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NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

INDICATOR DEVELOPMENT PROGRAMME

Consultation report on indicators

Indicator area: Weight management

Consultation period: 1 February – 29 February 2016

Potential output: Recommendations for NICE Menu

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Indicators included in the consultation

ID	Indicator	Evidence source
QOF7 **(NM143[1])**	The percentage of patients aged 18 or over who have had a record of a BMI being calculated in the preceding 5 years.	The indicator is supported by recommendation 6 from the NICE public health guideline on Weight management in adults The indicator is supported by recommendation 6 from the NICE public health guideline on Weight management in adults
QOF8:	The percentage of patients aged 18 years and above with a BMI ≥25 in the preceding 12 months who have been given appropriate weight management advice within 90 days of their BMI being recorded	This indicator is supported by recommendation 1.4.2 from the NICE guidance on obesity and recommendation 6 from the NICE public health guideline on Weight management in adults

[1] This indicator has been added to the NICE Indicator menu in August 2016 under the ID NM143

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Record of BMI in preceding 5 years (QOF7)

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

Background

The following indicator is live in the 2016/17 QOF in England:

> *OB002 The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥30 in the preceding 12 months. (NICE, 2014)*

In addition following indicator is included on the NICE menu for general practice:

> *NM121 the percentage of patients with coronary heart disease, stroke or TIA, diabetes, hypertension, peripheral arterial disease, heart failure, COPD, asthma, and/or rheumatoid arthritis who have had a BMI recorded in the preceding 12 months.*

Calculating BMI will support general practice to identify people who are overweight and obese, which can then lead to primary care playing a key role in weight management through assessing risk and morbidity, and facilitating access to weight management support .

The proposed indicator may also support general practice in identifying people that have unexplained lost weight.

What are we trying to achieve?

The purpose of this indicator is to embed and normalise weight and BMI measurement as part of routine care in general practice.

(This indicator has a greater public health / prevention focus compared to the current NICE indicator NM121)

Comments

A number of stakeholders highlighted their support for this indicator and the importance of detecting excessive weight gain to prevent complications associated with it. The potential cost savings to the NHS of this indicator were also highlighted, should it lead to a reduction in obesity.

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Conversely a number of stakeholders highlighted potential problems with implementing this indicator in the QOF. A number of stakeholders felt patient compliance and non- attendance at GP practices would make this indicator difficult to achieve. It was also felt this may even undermine the doctor patient relationship especially if the patient could not relate BMI measurement with the reason for attending an appointment.

It was highlighted that the timeframe for this indicator (every 5 years) was too long to be useful for the early identification of complications associated with excess weight. This is because there is a high possibility of weight gain especially in older people so a 5 year timeframe would not be sensitive enough to prevent excessive weight gain and the increased risk of complications that come with this. A maximum timeframe of 2 years was therefore suggested.

It was highlighted that this may be repetition of the current QOF indicator OB002 and should go beyond simply measuring BMI to ensure steps are taken e.g. nutritional screening and advice to help people overcome this problem. It was suggested indicators QOF7 and QOF8 should be considered as paired indicators to ensure action is taken above simply measuring peoples BMI.

Stakeholders commented on the increased workload this indicator may cause GPs It was highlighted that if the BMI was high enough to require further intervention then this indicator would impact on resources. However it was also noted by some that simply recording BMI should not be a barrier to implementation as this could be calculated by non-registered health care staff.

A potential inequality was highlighted for people who are wheelchair bound and cannot stand. It was also highlighted that for people with certain learning disability syndromes may need some syndrome-specific BMI figures

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Considerations for the Advisory Committee

The committee is asked to consider:

- Should the indicator be limited to those people that have attended their GP practice within the timeframe specified by the indicator?
- Would this have a potential for a detrimental effect upon the doctor-patient relationship?
- Is the timeframe of 5 years appropriate given it is a prevention indicator?
- The workload implications for general practice:
    - To what extent could this be undertaken on an opportunistic basis?
    - Would this indicator add to GP workload or would it be carried out by other healthcare staff e.g. practice nurses or HCAs?

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BMI ≥25 appropriate weight management advice (QOF8)

The percentage of patients aged 18 years and above with a BMI ≥25 in the preceding 12 months who have been given appropriate weight management advice within 90 days of their BMI being recorded

Background

NICE guidance recommends that people who are classified as overweight and obese defined as a BMI of 25 or over should be involved in a discussion with a health professional regarding their weight and given general advice on weight and lifestyle.

What are we trying to achieve?

The purpose of this indicator is to ensure adults who are identified as being overweight or obese are given the information and advice they require to support them in reducing their weight.

Comments

Some stakeholders including the Primary Care CVD Leadership Forum highlighted their support for the inclusion of this indicator in the QOF

Stakeholders including the Royal College of General Practitioners (RGCP) commented there is a need for clear consistent guidance on what weight management advice is effective in achieving weight loss in overweight patients for any potential indicators to be useful. In addition the Royal College of Nursing queried whether well informed nutritional advice is available from primary care and whether primary care professionals have access to other weight management resources to be able to succeed with this indicator.

