CONFIDENTIAL

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

INDICATOR DEVELOPMENT PROGRAMME

Consultation report on indicator(s)

Indicator area: Obesity

Consultation period: 26 January 2015 – 23 February 2015

Potential output: Recommendations for the NICE Menu for the Quality and Outcomes Framework (QOF)

Contents

CONFIDENTIAL

Indicator included in the consultation

ID	Indicator	Evidence source
IND-2	The percentage of patients with coronary heart disease, stroke or transient ischemic attack, diabetes, hypertension, peripheral arterial disease, heart failure, chronic obstructive pulmonary disease, asthma, osteoarthritis and / or rheumatoid arthritis who have had a body mass index (BMI) recorded in the preceding 12 months.	Recommendation 1 from the NICE public health Guideline (PH53) on managing overweight and obesity in adults and recommendations 1.2.2 and 1.2.3 from NICE clinical guideline (CG189) on obesity: identification, assessment and management of overweight and obesity in children, young people and adults.

Summary of consultation responses

There were mixed responses about this indicator with some stakeholders feeling this should be adopted and others stating that there is no rationale for this indicator suggesting it is a poor use of GP consultation time.

Other stakeholders felt that the indicator was useful but may require some amendments. The omission of an intervention was highlighted by a large number of stakeholders.

Comments by indicator (IND-2)

> *The percentage of patients with coronary heart disease, stroke or transient ischemic attack, diabetes, hypertension, peripheral arterial disease, heart failure, chronic obstructive pulmonary disease, asthma, osteoarthritis and / or rheumatoid arthritis who have had a body mass index (BMI) recorded in the preceding 12 months.*

Specific amendments were suggested around the population that this indicator should cover to improve measurability. This came in the form of age (over 18) and a focus on additional co-morbidities such as learning disabilities. Mental health was also raised as a co-morbidity to be included within the population as mental health treatment (specifically the use of antipsychotics) is associated with weight gain. A measurement of sleep disorders such as sleep apnoea was also felt to be beneficial given its correlation with obesity.

CONFIDENTIAL

Several stakeholders questioned the rationale that BMI should be recorded every 12 months as this may not be enough time for changes in weight to be achieved.

A number of stakeholders had concerns about the use of BMI as a sole measurement of obesity and that it would be better to combine BMI with waist circumference. This was due to the fact that BMI as a single measure may miss subgroups of the population such as people of a particular ethnic origin.

Finally, for general amendments to the indicator, stakeholders felt that there should be a focus on an intervention. This would be that people who are identified as obese receive a referral to services and support. However different examples were given about what these services or support would entail. Without this interventional aspect stakeholders felt obesity would not be tackled in this indicator.

Specific issue for consideration during consultation

- people with chronic conditions were identified as an appropriate population for BMI assessment as a precursor to indicators focused on intervention. Do stakeholders consider the scope of the conditions covered in the indicator suitable?

A range of comments were received about the specific issue for consideration, with comments on supporting the existing chronic conditions and suggestions for alternative or additional conditions.

Several stakeholders commented positively on the inclusion of osteoarthritis given that obesity is a risk factor for its development. While agreeing that it should be included stakeholders did feel that this would be difficult to measure as it is not an existing QOF disease area, and additional work would be needed need to ensure a register for these patients can be effectively coded. A stakeholder felt that further musculoskeletal chronic conditions could be included such as back pain.

Stakeholders did suggest additional chronic conditions for inclusion in this indicator including chronic kidney disease, Parkinson's disease, anxiety disorders and depression.

Stakeholders suggested alternatives for the population to be covered, this was those people presenting with high blood pressure, high cholesterol and sugar levels. Other stakeholders felt that this should not focus upon other comorbidities or risk factors and instead focus on all adults as this was found

CONFIDENTIAL

to be cost effective in NICE guidance on lifestyle weight management services which would ensure that this indicator is preventative and more effective.

Stakeholders did advise that this indicator could result in double counting as many of the chronic conditions mentioned will be covered by existing QOF indicators. A stakeholder also felt that people with these conditions would already have an annual check and wondered what benefit this indicator would have for these people.

Considerations for the Advisory Committee

The specific issues that the Advisory Committee is asked to consider when making recommendations on which indicators should be published on the NICE menu are stated below.

These issues are also addressed in the indicator development reports which will include suggestions for possible amendments to how the indicators should be specified following piloting and public consultation.

The Advisory Committee is asked to consider:

- if scope of the conditions covered in the indicator are suitable and sufficient?
- if a focus on co-morbidities is necessary or should all people be included?
- if there is potential for double counting?
- if the use of BMI is appropriate as a sole measure of obesity in this indicator is appropriate?
- if a recording of BMI in the preceding 12 months is appropriate, is this too frequent?
- the potential for this indicator to be linked to an intervention.

