

National Framework for Clinical Obesity Services

First Edition



NACOS[™]
National Association of
Clinical Obesity Services

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Foreword

As Founding President of the National Association of Clinical Obesity Services (NACOS), I am honoured to present this report on the first National Framework for Clinical Obesity Services in Australia.

The prevalence of obesity has tripled in most countries, including Australia, since the mid-1970s.¹ According to the most recent data, there are over 2 million young people and over 12 million adults with overweight or obesity in Australia²; and approximately 7 million of these people have clinically significant weight-related health impairments. As such, excess weight likely affects all of us in some way.³

While the causes of the global obesity issue are the subject of, at times, divisive debate, 'individual risk factors' (biological and behavioural) are often implicated in explaining this phenomenon. While a better understanding of these risk factors is clinically important for developing treatments and care models, it is now recognised that increasingly 'obesogenic'⁴ environments and their interactions with individual risk factors most likely explain the rapid worldwide changes in body weight and the differences in obesity rates between countries.

At present, the rapidly increasing evidence base around the causes of obesity has not yet entered public discourse and the shaming and blaming of individuals for having excess body weight persists. Consequently, the stigma of obesity is pervasive in Australia today, as it is in most societies in the world. This, alongside policy inertia, probably explains why access to adequate clinical obesity care is very limited in our health system.

We recently reported that public hospitals are not adequately resourced to service the estimated one million adults in Australia with clinically very severe obesity (based on bariatric surgery eligibility criteria⁵), the majority of whom also have complex health care needs and require access to social support services⁶. This inequity is what motivated us to form NACOS. Our vision is to live in a society that provides timely and equitable access to the best available care for the effective management of obesity and its complications. We believe that the development of the first National Framework for Clinical Obesity Services (the Framework) is an important step towards realising this vision.

The purpose of the Framework is to offer practical guidance on how to best design, deliver, and access clinical obesity (or 'weight management') services for key stakeholders, including health care professionals (HCPs), consumers, those working in the health insurance industry, and policy makers. The Framework was developed using an iterative process involving rigorous methods to solicit expert views and ideas that were further tested against existing evidence, where available. An unrestricted grant from Novo Nordisk Pharmaceuticals Pty Ltd was provided to the NACOS for this project. The NACOS had subsequently commissioned PwC to facilitate the development of this Framework.

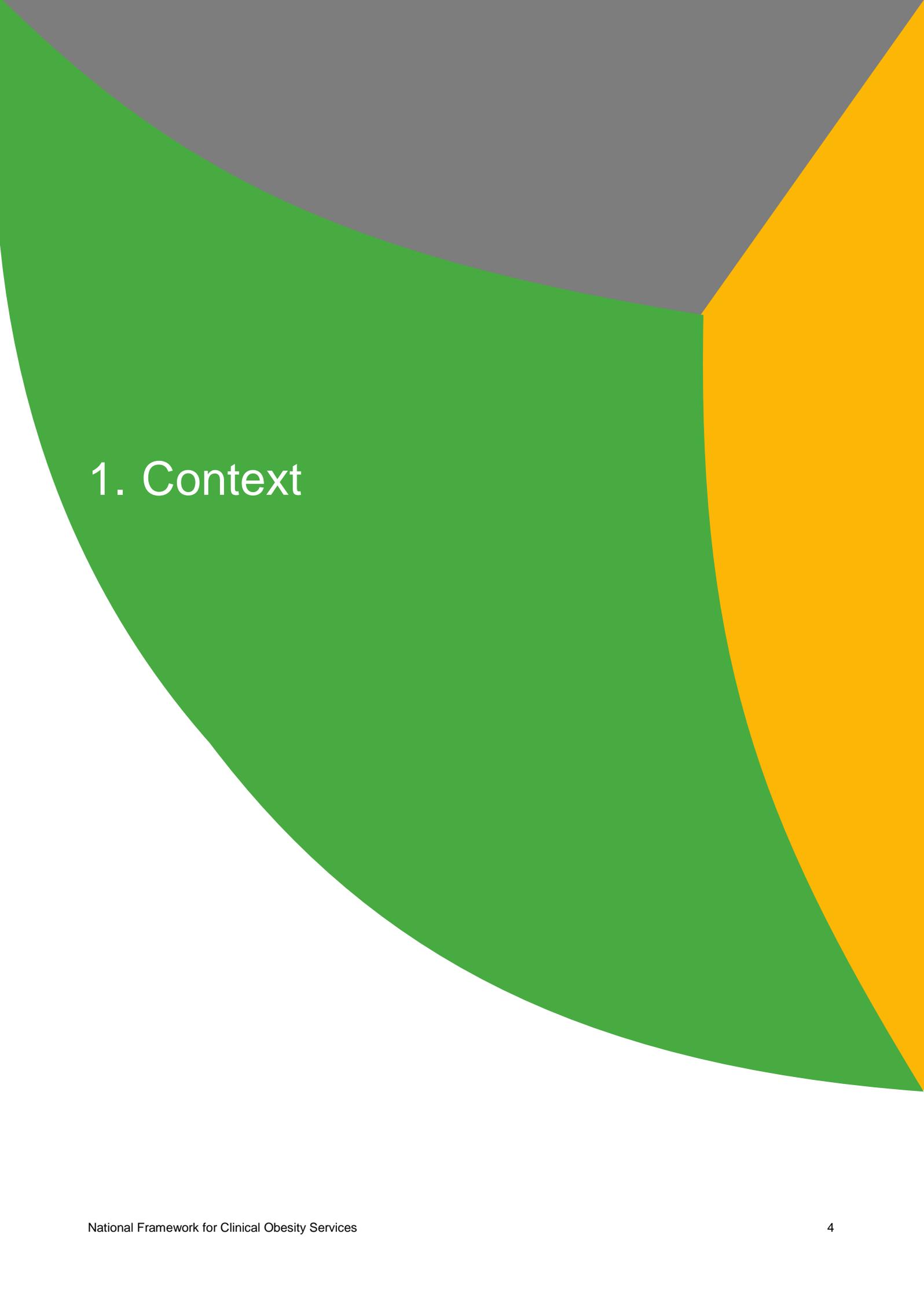
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1. Context

1. Context

1.1. Introduction

Overweight and obesity are terms used to define excess body weight in the form of fat causally linked to poor health and wellbeing.⁷ They are most commonly classified using the Body Mass Index (BMI), which is calculated by dividing weight in kilograms by height in metres squared (expressed in kg/m² units). The BMI is generally considered an easily obtained indicator of body fatness.⁸

More than 12 million Australians aged 18 years and over live with overweight or obesity as defined by having a BMI of 25 kg/m² or higher.

In Australia, there is a common misconception that the solution to overweight and obesity is to 'eat less and move more'. This societal perception has led to a high level of stigma around those experiencing the condition, often resulting in a reluctance to access treatment and subsequent adverse health outcomes for the individual. In response to this challenge, the National Association of Clinical Obesity Services (NACOS) recognises obesity with weight-related complications as a chronic disease that requires immediate attention, funding, advocacy, and most importantly, clinical service improvements. As an organisation, the NACOS is committed to:

- Promoting higher standards of care for clinical obesity services, including benchmarking and evaluation for quality improvements, research, and accreditation
- Increasing access to information and networking opportunities among clinical obesity services that are focused on the provision of quality care for people with obesity and related health impairments
- Developing policies and procedures to deliver the highest quality care and education
- Encouraging and supporting clinical obesity services to work with all relevant health professionals to optimise quality care delivery
- Providing support to smaller clinical obesity services in regional, rural, and remote communities
- Providing support to clinicians and other HCPs delivering weight management services

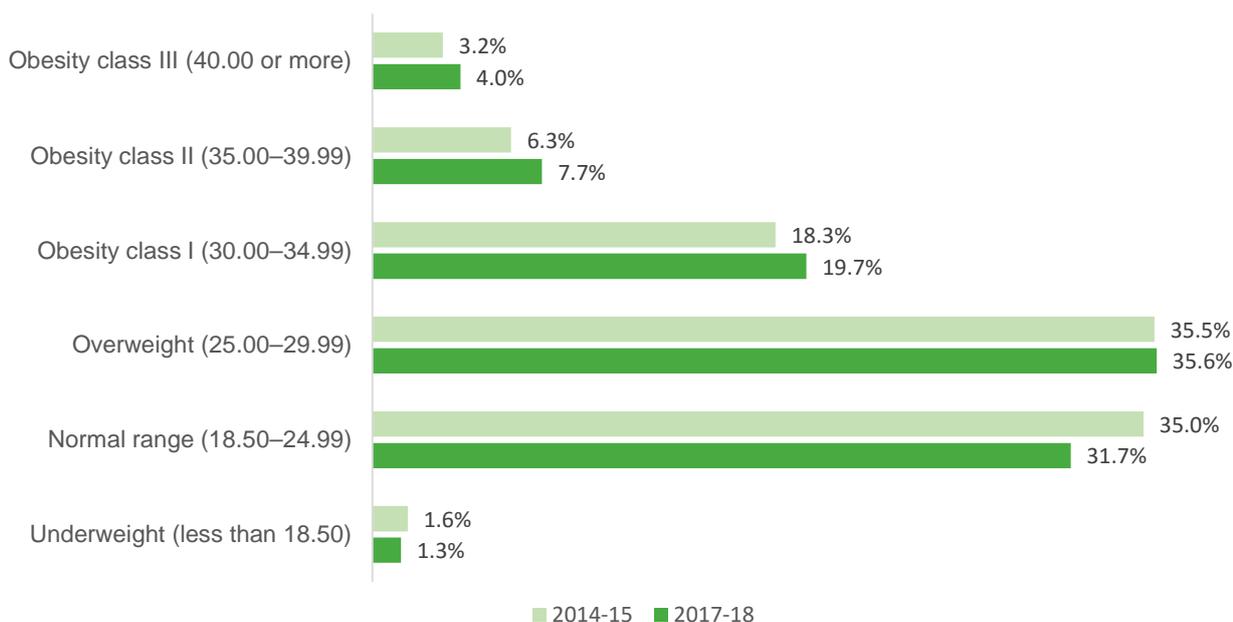
The NACOS believes that patients should have equitable access to a range of evidence-based, effective treatment options that are proportionate to their health care needs and preferences. The NACOS supports recommendations that clinical obesity care should be delivered by a multidisciplinary team (MDT) of HCPs using well-established principles for long-term chronic disease management.

The NACOS is leading a programme of activities to achieve this outcome, including the development of the first National Framework for Clinical Obesity Services (the Framework) and the continued development of clinical pathways for clinical obesity services to address the existing resource gaps and future needs in the health system.

1.2. Overweight and obesity as a national health issue

Overweight and obesity is a national health issue in Australia. As shown in **Figure 1** below, a significant percentage of the population has overweight (35.6%) and obesity (31.4%) in 2017-18. Whilst the proportion of Australians with overweight has remained relatively stable over time, the proportion of those with obesity has risen from 27.8% in 2014-15. In 1995, this group of the population accounted for only 18.7% of Australians,² demonstrating that the proportion of the population with obesity has grown by 67.9%.

