

**NATIONAL INSTITUTE FOR HEALTH AND CARE  
EXCELLENCE**

**INDICATOR DEVELOPMENT PROGRAMME**

**Consultation report**

**Indicator area:** Obesity

**Consultation period:** 26 June 2020 – 15 July 2020

**Date of Indicator Advisory Committee meeting:** 04 August 2020

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## Summary of indicators included in the consultation

ID	Indicator	Evidence source
IND 2020-90	The percentage of patients with a BMI $\geq 27.5$ kg/m <sup>2</sup> (or $\geq 30$ kg/m <sup>2</sup> if ethnicity is recorded as White) in the preceding 24 months who have been referred to a weight management programme within 90 days of the BMI being recorded.	<p><a href="#">BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups</a> (2013) NICE guideline PH46 recommendations 1 and 2</p> <p><a href="#">Weight management: lifestyle services for overweight or obese adults</a> (2014) NICE guideline PH53 recommendations 6 and 7.</p> <p><a href="#">Obesity: identification, assessment and management</a> (2014) NICE guideline CG189 recommendations 1.2.1, 1.2.8, 1.2.10, 1.3.1, 1.3.4, 1.3.6.</p>
IND 2020-91	IND 2020-91: The percentage of patients with hypertension or diabetes and a BMI $\geq 27.5$ kg/m <sup>2</sup> (or $\geq 30$ kg/m <sup>2</sup> if ethnicity is recorded as White) in the preceding 12 months who have been referred to a weight management programme within 90 days of the BMI being recorded.	<p><a href="#">Weight management: lifestyle services for overweight or obese adults</a> (2014) NICE guideline PH53 recommendations 6 and 7.</p> <p><a href="#">Obesity: identification, assessment and management</a> (2014) NICE guideline CG189 recommendations 1.2.1, 1.2.8, 1.2.10, 1.2.11, 1.3.1 1.3.4, 1.3.6.</p>

## General comments on obesity indicators

The percentage of patients with a BMI  $\geq 27.5$  kg/m<sup>2</sup> (or  $\geq 30$  kg/m<sup>2</sup> if ethnicity is recorded as White) in the preceding 24 months who have been referred to a weight management programme within 90 days of the BMI being recorded.

The percentage of patients with hypertension or diabetes and a BMI  $\geq 27.5$  kg/m<sup>2</sup> (or  $\geq 30$  kg/m<sup>2</sup> if ethnicity is recorded as White) in the preceding 12 months who have been referred to a weight management programme within 90 days of the BMI being recorded.

## Summary of consultation comments

Some stakeholders welcomed the inclusion of these indicators, commenting that:

- Evidence suggests that weight management services are effective.
- Referrals should ideally be made in person.
- BMI thresholds stratified by ethnicity recognises difference in risk.
- They would improve on existing indicators.
- They will lead to improvement in patient outcomes.

Other stakeholders raised several issues, commenting that:

- GPs did not currently play a key role in most weight management processes.
- Adequate weight management programmes are not always available.
- There could be a risk of meaningless referrals.
- The BMI threshold is too low and identifies a large number of patients.
- They could lead to GPs avoiding BMI measurement.
- General practice staff can be uncomfortable raising issues of weight

Stakeholders also suggested that:

- Frequency should mirror other screening services at 3 years.
- Patients declining referral or already referred should be excluded.
- Specialist weight management services may be required at higher BMI measurements.
- Discussions should be sensitive and person centred.
- Follow ups should be required where referral has been declined.
- Other measurements such as waist circumference could be used.
- Outcomes should be measured as well as the number of referrals.

## IND 2020-90: Obesity: all patients

The percentage of patients with a BMI  $\geq 27.5$  kg/m<sup>2</sup> (or  $\geq 30$  kg/m<sup>2</sup> if ethnicity is recorded as White) in the preceding 24 months who have been referred to a weight management programme within 90 days of the BMI being recorded.

### Rationale

This indicator aims to increase the proportion of people referred to digital and non-digital weight management programmes by general practice when they have been identified as obese based on their BMI measurement. Additionally, weight management advice can include discussion of the patient's weight and risks, healthy diet and exercise. Some population groups, such as people from BAME backgrounds, have higher risks for certain conditions, such as Type 2 diabetes, at lower BMIs.

Twenty-four months has been chosen as a pragmatic timeframe for measurement purposes and to align with other health promotion activities in the general population in QOF such as smoking cessation offers.

