University of Birmingham and University of York Health Economics Consortium (NCCID)

Development feedback report on piloted indicators

QOF indicator area: Weight Management

Pilot period: 1st October 2015 – 31st March 2016

Potential output: Recommendations for NICE menu

Contents

Summary of recommendations

Indicator

1. The percentage of patients aged 18 or over who have a record of a BMI being calculated in the preceding 5 years.

Acceptability recommendation:

- Band 2: 60-69% of practices support inclusion

Implementation recommendation:

- Band 3: major problems identified during piloting or anticipated in wider implementation. Possibly resolvable through actions described in band 2 but indicator requires further development work and/or piloting.

The requirement for further piloting is to support the recommended revised wording and to test the feasibility of identifying and extracting consultations.

Cost effectiveness recommendation:

See summary report.

Issues to consider:

Issue	**Detail**	**Mitigating activity**
Patients who do not attend the practice	Some patients will not attend the practice in the 5-year window. Practices lacked time and resources to invite patients to attend the practice specifically to have their BMI measured.	We could explore limiting the denominator only to those patients who have had a consultation, or to set the achievement threshold to account for this.
Potential impact upon consultation time	Measuring BMI may naturally lead to giving weight management advice if required. This would have an impact on consultation time.	

Indicator

2. The percentage of patients with a BMI ≥25 in the preceding 12 months who have been given appropriate weight management advice within 90 days of the BMI being calculated.

Acceptability recommendation

- Band 3: 50-59% of practices support inclusion

Implementation recommendation

- Band 2: minor problems identified during piloting or anticipated to arise in wider implementation. Problems resolvable prior to implementation through either 1) an amendment to indicator wording, 2) an amendment to the business rules and/or 3) by giving clarification of indicator terms in associated guidance.

Cost effectiveness recommendation

See summary report.

Issues to consider:

Issue	**Detail**	**Mitigating activity**
Workload implications	A large proportion of the general practice population were expected to have a BMI of 25-30 so giving weight management advice would increase workload.	
Lack of support and resources	Practices lacked resources to give comprehensive advice to all patients. Most external weight management services are currently restricted to patients with a BMI ≥30.	The committee may wish to consider a CCG level structural indicator considering access to weight management services.
Differences in access to specialist services	Due to the known differences in access to specialist weight management services the indicator does not link specific advice for given levels of BMI as detailed in the NICE Guideline.	

Background

As part of the NICE-managed Quality and Outcomes Framework (QOF) process, all clinical and health improvement indicators are piloted, using an agreed methodology, in a representative sample of GP practices across England, Scotland, Wales and Northern Ireland.

The aim of piloting is to test whether indicators work in practice, have any unintended consequences and are fit for purpose.

Practice recruitment

Number of practices recruited:	33
Number of practices dropping out:	1
Number of practices unable to interview:	0
Number of practices interviewed:	32

[31 GPs, 10 practice nurses, 11 practice managers, 1 health care assistant and 1 administrative staff = 54 primary care staff most involved in QOF piloting]

All percentages reported have been calculated using the 33 practices recruited to the pilot as the denominator.

Piloted indicators

1. The percentage of patients aged 18 or over who have had a record of a BMI being calculated in the preceding 5 years.
2. The percentage of patients with a BMI ≥25 in the preceding 12 months who have been given appropriate weight management advice within 90 days of the BMI being recorded.

Assessment of clarity, reliability, feasibility, and acceptability

Clarity

During the focus group it was noted that the activities included in 'weight management advice' would need to be clearly specified.

Practices were provided with clear guidance prior to piloting. This specified they should give patients weight management advice appropriate to their recorded BMI. NICE Guidance recommends interventions based upon BMI and whether the patient has a low, high or very high waist circumference.

Waist circumference table

	Men	**Women**
Low	<94 cm	<80 cm
High	94-102 cm	80-88 cm
Very high	>102 cm	>88 cm

BMI 25-29.9: these patients should be offered general advice on healthy weight and lifestyle. They should also be offered advice on diet and physical activity if they have a high or very high waist circumference. If they have other comorbidities medication to help weight loss could also be considered.

BMI 30-34.9: these patients should be offered advice on diet and physical activity. If they have other comorbidities medication to aid weight loss could also be considered.