Figure 1 Measured Body Mass Index of persons in Australia 2017-18 and 2014-15



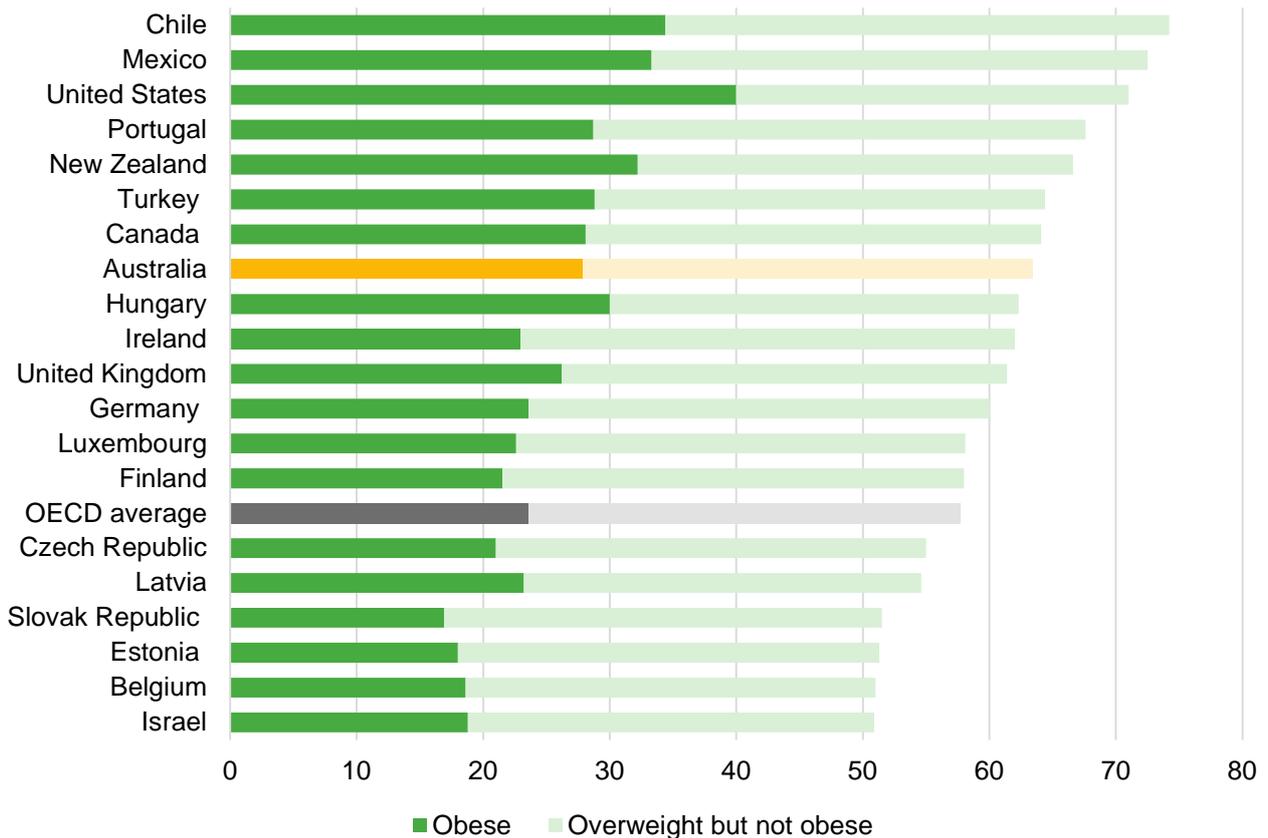
Source: Australian Health Survey: First Results, 2017-18 and 2014-15.

The prevalence of obesity among children and adolescents has also increased. In 2017-18, the prevalence of obesity among children and adolescents aged 2 to 17 years was 8.2%.³ The highest prevalence of obesity was at age 16-17 years for boys (8.0%), and at age 5-7 years for girls (12.0%).⁹

In 2011, 7.0% of the total burden of disease (healthy life-years lost) in Australia was due to overweight and obesity. About 38.0% of the burden of disease due to overweight and obesity was from cardiovascular disease, followed by diabetes mellitus (17.0%) and osteoarthritis (12.0%).⁹ Compared to people with a normal BMI, the life expectancy of people with class I obesity (defined as a BMI of 30.0 to 34.9 kg/m²) was reduced by 2-4 years; and by 8-10 years for those with class III obesity (defined as a BMI of equal to or over 40 kg/m²).⁹

As shown in **Figure 2** below, Australia had the 8th highest proportion of overweight or obesity for populations aged 15 years and over among Organisation for Economic Co-operation and Development (OECD) member countries. This is above the OECD average and international counterparts such as the UK.³ Compared to other conditions with similar health outcomes, there is insufficient attention paid to the level of access to appropriate care for obesity and clinically severe obesity in Australia. It is time to act to improve obesity treatment access and effectiveness.

Figure 2: Proportion of overweight or obese adults across OECD countries, 2017 or nearest year



Source: OECD 2018; Table S13.

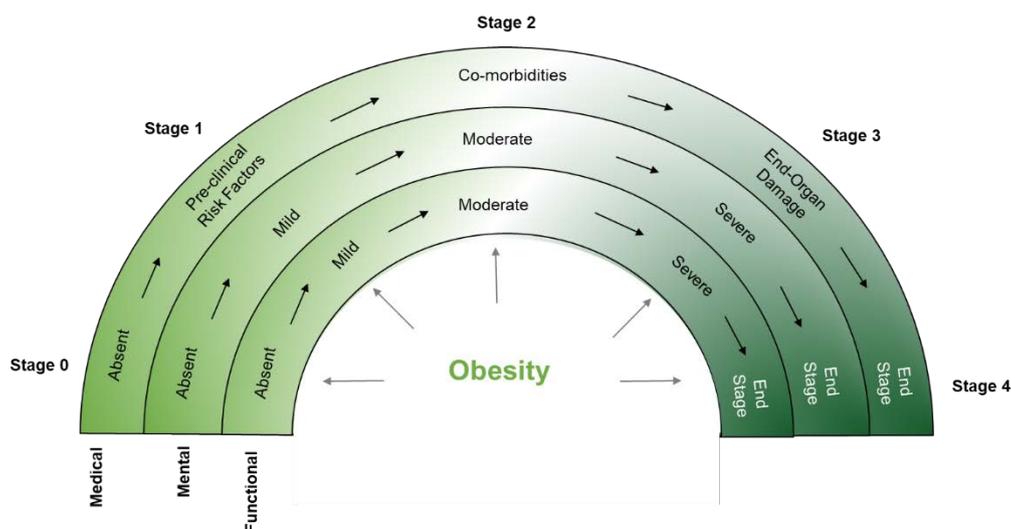
Clinically significant excess weight

While acknowledging the usefulness, simplicity, and broad applicability of the BMI, it is increasingly recognised as a poor indicator of obesity as a health issue because it ‘does not necessarily reflect the body fat distribution or describe the same degree of fatness in different individuals’.¹⁰

The Edmonton Obesity Staging System (EOSS) has become one of the most widely validated and researched obesity staging systems since it was introduced in 2009.¹¹ Conceptually, the EOSS is a clinical staging system based on weight-related complications among individuals with overweight and obesity. It is a more comprehensive measure of weight-related complications and a stronger predictor of mortality compared to BMI or waist circumference. It is useful as a scoring system for the selection of patients for bariatric surgery and may also be useful for pre-surgical stratification and risk assessment in clinical practice.¹²

Individuals with an EOSS 2 or higher (see **Figure 3**, below) typically have clinically significant weight-related complications and will likely have complex health care needs requiring multidisciplinary care.

Figure 3: The Edmonton Obesity Staging System



Source: Sharma (2012), Edmonton Obesity Staging System.

More than 12 million Australians aged 18 years and over live with overweight or obesity defined by a BMI of 25 or higher.² It is estimated that more than 7 million of these individuals have clinically severe excess weight defined using an EOSS score of 2 or higher (based on unpublished analysis of the Australian Health Survey 2011-13). The extent of weight-related complications in our community has a range of health impacts on millions of individuals and their family members as well as wider community and economic costs such as premature workforce loss, government subsidies, and foregone taxes.

1.3. Priority populations

Access to care for people with clinically significant weight-related complications must be increased Australia-wide, especially among vulnerable population groups. Given that the prevalence of overweight and obesity in Australia varies considerably across specific population groups, treatment access for these people should be prioritised. The Australian Institute of Health and Welfare (AIHW) reported that the populations most at risk of overweight or obesity were:

- **Regional/remote location** – the prevalence of overweight or obesity is higher in regional/remote areas than in major cities for men (75% vs 69%) and women (63% vs 53%).⁹
- **Low socioeconomic status** – the prevalence of overweight or obesity is higher for women in the lowest socioeconomic group (61%) compared to those in the highest socioeconomic group (48%).³
- **Aboriginal and Torres Strait Islander Australians** – the prevalence of overweight or obesity for adults identifying as Aboriginal or Torres Strait Islander was 69% in 2012-13 vs 63% for the general population in 2014-15.⁹ Men and women identifying as Aboriginal or Torres Strait Islander had similar rates of overweight and obesity (69% vs 70% with overweight or obesity in men and in women, respectively).⁹
- **People with severe obesity** – for some patients, access to surgery or other treatments may be an emergency given the severity of their obesity and the impact of its associated complications on their health and wellbeing. Obesity presents to health care at a variety of stages and the appropriate intervention for that stage should be available and expedited when required.

Barriers to accessing care and support persist for all Australians but they are particularly acute for these priority populations. For instance, access to specialist (public hospital-based) clinical obesity services is limited to a few major cities only.⁵ Similarly, access to weight loss pharmacotherapies and bariatric surgery is low and is least likely among those living in socially disadvantaged communities, a situation exacerbated by a system that often results in out-of-pocket costs.^{5, 13, 14}

The factors contributing to this disparity in the prevalence of obesity are complex and multifactorial and include genetics, food systems, the built environment, policy, education, early life experiences and psychology. This means that policy solutions need to place equity and local needs at the centre of how programmes and clinical obesity services can address the distribution of obesity.¹⁵

1.4. Clinical obesity services in the health system challenges

Clinical obesity services are generally recognised as those services delivered by an HCP in any health setting for the management of excess weight and its complications. Low access and uptake of services, especially for those living in socially disadvantaged communities, is due to a range of challenges in Australia's health system. To address inequities and the limited access to effective obesity clinical services and treatments for all Australians, the following challenges need to be tackled when setting health policy and planning.

Access

- There are significant out-of-pocket costs and access barriers to treatment for obesity, evidence of which includes:
 - an affordability barrier exists for patients accessing clinical obesity services in Australia. Only four pharmacotherapies have been approved by the Therapeutic Goods Administration (TGA) in Australia, and none of these are listed on the Pharmaceutical Benefits Scheme (PBS). This differs to the medications available on the PBS for other conditions such as heart disease, cancer, and diabetes;
 - access to allied HCPs via the existing Chronic Disease Management (CDM) Medicare items is limited to five visits per calendar year per patient and more services under these item numbers are not available to be claimed under any circumstances;¹⁶
 - in 2016-17 the median cost of non-hospital specialist service was \$64 per occurrence (with the 10% of patients with the highest costs spending \$137 or more per service);¹⁷
 - a high variation between local areas exists, with some patients spending three times more for the same service from a specialist,¹⁷ such as a psychologist, exercise physiologist or dietitian. This could be due to a lack of referral pathways for HCPs in many areas;
 - approximately 23,000 bariatric procedures are performed each year, which represents just 1.5% of patients who could benefit from the surgery.¹⁸ Of these procedures, 90% were performed in private clinics, and of the 10% performed in public hospitals, only 4% were fully publicly funded.¹⁸

Service delivery

- Australia's health system has limited capacity to effectively deliver the health care needs of the millions of Australians living with clinically severe excess weight. Evidence of this includes:
 - hospital-based services are only available in a few major cities and they tend to have limited onsite multidisciplinary staff resources specialising in obesity, particularly from allied health in the areas of exercise physiology and clinical psychology.⁵ Because of this, many public hospital clinical obesity services have long patient wait lists for accessing surgery, which can be months or years long;⁵
 - accessible facilities and equipment (for example wide chairs and scales that weigh above 250 kilograms) are not always provided in many service delivery settings for patients with overweight or obesity. Further, data shows that two in five people with a disability report difficulty in accessing medical facilities in Australia;¹⁹
 - there are very few primary care practices with a special interest in clinical obesity service delivery (estimated <25 nationwide);
 - there are very few paediatric clinical obesity services (estimated at <6 nationwide) available for children and young people.
- Time, a lack of understanding, inertia and limited belief in effective treatments act as barriers to service delivery in some settings. For example, of every 200 children presenting to their family doctor, 60 live with overweight or obesity (23 live with obesity) and only one will be offered weight management intervention due to a lack of recognition.²⁰
- There are limited data available to support service planning:
 - few existing services use an electronic database for systematically capturing minimum and standardised clinical data for the ongoing monitoring and evaluation of their service, and to promote collaboration between services such as information sharing for quality assurance as well as data linkage for future research purpose.
 - there are no reliable data sources for monitoring the number of primary care practices with a special interest in clinical obesity service delivery.