CONFIDENTIAL

Appendix A: Consultation comments

Indicator ID	Stakeholder organisation	Comment
IND 2	Arthritis Research UK	1. Arthritis Research UK is the charity dedicated to stopping the devastating impact that arthritis has on people's lives. Everything that we do is focused on taking the pain away and keeping people active. Our remit covers all conditions which affect the joints, bones and muscles including osteoarthritis, rheumatoid arthritis, back pain and osteoporosis. Together, these conditions affect around ten million people across the UK and account for the fourth largest NHS programme budget spend of £5 billion in England. We fund research into the cause, treatment and cure of arthritis, provide information on how to maintain healthy joints and bones and to live well with arthritis. We also champion the cause, influence policy change and work in partnership to achieve our aims. We depend on public support and the generosity of our donors to keep doing this vital work. 2. Arthritis Research UK funds a national centre looking into musculoskeletal ageing. The MRC-Arthritis Research UK Centre for Musculoskeletal Ageing Research focuses on the role of obesity in the development of inflammation and joint problems in older people, with the aim of identifying both nutritional and physical activity interventions that can reduce age-related disease. 3. Arthritis Research UK funds a centre of excellence in primary care. The Arthritis Research UK Primary Care Centre based at Keele University looks to address the way that musculoskeletal conditions are managed in primary care. The centre has submitted its own response to this consultation, supporting the inclusion of osteoarthritis, back pain and rheumatoid arthritis in the new obesity indicator.
IND 2	Arthritis Research UK	Musculoskeletal conditions and obesity 4. Arthritis Research UK strongly supports the inclusion of a new obesity indicator that includes musculoskeletal conditions. 5. Musculoskeletal conditions are primarily long term conditions causing pain and disability. Around 20% of the general population consult their GP about a musculoskeletal problem each year. That amounts to over 100,000 consultations a day, the majority of which are for

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
		osteoarthritis and back pain, accounting for a substantial attendance and demand for resource in primary care. 6. The impact and burden of musculoskeletal conditions is recognised by the World Health Organisation, which describes them as 'leading causes of morbidity and disability, giving rise to enormous healthcare expenditures and loss of work'. Musculoskeletal conditions are the largest contributor to the burden of disability in the UK – in 2010, such conditions accounted for 30.5% of all years lived with disability. With the prevalence of musculoskeletal conditions rising over time, the area requires 'urgent policy attention'. 7. The relationship between excess weight and musculoskeletal conditions is significant. Excess weight places additional stress on the joints, particularly weight-bearing joints like the back, knees and hips, causing damage and limiting mobility. People who are overweight or obese are more likely to develop a musculoskeletal condition, particularly osteoarthritis of the knee. 8. Given the strong relationship between obesity and osteoarthritis, more must be done to prevent the onset of osteoarthritis – clinical guidelines recommends everyone maintains a healthy weight to reduce their risk of developing osteoarthritis. NICE should look to develop approaches that are targeted and multidisciplinary, involving not just interventions targeted at obese people with osteoarthritis, but preventative interventions designed to reduce the risk of people developing osteoarthritis at all. 9. For people with a musculoskeletal condition, the impact of the condition can be reduced by achieving and maintaining a healthy weight. Everyone with a musculoskeletal condition who is overweight or obese should be offered advice and support to reduce their weight. The new obesity indicator provides a significant opportunity to systematically identify overweight or obese people with musculoskeletal conditions, where interventions can be put in place to help support people to maintain a healthy weight and improve their health.

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
IND 2	Arthritis Research UK	10. We note that the proposed new obesity indicator does not specify the age range of patients to be included. Conditions of musculoskeletal pain are relatively common among young people. For example, between one in four and one in seven young people have chronic low back pain. Obese young people are more likely to experience persistent or recurrent joint pain, including knee pain, and obesity is associated with more severe pain overall. 11. Childhood obesity may have an impact on persistent pain later in life by placing strain on vulnerable joints. Reducing obesity in childhood may reduce both the risk of developing persistent pain in adolescence, and pain continuing into adult life. Given the prevalence of musculoskeletal conditions among children and young people, it would be useful for NICE to clarify the age range at which the indicator is targeted.
IND 2	Arthritis Research UK	Osteoarthritis 12. Osteoarthritis should be included in the new obesity indicator as a priority. 13. Around 7.3 million people in England have sought treatment from their GP for osteoarthritis. A strong evidence base establishes obesity as a risk factor for both the onset and progression of osteoarthritis. 14. Obesity is the single biggest avoidable cause of osteoarthritis in weight-bearing joints. Osteoarthritis of the knee is particularly associated with excess weight – obesity is the largest modifiable risk factor for knee osteoarthritis. The increase in risk of developing knee osteoarthritis due to obesity appears to be similar to that of developing high blood pressure or type 2 diabetes due to obesity. Every 5kg of weight gain confers a 36% increase in the risk of developing knee osteoarthritis. Obese people are more than twice as likely to develop knee osteoarthritis than those of normal body weight, with many estimates assessing the risk as between four and six times greater. 15. The relationship between obesity and osteoarthritis presents a growing challenge. The rising prevalence of obesity alone will increase the number of people in the UK consulting a GP about knee osteoarthritis from 4.71 million to 6.61 million by 2035. 16. Weight loss is effective in reducing the symptoms of osteoarthritis for people with excess weight. The combination of diet and exercise in particular helps to reduce the pain of knee

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
		osteoarthritis. A load of around three to six times body weight goes through the knee, a force which is increased with excess weight. For people with knee osteoarthritis, even a small amount of weight loss can make a big difference to their condition – noticeable improvements in symptoms can start from 5% weight loss. Weight loss of 10% would be expected to lead to a substantial improvement in symptoms particularly in terms of increased functional ability, walking speed and quality of life, and may slow disease progression. 17. The NICE clinical guideline for osteoarthritis states that weight loss should be a core treatment for people with osteoarthritis who are overweight or obese, and people should be provided with advice on appropriate interventions to achieve weight loss. 18. Alongside coronary heart disease, cancers and diabetes, osteoarthritis is a major contributor to healthcare costs attributed to obesity-related diseases in the UK. More than two in three knee replacements and one in four hip replacements in middle-aged women are attributable to obesity. The vast majority of joint replacements are due to osteoarthritis – in 2012, 94% of all primary joint replacements were due to osteoarthritis. Implementation 19. There exists some inconsistency in the diagnosis and coding of osteoarthritis in general practice. Such technical issues are not a barrier to implementation however, and should not preclude the identification of people with osteoarthritis and data collection in general. Centres of excellence such as the Arthritis Research UK Primary Care Centre have well-established protocols that could be adopted more widely. Arthritis Research UK and the Primary Care Centre would be happy to provide technical expertise, for example around the identification of appropriate Read codes for osteoarthritis.
IND 2	Arthritis Research UK	Back pain 20. Back pain should be included in the new obesity indicator. Back pain is currently included in the rationale for the new obesity indicator but is omitted from the wording of the indicator itself. We recommend the indicator wording is amended to specifically include back pain alongside osteoarthritis and rheumatoid arthritis. 21. Back pain is a common problem, often caused by a muscle, tendon or ligament strain.