BMI 35-39.9: these patients should be given advice on diet and physical activity and the use of medication should also be considered. Where the patient has comorbidities surgery may be considered.

BMI 40 or more: these patients should be advised about diet and physical exercise and should also be considered for medication and surgery.

It was not anticipated that all these services will be delivered in general practice and appropriate advice in this context included referral to weight management services.

Reliability and feasibility

We were able to develop business rules to support this indicator. In relation to 'weight management advice' this was not linked to specific levels of BMI. There are two reasons for this: 1) technical simplicity and 2) known lack of access to specified services.

Issues to be resolved prior to implementation:

Issue	Detail	Mitigating activity
Not all patients are suitable for BMI calculation	Not all patients are able to be weighed in general practice due to issues such as disability.	Add 'unsuitable for body weight measurement' exception reporting codes to the business rules.
The time period for the giving of weight management advice could cross two QOF years.	The 90 day time period for the giving of weight management advice will cross two QOF years where patients are identified with an elevated BMI between January and March.	Modify the business rules to look back 15 months rather than 12 months.
Clarification of the time period for giving weight management advice	The usual period for meeting a process indicator is 3 months. During the pilot this was expressed as 90 days. The negotiating committee has indicated that 3 months =93 days.	Change business rules accordingly and clarify with NHS Employers how this should be expressed in indicator wording.

Acceptability

Indicator 1: The percentage of patients aged 18 or over who have had a record of a BMI being calculated in the preceding 5 years

Twenty practices (62.5%) thought this indicator should be considered for inclusion in QOF. Of these twenty practices, five stated it could be included if the denominator was changed to patients who had attended the practice during the past five years. Eleven practices (34.4%) did not think this indicator should be considered for inclusion in QOF, primarily due to the potential impact on workload. One practice (3.1%) was ambivalent about its inclusion.

The 5-yearly time period for BMI recording was chosen pragmatically and to be in line with other population based indicators such as the current indicator focused on blood pressure recording (BP002: The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years). Most practices felt that this recording frequency had clinical value. More frequent measurement was described as clinically beneficial for particular patient groups such as the elderly. Keeping a baseline figure was described as useful for monitoring either a loss or gain in weight which may be a symptom of an unidentified health issue.

"I think there's a public health function to this. So I can see the value of it. I very much make a point in the elderly of doing annual BMIs because I'm interested to have accurate baselines if they come in with a change." (GP, Practice ID13)

"I saw a lady yesterday and she was very anxious and she was telling me she was losing weight and, looking at her I thought - I didn't believe her. But when I did all the things and put the data in and looked at her she'd lost a humungous amount. It was 40 kilos. She was 120 and she's now 80-something. So then I was doing bloods and stuff, talking to relatives and then realised that she's not eating. Somehow she's isolated for the last few years. So it has got a value I would think with the first-hand example that I've seen. And it's very recent, a couple of days ago." (GP, Practice ID19)

Conversely, some practices felt a population based approach to monitoring BMI added little clinical value. Three practices felt that measuring BMI was useful only in people who were overweight, underweight or those with a comorbidity affected by their weight. These practices felt that they were usually able to make a subjective assessment of whether patients were in the normal BMI range without actually measuring this.

"For a lot of patients who have been stable in weight for years and have healthy diets and really don't need any advice, then repeating their BMI every five years really doesn't have any clinical value but for certain people, particularly those who have co-morbidities, then yes, it does." (GP, Practice ID14)

"I mean would you, we do tend to weigh people maybe if they're under weight and over weight, it's just the people in between, should you weigh them or not necessarily?" (GP, Practice ID05)

A key concern across almost all practices related to the practicalities of collecting BMI data about all adults on their practice list within the five year period. BMI tended to be recorded at new patient checks, NHS health checks, chronic disease reviews and opportunistically during consultations. Two practices also trained their receptionists to measure BMI opportunistically. However, it was noted that this would result in under-recording in groups less likely to visit their GP e.g younger men. All practices felt that inviting these patients to the surgery to measure their BMI was not an effective use of resources. Some commented that people would also be unlikely to attend. Self report methods such as phoning patients and the use of scales in the waiting room had been considered although there were concerns about the accuracy of this.