It was queried if weight management advice would be required every time BMI is measured. If so stakeholders highlighted the impact this would have on GP times as well as weight management services. Another stakeholder felt that for this reason an unintended consequence of including this indicator in QOF would be GPs will stop measuring BMI. To prevent this it was suggested that this indicator should have a higher BMI threshold for intervention.

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Stakeholders commented on the increased workload this indicator may cause GPs. It was noted that 3 to 4 extra minutes for each consultation for patients with a BMI ≥25 would cause a significant amount of work for each practice. In addition to increased workload for GPs it was noted that this may impact on other weight services such as bariatric surgery.

The importance of ensuring only appropriately trained qualified staff would be providing the weight management advice measured by this indicator was highlighted.

Stakeholders highlighted the potential health inequality caused by misinterpretation of BMI results, as a single value for BMI does not adequately reflect the differential risk of identical BMI in different groups such as people with learning disabilities, different racial groups and the elderly. Stakeholders therefore felt there would be a need for specific BMI calculators for some groups.

Considerations for the Advisory Committee

The committee is asked to consider:

- Clarity around what is meant by 'weight management advice'
- The workload implications for general practice[2]
- Should this indicator be amended to focus on people with higher BMIs?
- Would a GP intervention have a positive benefit for patients, would this have a potential for a detrimental effect upon the doctor-patient relationship?
- How if at all does this indicator fit in with the overall societal approach to weight management?'

[2] In 2012, an estimated 62% of adults had a BMI ≥25, an estimated 24.7% had a BMI ≥30 and 2.4% had a BMI ≥40 (PHE, 2014)

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Appendix A: Consultation comments

Indicator no.	Proforma question no	Stakeholder organisation	Comment
18.1 Do you think there are any barriers to implementing the care described by this indicator?			
QOF7	18.1	Association for the study of obesity	Yes, a perceived resistance to measuring BMI by health professionals
QOF7	18.1	Association of British Clinical Diabetologists	Yes. Not everyone will visit their GP even once in five years.
QOF7	18.1	British Thoracic Society	No, recognising accurate height recordings
QOF7	18.1	Cambridge Weight Plan	No
QOF7	18.1	Cheshire and Merseyside Directors of Public Health, Champs Public Health Collaborative	no
QOF7	18.1	GP Principal/ NICE clinical advisor	Increased workload.
QOF7	18.1	Independent GP	it may be deemed by the patient to be irrelevant to the reason why the patient came to see the doctor and undermine the doctor patient relationship
QOF7	18.1	Independent GP	Obesity is a Public Health and Sociology issue and totally unsolvable. It simply dumbs down in the public's eye what skills we actually possess in General Practice. If somebody looks overweight or obese then I'm happy to document and advise. Doing this on BMI appropriate individuals is of no value.
QOF7	18.1	Independent GP	reluctance of the public to be weighed and measured - they are reluctant enough to provide smoking data.
QOF7	18.1	Independent GP	probably good

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QOF7	18.1	Independent GP	Ineffectiveness of interventions, so why introduce something that will not significantly change outcomes, but just increase cost.
QOF7	18.1	Independent GP	It interferes with the dr patient relationship to be weighing them when it is not relevant and can be shaming and upsetting for obese patients.
QOF7	18.1	Individual comment	I am not sure of the point of this.
QOF7	18.1	Individual comment	no
QOF7	18.1	Liverpool LA public health team	No
QOF7	18.1	London Borough of Redbridge	Patients accessing primary care.
QOF7	18.1	London Diabetes Strategic Clinical Network	For those people who are wheelchair bound and cannot stand – this will be impossible to get without lying patient down, if any contractions are present this may add to the difficulty.
QOF7	18.1	National Centre for Eating Disorders	I am not sure that this would be a valid group since body weight / BMI changes a great deal during this time. However it is useful to have BMI tracked over the lifespan because weight change can be progressive and ignored.
QOF7	18.1	National Obesity Forum	No
QOF7	18.1	NHS Employers	Workload and patient compliance will be a major barrier to this indicator.
QOF7	18.1	Nightingale Valley Surgery.	this is a good idea. Is manageable and worthwhile I feel.
QOF7	18.1	Obesity Group of the British Dietetic Association (formerly domUK)	Time and local resources are likely to be identified as a potential barrier although this may be offset by early identification of high risk individuals.

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QOF7	18.1	RCGP	Aside from an increase to GPs' workload in a population who do not all regularly need to see a GP, this indicator means that under 18s would need to have BMI centile recorded or an alternative method of assessing how BMI relates to age and sex during child growth. This is essential to correct understanding of BMI/ BMI centile in childhood and should therefore be made clear here. However current GP computer systems do not facilitate (or even allow with some GP systems) recording of BMI centile and so this is a challenge, although this has been flagged up with PHE and GPSOC.
QOF7	18.1	Royal College of Nursing	No, this can be calculated easily by non-registered health care staff
QOF7	18.1	Slimming World	From an equipment point of view it will be necessary to ensure that all health care settings have access to accurate weighing scales (which can measure a range of weights including those patients at particularly raised BMIs) to ensure there is no embarrassment or discrimination of patients.
QOF7	18.1	Somerset CCG	Yes. This is population screening. Many people may not attend to see their GP for a problem related to their weight. They also may not attend within a 5 year time frame.
18.2 Do you think there are potential unintended consequences to implementing / using this indicator?			
QOF7	18.2	Association for the study of obesity	No
QOF7	18.2	Association of British Clinical Diabetologists	No