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
		Although some people experience mild, self-limiting back pain, one in six adults aged over 25 years reports back pain lasting over three months in the last year. It is a leading cause of working days lost, accounting for 12.5% of sick days in the UK. Low back pain affects around one-third of the UK adult population each year and around 20% of people with low back pain consult their GP. 22. Overweight and obesity increases the risk of low back pain, and is most strongly associated with seeking care for low back pain and chronic low back pain. Compared to someone of a healthy weight, obese people (with a BMI over 36) are four times more likely to develop low back pain. , Evidence suggests that physical activity can play a significant role in mitigating the risk of developing low back pain among overweight and obese populations. 23. The NICE clinical guideline recommends that people with low back pain are advised to exercise and advised on the likely benefits of staying active. However excess weight can act as a barrier to exercise and is associated with an increase in sedentary behaviour. Interventions must be designed and tailored to address these barriers. 24. For morbidly obese people, weight loss following bariatric surgery is associated with a decrease in disease severity, and broader improvements in gait parameters, walking speed and quality of life.
IND 2	Arthritis Research UK	Rheumatoid arthritis 25. Rheumatoid arthritis should be included in the obesity indicator. 26. Around 400,000 adults in the UK have rheumatoid arthritis. Approximately one-third of people stop working within two years of onset due to the disease. The total cost of rheumatoid arthritis in the UK, including indirect costs and work-related disability, is estimated between £3.8 and £4.75 billion per year. 27. Obesity is associated with a modest risk of developing rheumatoid arthritis, although the mechanism by which obesity contributes to the condition is unknown. 28. For overweight or obese people with rheumatoid arthritis, weight loss can help reduce existing inflammation of the joints. Obesity is associated with increased risk of total joint replacement, reduced functional capacity, higher disease activity, reduced remission rates, and

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
		lower quality of life. , , Achieving and maintaining a healthy weight can therefore improve clinical outcomes and overall health for people with rheumatoid arthritis. 29. Obesity is associated with a higher prevalence of comorbidities in people with rheumatoid arthritis, including osteoarthritis, diabetes, hypertension and chronic pulmonary disease. , The management of overweight and obesity in people with rheumatoid arthritis is therefore crucial to addressing the risk of increasing comorbidities. 30. People with rheumatoid arthritis often require treatment with steroids, which are strongly associated with weight gain – an additional reason to offer support to maintain a healthy weight. Being obese may also mean that people with rheumatoid arthritis are less likely to respond to anti-TNF biological therapies. Implementation 31. Rheumatoid arthritis indicators are already included in QOF, which would enable straightforward inclusion of rheumatoid arthritis in the new obesity indicator. Clinical guidelines recommend that people with satisfactorily controlled rheumatoid arthritis are offered review appointments, including an annual review, at a frequency and location suitable to their needs. Review appointments would provide an opportunity for body weight measurement.
IND 2	Arthritis Research UK	Multimorbidity 32. The interrelationship between musculoskeletal conditions and other long term conditions provides additional rationale for the inclusion of musculoskeletal conditions in the new obesity indicator. 33. Long term conditions are more common in obese people than those of a healthy weight. A third of obese adults in England have a long term condition, compared to a quarter of adults in the general population. Although the number of people with long term conditions in England is expected to remain stable over the next decade (at around 15 million), the number of people with multiple long term conditions is expected to rise. , The proportion of general practice consultations for people with multimorbidities is already high (78%) – addressing the challenges of multimorbidity will place further demand on healthcare services. 34. Musculoskeletal conditions are a major contributor to multimorbidity. 82% of people with

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
		osteoarthritis have at least one other long term condition such as cardiovascular disease, hypertension or depression, which can exacerbate the impact of osteoarthritis. Equally, a musculoskeletal condition can increase the severity of other conditions or limit treatment options.
IND 2	British Geriatrics Society	The scope is suitable but the indicator is unlikely to capture all patients with chronic conditions
IND 2	British Heart Foundation	We agree, but believe the scope of this indicator should also include chronic kidney disease.
IND 2	British Medical Association	We do not support this indicator, as we do not believe the annual recording of BMI will result in a reduction in the BMI of those patients, and would request that evidence be produced that this activity, within a general practice setting, alters outcomes. The list will select far too many patients for whom obesity is no more a problem than for the general population, particularly young patients with mild asthma or patients with localised osteoarthritis of upper limb joints, such as the thumb (a very common site for OA). Many patients dislike regular BMI checks and this may dissuade some from attending annual review. The collecting of this data will impact on other useful activities during review consultations. Even if it only takes 1 minute to do this represents 10% of a normal GP consultation and a larger proportion of the time available within that consultation for clinical work, and so will divert time away from problems that the patient may wish addressed. The time available for a review should be 15 months not 12. If a patient were to miss an annual review late in the qof year there will be no incentive to chase that patient up to ensure prompt review, as the payment will already be lost even if they come after 13 months.
IND 2	British Thoracic Society	We support this but welcome some explicit reference to sleep disordered breathing which is a major health problem linked to obesity.
IND 2	British Thoracic Society	We would welcome a focus on the proportion of patients with long term conditions – in particular COPD and asthma - who are smokers being identified with an incremental annual target to reduce this.
IND 2	Cambridge Weight Plan	Cambridge Weight Plan (CWP) would like to thank NICE for the opportunity to comment on the potential new indicators for inclusion in the NICE Quality and Outcomes Framework (QOF) menu.