- despite it being in its seventh year of operation, in 2018-19 the data in the National Bariatric Surgery Registry is only 75 percent complete.²¹
- there are no high-quality studies of bariatric surgery with long-term follow-up outcomes (benefits and harms) in young people.²²
- there are no reliable data sources for monitoring weight-related complications, disability, and health service use.²³

Uptake

- **Obesogenic environment:**
 - the obesogenic environment in Australia, defined as the environment that promotes obesity, including schools, workplaces, communities, the media and availability of convenience foods, is becoming increasingly complex and difficult for individuals to avoid.³
- **Stigma of obesity:**
 - there is a general lack of accurate information available to the community regarding the contributors to obesity. Moreover, there is persistent stigmatisation of individuals living with obesity. The stigma of obesity is propagated by individuals who are either consciously or unconsciously uninformed about the plausible causes of obesity.²⁴ Consumers note that the issue of obesity bias, internalised stigma, and discrimination impacts on the individual's ability and willingness to access care.²⁵
 - some HCPs carry misconceptions that people with obesity lack motivation.²⁶
 - weight bias, stigma, and discrimination are often faced by those with obesity in the workplace, which can have the effect of limiting educational and employment opportunities.²⁷

1.5. Cost of obesity

The cost of obesity to Australia's economy and to the community more broadly is significant. An analysis of the economic costs of obesity in Australia and the benefits of investment in obesity interventions estimated that the total cost of obesity in Australia was \$8.6 billion in 2011-2012 (in 2014-15 dollars).²⁸ This comprised:

- the direct costs of obesity to individuals and society (including but beyond what is spent directly on treatment and management) compared to healthy weight, estimated at \$3.8 billion including: GP services, allied health services, specialist services, hospital care, pharmaceuticals, public health interventions and other costs to individuals;
- the indirect costs of obesity to individuals and society, estimated at \$4.8 billion including: absenteeism, presenteeism, government subsidies and foregone tax. Reduced wellbeing and foregone earnings are further indirect costs of obesity but were not included in this analysis.

The PwC analysis found that if no further interventions are taken by Australia to control the increasing prevalence of obesity, an additional 2.4 million Australians will have obesity by 2025 compared to 2011-12, costing an estimated \$87.7 billion in direct and indirect costs over the period of 2015-2025.²⁸ Additional wellbeing costs (including adverse impacts on mental health and relationships) and social welfare costs occur for both the individual and government when the condition is left untreated, highlighting the importance of investment in a set of well-designed obesity interventions that focus on both weight management and health improvements.²⁸

In addition to the impacts and out-of-pocket costs associated with obesity in adults, children also present a current cost for obesity care. Compared to a child with healthy weight, a child with obesity presents an additional \$1,332 in healthcare costs over a three-year period.²⁹ The PwC report showed that investment into prevention and intervention initiatives for obesity would be cost effective. It estimated that Australia would save \$2.1 billion from a \$1.3 billion investment in interventions including weight loss management programmes and GP interventions, education, reformulation, labelling, and tax on unhealthy foods, bariatric surgery and pharmaceuticals.²⁸ To meet the World Health Organisation's target of returning obesity prevalence levels back to those measured in 2010, there would need to be 1.6 million fewer Australians with obesity by 2025. It has been evaluated that an investment of \$6 billion to 2025 is needed to meet this target in Australia.

1.6. Prevention strategies

Various obesity prevention strategies exist nationwide, including the work being conducted by clinical and advocacy groups³⁰ and The Obesity Collective.³¹ The most effective obesity prevention strategies are likely to be those focused on all levels of the health system in addition to environmental and policy interventions to effect change.

A series of obesity prevention strategies that have been prioritised by governments in recent years is encouraging. At a federal level, the Department of Health announced at the end of 2018 that a National Obesity Strategy³² would be developed. The first phase of this development occurred in February 2019 at the Commonwealth-funded National Obesity Summit and in December 2019 public consultations on the strategy closed, having allowed all Australians a say through open community forums, community discussions and a national interactive webinar.

Some other initiatives at a jurisdiction level include:

- the NSW Premier's Priorities for 2015-2019,³³ which include tackling childhood obesity. Specifically, the Government of NSW aims to reduce overweight and obesity rates in children by five percentage points by 2025;
- in Victoria, the Healthier Start for Victorians consensus statement outlines practical steps that the government can lead to decrease obesity prevalence, including initiatives in community, focused on advertising and the food environment in schools;
- *Queensland's Health and Wellbeing Strategic Framework 2017-2026* contains a blueprint for integrated actions to address overweight and obesity;
- *Western Australia's Health Promotion Strategic Framework 2017-2021* cites obesity reduction as a priority.

1.7. The role of a national framework

National frameworks have underpinned positive progress on some of the most prevalent health issues in Australia, including:

- the recent *National Strategic Framework for Chronic Conditions*, which provides guidance for the development and implementation of policies, strategies, actions, and services to reduce the impact of chronic conditions in Australia.
- *A Framework for Optimal Cancer Care Pathways in Practice*, defines pathways for the management and treatment of cancer conditions. This example demonstrates how frameworks can provide tools for the implementation of optimal care into every day practice.³⁴
- the *National HIV Strategy*, which, now in its eighth iteration, has been an important national strategic approach that has adapted and evolved in line with the changing environment so that it is relevant and effective. Over time, and in line with this strategy, HIV prevalence has continued to decline.

Because weight-related complications now affect the majority of Australians with excess body weight, the development of a framework which will support better access to clinical obesity services should be a national priority. A dedicated national focus on the timely and equitable access to the best available care for obesity with weight-related complications is fundamental to improve the management of obesity in the future.



2. The National Framework for Clinical Obesity

2. The National Framework for Clinical Obesity Services

The National Framework for Clinical Obesity Services (the Framework) aims to provide the first guidance and recommendations on principles and standards of care for clinical obesity services in Australia. It also addresses key elements of efficient referral pathways. It is intended that the Framework will be used by a range of HCPs across all relevant disciplines as well as consumers and policy makers within different levels of government.

The NACOS has a vision to live in a society that provides timely and equitable access to the best available care for the effective management of obesity and its complications. The NACOS members are committed to driving improvements in the quality of obesity care by implementing and evaluating new evidence-based policies and practices in Australia's health system.

2.1. Vision

The vision for the Framework is to contribute to the creation of a health system that provides timely and equitable access to the best available care for the effective management of obesity and its complications. This vision includes both clinical obesity services and the community support networks necessary to ensure ongoing wellbeing during and after care.

It is anticipated that the Framework will drive improvements in access to, as well as quality of, clinical obesity services in Australia. It is expected that it will support scalable and consistent national implementation of clinical obesity services. It will also provide consumers with the information that they need to be best placed to access quality clinical obesity services.

2.2. Objectives

The National Framework for Clinical Obesity Services has four objectives:

- **Objective 1** – To define national principles and standards of care relevant to all types of clinical obesity services in the Australian health system for all groups and ages.
- **Objective 2** – To define the core elements of clinical obesity services including HCPs involved, service settings and care approaches.
- **Objective 3** – To identify existing barriers and detail enablers to understand how best to instigate change in the clinical obesity services setting.
- **Objective 4** – To develop a set of recommendations that will enable the adoption and nationwide implementation of the new clinical obesity principles and standards of care.

2.3. Aspirational outcomes

This Framework aims to drive the development of a health system where individuals with obesity can access the appropriate means and resources to improve their health and wellbeing. They will be enabled to do this through equitable access to timely, effective, and consistently high standards of care. Clinical obesity services will be recognised as a nationally accredited specialty which demonstrates integration of care between health service settings and to community-based support networks through collaborative and co-ordinated referral and communication protocols.

The aspirational outcomes of the Framework are:

- an informed community that understands the causes of obesity through a discourse that is free of stigma
- nationally recognised and endorsed principles and standards of clinical obesity care
- informed and empowered consumers of clinical obesity services
- clinical obesity services that are delivered by informed, empowered, and enabled HCPs who place their patients at the centre of their care
- equitable and timely access to clinical obesity care/services across Australia with consideration for how

rural and remote locations (lower population density communities) can be networked with metropolitan counterparts.

2.4. Scope

The Framework does not focus on obesity prevention, nor does its scope include detail on the challenges associated with or recommendations related to other risk factors in the obesogenic environment (such as transportation, school education, workplaces, and access to nutritious food) that may increase the risk of obesity. Rather it focuses on providing guidance on principles and standards of care for obesity in Australia for HCPs in all relevant clinical and health disciplines and detailing how clinical obesity services should be delivered.

2.5. Methods

The Framework has been developed using an iterative approach, aligning a design team of expert stakeholders from a range of disciplines including clinicians, academics and a consumer representative with lived experience. The design team have met regularly over the course of 6 months to inform the direction and development of the Framework.

The following steps were undertaken to develop the Framework content:

- Desktop review – a national and international literature and grey-literature scan informed several of the Framework elements. Components of the Framework draw from relevant and contemporary research.
- Online survey input – two online surveys were conducted to gather input from two cohorts:
 - an online survey aimed at clinicians, academics, policy makers, and providers – to test suitability of the identified principles and standards;
 - an online survey aimed at individuals with lived experience of obesity, which sought to provide a forum for individuals to share their experiences and expectations of clinical obesity services.
- A facilitated workshop – a full-day workshop was held with the design team and additional obesity experts including HCPs, key industry stakeholders, and academics to review and provide input into the draft Framework as well canvas recommendations for changes and additions.
- Online validation survey – a second online survey was sent to workshop attendees along with the draft document to measure their satisfaction with the framework prior to its finalisation.

Qualitative results

Qualitative responses were individually assessed and then grouped according to the identified common themes. Each theme was stratified according to the number of times that theme was mentioned in the responses. Themes were then considered in terms of the number of times they were expressed by respondents as well as how they aligned to the evidence and design team inputs. The full set of extrapolated qualitative responses are available at the NACOS website.

Online clinician/health care provider survey summary

1. Demographics

A total of 53 clinicians, providers and academics responded to the online survey. The most commonly identified professional titles by participants were: general practitioner (28%), dietitian (19%), bariatric surgeon (19%) and academic (15%). Other professionals represented in the survey include: other medical specialists (particularly endocrinologists), nurses, mental health practitioners, health policy/economists, health planning/administrators, and allied HCPs.

There was a spread in where these respondents worked, with representation from the public (30%), private (36%) or both (28%) sectors. Additionally, there was a range of service location demographics, with 25% of respondents reporting that they worked solely in rural or remote areas, and 13% reporting that they worked in a combination of metropolitan, regional or rural areas.

Almost all (98%) respondents reported that their work focused at least some of the time on the delivery of clinical obesity care, with 70% reporting that most or all of their work focused on clinical obesity care delivery.

2. Results consensus

A 'strong consensus' of expert views and opinions was defined as a minimum threshold of 65% for levels of

'agreement' or 'priority' for categorical survey questions based on a Likert type scale. The results indicate a strong consensus for the following items:

- 91-100% of respondents agreed with each of the proposed Framework principles (see Objective 1).
- 96-100% of respondents agreed with each of the proposed Framework standards for all providers (see Objective 1).
- 85-100% of respondents agreed with each of the proposed additional Framework standards of care for clinicians (see Objective 1).
- The most "essential" members of a multidisciplinary team for clinical obesity services, respondents selected: dietitian (89%), GP (68%), psychologist (57%) and nurse (55%) (see Objective 2).
- 85% of respondents believed that the inclusion of an obesity management algorithm in the Framework was necessary (see Objective 2).