### Summary of consultation comments

Stakeholders that welcomed the inclusion of this indicator commented that the focus on referrals is positive, and that it may incentivise commissioning of weight management services.

Stakeholders were uncertain if positive outcomes could be achieved without a multi-disciplinary approach. Stakeholders recommended that the indicator be extended to include those classed as overweight and should specify that services referred to are in line with NICE guideline on weight management ([NICE, PH53](#)).

**Consultation question: For the purposes of a performance measure, should the indicator include an upper age limit, or should clinical judgement be used to exclude certain patients? Are you aware of evidence or case studies that indicate an upper age limit should be applied to this indicator?**

Stakeholders were generally in agreement that the indicator should not include an upper age limit and that there was no evidence to support one. Stakeholders also felt that any exclusions based on age should be made through case by case clinical judgement.

**Consultation question: Are you aware of evidence or case studies that indicate that this indicator should have exclusions based on patient frailty?**

Stakeholders were generally in agreement that the indicator should not include exclusions based on frailty and that there was no evidence to support doing so.

Stakeholders also felt that any exclusions based on frailty should be made through case by case clinical judgement.

**Consultation question: Is 24 months an appropriate timeframe for the repetition referral to a weight management programme?**

While some stakeholders agreed that 24 months was an appropriate timeframe, there were also suggestions of longer (e.g. 3-5 years to match public health activities), shorter (18 months, 12 months) and case by case.

## **IND 2020-91 Obesity: patients with hypertension or diabetes**

The percentage of patients with hypertension or diabetes and a BMI  $\geq 27.5$  kg/m<sup>2</sup> (or  $\geq 30$  kg/m<sup>2</sup> if ethnicity is recorded as White) in the preceding 12 months who have been referred to a weight management programme within 90 days of the BMI being recorded.

### **Rationale**

This indicator aims to increase the proportion of patients with hypertension or diabetes referred to digital and non-digital weight management programmes by general practice when they have been identified as obese based on their BMI measurement. Additionally, weight management advice can include discussion of the patient's weight and risks, healthy diet and exercise. Patients with hypertension or diabetes may experience additional benefits from attaining and maintaining a healthy weight, and patients should be given a targeted offer of support.

### **Summary of consultation comments**

Stakeholders that welcomed the inclusion of this indicator commented that the 12-month timescale was suitable considering the additional health needs, and that having different BMI thresholds for BAME populations was positive.

Stakeholders recommended that the BMI thresholds be extended to include those classed as overweight, and that an 18-month timescale might help to account for missed appointments.

**Consultation question: For the purposes of a performance measure, should the indicator include an upper age limit, or should clinical judgement be used to exclude certain patients? Are you aware of evidence or case studies that indicate an upper age limit should be applied to this indicator?**

Stakeholders were in agreement that the indicator should not include an upper age limit and that there was no evidence to support one. Stakeholders also felt that any exclusions based on age should be made through case by case clinical judgement.

**Consultation question: Are you aware of evidence or case studies that indicate that this indicator should have exclusions based on patient frailty?**

Stakeholders were in agreement that the indicator should not include exclusions based on frailty and that there was no evidence to support doing so. Stakeholders also felt that any exclusions based on frailty should be made through case by case clinical judgement.

## Appendix A: Consultation comments

ID	Proforma question no.	Stakeholder organisation	Comment
		<b>Question 1:</b> Do you think there are any barriers to implementing the care described by these indicators?	
IND 2020-90 / IND 2020-91	1	Cancer Research UK	Barriers - for this indicator to be successful, there has to be community services available to support primary care and the patient. There is little point primary care giving advice to patients about weight loss without any services to refer to for more formal advice and support. However, we know that weight management services are only patchily available in England.
IND 2020-90 / IND 2020-91	1	Cancer Research UK	Barriers - whilst digital options will be in scope – these do not suit all patients especially those with poor digital access or digital literacy.