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
		CWP offer a variety of weight management options, including Very Low Calorie Diet (VLCD) programmes for obese and Low Calorie Diet (LCD) programmes for obese and overweight individuals seeking to lose or manage their weight. CWP will therefore be focusing on the proposed new QOF indicator on obesity.
IND 2	Cambridge Weight Plan	CWP welcomes the recommended inclusion of a reformed obesity QOF indicator in NICE's menu. CWP believes a reformed obesity indicator is much needed: the existing obesity indicator is only focused on identifying obese individuals, rewarding General Practitioners (GPs) just for this, as opposed to helping obese patients in a more practical manner. Given the current, extremely high levels of obesity, (currently 26% of adults in the UK), a more effective approach is needed. CWP strongly endorses the suggested introduction of a new obesity indicator, as well as the acknowledgment included in the draft indicator in the consultation document that "primary care has a key role in managing obesity through assessing risk and morbidity, and facilitating access to weight management support".
IND 2	Cambridge Weight Plan	It is not clear, however, whether the proposed new obesity indicator goes far enough to ultimately tackle this high level of obesity. Despite the positive development of the Indicator Committee's acceptance of the necessity to reform the obesity QOF indicator to reinforce more active screening, CWP believe screening's primary goal should be to prevent the onset of secondary diseases associated with obesity (e.g. diabetes, hypertension and coronary heart disease, amongst others). Under the proposals for the new indicator, however, screening and maintaining a register of those who already have such conditions is advocated with the goal of ameliorating those comorbidities through providing assistance to identified individuals with weight loss or management. Though this is valid, and CWP welcome this step, CWP also believe that steps should be taken to screen individuals prior to them developing any conditions. This would be far more cost-effective in the long-run to the NHS.

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
IND 2	Cambridge Weight Plan	CWP believe that a broader reform of the obesity indicator is needed, including requiring GPs to provide screening of obese individuals for high blood pressure, high cholesterol and sugar levels – amongst other indicators. This would offer a clear indication of an individual's likelihood of acquiring comorbidities linked to obesity, ensuring that they are avoided. More importantly, this reform is feasible at no additional cost and would result in long-term savings for the NHS through the reduction of the need for treatment and management of comorbidities related to obesity.
IND 2	Cambridge Weight Plan	Finally, CWP strongly urge any reformed QOF indicator to better incentivise GPs to help manage the weight of individuals attending their surgery. The QOF should reward GPs who send patients to see specialist practice nurses, or send their patient to local weight management services or take similar steps towards actually helping an individual lose weight. Many GPs do, of course, already do this, but a reformed QOF indicator will formalise and solidify this practice amongst all GP surgeries, helping overweight and obese individuals wherever they are.
IND 2	County Durham and Darlington Local Medical Committee	There is no evidence that recording a BMI has any benefit for the patient. If this indicator remains in the basket of measures than it need not be carried out more often than every 36 months. If asthma is to remain in the basket of conditions for which this is required than there needs to be some age limits set.
IND 2	Department of Health (Obesity and Food Policy Branch)	• We welcome the inclusion of a specific indicator on obesity and consider that the approach which links obesity with its co-morbidities is sensible. This approach that may make it easier for GPs to have a discussion with overweight and obese patients about their weight. • We welcome the emphasis that the indicator puts on the important role that primary care can have in overweight and obesity identification and treatment. • The indicator could be more ambitious to improve outcomes for overweight and obese patients and have a requirement to refer patients to appropriate weight management services, not only record BMI. • The list of comorbidities is appropriate and comprehensive and we have no suggested additions.

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
IND 2	Diabetes UK	To better align with the Five Year Forward View ambition to reduce the burden of avoidable illness this indicator should also include people who have been identified to be at high risk of diabetes. To do this, practices will need to keep a register of people who are found to be at high risk of diabetes. The steps to identify those at high risk should be in line with NICE guidelines, PH38: http://www.nice.org.uk/guidance/PH38. Establishing this register is important. It will support practices to implement PH38, which suggests they should keep an up to date list of people's risk and introduce a recall system for those identified to be at high risk. It would also significantly contribute to the aims of this indicator by identifying a wider group of people whose symptoms may be helped by weight loss and by encouraging intervention at an earlier point. It is important that in addition to recording the combined data for this indicator the data is available for all the individual conditions to allow disparities across conditions to be tracked.
IND 2	Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association.	We are pleased to see that excess body fatness may be recognised as a QOF indicator. As a major driver of other clinical conditions (e.g. type 2 diabetes, cardiovascular disease, hypertension, some cancers, osteoarthritis), in our view the identification and treatment of obesity is a fundamental public health measure. However in terms of the scope described, those with such diagnosed conditions are already highly likely to be overweight or obese. For preventative purposes, it would be more useful in our view to have a record on BMI in the preceding 12 months in all adults (>18 years). That would enable clinical identification of those at high risk of developing such conditions, and effective weight and lifestyle management would reduce their risk.
IND 2	Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association.	We recognise the utility of BMI but would caution against its sole use as a clinical measure in individuals. The distribution of body fat as measured by waist circumference combined with BMI would give a more accurate picture of risk in those with a BMI ≤35kg/m2.
IND 2	Dietitians in Obesity Management UK (domUK), a specialist group of the British	In addition we have concerns that the use of BMI only, with cut-off points of ≥25kg/m2 (overweight) and ≥30kg/m2 (obesity), may underestimate health risks in some population subgroups e.g. South Asians.