"We would do it at registration, at every opportunity really, so appointments, blood pressure checks, CHD checks and reviews, annual reviews." (GP, Practice ID27)

"That's not a problem in the patients who come to us. The issue we have is that taking the age 18 and over, it's obviously a very large number of patients. If it's going to be a percentage-based target a lot of these patients, we don't see. We don't see the 18-40 year old males very frequently, unless they're unwell." (GP, Practice ID14)

"For the times that the surgery is open then patients can just come up to the desk and say 'want my height done, I want my blood pressure done, I want my cholesterol done' and the girls on reception

are trained to take them in to the side room and just get that information from them." (GP, Practice ID29)

"The only other way we could do it is actually send out invitations which would probably fall on deaf ears in most cases." (GP, Practice ID32)

Practices reported that BMI measurement was acceptable to most patients although they noted some discomfort in weighing people if it appeared unrelated to the reason for the consultation. It could also prolong a consultation because a discussion about the BMI would naturally follow.

"They're generally fairly accepting of it. They see it as part of their, their health." (GP, Practice ID32)

"People are much more receiving of it if you're doing a pill check where you can explain the relevance or an asthma check where it's useful for working out other predictors. People don't like standing on the scales for the sake of standing on the scales often...if it doesn't seem to be directly relevant to the consultation it can be awkward." (GP, Practice ID23)

Due to the issues associated with collecting BMI, it was felt that if a quality indicator was implemented it would need to have a low achievement threshold. Some also suggested the denominator should be changed to patients attending the practice during a five year period. One practice expressed a concern some practices would use historical weight and height data to calculate an inaccurate BMI.

"It's a dodgy one because you can just do it on historic data so provided you've got a weight and a height in there, you can just recalculate the BMI. Which is not measuring anything at all... So somebody looking at QOF at the end of the year can just go through and do it as an admin task." (GP, Practice ID18)

"When we talked about it we thought maybe the QOF indicator should be a target of those patients that attend the surgery or of those patients with a chronic disease or of those patients who are on a contraceptive. So for those patients we should have a BMI recorded but obviously if they never come in then it's impossible to get it, so you can't then be judged on something that will never happen. But of the patients that do come in and we are seeing or who have a repeat prescription, then at some point in the five years it shouldn't be impossible to get their BMI." (GP, Practice ID15)

<u>Indicator 2: The percentage of patients with a BMI ≥25 in the preceding 12 months who have been given appropriate weight management advice within 90 days of the BMI being recorded.</u>

Eighteen practices (54.6%) were supportive of this indicator being considered for QOF with four of these practices agreeing to the indicator being included if the BMI criteria was changed to ≥30. Thirteen practices (39.4%) did not think that this indicator should be considered for QOF and one practice (3%) was ambivalent.

Most practices were unenthusiastic about giving weight management advice to people with a BMI of between 25 and 30 due to the numbers of people this would include and an associated impact upon workload.

Most, but not all practices, had external referral options available including gym vouchers, community and council run weight management programmes, exercise on prescription, and access to commercial programmes such as Slimming World and Weight Watchers. Across the majority of practices these referral options were available to people with a BMI ≥30, two practices were able to refer patients with a BMI ≥25 and a further three practices said services were available to any patient if this was recommended by their GP. A small number of practices also had practice nurse and health trainer led individual or group weight management programmes. A very small number of practices had no external referral options available or explained that services which were previously available had been subject to local council or CCG level cuts.

"For somebody who wanted particularly to tackle their weight then they'd normally get an appointment with the nurse who would spend 20 minutes with them...it's not BMI dependant. It's just dependant on patient motivation. So if a patient wants to lose weight, so that would be a reason to measure their BMI and to give them the weight management advice and that would be a suggested indicator." (GP, Practice ID16)

"They're stretched. We used to have exercise on referral which we don't have now, we used to have Weight Watchers vouchers which we'd give to patients." (GP, Practice ID32)

"If you have to think everybody with a BMI over 25, you would be talking about a huge amount of patients, I think I've got enough on my plate to do with people with BMIs over 30. So I don't think going down to 25 is particularly helpful" (GP, Practice ID25)

Almost all practices described patient motivation as crucial to weight loss success. Concerns were raised by some about the evidence base that weight management advice in primary care could make a difference. An individual approach was described as more important where they gauged whether patients were accepting of their weight and motivated to change rather than giving unsolicited advice to everyone with a BMI ≥25. This approach was described by most practices as having the potential to upset and alienate people who may not recognise a problem. Practices felt more comfortable broaching the subject as people approached a BMI of 30 due to the increased potential health risks.

