) Bill on enactment, and by Curriculum for Excellence. The Scottish Schools Parental Involvement Act is also important here.*

5b Schools – Strategy: for head teachers and chairs of governors

Recommendation 5.2:

Head teachers and chairs of governors, in collaboration with parents and pupils, should assess the whole school environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight, eat a healthy diet and be physically active, in line with existing standards and guidance. This includes policies relating to building layout and recreational spaces, catering (including vending machines) and the food and drink children bring into school, the taught curriculum (including PE), school travel plans and provision for cycling, and policies relating to the National Healthy Schools Programme and extended schools.

Evidence base for Recommendation 5.2:

1. The evidence on the effectiveness of multi-component school-based interventions to prevent obesity (addressing the promotion of physical activity, modification of dietary intake and reduction of sedentary behaviours) is equivocal. Some identified interventions demonstrated a reduction in mean BMI and the prevalence of obesity while the intervention was in place, but this finding was not universal. UK-based evidence in particular is lacking. [2+]
2. There is a body of evidence that school-based multi-component interventions addressing various aspects of diet and/or activity in the school, including the school environment are effective in improving physical activity and dietary behaviour, at least while the intervention is in place. However, UK-based evidence to support multi-component interventions (the ‘whole-school approach’) is limited. [1+]
3. There is a body of evidence to suggest that short- and long-term school-based interventions to improve children’s dietary intake may be effective, at least while the intervention is in place. This includes interventions aiming to increase fruit and (and to a lesser extent) vegetable intake, improve school lunches and/or promote water consumption. [1+]
4. There is evidence from multi-component interventions to suggest that both short- and long-term physical activity focused interventions may be effective, at least while the intervention is in place. [1+]

HS Comments/Conclusions on Recommendation 5.2:

1. *Recommendation endorsed subject to adaptation to fit Scottish schools organisational context.*
2. *Additional Scottish contextual points – In Scotland, action consistent with this Recommendation will be promoted by impacts of the Schools (Health Promotion and Nutrition) (Scotland) Bill on its enactment. The Bill seeks to improve child health by: requiring local authority schools to be health promoting schools; enabling local authorities to provide free snacks; requiring local authorities to meet statutory nutritional standards; and ensuring the anonymity of children entitled to free school meals. The Bill builds on the implementation of Hungry for Success, which introduced nutritional standards for Scottish schools within a whole school approach in 2003, and takes forward the health promoting school concept promoted internationally by the World Health Organization and in Scotland by NHS Health Scotland, Learning and Teaching Scotland and the Scottish Health Promoting Schools Unit. The Scottish Schools Parental Involvement Act is also of relevance to this Recommendation.*

Recommendation 5.3:	Head teachers and chairs of governors should ensure that teaching, support and catering staff receive training on the importance of healthy-school policies and how to support their implementation.
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Evidence base for Recommendation 5.3:	<ol style="list-style-type: none"> 1. There is limited UK evidence to indicate that in terms of engaging schools it is important to enlist the support of key school staff. [2+] 2. 'Opinion of the GDG'
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HS Comments/Conclusions on Recommendation 5.3:

1. *Recommendation endorsed subject to adaptation to fit Scottish schools organisational context.*
2. *Additional Scottish contextual point – The Schools (Health Promotion and Nutrition) (Scotland) Bill is of relevance here.*

Recommendation 5.4:	Schools should establish links with relevant organisations and professionals, including health professionals and those involved in local strategies and partnerships to promote sports for children and young people.
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Evidence base for Recommendation 5.4:	1. 'Opinion of the GDG'
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HS Comments/Conclusions on Recommendation 5.4:

1. *Recommendation endorsed.*
2. *Scottish contextual points – Active Schools Coordinators have a key role here. The Schools (Health Promotion and Nutrition) (Scotland) Bill emphasises, as a cross-cutting theme, the importance of partnership working. The Scottish Schools Parental Involvement Act is also of relevance to this Recommendation.*

Recommendation 5.5:

Interventions should be sustained, multicomponent and address the whole school, including after-school clubs and other activities. Short-term interventions and one-off events are insufficient on their own and should be part of a long-term integrated programme.