Consumer Survey

1. Demographics

Nine consumers responded to the online survey. Respondents had a range of experiences with obesity; 56% reported currently living with obesity and 44% reported they had previously lived with obesity. Additionally, over half of the respondents (56%) had or are currently receiving clinical obesity care.

2. Results consensus

A 'strong consensus' of views and opinions was defined as a minimum threshold of 65% for levels of 'agreement' or 'priority' for categorical survey questions based on a Likert type scale. The results indicate a strong consensus for the following items:

- 89% of respondents believed that psychology would be the most useful specialty in managing their obesity. This was closely followed by specialist, e.g. endocrinologist (78%) and GP (67%).
- 67% of respondents believed that the biggest barriers to care access were the cost of services and the feeling of being stigmatised.
- 100% of respondents stated that they wished to reduce risks associated with excess weight and prevent a health condition (as opposed to losing a specified amount of weight).
- A large percent of respondents (78%-89%) also expressed that they wished to:
 - improve their appearance
 - have more energy
 - live longer
 - improve existing health conditions
 - feel more confident.

While we acknowledge the small sample sizes achieved in the above surveys, our results are consistent with those published from other studies with much larger samples.²⁶ Second, the methods used sought to gather input from a diverse range of stakeholders in a number of forms to ensure that its content was built from a broad set of perspectives rather than to achieve representativeness of a 'general' population. The Framework is intended to be an ongoing iterative body of work that will be open to receiving additional input and further refinement in the future via the NACOS. One of the recommendations put forward in this Framework is to undertake an update in 2-3 years' time.

Online validation survey

An online survey was sent to all stakeholders along with the final draft of the Framework to measure their agreement with the objectives and principles contained in the document. A total of 30 stakeholders responded, with results showing:

- 97% of respondents agreed with the Framework's Vision, Objectives and Scope
- 97% of respondents agreed with Objective 1 and its content
- 83% of respondents agreed with Objective 2 and its content
- 90% of respondents agreed with Objective 3 and its content

- 97% of respondents agreed with Objective 4 and its content
- 93% of respondents agreed with the Framework's Next Steps.

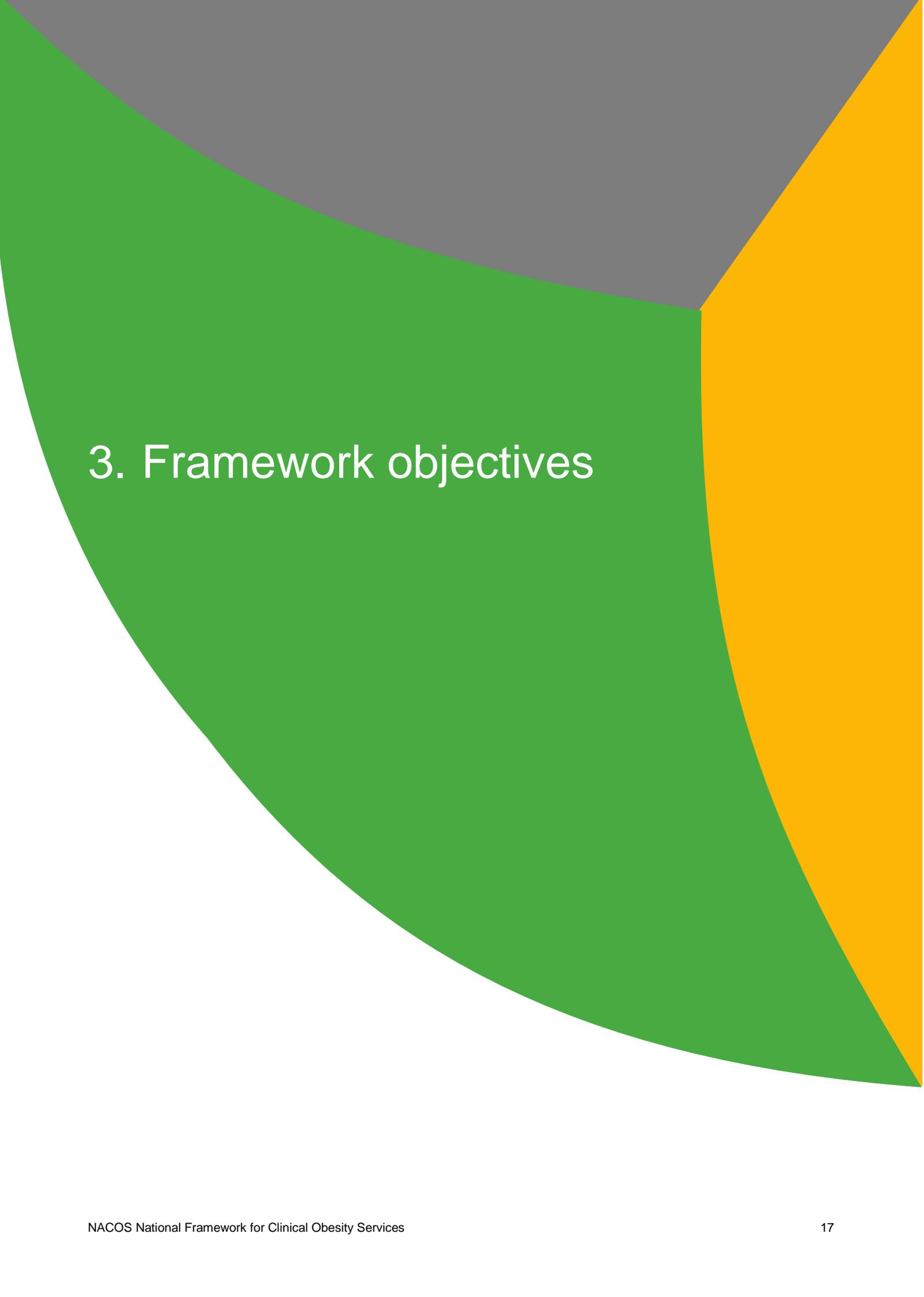
In addition to these responses, respondents provided further qualitative comments that were considered and incorporated into the final iteration of the Framework.

2.6. Intended audience

This Framework is intended to be read by a range of audiences. These include consumers, clinicians and other HCPs, governments (health service policy makers and planners from Federal, State and Territory health departments including Primary Health Networks, Local Hospital Networks), industry (health insurers, pharmacological and surgical device companies, diet replacement companies), and researchers. The table below outlines the intended use of the Framework for each audience member.

Table 1: Intended audience and uses

Intended audience	How this Framework will be used
Consumers	To better understand the types of care available and to support consumers to advocate for themselves as they engage in dialogue with their care team or others in the community.
Clinicians and other HCPs	To better understand their role in the delivery of obesity care and treatment and to encourage regular upskilling so that they can support both treatment and patient referrals to the right care at the right time.
Governments	To prioritise the design and delivery of future clinical obesity services and treatments, aligned to Australia's needs.
Researchers	To prioritise future research focused on clinical obesity care/service delivery.
Politicians and advisors	To take immediate action and commit to addressing the poor access and standards in clinical obesity care as a major national health priority.



3. Framework objectives

3. Framework objectives

3.1. Objective 1 – Principles and Standards

Objective 1 – Principles and Standards: To define national principles and standards of care relevant to all types of clinical obesity services in the Australian health system for all groups and ages.

The Framework proposes the following set of core principles to guide clinical obesity service provision:

1. Excess weight (overweight and obesity) with weight-related health impairment should be treated as a chronic disease that is managed free from stigma or bias.
2. Patients deserve access to the best available evidence-based care, no matter where, when, or how they present to the health system. Clinical obesity services are to be distributed in an equitable manner and access barriers (including stigma) reduced.
3. The patient voice is central to all interactions and shared decision-making and bidirectional communication between consumers and providers is essential.
4. All HCPs are sensitive to environmental, organisational, and professional stigma and make accommodations for patient care (e.g. adequate furniture/equipment, protocols for patient centricity and culturally competent language).
5. Continuous upskilling and learning opportunities (including training and resources) are available to all HCPs based on the current research and evidence. Formal tertiary education, industry and workplace curricula revision is undertaken as necessary over time to ensure that new and existing HCPs are receiving the most up to date information and guidelines.
6. Social, cultural, and environmental causes of obesity are considered by HCPs who are aware of the individual's home, work, and community environments; including relationships, stressors and cultural preferences. Providers have a comprehensive understanding of the obesogenic environment and how it can act to inhibit or encourage health dietary and physical health patterns.⁹

These principles draw from those principles identified in the Proposed Standard of Obesity Care, convened by the STOP Obesity Alliance at The George Washington University in 2019³⁵. They have been revised for the Australian context. They have subsequently been validated and endorsed by clinical/provider survey respondents.

Standards of care for adult obesity treatment

Clinical standards are defined as explicit statements related to the level of care individuals should expect from health services.³⁶ A well-defined set of clinical service standards for obesity will promote the consistent delivery of the best available care for individuals living with obesity. Application of the Standards will

- promote higher quality health care delivery
- reduce variation across different service providers
- limit adverse events.

Standards support better patient outcomes, particularly in instances of complex and ongoing care. Consumers of such services stand to benefit from understanding what to expect of their clinical care pathway, treatments, and overall health care experience³⁷. Millions of consumers and existing clinical obesity service providers stand to benefit from application of care standards.

The standards are intended to provide HCPs, community organisations, policymakers, and consumers with guidance for evidence-based obesity care. The standards represent a set of practices that aim to positively impact the health of individuals with obesity. They are categorised as standards that apply to all providers and those that apply specifically to clinical providers.

Proposed standards of care for all providers

The following standards apply to all providers, defined as the full spectrum of clinical, community and digitally-based entities that support the health of individuals with obesity.

Table 2: Standards of care for all providers

1. Standards of care for all providers
1.1 Apply a chronic care model to the management of obesity and its complications, recognising the multidisciplinary skill set needed to effectively manage obesity and its complications. Providers should become leaders in breaking down the barriers of stigma and bias associated with obesity.
1.2 Address obesity through shared decision-making processes. Providers should consider the circumstances, needs, and preferences of the individual in developing an obesity management plan that is individualised and person-centred.
1.3 Use patient-centred communication, service design and operations. This includes a process of active co-design and collaboration to avoid discrimination and encourage an empathic environment toward individuals with obesity. Engage in educational opportunities with the patient to encourage self-management strategies alongside treatment.
1.4 In addition to reduction in body weight, providers should emphasise changes in behaviours and health outcomes as measures of success. When analysing body weight, include a consideration of weight trajectory as opposed to only weight at a point in time.
1.5 Recommend evidence-based strategies to prevent weight regain and regularly monitor patients for weight regain, understanding that relapses are to be expected and are part of the normal course of chronic disease management.
1.6 Do not use, recommend, or refer patients to obesity treatments for which the potential risks outweigh the expected benefits for a given patient, such as treatments that are unproven and/or potentially harmful.

Proposed standards of care for clinical providers

The following standards apply specifically to providers who deliver clinical services, such as GPs, physicians, allied health and nurses for whom a more detailed knowledge of obesity and its pathophysiology is required.