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QOF7	18.2	British Thoracic Society	May find an increase in weight loss referrals especially into Bariatric services
QOF7	18.2	Cambridge Weight Plan	Cambridge Weight Plan believes that introducing this draft indicator in isolation - without IND QOF8 – could lead to a continuation of GPs simply providing the data required by this draft indicator and not taking steps to effectively assist overweight and obese individuals in getting weight management support. As such, the principal aim of this draft indicator would be defeated.
QOF7	18.2	Cheshire and Merseyside Directors of Public Health, Champs Public Health Collaborative	No
QOF7	18.2	GP Principal/ NICE clinical advisor	We have no dietician services.
QOF7	18.2	Independent GP	Yes, it will adversely affect doctor-patient relationships. My patients know that they are overweight. They don't need telling. Forcing the indignity of standing on a set of scales is humiliating.
QOF7	18.2	Independent GP	devaluing the doctor patient relationship and hence it's therapeutic value
QOF7	18.2	Independent GP	No
QOF7	18.2	Independent GP	Diversion or resources and increased costs
QOF7	18.2	Independent GP	BMI is a very imperfect indicator in the very small the very muscly etc. Fixating on weight gets in the way of a good relationship…see article from the patients point of view in the BMJ
QOF7	18.2	Individual comment	There is currently an indicator in the QOF which effectively offers a payment for each patient who has a

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			BMI recorded of greater than 30 in the QOF year. There is therefore an incentive to record BMI in the obese.
QOF7	18.2	Individual comment	No
QOF7	18.2	Lancaster University	Need syndrome-specific BMI calculators?
QOF7	18.2	Liverpool LA public health team	No
QOF7	18.2	London Borough of Redbridge	BMI can vary over a 5 year period, so might give a false sense of security both to the provider and service user if the recorded BMI was within normal range the range but the patient gained weight subsequently. An opportunity to provide advice on weight management may be lost unless the patient is provided advice on maintaining healthy weight at the time of measurement.
QOF7	18.2	London Diabetes Strategic Clinical Network	No, this will work for the majority of people.
QOF7	18.2	National Centre for Eating Disorders	You will not always pick up people with eating disorders and harmful weight control practices
QOF7	18.2	National Obesity Forum	The National Obesity Forum (NOF) submits that, if this draft indicator were introduced on its own without IND QOF8, there is a risk that its underlying aim of “primary care playing a key role in weight management through assessing risk and morbidity, and facilitating access to weight management support” would not be achieved.
QOF7	18.2	NHS Employers	There will be an indicator for patients with a BMI, but no requirement for follow up or advice. Surely expanding the existing OB002 to require action for those over 18 with a BMI >= 30 would be a better use of time and resource?
QOF7	18.2	Obesity Group of the British Dietetic Association (formerly domUK)	No.

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QOF7	18.2	RCGP	The RCGP feels that implementing this indicator will be time consuming to the GP, particularly in calculating the BMI of young and middle aged patients who clearly don't have weight problems.(DJ) This indicator could also lead to a large increase in patients being referred for weight management and/or having prescriptions for this. Locally the services are limited and underfunded/oversubscribed already and this would need to be addressed. (RM) Where GP practices do not have in-house dietician services, the patients may not be keen on attending services such as Weight Watchers where they have to pay, leading to an increased workload on PNs. (CC-G)
QOF7	18.2	Royal College of Nursing	If BMI indicates intervention, there would be an impact on resources
QOF7	18.2	Slimming World	If conversations around weight are not handled sensitively then this could lead to a less engaged patient population. It is therefore vital that training for health professionals is provided.
QOF7	18.2	Somerset CCG	example – 54 year female who attends with depression and after developing a rapport over a couple of months you discover she is in an abusive relationship. You then support her over the following year to improve her health and wellbeing, and probably her self-worth.
18.3 Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.			
QOF7	18.3	Association for the study of obesity	No

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QOF7	18.3	Association of British Clinical Diabetologists	No
QOF7	18.3	British Thoracic Society	No
QOF7	18.3	Cambridge Weight Plan	No
QOF7	18.3	Cheshire and Merseyside Directors of Public Health, Champs Public Health Collaborative	No
QOF7	18.3	Independent GP	people will feel this is intrusive and not a role for gp's to monitor
QOF7	18.3	Independent GP	perhaps more denial
QOF7	18.3	Individual comment	No
QOF7	18.3	Lancaster University	Yes, by certain learning disability syndromes (e.g. Down Syndrome). May need some syndrome-specific BMI norms?
QOF7	18.3	Liverpool LA public health team	No
QOF7	18.3	London Borough of Redbridge	No
QOF7	18.3	London Diabetes Strategic Clinical Network	This may not be a good indicator of health status in those who have developed excessive muscle mass.
QOF7	18.3	National Centre for Eating Disorders	Yes, possibly among women who have recently given birth and who may become unduly worried about normal and temporary weight changes.
QOF7	18.3	National Obesity Forum	No