<p>IND 2020- 90 / IND 2020- 91</p>	<p>1</p>	<p>Cancer Research UK</p>	<p>Barriers – Cancer Research UK has commissioned research which shows there are many barriers regarding GPs raising the issue of weight management with patients.</p> <ul style="list-style-type: none"> <li>· Independent research commissioned by CRUK in 2018 regarding its E-learning module on Behaviour Change and cancer prevention (including Very Brief Advice) found that:             <ul style="list-style-type: none"> <li>• Health professionals cite a fear of “turning patients off” to advice</li> <li>• Health professionals having insufficient time and a concern that their already stretched time would be wasted giving advice to deaf ears</li> <li>• Embarrassment and levels of discomfort on part of the health professional and fear of offending patients</li> <li>• Feelings of hypocrisy on the part of the health professional if they themselves are overweight/obese</li> </ul> </li> </ul> <p>“I still hesitate with the obesity because I don’t want to upset the patient.” Practice Nurse  “Some of the patients maybe don’t accept that they have a problem with weight.” GP</p> <p>“Weight is harder to broach than smoking and alcohol because everybody knows their doctor is going to give them lots of smoking and alcohol advice but not necessarily expecting it for being slightly overweight.” GP</p> <p>“Obesity ... it’s less easy to approach sometimes because it feels more personal. With alcohol and smoking it’s an external substance whereas when you’re talking about somebody’s weight, you’re specifically talking about them, it’s less easy to identify it as a behaviour, it’s more about them as they are. What they hear is, ‘you’re telling me I’m too fat’... They feel it’s a very personal comment. As well, it’s very rare that somebody who is overweight has not considered that or tried to do something about that at some point in their lives.” GP</p> <p>According to CRUK’s Health Professional Tracker survey in 2018, 1/3 of GPs and 1/5 of Nurses are not comfortable raising</p>
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			<p>the issue of weight. Lack of time and available training are the key barriers for all groups. Over 30% of GPs and 20% of practice nurses do not feel they have the knowledge to encourage weight loss.</p> <ul style="list-style-type: none"> <li>• Findings from the CRUK/Cogora Round Table on obesity 2019 (for GPs/practice nurses) show:</li> <li>• Barriers to having these conversations include fear of upsetting patient and damaging patient relationships, belief that tackling obesity is down to individual responsibility (as without their determination to lose weight, efforts of health professionals are not effective)</li> <li>• Health professionals feel that weight discussions are only valuable and have impact if there are additional services to refer patients for further support (weight management and psychological support services). The services available are inconsistent and insufficient and if they are to provide any benefit to patients, such services need to be better resourced. In addition, not all health professionals are aware of what is locally available.</li> <li>• There was inconsistent advice about nutrition e.g. around low-fat diets and so would like standardised guidance on nutrition in order to have effective weight conversations</li> </ul> <p>In 2019 a survey with 151 GPs and 100 Practice nurses showed that:</p> <ul style="list-style-type: none"> <li>• Only 35% were very comfortable initiating a conversation with patients who are overweight/obese about their weight.</li> </ul> <p>When asked 'what is preventing you from initiating a conversation about weight</p> <ul style="list-style-type: none"> <li>• 59% said they didn't have the time to provide advice</li> <li>• 48% feared upsetting patients</li> <li>• 27% said risk of conflict</li> </ul> <p>22% said impact on a patient's mental health</p>
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ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	1	Cancer Research UK	Barriers - There may be barriers around re-referral to programmes if patients have not had a positive experience – perhaps needs to be reframed as opportunity for re-referral, as per PH53 guidance “Give people the opportunity for a re-referral, as necessary, because weight management is a long-term process. Use clinical judgement, taking into account the person's circumstances, previous experiences of weight management and commitment to change.”
IND 2020-90 / IND 2020-91	1	Cancer Research UK	Barriers - most of the evidence on effectiveness of weight management programmes comes from research in white affluent groups. Therefore, there is a possible unintended consequence of widening health inequalities if they are less effective for ethnic minority groups and/or lower socio-economic status groups. Collectively, we need to know more about how they work for these groups.
IND 2020-90 / IND 2020-91	1	Cancer Research UK	Barriers - the weight threshold for non-white ethnicity is higher in the proposed QOF (27.5KG/M2) than related guidance signposted to (25kg/m2) and may cause confusion.