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
	Dietetic Association.	
IND 02	Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association.	We agree that identification of overweight or obesity are the first steps required but would like to see this indicator linked to access to effective weight management advice and support services.
IND 2	Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association.	In our view, time may be seen as a major barrier to implementing this indicator, but we would argue that identifying risk is a clinical duty of care. We are also concerned about potential underestimation of risk in some population subgroups. Provision of accessible and effective weight management advice and support will have financial implications, which are likely to be offset by improvements in co-morbidities if sustained weight loss occurs, but must be met in the short term nonetheless.
IND 2	Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association.	We also feel that there may be potential for differential impact given that the prevalence of overweight and obesity varies by age, gender, ethnicity, income; that pregnancy and maternity may be linked long term with increased weight gain and that some disabilities may be linked with increased weight gain especially if activity levels are affected. However we feel that identification followed by treatment is likely to have a positive impact in those groups.
IND 2	East and North Hertfordshire CCG	Would not recommend rheumatoid arthritis with obesity as rheumatoid arthritis treatment can predispose someone to obesity.
IND 2	East Sussex Public health	With regards to the scope, could consider including those presenting with depression or anxiety too, due to their association with obesity. Suggest also include high risk diabetes diagnosis (also referred to as pre-diabetes or IGL, IFT or IGT)
IND 2	EQUIP	You have not previously asked about osteoarthritis which is widespread but probably not very accurately coded by practices.Whilst symptoms can be improved by weight loss this is exceedingly difficult to achieve and maintain. However there is good evidence that if obese patients can do one of healthy eating, taking exercise, not smoking and drinking sensibly than can halve their excess risk of death. If they can do all four the risk is reduced to that of a person of 'normal' BMI
IND 2	Hambleton, Richmondshire and Whitby CCG	BMI measurement ok but an intervention should be offered to the patient if indicated by their BMI and comorbidity status

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
IND 2	Heart UK	• People with chronic conditions were identified as an appropriate population for BMI assessment as a precursor to indicators focused on intervention. Do stakeholders consider the scope of the conditions covered in the indicator suitable? Yes, HEART UK considers the scope suitable.
IND 2	Institute of Primary Care & Health Sciences/ Arthritis Research UK Primary Care Centre, Keele University	Eligible chronic conditions. (1) We strongly agree with the inclusion of osteoarthritis (OA) within this indicator. Systematic reviews of existing research consistently confirm obesity as a major risk factor for OA (onset and progression), particularly painful knee OA (Blagojevic et al., 2010 doi: 10.1016/j.joca.2009.08.010; Silverwood et al., 2014 doi: 10.1016/j.joca.2014.11.019) with patients often not connecting the benefits of losing weight on reducing joint pain (Morden et al., 2014 doi10.1002/msc.1054.). An indicator encouraging recording of BMI among prevalent cases of OA (and hoping to influence weight loss among those overweight/obese) may have some effect on preventing the future onset of OA in other joints within a patient with already-developed OA but its main value would be to reduce associated pain and disability and slow disease progression. This is consistent with current evidence-based guidelines (e.g. Fernanades et al 2013 doi:10.1136/annrheumdis-2012-202745).
IND 2	Institute of Primary Care & Health Sciences/ Arthritis Research UK Primary Care Centre, Keele University	Potential barriers include the ability of general practice to capture this data (Clarson et al., 2013 doi:10.4137/CMAMD.S12606). Only a proportion of patients consulting for painful OA and who would benefit from the indicator currently receive a specific diagnostic code for OA. Many others, particularly younger patients, are managed in general practice under symptom codes (e.g. knee arthralgia). The ratio of OA symptom coding varies between practitioners and practices. Our Institute has developed code lists for musculoskeletal conditions that incorporate both diagnostic codes and relevant symptom codes which we have demonstrated can support the extraction of relevant data for OA, RA and back pain in primary care (e.g. Jordan et al 2010 doi: 10.1186/1471-2474-11-144; Jordan et al., 2014 doi: 10.1136/annrheumdis-2012-202634).
IND 2	Institute of Primary Care & Health Sciences/ Arthritis Research UK Primary Care Centre, Keele University	We feel this quality indicator should include the need to provide weight loss advice (as opposed to measurement of BMI) (Morden et al, 2014 doi 10.1186/1471-2474-15-427, Edwards et al., 2015). We have developed an OA template which records key information (written and oral) offered to patients (in accordance with NICE guidelines) (Edwards et al. 2015

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
		doi:10.1135/annrheumdis-2013-203913; Edwards et al, 2014 pii:keu411). We feel that the best approach to providing brief advice for weight loss in primary care should be identified and disseminated to support both patients and practitioners in these discussions. We have worked closely with general practices and practice nurses to support them in implementing nurse led clinics for patients with OA (Dziedzic et al. 2014 and would be able to share the implementation of this work (funded by NHSE Regional Innovation Fund, 2014). The rationale for the indicator refers to obesity being associated with increased risk of a number of conditions including back pain, but the indicator does not cite back pain within this. We feel the indicator should include back pain as per the indicator rationale.
IND 2	LighterLife	LighterLife would like to thank NICE for the chance to respond on this consultation on the Quality and Outcomes Framework (QOF) menu. LighterLife offers multi-component weight management programmes, including Very Low Calorie Diet (VLCD) programmes for obese and Low Calorie Diet (LCD) programmes for overweight individuals seeking to lose or manage their weight. LighterLife will therefore be focusing on the proposed new QOF indicator on obesity.
IND 2	LighterLife	LighterLife strongly endorse the principle of reforming the obesity indicator already on the QOF menu. LighterLife believe such a change is long overdue: the current indicator, which rewards General Practitioners (GPs) simply for identifying obese individuals, is simply not sufficient, particularly in view of the fact that 26% of adults in the UK are already obese. A more effective indictor is clearly needed, which is acknowledged in the consultation document. LighterLife welcome and agree with the contention that “primary care has a key role in managing obesity through assessing risk and morbidity, and facilitating access to weight management support”.
IND 2	LighterLife	LighterLife believe, however, that the new obesity indicator does not go far enough. Although the suggestion that a revised obesity QOF indicator should encourage more active screening is welcome, LighterLife believe that it is not sufficiently focused on weight loss or management