"I have yet to see any good evidence that minimal intervention in primary care makes any difference to people's weight. People walk in and they are very big and they don't see it, they don't want to see it, and they don't want it pointed out to them, which is why this has created a lot of work in my practice and that work is, that we now code, as a problem title." (GP, Practice ID22)

"We felt that the BMI of 25 and over, the threshold 25 to 29 or 30 was a little stringent, and patients who had a BMI of 25 didn't respond well to advice on being given weight management." (GP, Practice ID12)

Reflecting a normalisation of being overweight some practices queried the use of a BMI ≥25 as the threshold for giving weight loss advice. Examples were given of people who the practice viewed as healthy who had BMIs greater than this. Some practices suggested that waist circumference should also be used in these circumstances.

"I think obviously, if anyone's over 30, then we do need to be working hard with them and maybe there's a grey area around 25-27, where actually that weight is normal for that person." (GP, Practice ID24)

"The 25 target is very tight; obviously there are a lot of people who have a BMI of 25 and really are pretty fit and healthy, particularly a lot of very fit males would have BMIs of 25 and really the question about whether there's any advantage to starting to give them a lot of dietary advice or weight management advice." (GP, Practice ID14)

Some practices also noted that weight management advice should be given for people with a BMI ≥23 for Asian ethnic groups. A barrier to incorporating this as marker of quality in general practice is the relatively low level of recording of ethnicity in general practices. In the pilot cohort ethnicity was recorded for 61% of patients.

Assessment of implementation

Assessment of piloting achievement

Table 1: patients with a BMI recorded in the last 5 years

% patients aged 18 or over with a BMI recorded in the last 5 years	Baseline	Final (6 months)	Final (5 years)
Number of practices uploading	24	24	24
Practice population	159,840	162,203	162,203
Register	130,068	132,347	132,347
Exception reported			
Rule 2 True (recent registration)	1,529	1,251	1,251
Total exceptions	**1,529**	**1,251**	**1,251**
Exceptions as a % of the eligible population	**1.18**	**0.95**	**0.95**
Denominator	128,539	131,096	131,096
Numerator	85,118	28,621	87,845
Numerator as a percentage of denominator	**66.22**	**21.83**	**68.34**
Underlying patient achievement (%)	**65.44**	**21.63**	**66.37**

There was little change over the pilot period in the proportion of patients with a BMI recorded in the preceding 5 years. Practice achievement ranged from 46.41 – 84.06% at baseline and 46.17 – 89.59% at final upload (5-year success).

Over the pilot period, BMI was recorded for 21.63% of eligible patients.

Table 2: patients with a BMI greater than 25 in the preceding 12 months who have been given weight management advice within 90 days of the BMI recording

% of patients with a BMI >25 given weight management advice	Baseline	Final (6 months)	Final (12 months)
Number of practices uploading	23	23	23
Practice population	164,419	166,833	166,833
Register	126,625	128,855	128,855
Excluded regardless			
Rule 1 False (BMI <25)	99,352	95,183	95,183
Exception reported			
Rule 3 True (weight management advice exception)	280	481	336
Rule 4 True (recent registration)	828	707	696
Total exceptions	**1,108**	**1,188**	**1,032**
Exceptions as a % of the eligible population	**4.06**	**3.53**	**3.06**
Denominator	26,165	32,484	32,640
Numerator	2,158	1,562	3,633
Numerator as a percentage of denominator	**8.25**	**4.81**	**11.13**
Underlying patient achievement (%)	**7.91**	**4.64**	**10.79**

Changes in practice organisation

Some practices reported that receptionists regularly measure BMI to assist with the workload of the clinical team. Potential self report methods of collecting BMI were also considered by practices such as phoning patients or using scales in the waiting room. Concerns were expressed over the potential accuracy of self report methods. If BMI was measured outside a clinical consultation and the patient was identified as being overweight, practices would need to adopt a system to ensure these people were given weight management advice within the time frame specified in the indicator.

Resource utilisation and costs

Practices described a potential impact on consultation time with the calculation of a BMI naturally leading to a discussion of its significance.

It was noted that a large number of patients would have a BMI of between 25 and 30. This could have resource implications at both the practice level and for specialist weight management services.