Evidence base for Recommendation 5.5:

1. The evidence on the effectiveness of multi-component school-based interventions to prevent obesity (addressing the promotion of physical activity, modification of dietary intake and reduction of sedentary behaviours) is equivocal. Some identified interventions demonstrated a reduction in mean BMI and the prevalence of obesity while the intervention was in place, but this finding was not universal. UK-based evidence in particular is lacking. [2+]
2. There is a body of evidence that school-based multi-component interventions addressing various aspects of diet and/or activity in the school, including the school environment are effective in improving physical activity and dietary behaviour, at least while the intervention is in place. However, UK-based evidence to support multi-component interventions (the ‘whole-school approach’) is limited. [1+]
3. There is a body of evidence to suggest that short- and long-term school-based interventions to improve children’s dietary intake may be effective, at least while the intervention is in place. This includes interventions aiming to increase fruit and (and to a lesser extent) vegetable intake, improve school lunches and/or promote water consumption. [1+]
4. There is evidence from multi-component interventions to suggest that both short- and long-term physical activity focused interventions may be effective, at least while the intervention is in place. [1+]

HS Comments/Conclusions on Recommendation 5.5:

1. *Recommendation endorsed.*
2. *Scottish contextual point – The Schools (Health Promotion and Nutrition) (Scotland) Bill is of relevance here.*

5c. Schools – Delivery: for teachers and other professionals	
Recommendation 5.6:	Staff delivering physical education, sport and physical activity should promote activities that children and young people find enjoyable and can take part in outside school, through into adulthood. Children’s confidence and understanding of why they need to continue physical activity throughout life (physical literacy) should be developed as early as possible.
Evidence base for Recommendation 5.6:	<ol style="list-style-type: none"> 1. There is a body of evidence to suggest that young people’s views on barriers and facilitators suggest that interventions should (i) modify physical education lessons to suit their preferences, (ii) involve family and peers, and make physical activity a social activity, (iii) increase young people’s confidence, knowledge and motivation relating to physical activity, and (iv) make physical activities more accessible, affordable and appealing to young people. [1++] 2. ‘Opinion of the GDG’
HS Comments/Conclusions on Recommendation 5.6:	
<ol style="list-style-type: none"> 1. <i>Recommendation endorsed.</i> 2. <i>Scottish contextual point – The Schools (Health Promotion and Nutrition) (Scotland) Bill is of relevance here.</i> 	
Recommendation 5.7:	Children and young people should eat meals (including packed lunches) in school in a pleasant, sociable environment. Younger children should be supervised at mealtimes and, if possible, staff should eat with children.
Evidence base for Recommendation 5.7:	<ol style="list-style-type: none"> 1. ‘Opinion of the GDG’
HS Comments/Conclusions on Recommendation 5.7:	
<ol style="list-style-type: none"> 1. <i>Recommendation endorsed.</i> 2. <i>Scottish contextual point – The Schools (Health Promotion and Nutrition) (Scotland) Bill is of relevance here.</i> 	
Recommendation 5.8:	Staff planning interventions should consider the views of children and young people, any differences in preferences between boys and girls, and potential barriers (such as cost or the expectation that healthier foods do not taste as good).
Evidence base for Recommendation 5.8:	<ol style="list-style-type: none"> 1. There is a body of evidence to suggest that young people’s views of barriers and facilitators to healthy eating indicated that effective interventions would (i) make healthy food choices accessible, convenient and cheap in schools, (ii) involve family and peers, and (iii) address