Table 3: Standards of care for clinical providers

2. Additional standards for clinical providers

- 2.1 Consider current evidence of individual complications of obesity when applying BMI and/or waist circumference and/or body composition analysis for risk stratification and triaging patients.
-
- 2.2 Clinical service providers to be trained in the multimodal aetiology of obesity and understand stigma and bias to empathise with patients and develop tailored treatment strategies. Continuity of care should be a priority to ensure healthy weight maintenance and reduce the risk of relapse.
-
- 2.3 Assess patients for weight-related complications. Manage obesity complications and comorbidities within the scope of their practice and/or refer to other HCPs where necessary using established referral networks.
-
- 2.4 Recognise and raise obesity concerns in patients of all ages. Paediatricians should place a particular focus on early detection and management of obesity in children to reduce the barrier of access and prevent persistence into adulthood.
-
- 2.5 Educate patients to understand the relationship between excess body fat and overall health risks, including a discussion about the causes of obesity and the challenges most have in losing weight.
-
- 2.6 Make shared decisions with individuals on the most appropriate obesity care plan, enabled by patient education and choice.
-
- 2.7 Where appropriate, provide psychosocial supports and resources for individuals who may have weight management challenges. The services and/or resources supporting psychosocial needs should be evidence-based. Consideration should be given to strategies for behavioural change and adherence to treatment plans as well as addressing the potentially negative effect that weight loss may have on functioning, happiness or family lifestyle.
-
- 2.8 Where appropriate, discuss and/or prescribe obesity medications. Medications with a clear evidence base for weight management should be included in health care system formularies and used according to product label indications or current clinical guidelines. Minimise the use of medications that may cause weight gain and preferentially consider those that are weight neutral or associated with weight loss for patients with obesity.
-
- 2.9 Clinical obesity services should have mechanisms and staff in place to discuss surgery options with patients in a knowledgeable way. Medical practitioners should understand the indications, the types of surgery available, expected outcomes and have clear referral pathways in place for patients.
-
- 2.10 A personalised care approach to be taken by providers, in addition to enabling the continuity of care. This may include follow up appointments, remote patient monitoring or sharing event summaries e.g. on an individual's My Health Record, or other web-based information portals such as *HealthPathways* that is being used in Western Sydney to ensure that all members of the health care team are on the same page.³⁸
-
- 2.11 Where possible, include family members in obesity treatment and management approaches as opposed to treating the individual only. Encourage healthy habits for the family unit as a whole to act as a support network for the individual and also prevent obesity from arising in other family members.
-

3.2. Objective 2 – Clinical Obesity Services

Objective 2 – Clinical Obesity Services: To define the core elements of clinical obesity services including HCPs involved, service settings and care approaches.

Clinical obesity services should be delivered by a range of HCPs, at all levels of the health system. The range of interventions offered as part of clinical obesity service delivery should include behavioural interventions, pharmacotherapy and surgery, with clinical pathways dependent on the individual, their situation and treatment objectives.

Care will be delivered predominately through primary care, by GPs in a generalist or specialist clinic, as the GP is often the first point of call for individuals needing to engage with the health system. All clinical obesity services should be provided using an integrated, collaborative and co-ordinated care approach to enable a focus on each individual's preferences over the long term.³⁹ Collaboration between care team members and the inclusion of life skills as part of effective care delivery are important elements of clinical obesity service delivery.

Who is part of a clinical obesity service?

A diverse range of clinicians and HCPs are critical to the delivery of effective clinical obesity services, as they all have important roles in managing patient needs. Below is a list of their expected roles and key responsibilities. Whilst these are expected roles and responsibilities, each discipline and clinic delivering obesity services will have codes and standards and apply their own professional judgement as to their appropriate role.

Table 4: Expected roles and key responsibilities in the delivery of clinical obesity services

Key roles in the delivery of obesity services

General Practitioner

- Undertake patient assessments, considering the range of potential causes and risk factors of obesity.
- Support and manage MDTs to deliver holistic care.
- Undertake assessment for potential complications of obesity.
- Provide clinical support to determine, alongside the individual, which interventions, psychosocial supports and medications are most appropriate considering a patient's background, social determinants of health and goals.
- Determine the optimal pathway for obesity management and weight-related complications, which may include referrals to other services.
- Understand the multimodal aetiology of obesity and associated stigma and bias to empathise with patients and develop tailored treatment strategies.
- Prescribe to avoid weight promoting medications.
- Implement dietary and exercise programs and consider anti-obesity pharmacotherapy where appropriate (where GPs have the relevant skillset).
- Provide continuity of care over the long term to ensure healthy weight management and reduce the risk of relapse.
- Provide individualised care for those with a physical, mental or other disability.
- Remaining up to date with evidence-based management strategies.

Nurse

- Provide quality holistic care for patients and their families/carers.
- Understand the multimodal aetiology of obesity and associated stigma and bias to empathise with patients and develop tailored treatment strategies.
- Co-ordinate care, including:
 - Engaging in open and transparent communication between MDTs and patients/families
 - Collaborating with MDTs to facilitate tailored patient assessments and treatment plans, ensuring these strategies are established and implemented.

Key roles in the delivery of obesity services

- Provide education and support regarding obesity and/or other weight related comorbidities and complications, including diabetes and insulin stabilisation.
- Triage referrals/re-entry as appropriate, per guidelines.
- Outline service expectations and provide education on management and referral pathways.
- Act as role model to hospital nursing staff to identify nurse champions and reduce obesity stigma.
- Provide pre and post education to patients on bariatric surgery.
- Assist in identifying patients who may be suitable candidates for bariatric surgery.
- Motivate and encourage patients to follow program and treatment guidelines.
- Act to identify patient concerns or lack of knowledge and refer to specialised allied health.
- Refer to and involve social workers where appropriate and necessary.
- Refer to and liaise with community services to encourage individual links to external supports and resources.
- Provide individualised care for those with a physical, mental or other disability.
- Undertake additional training where available, e.g. becoming a Credentialed Diabetes Educator.
- Remaining up to date with evidence-based management strategies.

Physician

- Understand the multimodal aetiology of obesity and associated stigma/bias to empathise with individuals and develop tailored treatment strategies.
- Perform comprehensive patient assessments, including consideration of medical and psychosocial complications and/or comorbidities, and overall wellbeing and functional status.
- Initiate investigations to screen for/assess severity of any complications/comorbidities suspected/present.
- Provide support and education to their patients and promote self-care strategies.
- Communicate medical management strategies with other HCPs involved in the individual's care, ideally via MDT meetings, and work collaboratively to design appropriate care strategies.
- Manage complex diabetes care and manage secondary causes of obesity such as Cushing's and craniopharyngioma (endocrinologists only).
- Having a family-centred, age-appropriate approach to management (particularly for paediatricians).
- Provide individualised care for those with a physical, mental or other disability.
- Remaining up to date with evidence-based management strategies.

Clinical psychologist

- Understand the multimodal aetiology of obesity and associated stigma and bias to empathise with patients and develop tailored treatment strategies.
- Support the individual identify the biopsychosocial processes that contribute to and maintain obesity.
- Assist the individual to begin and maintain the process of lifestyle change with a focus on relapse prevention.
- Provide support for adherence to behavioural, pharmacological and surgical obesity interventions.
- Act as a consultant to the MDT regarding psychological care aspects.
- Improve treatment outcomes by assisting with adherence to diet and activity changes required for weight management and compliance with medication/supplements.
- Provide treatment for psychological conditions that can interfere with obesity management including chronic pain, disordered eating, low self-esteem and body image distress.
- Lead, train and support other health professionals (in the use of psychological approaches).
- Provide individualised care for those with a physical, mental or other disability.
- Remaining up to date with evidence-based management strategies.

Dietitian

- Understand the multimodal aetiology of obesity and associated stigma and bias to empathise with patients and develop tailored treatment strategies.

Key roles in the delivery of obesity services

- Support and manage MDTs to deliver holistic care.
- Provide personalised medical nutrition therapy tailored to the individual and their family.
- Translate evidenced-based research and clinical guidelines into patient-centred practical advice.
- Improve weight-related complications and optimise dietary intake to stabilise dietary patterns and food behaviours, tailored to the individual.
- Recommend appropriate treatment options including lifestyle modifications and dietary programs as adjuncts to anti-obesity pharmacotherapy or bariatric surgery.
- Provide nutrition education to patients including healthy shopping habits, budgeting, cooking and food preparation skills.
- Provide training, education and advice to other HCPs and partners.
- Provide individualised care for those with a physical, mental or other disability.
- Remaining up to date with evidence-based management strategies.

Physiotherapist

- Understand the multimodal aetiology of obesity and associated stigma and bias to empathise with patients and develop tailored treatment strategies.
- Assess the individual for barriers to physical activity e.g. acute and/or chronic pain, musculoskeletal injuries, weakened pelvic floor, fear of falling and cardiorespiratory limitations.
- Provide physiotherapy to address barriers and to promote sustainable physical activity through a variety of mediums including land, water and group-based exercise.
- Recommend obesity management strategies, including lifestyle advice, preservation of lean body tissue and improved cardio-metabolic fitness.
- Support minimising weight gain after weight loss therapeutic intervention.
- Prescribe tailored exercise programs with a focus on restoring optimal physical strength, function and overall health.
- Provide individualised care for those with a physical, mental or other disability.
- Remaining up to date with evidence-based management strategies.

Exercise physiologist

- Understand the multimodal aetiology of obesity and associated stigma and bias to empathise with patients and develop tailored treatment strategies.
- Assess the individual for barriers to physical activity e.g. acute and/or chronic pain, musculoskeletal injuries, weakened pelvic floor, fear of falling and cardiorespiratory limitations.
- Address barriers and promote sustainable physical activity through a variety of mediums including land, water and group-based exercise.
- Recommend obesity management strategies, including lifestyle advice, preservation of lean body tissue and, improved cardio-metabolic fitness.
- Support minimising weight gain after weight loss therapeutic intervention.
- Prescribe tailored exercise programs with a focus on restoring optimal physical strength, function and overall health.
- Provide individualised care for those with a physical, mental or other disability.
- Remaining up to date with evidence-based management strategies.

Community providers

- Deliver wellbeing, life skills and peer support to compliment clinical or medical services.
- Understand the multimodal aetiology of obesity and associated stigma and bias to empathise with patients and develop tailored treatment strategies.
- Link to clinical services and allied health to deliver collaborative and co-ordinated obesity care.
- Assist patients to navigate health system and associated social services.
- Provide individualised care for those with a physical, mental or other disability.
- Remaining up to date with evidence-based management strategies.

Key roles in the delivery of obesity services

Surgeon

- Understand the multimodal aetiology of obesity and associated stigma and bias to empathise with patients and develop tailored treatment strategies.
- Support and manage MDTs to deliver holistic care.
- Assess eligibility for bariatric surgery.
- Undertake pre-operative engagement processes, including provision of patient education.
- Clinically assess patients to ensure that pre-existing conditions and potential comorbidities and complications are well understood.
- Undertake surgery where appropriate, and tailor the operation to the metabolic health profile of the patient.
- Engage in comprehensive follow up care, including referrals to sub-acute, primary care and community care services.
- Provide individualised care for those with a physical, mental or other disability.
- Remaining up to date with evidence-based management strategies.

In addition to those HCPs whose roles are outlined above, the involvement of specialists (e.g. in cardiology, respiratory, and sleep, paediatric medicine etc.) as well as support from other professionals including social workers, occupational therapists, and health coaches may be appropriate.

Clinical obesity treatments

Clinical obesity treatments administered by HCPs range from behavioural interventions targeting diet/physical activity levels, psychological therapies targeting maladaptive behaviours to pharmacotherapy and bariatric surgery, to targeting biological drivers of appetite and obesity. As well as weight loss, the benefits of these interventions to individuals may include improved fitness, mobility, mental health, and social connectedness. These additional benefits may be of equal or more importance than weight loss or appearance changes.

The range of the most common clinical obesity treatments is outlined below in Table 5, this list is not exhaustive and emerging therapies should be considered as they become available. Interventions must be individualised for each person, and most especially for those with a physical, mental or other disability to ensure appropriateness and clinical effectiveness. Further detail on each of these interventions can be found in the **Appendix**.

Table 5: Summary of clinical obesity treatments

Behavioural interventions	TGA approved pharmacotherapy	Off-label pharmacotherapy	Bariatric surgery
<ul style="list-style-type: none"> • Energy restricting diets • Structured exercise • Psychological therapies • Peer and lifestyle support 	<ul style="list-style-type: none"> • Phentermine (Duromine®, Metermine®) • Orlistat (Xenical®) • Liraglutide (Saxenda®) • Naltrexone and bupropion (Contrave®) 	<ul style="list-style-type: none"> • Topiramate • Combined low dose Phentermine and Topiramate 	<ul style="list-style-type: none"> • Laparoscopic Sleeve Gastrectomy (LSG) • Laparoscopic adjustable gastric banding • Laparoscopic gastric bypass by Roux-en-Y (RYGB)

How should clinical obesity services be delivered?