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QOF7	18.3	Obesity Group of the British Dietetic Association (formerly domUK)	For all individuals, sensitivity while measuring and weighing is needed. So long as that is in place, there should not be a differential impact. Some ethnic/cultural groups may prefer measurements to be taken by individuals of the same gender, but they are likely to request this at the appointment booking.
QOF7	18.3	RCGP	The RCGP feels that patients with some types of physical disabilities (eg wheelchair-bound) would present more of a problem in recording weight in a primary care setting. Equally, we would recommend the indicator recognise that there is a variation in 'normal' between different ethnicities:
QOF7	18.3	Slimming World	Across all groups, it is important that a sensitive and positive approach is taken by health care professionals while taking measurements and discussing weight.
18.4 Do you have any general comments on this indicator?			
QOF7	18.4	Association for the study of obesity	It is important, however the frequency of BMI measurements, at five yearly intervals, appears very long. Given the history of weight gain and incidence of obesity in those with learning disabilities, annual weighing / BMI measurement can be justified.
QOF7	18.4	Association of British Clinical Diabetologists	ABCD supports this indicator.
QOF7	18.4	British Association of Dermatologists	Vulnerable groups should be particularly targeted for weight and blood pressure monitoring, highlighting the issue of the association of metabolic syndrome in psoriasis patients and the need to monitor these patients for co-morbidities. NICE guidelines CG153 (http://pathways.nice.org.uk/pathways/psoriasis)

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			identifies the importance of the co-morbid burden:
QOF7	18.4	British Holistic Medical Association	Obesity should be tackled by public health measures, not clinical.
QOF7	18.4	British Medical Association	This indicator would increase appointments for no clear benefit.
QOF7	18.4	Cambridge Weight Plan	Cambridge Weight Plan welcomes the fact that this draft indicator requires primary care practitioners to conduct an analysis of their register of patients aged 18 or over with a BMI ≥25, as opposed to simply passing information on and forgetting about it. This requirement will encourage greater consideration of the scale and prevalence of overweight and obesity by those best place to take the initial steps to help prevent more individuals becoming obese.
QOF7	18.4	Cheshire and Merseyside Directors of Public Health, Champs Public Health Collaborative	It will need to be linked with well-defined and resourced care pathways. It has the potential to address issues about population prevalence information
QOF7	18.4	Independent GP	Not my field of experience but sounds a good idea
QOF7	18.4	Independent GP	Please let GPs and nurse focus on the patient's reason for attending and giving that our full attention. I will feel that I have to weigh the depressed person who comes to see me when I should be focussing on what matters to them.
QOF7	18.4	Independent GP	perhaps more denial

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QOF7	18.4	Independent GP	is good
QOF7	18.4	Independent GP	Obesity management is not about BMI..its about political choices around INCOME for poorer people, the cost of good food, the availability of psychological care for those who have been abused (much more likely to be overweight)
QOF7	18.4	Individual comment	additional workload for no proven intervention that reduces long term mortality/morbidity; don't do it!
QOF7	18.4	Liverpool LA public health team	It will need to be linked with well-defined and resourced care pathways. It has the potential to address issues about population prevalence information
QOF7	18.4	London Borough of Redbridge	We welcome this indicator as it will provide vital data on overweight / obese adults in the area which will enable appropriate service planning.
QOF7	18.4	National Centre for Eating Disorders	It does not feel practical but could be useful
QOF7	18.4	National Obesity Forum	NOF also welcomes the focus of this indicator on getting primary care practitioners to analyse the data they have collected via the register of patients aged 18 or over with a BMI ≥25 (as required in existing indicator NM128) and in various other indicators in order to identify those at risk of becoming obese.
QOF7	18.4	NHS England	NHS England strongly supports this indicator. Overweight and obesity have been identified in the Global Burden of Disease Study as one of the leading causes of disability and premature death. Despite this it

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			is relatively uncommon for people to have their BMI measured at the common entry point into the health care system – ie primary care
QOF7	18.4	Obesity Group of the British Dietetic Association (formerly domUK)	It is really positive to see BMI featured. However in our view recording of BMI in the last 5 years will not be sensitive enough. The purpose of measurement is to calculate risk, and weight gain with increasing age is common so over a 5 year period weight gain is highly likely for most individuals. Someone whose BMI is 23/24kg/m^2 may not be measured again for another 5 years and by then may well be overweight. Likewise someone within the overweight category may not be so five years later. In our view measurement and recording should be more frequent (eg within the last 12-18 months, but at least every 2 years) although we recognise that this has resource implications. Early identification means that risk of complications due to excess weight may be reduced, offsetting the resources needed to weigh and record more often.
QOF7	18.4	Primary Care CVD Leadership Forum	We strongly support this indicator. Overweight and obesity have been identified in the Global Burden of Disease Study as one of the leading causes of disability and premature death. Despite this it is relatively uncommon for people to have their BMI measured at the common entry point into the health care system – ie primary care.
QOF7	18.4	Public Health England	We strongly support this indicator. Overweight and obesity have been identified in the Global Burden of Disease Study as one of the leading causes of disability and premature death. Despite this it is relatively

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			uncommon for people to have their BMI measured at the common entry point into the health care system – ie primary care.
QOF7	18.4	RCGP	The RCGP recognises that normalising weight measurement in clinical practice is a good thing but there is a need for training (especially in understanding BMI centile in childhood) and communication skills / motivational interviewing / behaviour change theory education regarding raising the topic of weight and appropriate goal setting in order for this indicator to be acceptable.
QOF7	18.4	Royal College of Nursing	What resources are available if BMI is abnormal? Need for nutritional screening and nutritional assessment.
QOF7	18.4	Slimming World	Overall we are in support of this indicator and feel regular weighing of all patients is a positive step as this will allow changes in weight to be identified more quickly and hopefully addressed. It will hopefully also reduce any nervousness from health professionals, as if everyone is being weighed and not just 'high risk individuals' then it should be easier to approach this with patients, providing conversations are handled sensitively.
QOF7	18.4	Somerset CCG	BMI is simple to measure but is not the best indicator of future health and wellbeing problems.
QOF7	18.4	The British Heart Foundation	We support this Indicator.