<p>Evidence base for Recommendation 5.8, contd:</p>	<p>personal barriers to healthy eating, such as preferences for fast food in terms of taste, and perceived lack of will-power. [1++]</p> <p>2. There is a body of evidence to suggest that young people's views on barriers and facilitators suggest that interventions should (i) modify physical education lessons to suit their preferences, (ii) involve family and peers, and make physical activity a social activity, (iii) increase young people's confidence, knowledge and motivation relating to physical activity, and (iv) make physical activities more accessible, affordable and appealing to young people. [1++]</p>
<p>HS Comments/Conclusions on Recommendation 5.8:</p> <p>1. <i>Recommendation endorsed.</i></p> <p>2. <i>Scottish contextual point – The Schools (Health Promotion and Nutrition) (Scotland) Bill is of relevance here.</i></p>	
<p>Recommendation 5.9:</p>	<p>Where possible, parents should be involved in school-based interventions through, for example, special events, newsletters and information about lunch menus and after-school activities.</p>
<p>Evidence base for Recommendation 5.9:</p>	<p>1. 'Opinion of the GDG'</p>
<p>HS Comments/Conclusions on Recommendation 5.9:</p> <p>1. <i>Recommendation endorsed.</i></p> <p>2. <i>Scottish contextual points – The Scottish Schools Parental Involvement Act is important in relation to this Recommendation. The Schools (Health Promotion and Nutrition) (Scotland) Bill is also of relevance here.</i></p>	

<p>Audience/setting 6 – Workplaces</p>	
<p>6a. Workplaces – Overarching Recommendation</p>	
<p>Recommendation 6.1:</p>	<p>All workplaces, particularly large organisations such as the NHS and local authorities, should address the prevention and management of obesity, because of the considerable impact on the health of the workforce and associated costs to industry. Workplaces are encouraged to collaborate with local strategic partnerships and to ensure that action is in line with the local obesity strategy (in England).</p>
<p>Evidence base for Recommendation 6.1:</p>	<p>1. 'Opinion of the GDG'</p>

HS Comments/Conclusions on Recommendation 6.1:

1. Recommendation endorsed subject to appropriateness when set against workplaces' capacity to deliver.
2. Scottish contextual points – In Scotland, local obesity strategies are not currently mandatory but have been developed in some areas. The Healthy Working Lives (HWL) Award Programme provides an important context for policies, strategies and activities to improve health through the workplace.

6b. Workplaces – For all workplaces

<p>Recommendation 6.2:</p>	<p>Workplaces should provide opportunities for staff to eat a healthy diet and be more physically active, through:</p> <ul style="list-style-type: none"> ▪ active and continuous promotion of healthy choices in restaurants, hospitality, vending machines and shops for staff and clients, in line with existing Food Standards Agency guidance ▪ working practices and policies, such as active travel policies for staff and visitors ▪ a supportive physical environment, such as improvements to stairwells and providing showers and secure cycle parking ▪ recreational opportunities, such as supporting out-of-hours social activities, lunchtime walks and use of local leisure facilities.
<p>Evidence base for Recommendation 6.2:</p>	<ol style="list-style-type: none"> 1. There is inconclusive evidence for the effectiveness of workplace-based physical activity interventions on weight outcomes. [Level not applicable] 2. The effectiveness of healthier food provision in workplaces on weight outcomes remains unclear. [2++] 3. Worksite behaviour modification programmes, such as health screening followed by counselling and, sometimes, environmental changes, can lead to improvements in nutrition and physical activity while the intervention is in place. [1+] 4. There is a body of evidence that the provision of healthier food choices can encourage consumption of a healthier diet. [2++] 5. Workplace physical activity programmes can have a positive effect on physical activity. [1++] 6. Environmental improvements in stairwells, such as decoration, motivational signs and music may increase stair use. Posters alone may be ineffective or effective only while the posters are in place. [2+/++] 7. A UK-based survey of Heartbeat Award schemes, recommended improved promotion and better integration with other health programmes. [3] 8. Behavioural/educational interventions to increase physical activity can be moderately effective, particularly for walking and non-facility-based activities, although increases may not be sustained over time. [1++]