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	1	Cancer Research UK	<p>Barriers - obesity all patients – some of the unintended consequences represent missed opportunities:</p> <p>For example, the signposted guidance PH46 3/7/13 does not reference the evidence of cancer risk and obesity and consequently there is a missed opportunity to raise awareness of this amongst health professionals</p> <ul style="list-style-type: none"> <li>• The exclusion of this indicator for under 18 years is not helpful as this is a time when many 16-18 year olds may require support to lose weight. Although the signposted guidance signposts to childhood obesity, there is a lack of focus in the QOF to highlight the importance of impact for this group over the life course, with an over-emphasis on when not to refer at an older age.</li> <li>• The importance of having a very brief advice conversation with a primary care health professional cannot be underestimated. VBA can prompt patients to take the next steps to seek further support for what has often been a long-standing issue. This should ideally be available at every visit with primary care professionals</li> </ul>
IND 2020-90 / IND 2020-91	1	Royal College of Physicians (RCP)	Barriers are mainly lack of funded resources.

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	1	Slimming World	<p>In response to the question, are there any barriers to implementing the care described - yes, we feel there are some potential barriers. Firstly, it's vital that clear care pathways are in place so GPs are well aware of the services available to their patients and that services are commissioned across all areas. Currently, there will be some GPs able to engage with this QOF system as they have access to refer to services which meet the NICE core components outlined in PH53, and other GPs in other areas with little or no access to services to refer to. More needs to be done to address this variability in access to commissioned services and to ensure nationwide, more consistent commissioning of weight management services.</p> <p>Another potential barrier is in relation to GPs raising the issue with patients identified as having a raised BMI. It's vital that when GPs are discussing issues such as excess weight with patients that they are skilled to raise the issue sensitively. We would suggest that specific training is given to include skills and confidence in the ability to be able to sensitively raise the issue of weight with their patients. It's vital that any conversations around weight are supportive and compassionate and avoid any feeling of judgement or stigma around weight. This is an area which many health care professionals struggle with* and often leads to any discussion being avoided and should be addressed through nationwide and consistent training to ensure they have the relevant skills and competence in this area.</p> <p>* Lavin, et al. (2015). Tackling the subject of weight with patients: the difficult conversation. <i>Journal of Primary Health Care</i>, 25(2): 18-22</p> <p>Swift, et al Talking about obesity with clients: preferred terms and communication styles of U.K. pre-registration dieticians, doctors, and nurses <i>Patient Educ. Couns.</i>, 91 (2) (2013), pp. 186-191</p>