Barriers to implementation

Two main barriers to implementation were reported:

Firstly, in relation to BMI recording most practices reported that a proportion of patients would be unlikely to attend the practice within 5 years to enable them to record a BMI.

Secondly, the potential impact upon consultation time.

Assessment of exception reporting

Exception reporting was generally low at 1% for recording of BMI and 3.53% for giving weight management advice to people with a BMI ≥25. Given the permitted reasons for exception reporting against BMI measurement this is unlikely to change on widespread implementation unless new exception criteria are added. The addition of exception codes for patients being 'unsuitable for body weight measurement' has been recommended to bring this indicator in line with existing QOF indicators, which may have a modest effect.

Exception reporting against the giving of weight management advice might reasonably be expected to increase on widespread implementation given both the low levels of achievement and current exception reporting..

Assessment of potential unintended consequences

None identified.

Assessment of overlap with and/or impact on existing QOF indicators

OB001. The contractor establishes and maintains a register of patients aged 16 and over with a BMI ≥30 in the preceding 12 months

Suggested amendments to indicator wording

The committee could consider amending the indicator wording as follows:

The percentage of patients aged 18 or over, who have attended general practice within the preceding 5 years, who have a record of a BMI being calculated in the preceding 5 years.

Current advice from the HSCIC is that if we wished to explore this rewording then the revised indicator would need to be piloted. This is due to us needing to use a new 'table' within the GP system which records encounters/ consultations. This table is supported by both BPES and system suppliers but it requires practices to activate it. We currently have no information as to whether practices use this table and whether it is updated correctly for each consultation type e.g. telephone, home visit, repeat prescription. Given these concerns about data quality HSCIC has recommended that this approach would require further testing prior to implementation.

Appendix A: Practice recruitment

We planned to recruit 34 practices in England and 2 in each of the Devolved Administrations. English practices were to be representative in terms of practice list size, deprivation and clinical QOF score. Given the limited variability in clinical QOF score we excluded practices with a score of ≤ 10th centile. Practice list size and IMD scores were divided into tertiles and a 3x3 matrix created with target recruitment numbers for each cell. These are detailed in the table below.

	List size		
IMD Score	Low	Medium	High
Low	3	4	5
Medium	3	4	4
High	4	4	3

As previously presented to the Committee, practice recruitment has been extremely challenging. At the beginning of this pilot we had recruited 30 practices in England and 3 in the Devolved Administrations (2 in Northern Ireland, 1 in Scotland). Practice recruitment by strata is shown in the table below with cells in bold where we failed to meet target numbers. We also over recruited in two stratas which is shown by the numbers in the table.

	List size		
IMD Score	Low	Medium	High
Low	**2/3**	4/4	**2/5**
Medium	3/3	4/4	**2/4**
High	5/4	4/4	3/3

Appendix B: Indicator development

Following the June 2015 Advisory Committee meeting the NCCID was asked to develop new indicators for weight management.

GP focus group

A focus group to discuss potential indicators was held on 9th July 2015 where all potential indicators were discussed. Focus group attendees were volunteers recruited via our database of GPs who had responded to previous invitations. From the volunteers we purposively selected 15 GPs to attend the focus group to ensure an equal balance of men and women, representation from minority ethnic groups and a range of ages.

13 of those invited attended the meeting. Eight (61.5%) were male. Approximately one third of the participants described themselves as being of white ethnicity (n=5). Participants were reimbursed £250 for their attendance.

Stephanie Birtles and Dr Karen Slade attended on behalf of NICE.

Five indicators were presented to the group. The potential indicator relating to recording BMI was well received and the group could see the value in population based weight monitoring. Participants expressed this may be difficult to achieve for some patients who do not attend the surgery regularly. For the potential indicator relating to giving weight management advice, the group expressed some concerns about the positive benefit of GP intervention for patients, and a concern that a broader societal response was required to resolve this issue. The indicator was recommended to be progressed to piloting by the group.

Two indicators are to be progressed to piloting.

Indicator wording as piloted

1. The percentage of patients aged 18 or over who have had a record of a BMI being calculated in the preceding 5 years.
2. The percentage of patients with a BMI ≥25 in the preceding 12 months who have been given appropriate weight management advice within 90 days of the BMI being recorded.