Evidence base for Recommendation 6.2, contd:	9. There is a body of evidence that creation of, or enhanced access to space for physical activity (such as walking or cycling routes), combined with supportive information/promotion, is effective in increasing physical activity levels. [2++]
HS Comments/Conclusions on Recommendation 6.2: 1. <i>Recommendation endorsed.</i> 2. <i>Scottish contextual point – The Healthy Working Lives (HWL) Award Programme provides an important context for such action.</i>	
Recommendation 6.3:	Incentive schemes (such as policies on travel expenses, the price of food and drinks sold in the workplace and contributions to gym membership) that are used in a workplace should be sustained and part of a wider programme to support staff in managing weight, improving diet and increasing activity levels.
Evidence base for Recommendation 6.3:	1. Payroll incentive schemes (such as free gym membership) are either only effective in the short term (during the period of the intervention) or ineffective for weight control. [1+] 2. Limited evidence suggests that using an incentive of free access to leisure facilities is likely to increase activity levels but only during the period of the intervention. [1+]
HS Comments/Conclusions on Recommendation 6.3: 1. <i>Recommendation endorsed.</i>	
6c. Workplaces – For NHS, public organisations and large commercial organisations	
Recommendation 6.4:	Workplaces providing health checks for staff should ensure that they address weight, diet and activity, and provide ongoing support.
Evidence base for Recommendation 6.4:	1. Worksite behaviour modification programmes, that include health screening with counselling/education can result in short-term weight loss. Weight loss may be regained post intervention. [1+]
HS Comments/Conclusions on Recommendation 6.4: 1. <i>Recommendation endorsed.</i> 2. <i>Scottish contextual point – The Healthy Working Lives (HWL) Award Programme provides an important context for such action.</i>	

<p>Recommendation 6.5:</p>	<p>Action to improve food and drink provision in the workplace, including restaurants, hospitality and vending machines, should be supported by tailored educational and promotional programmes, such as a behavioural intervention or environmental changes (for example, food labelling or changes to availability).</p> <p>For this to be effective, commitment from senior management, enthusiastic catering management, a strong occupational health lead, links to other on-site health initiatives, supportive pricing policies and heavy promotion and advertisement at point of purchase are likely to be needed.</p>
<p>Evidence base for Recommendation 6.5:</p>	<ol style="list-style-type: none"> 1. The effectiveness of healthier food provision in workplaces on weight outcomes remains unclear. [2++] 2. Worksite behaviour modification programmes, such as health screening followed by counselling and, sometimes, environmental changes, can lead to improvements in nutrition and physical activity while the intervention is in place. [1+] 3. There is a body of evidence that the provision of healthier food choices can encourage consumption of a healthier diet. [2++] 4. A body of UK-based case studies suggests that factors most likely to make a canteen-style five-a-day intervention work are: commitment from the top, enthusiastic catering management, a strong occupational health lead, links to other on-site health initiatives, free or subsidised produce and heavy promotion and advertisement at point of purchase. [3] 5. A body of UK-based case studies suggests that the more successful behaviour modification/education techniques include an interdisciplinary approach with broad representation including health and safety and human resources, and implementers from high grades and strategic positions; initiatives integrated into worksite objectives; staff involvement, communication and realistic objectives; activities that go beyond the superficial and address root causes. [3] 6. A UK-based survey of Heartbeat Award schemes, recommended improved promotion and better integration with other health programmes. [3]
<p>HS Comments/Conclusions on Recommendation 6.5:</p> <ol style="list-style-type: none"> 1. <i>Recommendation endorsed.</i> 2. <i>Scottish contextual point – The Healthy Working Lives (HWL) Award Programme provides an important context for such action.</i> 	