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19.1 Do you think there are any barriers to implementing the care described by this indicator?			
QOF8	19.1	Association for the study of obesity	Yes, health professionals are resistant to make these BMI measurements anyway.
QOF8	19.1	Association of British Clinical Diabetologists	No
QOF8	19.1	Cambridge Weight Plan	Cambridge Weight Plan notes that the phrase 'appropriate advice' is not qualified and would suggest that a broad definition be applied to ensure that this burden is not solely placed on GPs. This is because many GPs may not be able to provide in-depth advice to patients within their 10-minute appointment slot.
QOF8	19.1	Cheshire and Merseyside Directors of Public Health, Champs Public Health Collaborative	No
QOF8	19.1	Independent GP	The indicator is describing process, not care. We have no reason to believe the systematically giving advice to this group will make any difference to their health outcomes.
QOF8	19.1	Independent GP	Yes. The proposed workload is huge. An extra 3 or 4 minutes a year for each patient who is overweight will add hundreds of hours' work to a typical GP practice.
QOF8	19.1	Independent GP	Compliance!!!!
QOF8	19.1	Independent GP	time; what is the evidence base of the value of "appropriate weight management advice" in this group?

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QOF8	19.1	Independent GP	Time! Happy to hand out leaflets and sign-post people but totally unfeasible to have my valuable surgery time reduced by trotting out the usual dietary and lifestyle advice.
QOF8	19.1	Independent GP	Reluctance of the public to be weighed and measured - they are reluctant enough to provide smoking data.
QOF8	19.1	Independent GP	is epidemiology see comment 6.4
QOF8	19.1	Independent GP	Lack of belief in cost effectiveness of interventions. Why did Freud charge even when he was wealthy? He had to have some proof that the person wanted to change and would put in some effort to change.
QOF8	19.1	Individual comment	No
QOF8	19.1	Liverpool LA public health team	No
QOF8	19.1	London Borough of Redbridge	Although the indicator mentions weight management advice to be given within 90 days, there is no mention of appropriately qualified staff providing the advice. If it is the dietetic service, there might be capacity issues or if it other staff within the practice, then they should be appropriately trained.
QOF8	19.1	London Diabetes Strategic Clinical Network	This is a large proportion of the population, and weight management advice services are not available for this size of cohort.
QOF8	19.1	National Centre for Eating Disorders	People with a relatively high BMI who have sought weight management advice are more likely to have a clinically significant eating disorder which is not being addressed. It is useful to do follow ups but would expect the inverted J curve on outcomes

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QOF8	19.1	National Obesity Forum	NOF believes that the phrase 'appropriate advice' must be defined to ensure that overweight and obese individuals receive the most effective assistance. Furthermore, it may be challenging for GPs, who are already thinly stretched, to have the sole burden of providing advice and conducting follow up activity imposed on them, except in the case of severe or complex aspects of the condition. Instead, NOF suggests that a suitable definition of 'appropriate advice' could include GPs briefly discussing the need for weight management and then directing patients to existing weight management advice and support in the community for further, tailored advice.
QOF8	19.1	NHS Employers	Workload and patient compliance will be a major barrier to this indicator.
QOF8	19.1	NHS England	Some GPs and nurses may feel challenged in sensitively raising the issue of overweight and obesity with patients especially when they are consulting for unrelated reasons. Practices may need to create new face to face or other systems for follow up for patients identified as having a high BMI.
QOF8	19.1	Nightingale Valley Surgery.	This is worthwhile and manageable.
QOF8	19.1	Nottinghamshire County Council	Register – this is predicated on the weighing and measurement happening within the practice in order for BMI to be calculated. Evidence suggests that these sorts of registers are often very incomplete and there is a significant gap between observed and expected rates.