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
		itself. The proposed new indicator advocates screening and maintaining a register of those who already have secondary conditions associated with obesity, such as diabetes, with the aim of subsequently helping individuals manage these conditions by assisting with weight loss or management. Whilst this is certainly valid, GPs should be screening individuals before they get to the stage of developing conditions associated with obesity.
IND 2	LighterLife	LighterLife believe that a more constructive reform of the obesity indicator would be to require GPs to screen overweight or obese individuals for, amongst others, high blood pressure, high cholesterol and sugar levels. This would provide a clear indication of an individual's likelihood of acquiring obesity-related comorbidities and ensure that they are avoided. This is a reform that could be made at no additional cost and would save the NHS money in the long term by reducing the need to treat and manage obesity-related comorbidities, in particular type-2 diabetes.
IND 2	LighterLife	LighterLife also believe any obesity indicator within QOF should encourage and incentivise GPs to help manage the weight of individuals attending their surgery. Any indicator should therefore reward GPs who send patients to see specialist practice nurses, or send their patient to local weight management services or take similar steps towards actually helping an individual lose weight.
IND 2	London Borough of Bexley – Public Health	Yes, the scope of conditions in the indicator is appropriate given the negative impact of obesity on all of these conditions. If it was possible, the inclusion of sleep apnea may also be beneficial given the high correlation with obesity.
IND 2	NHS England and NHS Employers	There are a range of views with regards to the indicator in support of its implementation and against. These patients would have annual check anyway, so what added benefit is there to recording BMI status as a separate indicator. Could this be built in to existing reviews and care plans where necessary?

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
		The current OB002 requires that the practice establishes a register of patients over 18 with a BMI ≥30. This means that all of the patients included in OB002 will automatically be counted towards the achievement for this indicator. There is no age range for this indicator and the registers for the other disease areas have varying age ranges, so would there be any restrictions for this i.e. BMI not suitable for patients <18 so is there an upper age where this is no longer a suitable measurement?
IND 2	NICE (Centre for Public Health, Health and Social Care Directorate)	• The indicator should state that it applies to adults over age 18. • It is inappropriate for the indicator to only focus on patients with chronic conditions. Existing NICE guideline on lifestyle weight management services for adults (PH53) notes that lifestyle weight management is cost effective for all adults who are overweight or obese, as long as the weight loss is maintained in the long term. • It would be helpful for the indicator to include reference to 1) recording BMI; 2) identifying people who are overweight or obese; and 3) recording onward referral to weight management services (including lifestyle weight management). This is in line with the recommendations in NICE guidelines PH53 and CG189. • Within the evidence base for this indicator, it would be helpful to reference the NICE guideline on Assessing body mass index and waist circumference thresholds for intervening to prevent ill health and premature death among adults from black, Asian and other minority ethnic groups in the UK (PH46). The use of lower BMI thresholds (23 kg/m2 to indicate increased risk and 27.5 kg/m2 to indicate high risk) to trigger action to reduce the risk of conditions such as type 2 diabetes are recommended for black African, African–Caribbean and Asian (South Asian and Chinese) groups.
IND 2	Novartis Pharmaceuticals UK Ltd	We welcome the indicator to record the Body Mass Index (BMI) of patients with chronic conditions. We also consider the inclusion of heart failure patients in the indicator as appropriate. We would, however, wish to highlight that patients with chronic conditions are

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
		often older people. For instance, in heart failure the average age at first diagnosis is76 years . Appropriate support and advice on healthy lifestyles should be provided to patients alongside the recording of BMI.
IND 2	Parkinson's UK	Parkinson's UK urges NICE to include Parkinson's as one of the conditions who will have their Body Mass Index (BMI) recorded as part of this indicator. Weight fluctuation, dietary problems and difficulty swallowing can be common in Parkinson's. Several studies suggest that people with Parkinson's have a lower BMI compared to controls but also experience problems with obesity. This will likely have clinical implications, because low and high body weight is associated with negative health outcomes. Issues relating to Parkinson's that can cause a low BMI include swallowing difficulties, drug side-effects but may also be owing to practical problems such as problems with completing food shopping, preparing food for consumption and keeping food hot while eating. Problems with weight gain can be attributed to a person's condition making them less active, or even compulsive behaviour associated with Parkinson's such as binge eating. Therefore, we strongly advise NICE to insert Parkinson's as one of the conditions covered by this indicator.
IND 2	Participants of a parliamentary roundtable on morbid obesity services	A group of expert stakeholders with an interest in obesity (specified in the appendix) met in Parliament on 24th February 2015 to discuss the transfer of commissioning responsibility for morbid obesity surgery services from NHS England to CCGs. The proposed NICE CCG OIS and QOF indicators were discussed, and the comments arising are detailed in this document. First and foremost, the group welcomes the incorporation of new indicators for obesity in both the CCG OIS and QOF indicator sets to reflect the need for national action on the increased burden of obesity. The group considered that the proposed indicators will work together to contribute to quality improvement and should be therefore be included as a set. However, there remains a need to align incentives across the CCG OIS and QOF indicator sets to support a joined up clinical pathway for obesity which enables access to the right types of intervention in accordance with clinical need. This will require improved incentives for diagnosis and referral to treatment from primary care, which are not currently set out in the