Audience/setting 7 – Self-help, commercial and community programmes	
7a. Self-help, commercial and community programmes – Strategy: for health agencies and local authorities	
Recommendation 7.1:	<p>Primary care organisations and local authorities should recommend to patients, or consider endorsing, self-help, commercial and community weight management programmes only if they follow best practice by:</p> <ul style="list-style-type: none"> ▪ helping people assess their weight and decide on a realistic healthy target weight (people should usually aim to lose 5–10% of their original weight) ▪ aiming for a maximum weekly weight loss of 0.5–1 kg ▪ focusing on long-term lifestyle changes rather than a short-term, quick-fix approach ▪ being multicomponent, addressing both diet and activity, and offering a variety of approaches ▪ using a balanced, healthy-eating approach ▪ recommending regular physical activity (particularly activities that can be part of daily life, such as brisk walking and gardening) and offering practical, safe advice about being more active ▪ including some behaviour-change techniques, such as keeping a diary and advice on how to cope with ‘lapses’ and ‘high-risk’ situations ▪ recommending and/or providing ongoing support.
Evidence base for Recommendation 7.1:	<ol style="list-style-type: none"> 1. In both children and adults, there is a paucity of good-quality evidence on the effectiveness of interventions in non-clinical settings. 2. ‘Opinion of the GDG’
HS Comments/Conclusions on Recommendation 7.1:	
<ol style="list-style-type: none"> 1. <i>No supportive evidence cited, but Recommendation considered appropriate and endorsed subject to adaptation as applicable to meet the needs of people with disabilities that preclude, or limit, significantly energy-expending physical activity.</i> 	
7a. Self-help, commercial and community programmes – Delivery: for health professionals in primary and secondary care and community settings	
Recommendation 7.2:	<p>Health professionals should discuss the range of weight management options with people who want to lose or maintain their weight, or are at risk of weight gain, and help them decide what best suits their circumstances and what they will be able to sustain in the long term.</p>
Evidence base for Recommendation 7.2:	<ol style="list-style-type: none"> 1. ‘Opinion of the GDG’

HS Comments/Conclusions on Recommendation 7.2:	
1. <i>No evidence cited, but Recommendation considered appropriate and endorsed.</i>	
Recommendation 7.3:	General practices and other primary or secondary care settings recommending commercial, community and/or self-help weight management programmes should continue to monitor patients and provide support and care.
Evidence base for Recommendation 7.3:	1. 'Opinion of the GDG'
HS Comments/Conclusions on Recommendation 7.3:	
1. <i>No evidence cited, but Recommendation considered appropriate and endorsed.</i>	
Recommendation 7.4:	Health professionals should check that any commercial, community or self-help weight management programmes they recommend to patients meet best-practice standards.
Evidence base for Recommendation 7.4:	1. 'Opinion of the GDG'
HS Comments/Conclusions on Recommendation 7.4:	
1. <i>No evidence cited, but Recommendation considered appropriate and endorsed.</i>	
2. <i>For 'best-practice standards', see Recommendation 7.1.</i>	

<p>Recommendations for Research:</p>	<p>NICECG43 recommends that the following <u>research questions</u> be addressed.</p> <ol style="list-style-type: none"> 1. What are the most effective interventions to prevent or manage obesity in children and adults in the UK? 2. How does the effectiveness of interventions to prevent or manage obesity vary by population group, setting and source of delivery? 3. What is the cost effectiveness of interventions to prevent or manage obesity in children and adults in the UK? 4. What elements make an intervention that increase effective and sustainable, and what training do staff need? <p>NICECG43 makes the following <u>evaluation and monitoring recommendations</u> of relevance to the Public Health aspects of the guidance).</p> <ol style="list-style-type: none"> 1. <u>Population trends in overweight and obesity</u> <ol style="list-style-type: none"> 1.1 The continued collection of data on the prevalence of overweight and obesity at national and regional levels (with subgroup analysis by age, gender and social status) is strongly recommended. 1.2 More frequent* collection of data among children, black and minority ethnic groups and other vulnerable groups at national and local levels is encouraged, to allow full analysis of trends. (<i>*As compared with the Health Survey for England's provision of detailed data on children and on black and minority ethnic groups about every 5 years.</i>) 2. <u>Local and national action</u> <ol style="list-style-type: none"> 2.1 All local action – including action in childcare settings, schools and workplaces – should be monitored and evaluated with the potential impact on health in mind. 2.2 An audit of health impact should also be undertaken after each change has taken place. 2.3 The need to evaluate projects should be taken into account when planning funding for those projects. 2.4 The evaluation of local initiatives should be carried out in partnership with local centres that have expertise in evaluation methods, such as health authorities, public health observatories and universities. 2.5 All current and future actions should be rigorously monitored and evaluated with their potential health impact in mind. 2.6 Evaluation of campaigns (including social marketing campaigns) should go beyond the 'reach' of the campaigns and more fully explore their effectiveness in changing behaviour.
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HS Comments/Conclusions on Recommendations for Research:

1. *Research questions 1-4 endorsed with addition of the following Scottish contextual point: need to determine how best to identify and meet Scotland's research needs in this subject area, taking account of Scottish, UK and international opportunities and funding sources, and existing/planned research evaluation within and beyond Scotland.*
2. *It should be recognised that research questions 1-4 do not reflect all of the important Public Health evidence gaps in relation to healthy weight. For example, there is a need for a better understanding in relation to obesogenic environmental influences and the effectiveness of 'upstream' to counter these and foster environments conducive to the achievement and maintenance of healthy weight.*
3. *Evaluation and monitoring Recommendations 1.1 and 1.2 endorsed. Scottish contextual points – Data for adults are collected through the Scottish Health Survey and, from the 2008 survey, will be reported annually for Scotland and not less than 4-yearly for NHS Boards. Data for children are collected in the Scottish Health Survey and through the Child Health Surveillance Programme (CHSP), though not all NHS Boards participate in the latter. Data for black and minority ethnic and 'other vulnerable groups' are seldom available, and this should be addressed through the inclusion of appropriate classification questions in existing surveys where this is viable, and consideration should be given to boost samples and special surveys. Increased coverage of CHSP is considered desirable.*
4. *Evaluation and monitoring Recommendations 2.1-2.6 endorsed in principle, but it is considered neither feasible nor desirable to evaluate every single relevant initiative 'to the nth degree'. A coordinated research strategy is desirable to answer key research questions relating to effectiveness, including those concerning inequalities dimensions, and with attention to intended/unintended psychological outcomes (see also Comment 5 on 'Scope').*

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Box 1 – revised from box 1 in NICECG43(PH):**Strategies to help people achieve and maintain a healthy weight*****Diet***

- Base meals on starchy foods such as potatoes, bread, rice and pasta, choosing wholegrain where possible.
- Eat plenty of fibre-rich foods – such as oats, beans, peas, lentils, grains, seeds, fruit and vegetables, as well as wholegrain bread and brown rice and pasta.
- Eat at least five portions of a variety of fruit and vegetables each day, in place of foods higher in fat and calories.
- Eat a low-fat diet and avoid increasing your fat and/or calorie intake.
- Eat as little as possible of:
 - fried foods
 - drinks and confectionery high in added sugars
 - other food and drinks high in fat and sugar, such as some take-away and fast foods.
- Eat breakfast.
- Watch the portion size of meals and snacks, and how often you are eating.
- Remember – alcoholic drinks can provide a lot of calories. If you drink alcohol, watch how much you drink, take a sensible approach, and choose lower calorie drinks.

Activity

- Make enjoyable activities – such as walking, cycling, swimming, aerobics and gardening – part of everyday life.
- Minimise sedentary activities, such as sitting for long periods watching television, at a computer or playing video games.
- Build activity into the working day – for example, take the stairs instead of the lift, take a walk at lunchtime.
- Plan to be active with friends and family, and maximize opportunities for wider social support – for example through involvement in local groups or setting up a 'buddy' system.

Box 2 from NICECG43(PH):**Helping children and young people maintain or work towards a healthy weight*****Diet***

- Children and young adults should eat regular meals, including breakfast, in a pleasant, sociable environment without distractions (such as watching television).
- Parents and carers should eat with children – with all family members eating the same foods.

Activity

- Encourage active play – for example, dancing and skipping.
- Try to be more active as a family – for example, walking and cycling to school and shops, going to the park or swimming.
- Gradually reduce sedentary activities – such as watching television or playing video games – and consider active alternatives such as dance, football or walking.
- Encourage children to participate in sport or other active recreation, and make the most of opportunities for exercise at school.