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QOF8	19.1	Obesity Group of the British Dietetic Association (formerly domUK)	Time and local resources are likely to be identified as potential barriers. If appropriate advice is given within primary care this will have clear implications for staff time (giving of advice and training in appropriate information). Local facilities and interventions for weight management are likely to be highly variable, and more resources will be needed if the overweight as well as obese population are targeted. Staff training will be needed both in terms of appropriate weight management advice and in the most helpful ways to give it.
QOF8	19.1	Primary Care CVD Leadership Forum	Some GPs and nurses may fell challenged in sensitively raising the issue of overweight and obesity with patients especially when they are consulting for unrelated reasons. Practices may need to create new face to face or other systems for follow up for patients identified as having a high BMI.
QOF8	19.1	Public Health England	Raising the issue of weight status as early as practicable after identification of either low or excess weight is vital. A potential barrier to implementation is the issue around access to standardised training and development on 'how to raise the issue' with patients as some GPs and nurses may fell challenged in sensitively raising the issue of overweight and obesity with patients especially when they are consulting for unrelated reasons. A related barrier is access to training and access to information around weight management approaches; effective brief advice; and also awareness of evidence based local services to which to refer people into (if appropriate). Clearly there is a requirement for any such training to support HCP to provide the right support and advice to individuals of differing BMI's >25. Support is also

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			required so that HCP provide advice to tackle health inequalities and recognise and consider different motivation to act across genders and different cultures and ethnicity.
QOF8	19.1	RCGP	The RCGP would welcome a definition of what is considered 'appropriate' weight management advice) and suggests that the BMI value be changed to >29 in line with current evidence
QOF8	19.1	Royal College of Nursing	Is well informed nutritional advice available via primary care and does primary care professionals have access to other weight management resources?
QOF8	19.1	Slimming World	Training of health care professionals on how to talk to patients sensitively about weight is vital to ensure that conversations had are beneficial and do not harm the patient-health professional relationship. It's also necessary to ensure that these conversations take place rather than be avoided by health care professionals who do not feel able/informed enough to have a helpful conversation.
QOF8	19.1	Somerset CCG	Yes. The standard and content of advice regarding a weight management is generally poor.
19.2 Do you think there are potential unintended consequences to implementing / using this indicator?			
QOF8	19.2	Association for the study of obesity	No

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QOF8	19.2	Association of British Clinical Diabetologists	No
QOF8	19.2	Cambridge Weight Plan	Cambridge Weight Plan is concerned that the 90-day period for the provision of 'appropriate advice' laid out in draft IND QOF8 could potentially result in identified individuals simply being sent written advice in the post. The advantage of such an approach would, of course, be that it is more time efficient for healthcare practitioners. This would, however, be far outweighed by the drawback of individuals simply discarding this advice as they do not want to confront the issue of their weight.
QOF8	19.2	Cheshire and Merseyside Directors of Public Health, Champs Public Health Collaborative	No
QOF8	19.2	Independent GP	Yes. GPs will stop weighing people.
QOF8	19.2	Independent GP	What is this 90 days about? They haven't suddenly become fat, they've been overweight for years!!
QOF8	19.2	Independent GP	as always; time
QOF8	19.2	Independent GP	perhaps more denial
QOF8	19.2	Independent GP	as above can be a huge distraction for the issues more important to the patient. GPs are doctors, not risk management factories, we need to respond to the individuals and not shame them by banging on about their weight when they need to feel comfortable talking about the issues that matter to them.

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QOF8	19.2	Individual comment	Essentially this indicator says that no BMI should be measured without the chance of weight management advice.
QOF8	19.2	Individual comment	no
QOF8	19.2	Liverpool LA public health team	No
QOF8	19.2	London Borough of Redbridge	No
QOF8	19.2	National Centre for Eating Disorders	No, only the human fear of failure for those who did not or refused to adhere to lifestyle advice.
QOF8	19.2	National Obesity Forum	NOF believes that the 90-day timeframe for the provision of 'appropriate advice' set out in IND QOF8 could potentially result in identified individuals solely being sent literature in the post about their condition, without a face-to-face conversation about the need to manage their weight. This may be more likely given the aversion some GPs have to broaching the sensitive subject of weight with patients.
QOF8	19.2	NHS Employers	There is overlap with OB002, so would this replace it?
QOF8	19.2	Obesity Group of the British Dietetic Association (formerly domUK)	There is potential that overweight individuals given information may not welcome it, in some cases. The manner in which weight is raised and discussed will be important to minimise this risk.

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QOF8	19.2	Public Health England	Risk of poor advice or advice that individuals feel unable to act upon having deleterious impact on an individual's health and well-being. Depending upon advice being provided then there is a risk of over burden on local services and/or an adverse impact on individual going away from HCP contact motivated only to find no appropriate service in their area. PHE is aware that many LAs and CCGs currently provide lifestyle weight management services and to some extent tier 3 services for morbidly obese patients. Local health and public health systems will need to be mindful of patient expectations
QOF8	19.2	RCGP	The RCGP feels that this indicator will create an increase in demand on obesity and weight loss services as well as a greater burden on GP services without tangible benefit whilst potentially alienating obese people, dependent upon the level of sophistication of the interaction. It also risks generating a simplistic, superficial and potentially damaging reaction towards obese patients. Obesity pathways are currently grossly underfunded with the majority of funding going to prevention rather than treatment. Hence this risks generating unmanageable demand unless there is higher prioritisation of Obesity Tier 3 and 4 services.
QOF8	19.2	Royal College of Nursing	Yes as it depends on quality of advice given. Is it well informed and are resources available if a particular weight management pathway is identified? For example bariatric surgery. This may lead to raised expectations of care.