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
		proposed indicators.
IND 2	Participants of a parliamentary roundtable on morbid obesity services	Recognition of the link between obesity and the increased risk of a number of chronic diseases and co-morbidities is welcome. However, it is suggested that GPs should be incentivised to screen patients with a higher BMI for the named chronic diseases and co-morbidities rather than incentivised to record their BMI, with no clear purpose. This could be achieve using the existing register of patients aged 18 or over who have a recorded BMI ≥30. The group therefore recommends that the indicator should be amended to measure the percentage of patients aged 18 and over with a recorded BMI ≥30 who have been offered screening for known co-morbidities of obesity. These co-morbidities may be drawn from the list of conditions included in the proposed indicator wording, for which screening capabilities exist.
IND 2	PHE	It would be useful if the indicator could be more measurable, for example referring those identified as overweight or obese into services for support, rather than BMI and recording associated diseases
IND 2	PHE Learning Disabilities Observatory	We would extend this to people with learning disabilities where is clear evidence that higher proportions of people are overweight (http://www.ihal.org.uk/gsf.php5?f=312890 (p34)) and they have greater difficulty in taking the remedial steps.
IND 2	Primary Care CVD Leadership Forum	We agree. Obesity is one of the leading risk factors for preventable mortality and morbidity. Currently it is often not recorded or acted on in primary care.
IND 2	Public Health England	It would be useful if the indicator could be more measurable, for example referring those identified as overweight or obese into services for support, rather than BMI and recording associated diseases.
IND 2	RCGP	We all recognise the problems of obesity, and the conditions seem (mostly) appropriate. But again, what is the rationale that this must be done every year? People tend to stay normal weight or overweight for quite long periods of time. More importantly, doctors lack the evidence based tools and resources to make them effective in helping patients to lose weight. GPs may have a small role to play, but the national problem will only be dealt with by national public health policies on food, eating, transport, sport etc. This indicator could be very divisive as it may induce a sense of failure among patients and doctors, and possibly antagonistic

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
		relationships between them. Comments from the RCGP Overdiagnosis Group The list of chronic diseases should also include liver disease, as non-alcoholic fatty liver disease is an increasingly common condition that predisposes to NASH and cirrhosis. (RP)
IND 2	Royal College of Nursing	Question: People with chronic conditions were identified as an appropriate population for BMI assessment as a precursor to indicators focused on intervention. Do stakeholders consider the scope of the conditions covered in the indicator suitable? Our staff and members agree that the scope of the conditions covered in the indicator is suitable but consider that more research and guidance is required to identify what the appropriate exercises and delivery method are for people with co-morbidities.
IND 2	Sanofi	We welcome the continued focus on identifying people at risk of a cardiovascular event, including those whose BMI indicates that they may be at increased risk. However we believe that the indicator as currently structured could be strengthened, not only to capture the number of patients within the overweight/obese cohort but also to incentivise healthcare professionals to proactively support them towards the goal of a healthy BMI. For example, QOF IND 2 could be reframed as follows: “The percentage of patients with coronary heart disease, stroke or transient ischemic attack, diabetes, hypertension, peripheral arterial disease, heart failure, chronic obstructive pulmonary disease, asthma, osteoarthritis and/ or rheumatoid arthritis who have had a body mass index (BMI) recorded indicating that they are either clinically overweight or obese in the preceding 12 months, and who have been provided with additional support (information, structured education or referral to a weight management service) to help them reduce their BMI to clinically normal levels.” One of the recommendations in the NICE Public Health guidance on managing overweight and obesity in adults – lifestyle weight management services is to refer overweight and obese adults to a lifestyle weight management programme. It is for GPs and health professionals to

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
		determine what intervention may be best suited to the person in question. We welcome this guidance and believe it should be reflected in the QOF indicator. An enhanced indicator with a focus on active weight management would also support the direction of travel in the recently published Five Year Forward View , which alongside primary prevention measures highlights the importance of active management to avoid complications and co-morbidities. For example, most of the complications associated with diabetes could be avoided with earlier intervention and proactive management to better support people living with the condition .
IND 2	South Cheshire and Vale Royal CCG's	This indicator should drive up the recording and treatment of obese people with Asthma, Osteoarthritis and Back Pain. The other areas should already be covered by existing QOF indicators.
IND 2	South East Coast Cardiovascular Strategic Clinical Network (SEC CVD SCN)	Yes, but there is no mention of people with mental illness. Many of the drugs used to treat mental illness especially the atypical antipyschotics are associated with weight gain which can be considerable. I would suggest one might consider osteoarthritis (OA) of weight bearing joints eg hips, knees, ankles, spine rather than OA full stop.
IND 2	South East Staffordshire & Seisdon Peninsular CCG	Agree this should be a requirement but less sure that this is a good use of a QoF indictor in isolation, at the very least I suggest this should be accompanied by brief interventions and advice, but appreciate that this is captured elsewhere.
IND 2	Surrey County Council	Please go ahead with introducing this as it will inform local development of programmes such as Health Checks and underpin public health prevention strategies developed in agreement with local CCGs
IND 2	Telford and Wrekin council	Measurement of weight in heart failure patients will not always correlate to overweight/obesity so may be clinical objection to their inclusion
IND 2	The National Obesity Forum	The National Obesity Forum (NOF) would like to thank NICE for the opportunity to comment on the potential new indicators for inclusion in the NICE Quality and Outcomes Framework (QOF) menu, including a proposed new QOF indicator on obesity.
IND 2	The National Obesity Forum	NOF welcomes the suggested inclusion of a reformed obesity QOF indicator in NICE's menu. NOF believes a reformed obesity indicator is desperately needed: the current indicator for this