Clinical obesity services should be delivered through an integrated model of care approach to provide practical advice and referral pathways in a patient-centric manner, with wrap around services for complex conditions and enabling access to care when and where consumers need it.⁴⁰

An integrated care approach to the clinical care of obesity is:

- **person centred** – HCPs must adapt to each individual's needs and deliver care in a flexible and timely manner. Patients and their families should be active participants in their care, with oversight of their treatment pathway and assisting in decision making where possible. Care must be tailored to needs considering particular risk factors over different times in an individual's life, in addition to available services.
- **targeted** – mutual outcomes between each MDT member should be developed, relative to each patient and their requirements. Individuals requiring complex care will require additional co-ordination to enable sufficient care and the required clinical outcomes. Where possible, technology and new models of care should be adopted to enable shared responsibility. Examples of where this occurs include the *HealthPathways* system³⁸ and the *Beacon Model*.⁴¹
- **collectively responsible** – MDTs should operate on a premise of shared information and collective responsibility, regardless of setting. Collaborative management plans should be developed for patients detailing the roles and responsibilities of each MDT member.
- **holistic** – acknowledging and providing treatment with a longitudinal approach, taking into account the environmental, economic, and social causes of obesity to increase the clinical effectiveness of interventions and the likelihood of maintaining weight loss over the long term. Care provision must occur alongside practical advice and appropriate referrals for lifestyle and physical activity interventions, especially for those patients who have mobility challenges or musculoskeletal disorders and pain.
- **inclusive of community services** – community services, including peer support networks and the provision of life skills, should be leveraged by HCPs to manage and maintain the progress of patients and the potential disparity between their intentions and actions. Family services should be developed and encouraged to improve the dietary and other habits of the entire family rather than just the individual living with obesity.
- **focused on training and skill exchange** - provision of medical training/education and professional development on obesity treatment and management should be front of mind for education institutions and service delivery settings. Opportunities for skill exchange between practitioners should be encouraged in the workplace to share the most up to date techniques and approaches.

It is important to note that clinical pathways can represent a snapshot of a potential patient experience and do not fully capture the range of occurrences that may occur for an individual patient (e.g. relapse, comorbidity complications, life events, and service availability). Collaborative and co-ordinated care for obesity needs to be planned for the long term. All individuals will require personalised care that considers external situational factors in the treatment and management of obesity over their lifetime.

Approaches to the elements of clinical obesity services

An integrated care approach to obesity assessment

Assessment is an important step to determine the appropriate clinical obesity services pathway for each individual. Using a collaborative and co-ordinated care approach at this stage means that empathetic and judgement-free assessments should be undertaken to understand an individual's circumstances, preferences and goals. A comprehensive obesity assessment conducted by any clinician should consider the following factors for each individual:⁴²

- causes of obesity
- individual history regarding weight and weight loss attempts
- unhealthy lifestyle/behavioural risk factors
- psychological stressors
- physical and mental weight-related complications
- weight-related health impairments

Tools to support assessment and eligibility for clinical obesity services should include BMI as well as the EOSS.⁴³ Individuals with an EOSS 2 or higher typically have clinically significant weight-related complications and will likely have complex health care needs requiring multidisciplinary care.

An integrated care approach to treatment and management strategies

Treatment and management strategies should take into account each individual's goals. Goals should be considered in the short and long term, as lifelong management is often required to maintain weight loss and achieve improvements in health impairments. Patient actions may be an alternative frame for goal setting. Although weight loss is very important to many individuals, HCPs should recognise that patients often have other additional goals. In line with the ACTION IO study findings, respondents to the online survey outlined that a variety of factors other than weight loss were also important in managing their obesity.²⁶ These include to:

- reduce their risk of developing secondary health conditions, such as diabetes
- improve their appearance
- have more energy
- live longer.⁴⁴

Connecting patients to MDTs for the treatment and management of obesity is considered best-practice and important to effectively treat the various elements of obesity. Care should also include access to services that drive increased social connectedness to assist individuals to develop a sustainable network outside their MDT, with the objective of providing ongoing and long-term support.

Certain cohorts within the broader population may require specific supports whilst undergoing treatment and management for obesity. These supports may include information in different formats, or distinct adjustments. Cohorts for consideration include:

- children and adolescents
- older Australians
- Aboriginal and Torres Strait Islander Australians
- individuals from culturally and linguistically diverse backgrounds
- persons with physical or intellectual disability, this may include poor mobility due to obesity itself
- persons with a mental health condition
- persons in an isolated or marginalised environment
- other groups including pregnant women and people with diabetes or chronic kidney disease.

Proposed clinical obesity service settings

There are multiple settings for clinical obesity service delivery. Access to each setting should depend on patient needs, preferences and stage or severity of obesity. These settings are summarised on the diagram below. It is important to note that patients may access services from one or more settings over the course of their obesity treatment pathway and may enter this care network in any setting. A collaborative and co-ordinated approach should connect HCPs and organisations between care settings as required by individuals to collaboratively manage their care plans.

Figure 4: Clinical obesity care settings



Eligibility considerations for the range of obesity treatment and management strategies should be established as all HCPs have an important role to assess and determine an individual's eligibility for certain treatments. This is especially true for GPs, whether or not they specialise in obesity as they are likely be the first contact with the health system for people living with obesity.

Each of the settings detailed below play an integral role in the clinical obesity service network, as they provide an entry and referral point for patients and HCPs, dependent on the level of severity of the condition and preference.

A. Community services

The community services setting forms an important service layer for individuals in obesity management. Community services are broad, including those related to health promotion, screening, peer support groups and life-skills. They play a major role in empowering and re-enabling patients, knowledge sharing and encouraging the normalisation of obesity through sharing resources and increasing community awareness.

People with lived experience cite that the supports they access in their local communities, such as walking groups, peer support, and social media groups are a critical component to the ongoing management of obesity and its complications, as well as for improving their wellbeing. For example, research has shown that psychological support is one of the most significant but commonly overlooked components of care for those who have undergone bariatric surgery.⁴⁵

National and international bodies focused on giving patients with obesity a voice, through peer support and other means, are also essential to efforts in reducing obesity stigma. Two international case studies, outlined below, show what is possible and should be promoted in Australia.

Case study: The European Association for the Study of Obesity⁴⁶

The European Association for the Study of Obesity (EASO) has representatives from 20 countries in Europe. Its aim is to elevate and promote the needs and interests of Europe's patient community with a range of stakeholders including EASO scientific and clinical communities as well as media and industry. The EASO Patient Council forms an important part of this aim. The Patient Council includes patient representatives from multiple countries. Members come together as a single voice to lead patient-led position statements, networks connecting patients, scientific groups and HCPs, as well as patient education through workshops and online resources. The EASO patient representatives also champion European Obesity Day.

Case study: The Obesity Action Coalition⁴⁷

The Obesity Action Coalition (OAC) in the USA represents patients, seeking to give a voice to individuals affected by obesity, with a mission to link them to education, advocacy, and support as part of their journey. The OAC includes 70,000 members but supports over one million individuals every year. The OAC activities include the provision of education resources, development of position statements, and active management of an online community for members which, alongside providing education and resources, can link members to suitable and preferred services, and build connections between members.

Established in 2019, the Weight Issues Network (WIN) is an example of a community service in Australia. The WIN is a new organisation that represents the needs and perspectives of Australians and their families who are living with overweight and obesity. They aim to provide access to information and peer support in addition to highlighting the importance of weight issues in Australia and fighting stigma and bias surrounding obesity.

Community services for obesity often look different in an urban versus remote setting in Australia and play different roles accordingly. Despite some differences in delivery based on location, community services to treat and manage obesity are becoming increasingly important and valuable Australia-wide.

B. GPs and allied services

In Australia, the GP is very often the first point of call for an individual seeking care or treatment. This means that GPs and allied services (e.g. dietetics, psychology, exercise physiology, pharmacy, physiotherapy, podiatry⁴⁸) are essential to the Australian frontline primary care workforce, particularly for individuals with obesity. Allied HCPs provide services to 'enhance and maintain the function of their patients within a range of settings including hospitals, private practice, community health, and in-home care'.⁴⁸

All GPs can provide a range of services, for the prevention, treatment and management of obesity, and they refer to community health services, social services, specialist clinics, private specialists, and hospitals when necessary. Currently, GPs provide the majority of care to people living with obesity, and there are a number of GP clinics that offer clinical obesity services exclusively. These clinics provide personalised and integrated treatment plans to patients with obesity that draw on appropriate and preferred interventions. Although the exact number of these specialist GP obesity clinics is unknown at this time, it is likely to be fewer than 25.

These clinics use a model of care that connect individuals with a MDT so they can access other medical disciplines as required (e.g. hepatologists, cardiologists, sleep physicians, psychiatrists etc.) to support their treatment and management journey. Two case studies for a specialist GP led obesity clinics are provided below. There are a number of benefits of this approach to obesity care, including: the availability of GPs with extensive experience in treating obesity, the potential for a peer support network, access to other HCPs in the one clinic, additional education and training opportunities for patients and staff and an increased level of community awareness of the condition through visibility and marketing. These are two examples of enhanced clinical obesity services in primary care, but are only accessible to patients who can pay the associated out-of-pocket costs.

Case study: Alevia Medical Weight Loss

Alevia was established in April 2018 to meet a growing demand for patients who were seeking evidence based obesity treatment. Recognizing that there is limited time in a general practice consult, along with other competing demands, to provide best care to those living with obesity, Alevia was set up to be a dedicated clinical obesity service. Alevia has four sites across Melbourne with eight practitioners, as well as a dietitian, exercise physiologist, and a psychologist. Patients see the Bariatric GP for co-ordination of their care and where appropriate, the dietitian, exercise physiologist, psychologist or bariatric surgeon are involved. Alevia is also involved in the care of the bariatric surgery patients, providing unbiased information and advice as well as post bariatric care.

Upon setting up the practice, the organization found that there was limited obesity management training available for HCPs. Additionally, no time was dedicated to obesity in formal training pathways. Therefore, it was through the World Obesity Federation training - SCOPE, a series of seminars, research papers, and practical experience sitting in local hospital obesity services, as well as private obesity services, that Alevia was able to develop education programmes for patients and doctors covering the important competencies in obesity medicine

Whilst Alevia has been a success in Melbourne, it is important to note that there is still no formally recognised local obesity training course in Australia. Further, as a GP led weight specialist clinic, patients remain under the care of their regular GP, and so specialist clinics do not access the GP care plan item numbers. As such, they are limited to the standard Medicare attendance item and charge a gap fee to patients resulting in an out of pocket cost for patients per consult.

For more information, see <https://alevia.com.au/>

Case study: Re:You

Re:You is an Adelaide-based GP lead weight management clinic whose GP-founders had been working for many years with a multidisciplinary bariatric team in a private hospital. They realised that they could not provide their patients living with obesity with the same level of care in their routine GP clinics, which was a key driver to establish a GP lead specialist weight management service. Re:You offers both a surgical and non-surgical pathway for patients, external to a private hospital bariatric clinic, attracting patients who may want more information on their treatment choices.

Other GPs and specialists alike refer to the clinic, and patients can search for the clinic themselves through the internet and social media. When providing surgical treatment, Re:You will ensure patients see a bariatric GP in addition to a team of dietitians, exercise physiologists, and psychologists to determine if a patient is a suitable candidate to be referred onto a bariatric surgeon. Non-surgical options involve the use of newer pharmacotherapy agents and other evidence-based options. Non-surgical patients are referred to members of the allied health team, as deemed necessary. All patients receive follow up care, regardless of their pathway.