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QOF8	19.2	Slimming World	It is vital that advice given and conversations about weight are handled in a sensitive manner. Training for health professionals is needed to prevent an unintended consequence of reducing patient engagement. How the patient feels about their weight and what support they would like are important to discuss with patients alongside ensuring any positive changes they have already made are praised.
19.3 Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.			
QOF8	19.3	Association for the study of obesity	No
QOF8	19.3	Association of British Clinical Diabetologists	No
QOF8	19.3	Cambridge Weight Plan	No
QOF8	19.3	Cheshire and Merseyside Directors of Public Health, Champs Public Health Collaborative	No
QOF8	19.3	Independent GP	don't know
QOF8	19.3	Independent GP	Womens groups and already active chattering classes will be helped marginally, but the majority of those who really need to change will not as the foods that are so bad for them are also the cheapest.
QOF8	19.3	Individual comment	additional workload for no proven intervention that reduces long term mortality/morbidity; don't do it!

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QOF8	19.3	Lancaster University	Yes, an adverse differential impact in respect of people with learning disabilities. Need specific BMI calculators for some syndromes (e.g. Down syndrome)
QOF8	19.3	Liverpool LA public health team	No
QOF8	19.3	London Borough of Redbridge	No
QOF8	19.3	National Centre for Eating Disorders	No
QOF8	19.3	National Obesity Forum	Obesity management is profoundly different in children, adults and the sarcopenic elderly. The challenges are greater especially in South Asian populations who are more prone to abdominal obesity, more likely to develop co-morbidities such as diabetes at a lower threshold of obesity and are likely to undergo dietary restrictions in times of religious fasting.
QOF8	19.3	Obesity Group of the British Dietetic Association (formerly domUK)	We have concerns that a blanket cut-off point of ≥25kg/m^2 will risk missing those who may have increased health risks at lower BMI e.g. some ethnic groups. In our view differential cut-off points should be advised as per previous NICE guidance (National Institute of Health and Clinical Excellence. NICE guidelines. Obesity: Identification, assessment and management [CG189] Published date: November 2014)
QOF8	19.3	Public Health England	Previously raised comments as to the nature of the advice depending upon the individual's circumstances. If the advice is to some degree not tailored then it could have adverse effects.

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QOF8	19.3	RCGP	The RCGP recognises that obesity is not uncommonly linked to disability and so there is a significant risk of alienating a group of obese disabled people if appropriate communication skills and service provision are not made available/accessible. (Individual comment)
QOF8	19.3	Slimming World	During pregnancy we would suggest that any measurements taken should be linked to maternal records, so this can be looked at in context of weight gained during pregnancy. What advice will be offered to women during pregnancy in response to being weighed? It is important that consistent advice is given and that women are supported to manage their weight healthily during pregnancy aiming to prevent excess weight gain.
19.4 Do you have any general comments on this indicator?			
QOF8	19.4	Association for the study of obesity	It would be useful, however the content of the weight management advice requires clarification
QOF8	19.4	Association of British Clinical Diabetologists	ABCD supports the motivation behind this indicator, but a single value for BMI does not adequately reflect the differential risk of identical BMI in different racial groups and the elderly, as described in CG189 Recommendation 1.2.7
QOF8	19.4	British Association of Dermatologists	Vulnerable groups should be particularly targeted for weight and blood pressure monitoring, highlighting the issue of the association of metabolic syndrome in psoriasis patients and the need to monitor these patients for co-morbidities. NICE guidelines CG153 (http://pathways.nice.org.uk/pathways/psoriasis) identifies the importance of the co-morbid burden:

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QOF8	19.4	British Holistic Medical Association	Obesity should be tackled by public health measures, not clinical.
QOF8	19.4	British Medical Association	It is unclear why this should be done every year, especially as patients get irritated when given repeated advice on the same subject year on year. Does evidence suggest that such regular interventions will result in weight loss which is of a degree to influence positively on the health of the individual?
QOF8	19.4	Cambridge Weight Plan	Cambridge Weight Plan welcomes draft IND QOF8 and wishes to emphasise the important role that weight management providers can play in providing effective weight management advice and support. Cambridge hopes that the final IND QOF8 will provide explicit scope for weight management providers to contribute to efforts to address overweight and obesity in this way.
QOF8	19.4	Cheshire and Merseyside Directors of Public Health, Champs Public Health Collaborative	This appears to be a good idea.
QOF8	19.4	Diabetes UK	Diabetes UK support the inclusion of this indicator as this is an important component in identifying people at high risk of Type 2 diabetes who may be referred to the NHS Diabetes Prevention Programme.
QOF8	19.4	GP Principal/ NICE clinical advisor	See above.
QOF8	19.4	Independent GP	This will use up a lot of time in primary care, and will be rightfully seen as changing us to the patronising profession not the caring profession

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QOF8	19.4	Independent GP	If this indicator is introduced, it should be for a much smaller, more manageable number of patients with a higher BMI in order to make the workload manageable.
QOF8	19.4	Independent GP	Not my field of experience but sounds a good idea
QOF8	19.4	Independent GP	It will adversely affect GP-patient relationships by making consultations focus on the doctor's agenda and not the patient's
QOF8	19.4	Independent GP	if this is providing nurse time to nearly 50% of our population over 18 this is unfeasible!
QOF8	19.4	Independent GP	why add if have QOF7
QOF8	19.4	Independent GP	tackling obesity needs….easy access to cheap high quality vegetables, removal sweets and fizzy drinks from public places, taxes on and unit pricing of alcohol, employers being required to offer healthy food and proper breaks for exersize etc…demonising individuals will not work.
QOF8	19.4	Individual comment	no
QOF8	19.4	Individual comment	Targeting the wrong people to do the work,
QOF8	19.4	Lancaster University	Would be good for this to be routinely disaggregated according to learning disability
QOF8	19.4	Liverpool LA public health team	This appears to be a good idea.
QOF8	19.4	London Borough of Redbridge	In light of the obesity epidemic, this indicator is welcome however patients would need to be given appropriate support along with weight management advice in order for the advice to be effective.