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
		issue rewards General Practitioners (GPs) simply for identifying obese individuals as opposed to helping obese patients in a more practical manner. Given the current, staggering levels of obesity, with 26% of adults in the UK already obese, a more effective approach is needed. The proposal to introduce a new obesity indicator, combined with the acknowledgment set out alongside the draft indicator in the consultation document that "primary care has a key role in managing obesity through assessing risk and morbidity, and facilitating access to weight management support", is strongly welcomed by NOF.
IND 2	The National Obesity Forum	It is unclear, however, whether the suggested new obesity indicator goes far enough. Whilst the Indicator Committee's acceptance of the need to reform the obesity QOF indicator to encourage more active screening is a positive development, NOF believe that the primary purpose of conducting screening is to prevent the onset of secondary diseases associated with obesity such as diabetes, hypertension and coronary heart disease. The proposed new indicator, however, advocates screening and maintaining a register of those who already have such conditions, with the aim of subsequently ameliorating those comorbidities by assisting the identified individuals with losing or managing their weight. This would result in the NHS incurring unnecessary, additional costs linked to managing these secondary conditions, which may be improved with weight loss but would not disappear altogether.
IND 2	The National Obesity Forum	Moreover, focusing on screening those who already have these secondary illnesses is unlikely to assist the millions of children, teenagers and adults who are obese but have never presented to their GPs and have consequently never been identified or engaged with concerning their weight. These groups would benefit from assessment and advice about losing or managing their weight.
IND 2	The National Obesity Forum	NOF submits that a more constructive reform of the obesity indicator would be to require GPs to screen obese individuals for high blood pressure, high cholesterol and sugar levels. This would provide a clear indication of an individual's likelihood of acquiring obesity-related comorbidities and ensure that they are avoided. Crucially, this reform could be made at no additional cost and would save the NHS money in the long term by reducing the need to treat and manage obesity-related comorbidities.

CONFIDENTIAL

Indicator ID	Stakeholder organisation	Comment
IND 2	Whalebridge Practice, Swindon and QOF Database Website	Again this illustrates a problem with QOF in that it may be seen more as a data gathering exercise. In many cases the presence or absence of obesity is clear when a patient is seen in a consultation. What this indicator will add is a weight measurement in cases where both the doctor and the patient know that there is no problem. It will simply become a formality "for the computer". The same is true where obesity is present, although this is currently incentivised through the obesity register. The readout on a scale is seldom a surprise to either person. As an aside this would effectively add an osteoarthritis register to the QOF.
IND 2	Whitehall Surgery	Obesity is an epidemic and it is appropriate to promote weight reduction in the whole population, not just in those with already increased health risk due to conditions mentioned. The concern is the time implications on assessing BMI on yearly basis. An additional indicator to promote health advice regarding weight should also be added, as otherwise measuring will not necessarily result in any improvement.
IND 2	Yorkshire and Humber Commissioning Support Unit	Osteoarthritis is not currently included as a QOF disease area. Some work may need to be done by practices to ensure that the register is complete

CONFIDENTIAL

Appendix B: Equality impact assessment for IND-2 (obesity)

Table 1

Protected characteristics
Age
Disability
Gender reassignment
Pregnancy and maternity
Race
Religion or belief
Sex
Sexual orientation
Other characteristics
Socio-economic status Depending on policy or other context, this may cover factors such as social exclusion and deprivation associated with geographical areas or inequalities or variations associated with other geographical distinctions (e.g. the North/South divide, urban versus rural).
Marital status (including civil partnership)
Other categories Other groups in the population experience poor health because of circumstances often affected by, but going beyond, sharing a protected characteristic or socioeconomic status. Whether such groups are identifiable depends on the guidance topic and the evidence. The following are examples of groups covered in NICE guidance: • Refugees and asylum seekers • Migrant workers • Looked after children • Homeless people.

CONFIDENTIAL

Indicator Equality Impact Assessment form
Development stage: Consultation
Topic: Obesity

1. Have relevant equality issues been identified during this stage of development? • Please state briefly any relevant issues identified and the plans to tackle them during development
No equality issues have been raised; however obesity is related to social disadvantage, ethnicity and sex. These population groups will be taken into consideration during any development of indicators.
2. Have relevant bodies and stakeholders with an interest in equality been consulted • Have comments highlighting potential for discrimination or advancing equality been considered?
Yes – stakeholders from all 4 UK countries were encouraged to comment on the potential new indicators as part of the NICE consultation and a wide group of relevant groups and organisations were contacted. Please refer to appendix A of the 'process report for indicators in development' for a full list of stakeholders consulted directly via email.
3. Have any population groups, treatments or settings been excluded at this stage in the process? Are these exclusions legal and justified? • Are the reasons for justifying any exclusion legitimate?
All population groups are included in these indicators though a focus has been provided on certain co-morbidities in order to specify a target population.
4. Do any of the indicators make it impossible or unreasonably difficult in practice for a specific group to access a test or intervention? • Does access to the intervention depend on membership of a specific group? • Does a test discriminate unlawfully against a group? • Do people with disabilities find it impossible or unreasonably difficult to receive an intervention?
Comments from consultation have highlighted that in the use of BMI as sole measurement tool of obesity may not be suitable for people of south Asian origin.
5. Do the indicators advance equality? • Please state if the indicator as described will advance equalities of opportunity, for example by making access more likely for certain groups, by tailoring the service to certain groups, or by making reasonable adjustments for people with disabilities?
There were no consultation comments to suggest that the indicators would necessarily advance equalities in terms of people with protected characteristics or other relevant characteristics.