The founders of Re:You believe that GPs, with the correct training, are well-positioned to advise, manage, as well as to monitor patients along a pathway of lifestyle modification, Very Low Energy Diets (VLEDs), pharmacotherapy, or surgery for obesity. In primary care, GPs constantly deal with multimorbidity, chronic health issues, and psychosocial issues, and are very familiar with providing patients with continuity of care, which is crucial when managing obesity.

Currently, Re:You does not complete care or mental health care plans for patients, leaving this to a patient's regular GP, which means that open and ongoing communication between all treating HCPs is essential. To ensure a sustainable business model, patients at Re:You pay an out-of-pocket cost for appointments that are pre-/post-operative or non-surgical, with a two-year programme fee charged for surgical after care.

For more information, see <https://reyouhealth.com.au/>

C. Private specialists

Private specialist clinics include, for example, those run by endocrinologists, cardiologists, and gastroenterologists. These clinics are accessed via a referral from a GP. Each private specialist clinic will have its own processes for accepting referrals, assessing urgency of appointments, and fee structures. A patient's eligibility for Medicare reimbursement will, therefore, depend on the clinic and their GP's referral. Private specialist clinics may refer patients onto hospital services, dependent on patient care requirements and urgency of treatment.

D. Hospitals

Hospitals are an essential pathway for clinical obesity services and for referral to specialist services. All Australians can access treatment as a public patient in a public hospital, covered by Medicare. If a patient has private health insurance, they can also access care delivered in a private hospital setting and may pay a gap fee for their treatment. If not being admitted through the emergency department, patients will require a referral from their GP to access treatment in a hospital. Outpatient clinics located in hospitals typically provide access to a treating physician (often an endocrinologist but can be referred to other specialists where indicated), nurse, and allied HCPs.

Obesity interventions available in a hospital setting include bariatric surgery to eligible individuals who have been referred. Research has shown that non-surgical and surgical care delivered by obesity clinics within a hospital setting lead to significant and clinically important improvements in patient's physical capacity outcomes.⁴⁹ Although both private and public hospitals can offer bariatric surgery to treat and manage obesity, at present, over 90 per cent of bariatric surgery for obesity occurs in the private hospital setting. A Framework to outline how bariatric surgery should be provided in the public hospital setting is currently in development by the Australian & New Zealand Metabolic and Obesity Surgery Society (ANZMOSS).

In both public and private settings, equitable access to resources including staff, equipment, and space is essential for effective clinical obesity service delivery. Clinical obesity services in hospital settings should be formed around a MDT, which includes a bariatric surgeon, GP, dietitian, clinical psychologist, physiotherapist, and exercise physiologist. The MDT should meet at least monthly to discuss select patients seen and advise on comprehensive treatment plans within and beyond the service through co-ordinated

referral pathways where appropriate. Further, appropriate management pathways and protocols enable appropriate step-up/step-down care for patients of varying obesity severity levels, and surgery should only be considered as a single component of care, with ongoing follow-up being prioritised.

Referral pathways and networks

Establishing agreed referral pathways that are used by HCPs across Australia are critical for improving obesity care so that individuals can be seamlessly guided to step up or step down to the most appropriate care in line with their preferences and goals. The settings outlined above deliver a range of clinical obesity treatments/services as previously outlined in **Table 5** – but no single health care setting delivers all types of obesity interventions, demonstrating the need for referral protocols.

As no single health care setting can provide all obesity interventions at the required capacity level in Australia, clear referral pathways should be established for:

- HCPs managing individuals with obesity who present above the threshold appropriate for the setting, or, who require shared-care arrangements
- HCPs in any setting who do not have the capacity or capability to deliver obesity interventions due to waitlists, other operational constraints or the preference to provide specialist obesity treatment options. For example, GPs who do not specialise in obesity should regularly consider, assess, and support a patient's decision around obesity
- population health programmes
- patient support and advocacy organisations including those for specific groups (that may be based on gender, rural status, and cultural background etc.).

In some areas of Australia, particularly in regional or remote locations it may be challenging to maintain a facility with the appropriate equipment to cater for patients living with clinically severe obesity. These organisations should be networked with, and supported by, those that do have the ability to cater for all individuals living with obesity. In the future, there should be a focus on investing in telehealth as a possible mode of delivery for some services, as well as clinical hubs to better service regional and remote areas.

Organisations that offer specialist clinical obesity services should be identified and shared as part of a directory of services by location available to other clinicians for referral as well as to individuals with obesity, as well as their families and carers, for visibility. A specialist clinical obesity services directory will also support service planning based on geography and other demographics.

The Australian Obesity Management Algorithm

Clinicians often use algorithms or pathway tools to manage quality, safety, and efficiency across health care delivery. These tools are standardised, evidence-based multidisciplinary management plans, which identify an appropriate sequence of clinical treatment options, timeframes, milestones, and expected outcomes for a patient cohort⁵⁰.

Clinical pathways for obesity should be established, agreed, and implemented nationally because at present, there are a range of clinical obesity services that are different to one another and not easily accessible to individuals living with obesity. Clinical pathways should be put in practice alongside the standards outlined in this Framework.

The working group representing the Australian Diabetes Society, Australian and New Zealand Obesity Society (ANZOS) and the Obesity Surgery Society of Australian and New Zealand (the Working Group) is considering how clinical pathway components such as eligibility can work in practice, suggesting thresholds for care management in primary, shared-care arrangements, and specialist care depending on BMI. Their Australian Obesity Management Algorithm, which is currently being updated, aligns weight loss management to individual preferences and circumstances. The algorithm aims to:

1. assist GPs in the treatment decisions for non-pregnant adults with obesity
2. provide a practical clinical tool to guide GPs to implement treatment of obesity and its ongoing management in the primary care setting in Australia.

The updated Algorithm is due to be completed in 2020. Future revisions of this Framework will contain more detailed references and alignment to this Algorithm for obesity management in Australia.

3.3. Objective 3 – Barriers and Enablers

Objective 3 – Barriers and Enablers: To identify existing barriers and detail enablers for improving clinical obesity service delivery.

Barriers to the delivery of effective clinical obesity care

The barriers to accessing effective clinical obesity care have been identified from consumer and HCP/provider perspectives through online survey consultations. The primary barriers identified were similar between consumer and HCP/providers. The cost and funding of clinical obesity services as well as the perceived stigma towards obesity were identified as the greatest challenges to addressing the gap in adequate access to clinical obesity treatment.

The barriers identified by clinicians and consumers include:

- **Stigma:** The stigma of obesity and its causes pervade clinical services and community perceptions. Due to the negative perception of obesity in Australia, individuals are reluctant to approach the health system for treatment, which includes having a conversation with their GP. These are missed opportunities for early assessment and weight management intervention for preventing further progression to more severe stages of weight-related complications (EOSS).
- **Cost and funding:** There is a perception of insufficient Medicare reimbursement to provide primary care and access to subsidised obesity treatments and services. This includes a lack of Medicare bulk billed GP, physician or surgeon whom lead specialist obesity clinics, making it difficult for those people who need these services and yet cannot afford the associated out-of-pocket costs. Further, the cost of allied HCP services in the health care system was a major barrier also highlighted in the Framework.
- **Public sector service capacity:** There is either limited or no practical access to specialist clinical obesity services including bariatric surgery for patients with severe obesity and complications, as well as for children and adolescent patients, particularly in the public sector.
- **Service access for priority populations:** Access to timely, effective, and affordable person-centred treatments and support services is especially limited in priority populations living in regional or remote areas, and to those that cannot afford private service care.
- **Service co-ordination:** Despite a general consensus about the need to provide collaborative and co-ordinated services, few such models of care exists in the real world. Established referral pathways and networks for support services, including allied health, and community services to re-enable consumers to maintain health behavioural changes long term are lacking.
- **Population prevalence:** Current environmental, social structures and policies have not yet successfully addressed, nor abated, the increasing prevalence of obesity in the community.
- **Education gaps:**
 - *Patient education* – there is no current programme in Australia that informs patients with a sufficient level of knowledge to decide which intervention will be best suited to their individual preferences and circumstances
 - *HCP tertiary-level training* – there is a deficit in medical education in teaching and assessment of obesity and its management during training pathways.⁵¹ Australian tertiary-level curricula provide limited education to support future HCPs (across several HCP disciplines, including medical students, dietetics, physiotherapy, and psychology) to actively support individuals living with obesity.⁵²
 - *Ongoing professional training* – Mechanisms to overcome an individual’s reluctance to initiate a conversation on obesity are not adequately addressed through professional development resources. This manifests as missed opportunities for assessment and management discussions, as very few patients with obesity tend to discuss weight loss with their GP in Australia.⁵³
- **Patients with severe disability:** Improved partnerships between medical services and the NDIS are required to ensure that those patients with a severe disability do not experience a disconnected care and/or treatment.
- **Environment constraints:** Patients with clinically severe obesity can experience physical access restrictions, for example they may not easily be able to sit down or use bathroom and other facilities.

This can cause difficulties in attending and accessing clinical obesity services.

As no framework to define the principles and standards of clinical obesity care currently exists, and as current data to provide guidance on effective and appropriate models are limited, these barriers continue to prevent the effective delivery of clinical obesity services in Australia.

Enablers to delivery of effective clinical obesity care

A number of enablers have been identified to overcome these barriers. System-wide changes are required to provide better recognition and integration between services, HCPs require increased support and education to provide the best standard of care in these new systems and consumers must be better supported and empowered when accessing and navigating these services.

The National Framework for Clinical Obesity Services relies on these enablers for successful implementation and uptake as well as to maximise patient outcomes and wellbeing. Enablers were identified by the Framework design team, as well as the online survey respondents.

1. System enablers

System enablers will drive the continued development and implementation of this Framework. They include:

- widespread recognition, by governments and professional organisations, of obesity as a chronic disease that requires MDT involvement in all settings
- alignment of this framework to existing policies where possible and practical (e.g. NDIS)
- advocacy to promote this framework and implement clinical pathways in alignment with the development of the Australian Obesity Management Algorithm
- accreditation for specialised clinical obesity services so that they are easily identifiable by others to promote seamless referral networks
- private sector action and investment to develop strategies for improving access to evidence-based obesity treatments and to reduce stigma
- establishment of data collection policies and structures so that the progress and performance of clinical obesity services can be understood and scaled or changed accordingly. Data collection is critical to continuous improvement and outcomes measurement. All MDT members involved in delivery of clinical obesity care should be enabled to collect outcomes data
- research, including clinical research, population research and clinical audits to improve the understanding of health and wellbeing of people living with obesity. Research would be conducted ideally through collaborative partnerships and drawing on work already completed to define standardised data elements⁵⁴. New or novel therapies need to be formally studied and invested in (e.g. by prioritising obesity as a priority population for National Health and Medical Research Council (NHMRC) grants).

2. Consumer enablers

Consumer enablers will build individual capacity to determine and navigate treatment pathways. They include:

- easy access to education and resources to build understanding of obesity, health, and nutrition literacy, how to access available treatment options, and the potential for self-management where appropriate
- social inclusion and support, including targeted outreach services focused on high risk groups to create supportive environments
- support for increased involvement in decision making and research regarding the management of obesity
- clinical environments that aim to de-stigmatise obesity and empower individuals
- access to multidisciplinary services to manage obesity, regardless of location, that demonstrate genuine collaboration between settings.

3. Health care professional enablers

Health care professional enablers include those tools and supports targeted at clinicians and other health professionals such as allied health professionals and/or those working in the community setting. The enablers required for these stakeholders include:

- education and upskilling:

- interdisciplinary training in obesity management, incorporated into every discipline
- development of an Obesity Accreditation pathway
- endorsed education pathways including a focus on obesity, commencing at the tertiary education level, with opportunity to specialise and gain accreditation in obesity care and management. Education pathways should ensure that all training comprehensively acknowledges the complexity of obesity
- provision of upskilling, resources and ongoing professional development opportunities for GPs and other HCPs on evidence based best practices for the assessment and treatment of obesity, including support to attend professional development events, particularly in terms of allocated time. This includes advice on the obesity treatment individualisation for those with a physical, mental or other disability to ensure appropriateness and clinical effectiveness
- an emphasis on empathic and patient-centred care
- incorporation of research and audits into care pathways and educational materials as and when they become available
- networking opportunities to improve awareness of evidence-based clinical obesity care
- provision of continuity of care and co-ordinated service offerings between clinical and community health care and allied health, as appropriate, to ensure long term weight management and a reduced risk of weight regain.