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QOF8	19.4	London Diabetes Strategic Clinical Network	Clear consistent national guidance needs to be developed which is evidence based, so that all professions and weight management services give a consistent.
QOF8	19.4	National Centre for Eating Disorders	I take issue with the term “weight management advice” since I do not know what kind of advice this would mean. Dietary guidelines are usually not specific to lifestyle and context and many are arbitrary such as “eat less fat” which we now know is unhelpful. And who has delivered this advice and did it include issues like alcohol which has a lot of calories.
QOF8	19.4	National Obesity Forum	NOF warmly welcomes IND QOF8. Recommending those that have a BMI of 25 and above are given weight management advice is a simple, effective step in assisting this group with managing their weight. In capturing overweight individuals before they become obese or morbidly obese, this draft indicator would also support the Government’s broader focus on prevention in public health, which is also to be welcomed.
QOF8	19.4	NHS Employers	This would be difficult to gain any meaningful effect for a lot of effort.
QOF8	19.4	NHS England	NHS England strongly supports this indicator. Overweight and obesity have been identified in the Global Burden of Disease Study as one of the leading causes of disability and premature death. Despite this it is relatively uncommon for people to have their BMI measured at the common entry point into the health care system – ie primary care.

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QOF8	19.4	Obesity Group of the British Dietetic Association (formerly domUK)	In our view inclusion of this indicator is very positive; we agree that focusing on overweight individuals identifies a high risk pre-obese population who are likely to benefit from early intervention.
QOF8	19.4	Primary Care CVD Leadership Forum	We strongly support this indicator. Overweight and obesity have been identified in the Global Burden of Disease Study as one of the leading causes of disability and premature death. Despite this it is relatively uncommon for people to have their BNI measured at the common entry point into the health care system – ie primary care.
QOF8	19.4	Public Health England	This is a welcomed indicator as overweight and obesity have been identified in the Global Burden of Disease Study as one of the leading causes of disability and premature death. If implemented as part of a system level programme including training and development could provide patients with necessary advice, care and support.
QOF8	19.4	RCGP	The RCGP feels that the indicator would benefit from clarifying the nature of brief intervention messages as there will not be capacity (or indeed need) to refer all patients with BMI above 25. (Individual comment)
QOF8	19.4	Royal College of Nursing	Obesity is a big public health issue and resources for well informed and appropriate advice is key to supporting this issue. Poor or ill-informed advice is likely to do more harm than good.

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QOF8	19.4	Slimming World	Overall we are concerned that this indicator is unclear as to what 'appropriate advice' is. We would suggest that it should be re-worded and focus on appropriately discussing options with patients and signposting to services which can support patients to manage their weight. Simply providing advice could result in very inconsistent messages and be potentially ineffective. This would bring the indicator more in line with previous NICE guidance [PH53].
QOF8	19.4	Somerset CCG	A true health and wellbeing approach would ensure obesity and diet were addressed at an appropriate time and appropriate way (and not attempted to be addressed using the "medical model".). The creation of "Health and Wellbeing Centres" (which GPs are part of) is a setup which would be far more suited to addressing obesity.

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Appendix B: Equality impact assessment for QOF7 and QOF8 (weight management)

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.

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Indicator Equality Impact Assessment form

Development stage: Consultation

Topic: Weight management

1. Have any equality issues impacting upon equality groups been identified during this stage of the development process? • Please state briefly any relevant equality issues identified and the plans to tackle them during development.
Stakeholders highlighted the potential health inequality caused by misinterpretation of BMI results as a single value for BMI does not adequately reflect the differential risk of identical BMI in different groups such as people with learning disabilities, different racial groups and the elderly. Stakeholders therefore felt there would be a need for specific BMI calculators for some groups.
2. Have relevant bodies and stakeholders been consulted, including those with a specific interest in equalities? • Have comments highlighting potential for discrimination or advancing equality been considered?
Yes – stakeholders across England were encouraged to comment on the potential new indicators as part of the NICE consultation. A wide range of relevant groups and organisations was contacted.
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?
Indicator QOF7 is relevant to all people aged 18 years or over who are registered with a GP practice. QOF 8 is relevant to people aged 18 years or over who have a BMI of 25 or higher. The inclusion criteria of these indicators reflect the clinical guideline on which they are based.
4. Do any of the indicator statements 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?
At consultation it was highlighted that for wheelchair users who cannot stand it may be impossible to measure their BMI without lying them down. It was also commented that if these patients had any contractions this would be even more difficult. It was also highlighted that for people with certain learning disability syndromes (e.g. Down Syndrome) may need some syndrome-specific BMI norms.
5. Do the indicator statements 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

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in terms of people with protected characteristics or other relevant characteristics.