3.4. Objective 4 – Recommendations

Objective 4 – Recommendations: To develop a set of recommendations that will enable the adoption and nationwide implementation of the new clinical obesity principles and standards of care.

The series of recommendations coming out of this Framework are intended to continue the momentum to change the way that clinical obesity services are accessed and delivered to Australians living with obesity. There are three recommendation categories:

1. Reduce the stigma of obesity and clinical obesity services and treatments
2. Develop clinical obesity services to address limited access and standards of care
3. Fund clinical obesity services and evidence-based treatments

Each of the recommendations that sit under these categories are detailed in turn below:

1. *Reduce the stigma of obesity*

1.1. The Australian Government should recognise excess weight with clinically significant health impairments as a chronic disease. As defined by the National Strategic Framework for Chronic Conditions, chronic conditions:

- a. have complex and multiple causes
- b. may affect individuals either alone or as comorbidities
- c. usually have a gradual onset, although they can have sudden onset and acute stages
- d. occur across the life cycle, although they become more prevalent with older age
- e. can compromise quality of life and create limitations and disability
- f. are long-term and persistent, and often lead to a gradual deterioration of health and loss of independence
- g. while not usually immediately life threatening, are the most common and leading cause of premature mortality.

Overweight or obesity with weight-related complications fits the above criteria and should be recognised accordingly to allocate funding and shift priorities and conversations.⁵⁵

- 1.2. Strategies to overcome the stigma of obesity and obesity treatments should be developed alongside a national awareness campaign. Given the high levels of stigma associated with the condition and the detrimental impact that this has on access and maintenance of treatment, such a campaign is an essential step to ensuring sustainable health progress.
- 1.3. All discussions and campaigns should involve Australians with lived experience of obesity. This will ensure that communications and strategies are aligned with consumer expectations and experiences. Where possible, organisations such as WIN and The Obesity Collective should be involved to provide additional advocacy and justification for action.

2. *Develop clinical obesity services to address limited access and standards of care*

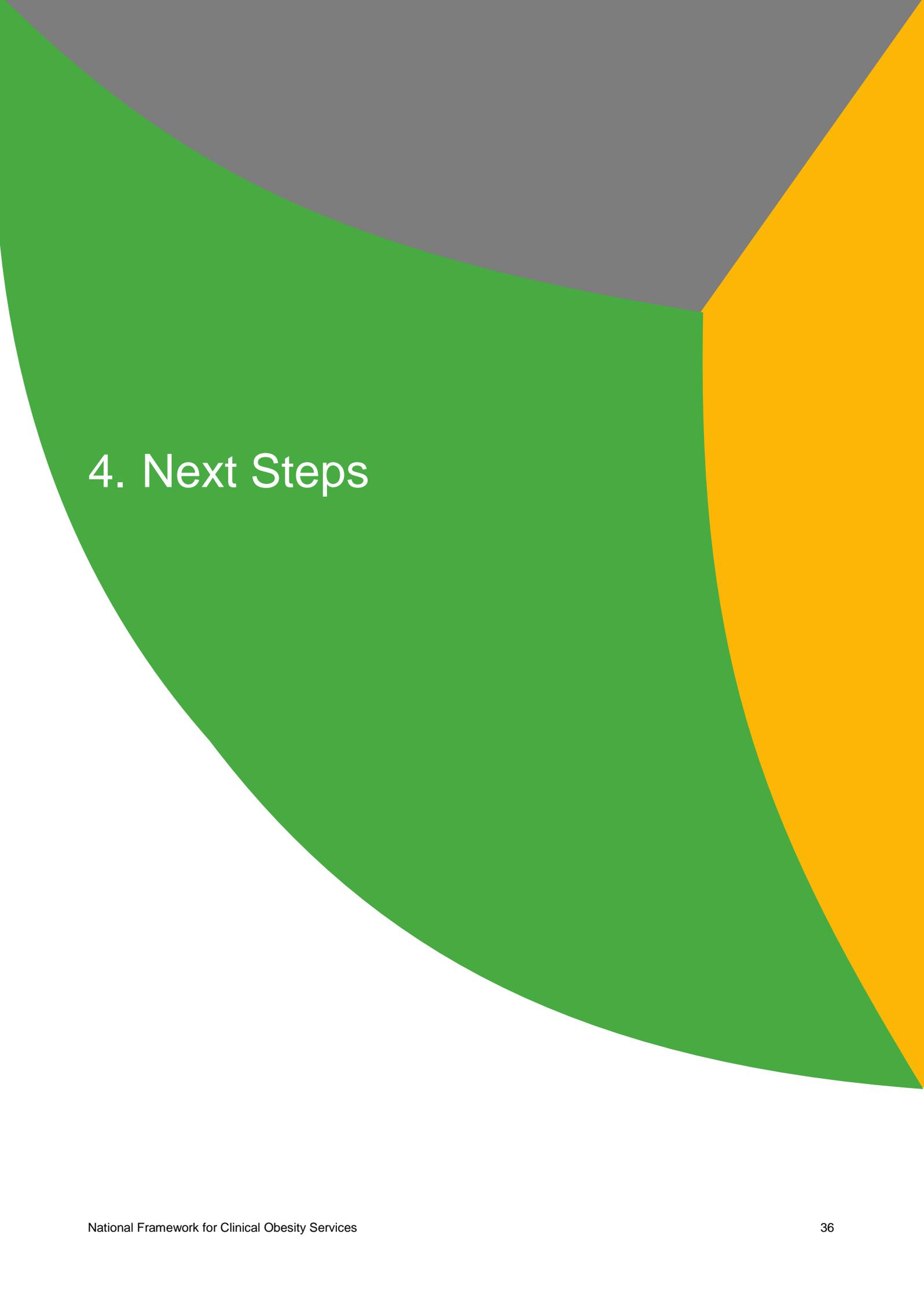
- 2.1. Prioritise access to clinical obesity services and advocacy efforts in the communities at highest risk of obesity, including those who require emergency assistance or urgent surgery.
- 2.2. Develop, test, and refine new clinical pathways and care models in targeted Local Hospital Networks and/or Primary Health Network areas. Clinical pathways should include links and referral pathways to community and allied health services to maximise the opportunity for individuals' post-intervention to maintain health behavioural changes. Provisions for professional development and education opportunities of HCPs in new clinical pathways will be required to ensure best practice.
- 2.3. Develop clinical obesity medical education and accreditation programmes focused on patient preferences and the need for flexible service delivery models, including the options of in-home care or telehealth where available and appropriate.
- 2.4. Develop evidence-based clinical practice guidelines for all obesity interventions, particularly VLEDs, to develop clinical awareness and encourage their liberal use as treatments for obesity.
- 2.5. Take steps to enable holistic family-based obesity care to treat adults and their adolescents or

children together, allowing for a more collaborative and co-ordinated approach to treatment and acknowledgement of the importance of the interpersonal environment of obesity.

- 2.6. Develop culturally specific obesity management programmes for populations such as Aboriginal and Torres Strait Islander and those from a culturally or linguistically diverse (CALD) background to address both racial and obesity bias, stigma, and discrimination by simultaneously breaking down the barriers to access and addressing bias.
- 2.7. The NHMRC Clinical Practice Guidelines for the management of overweight and obesity in adults, adolescents and children in Australia were developed in 2010 (with minor amendments being made in 2013) and were intended to provide clinicians guidance on the management of individuals with a BMI greater than or equal to 25.0kg/m² and who are at risk or currently have an obesity related comorbidity.⁵⁶ As these guidelines have since been rescinded, we recommend that they are updated using the principles in this Framework and be relevant to the future National Obesity Strategy.

3. Adequately fund clinical obesity services and evidence-based treatments

- 3.1. Review and reform new Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) provisions and referral rules to provide equitable access to evidence-based clinical obesity services and treatments. Include specific attention to:
 - the nurse co-ordination role in a primary care setting. Consideration of the application of the Mental Health Nurse Incentive Program (MHNIP) model of care and its funding model in the provision of clinical obesity services
 - ensuring access to the NDIS for those with obesity and severe disability (physical or mental)
 - weight loss pharmacotherapies
 - psychological services as an element of obesity treatment
 - disordered eating education provisions for dietitians and psychologists
 - low income households
 - bariatric surgery and its service provision settings (public versus private) and the impact of this on wait lists and accessibility.
- 3.2. Ensure adequate funding and resources are available for community services, including peer support and life-skill services to support individuals with obesity to make and maintain health behavioural changes.



4. Next Steps

4. Next Steps

There are several immediate next steps arising from this Framework in addition to the recommendations outlined above. Each of these steps are outlined below.

1. Develop an implementation plan

An Implementation Plan for the Framework should be developed in collaboration with key stakeholders and organisations, including patient representative groups. This implementation plan should include:

- a. a definition of key action areas and identification of the organisations responsible to implement the recommendations contained in the Framework
- b. time frames for each key action area
- c. a communication and campaign strategy with a focus on de-stigmatisation
- d. a funding strategy to ensure sustainability
- e. accompanying actions for specific cohorts (such as those from an Aboriginal and Torres Strait Islander or CALD background and those with disabilities including intellectual disabilities) in collaboration with representative individuals and organisations to ensure awareness, applicability and relevance for each group.

2. Engage with priority stakeholders and representatives of high-need cohorts

To assist in developing the Implementation Plan and its accompanying advice as well as building advocacy, recognition and buy-in for the Framework from governments consumer representatives, industry speciality groups, and allied health organisations, should be engaged and consulted. For the guidelines to become enacted, it is vital that the appropriate partners are identified and relationships are formed. These stakeholder groups include, but are not limited to, the following:

Consumer representatives	Industry specialty groups	Allied health organisations
<ul style="list-style-type: none"> • Organisations representing high priority groups (such as individuals in a rural/remote setting, from an Aboriginal and Torres Strait Islander or CALD background and those with a disability) • WIN • The Collective 	<ul style="list-style-type: none"> • ANZOS • ANZMOSS • Royal Australian College of General Practitioners (RACGP) • Royal Australasian College of Physicians (RACP) • Carer groups 	<ul style="list-style-type: none"> • Dietitians Association of Australia (DAA) • Australian Clinical Psychology Association (ACPA) • Exercise and Sports Science Australia (ESSA) • Australian Primary Health Care Nurses Association (APNA) • Australian Physiotherapy Association (APA)

3. Monitor Framework progress and outcomes

To ensure that the Framework is achieving its objectives and intended impacts, a Monitoring and Evaluation Plan should be developed immediately. This plan should consider the inputs, outputs and outcomes (short medium and long term) required to implement the Framework. Not only will this demonstrate the impact of the Framework from its initiation, but it will also assist in identifying opportunities for continuous improvement. This monitoring process should also incorporate a mechanism for tracking feedback on the Framework and its effectiveness from key stakeholders (including patients). The Framework should be reviewed and updated in 1 to 2 years' time based on the results of monitoring its progress and outcomes.

4. Begin to source existing and build new educational materials

As part of the implementation and roll-out of the Framework, educational materials on the treatment and management of obesity in a clinical setting must be updated. The first step in this process is to gather a list of the current educational tools aimed at individuals and HCPs and determine whether these are suitable for use in their current state, need updating or require a completely new approach. Dependent on the outcomes of this review, industry partnerships may be developed and tasked with building the updated and additional educational materials for HCPs.

Acknowledgements

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National Framework for Clinical Obesity Services

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