<p>IND 2020- 90 / IND 2020- 91</p>	<p>1</p>	<p>SweatCo Ltd</p>	<p>Do you think there are any barriers to implementing the care described by these indicators?</p> <p>Since the NICE indicators were developed in 2013/14, there have been major advances in new and novel approaches to behavioural modification as it relates to obesity including fitness and eating behaviours.</p> <p>The means of communication and public commitment to programmes based on attending and/or joining fitness centres or fitness programmes dramatically limited the audiences to whom it appeared relevant and economically feasible.</p> <p>Richard Thaler was awarded the Nobel Prize in 2017 for his “nudge” and “irrational economic” theories  <a href="https://www.ft.com/content/aa08d810-acd8-11e7-aab9-abaa44b1e130">https://www.ft.com/content/aa08d810-acd8-11e7-aab9-abaa44b1e130</a></p> <p>Digital Technology, using on irrational economic theories, has allowed companies like SweatCo., to develop digital app-based solution that are now used by millions throughout the UK, Europe, North America &amp; APAC.</p> <p>The initial primary focus, has been improving physical activity and fitness. The app. harnesses the behavioural modification (nudge) concepts to engage individuals and uses rewards to drive, monitor and incentivise sustained behaviour change. Importantly it has independent evidence of its sustained impact and has demonstrated effectiveness in engaging all socio-economic groups and specific targeted, at risk, ethnic or geographic groups. Independent academic studies have proven the dramatic benefit of this approach in achieving sustained improvements over traditional media and didactic educational campaigns.</p> <p>The new QOF should provide the incentives to overcome the barriers and embrace such disruptive technologies that have academic independent evidence of their effectiveness.</p> <p>This approach has the benefit of enabling IHS’s, local commissioners and primary care groups to customise the approach to ensure engagement within their localities. The tools and incentives can be configured to ensure the commitment of the target population to take account of the widely varied socio-</p>
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ID	Proforma question no.	Stakeholder organisation	Comment
			<p>economic, ethnic and demographic challenges, that exist throughout the UK and have been a barrier to “one stop fits all” solutions.</p> <p>The approach also provides a means of co-ordinating the campaigns and programmes across the various partnerships and thereby addressing all partners needs and priorities and ensuring the engagement of all partners.</p>
		<p><b>Question 2:</b> Do you think there are potential unintended consequences to implementing/ using any of these indicators?</p>	
IND 2020-90 / IND 2020-91	2	Royal College of Physicians (RCP)	Unintended consequences is overload of current services.
IND 2020-90 / IND 2020-91	2	Slimming World	<p>We feel there are potential unintended consequences to implementing / using the indicators. It feels there’s incentive to refer a patient to a service but no emphasis on the quality of the service referred to or any drive to monitor outcomes or assess whether it was beneficial for the patient. It’s vital that all services referred to meet the NICE core components (set out in PH53), these services provide accurate and timely data back to those commissioning services and this is fed back to GPs so they can monitor patient outcomes, look at levels of engagement and patient satisfaction.</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	2	SweatCo Ltd	<p>Do you think there are potential unintended consequences to implementing/ using any of these indicators?</p> <p>The suggested approach using the digital power of app is an example of a disruptive technology that will require a significant rethink of how commissioners and primary care groups and public health manage obesity and diabetes. One hopes its potential benefits will overcome the likely professional interest barriers that often can block innovation.</p>
		<p><b>Question 3:</b> 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.</p>	
IND 2020-90 / IND 2020-91	3	Cancer Research UK	<p>Differential impact – digital literacy differs and will result in inequalities if the indicator relies heavily on the digital option. The ‘Digital Divide’ varies according to many factors including age, income, urban/rural location. Therefore, there is the potential for this to adversely affect older people.</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	3	Slimming World	<p>There is potential for differential impact as a result of this new proposed indicator and it is important monitoring is in place to ensure referrals are being offered to patients across all groups. Men are likely to be under-represented in referrals. Men are generally less likely to engage with the health service and therefore there is less opportunity for referral. There's also gender bias when it comes to offering men referral to services such as weight management services. While men are less likely to engage initially, research suggests they are actually often more successful in terms of weight loss, and engage well with programmes once accessed (for example <a href="https://www.ncbi.nlm.nih.gov/pubmed/26359180">https://www.ncbi.nlm.nih.gov/pubmed/26359180</a>).</p> <p>More should be done to support men to engage with weight management programmes and to ensure there is no gender bias, for example from health professionals referring patients into weight management programmes. A Study by the University of Oxford demonstrated that when health professionals verbally offer referral to men and women equally, based on BMI and without the risk of gender bias, the proportion of referrals who are male jumps from an average of one in 10 to nearly four in 10. <a href="http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31893-1/fulltext">http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31893-1/fulltext</a>.</p> <p>With regards to pregnancy/maternity, this is another key area where there could be a differential impact. Many weight management referral schemes exclude women during pregnancy yet this could be a key time to not only impact on the mother through supporting healthy behavior changes around diet and activity, and reducing excess weight gain during this time, but also has the potential to carry further benefit through to the child later in life.</p>



ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	3	SweatCo Ltd	<p>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?</p> <p>As mentioned, the major benefit of the suggested use of a digital app. with targeted and customisable campaigns to address the range and local priorities with regard to socio-economic, ethnic and gender priorities , helps alleviate such issues.</p>
		<p><b>Question 4:</b> If you think any of these indicators may have an adverse impact in different groups in the community, can you suggest how the indicator might be delivered differently to different groups to reduce health inequalities?</p>	
IND 2020-90 / IND 2020-91	4	Cancer Research UK	<p>Adverse impact in communities - digital literacy differs and will result in inequalities if the indicator relies heavily on the digital option. The 'Digital Divide' varies according to many factors including age, income, urban/rural location. Therefore, there is the potential for this to adversely affect people on lower incomes. If delivered in conjunction with 'exercise on prescription' schemes this could work however.</p>
IND 2020-90 / IND 2020-91	4	Cancer Research UK	<p>Adverse impact in communities - in terms of the indicator itself there isn't much that can be delivered differently – it is the weight management programmes themselves that will need altering.</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	4	SweatCo Ltd	<p>If you think any of these indicators may have an adverse impact in different groups in the community, can you suggest how the indicator might be delivered differently to different groups to reduce health inequalities?</p> <p>As outlined above, solutions such as offered by Sweatco, use the “irrational economic and nudge theory” approach, and are designed to support the HIs, commissioners and primary care partnership’s campaigns that are customised and targeted for the very reasons stated in this question.</p>
<b>General comments on both indicators</b>			
IND 2020-90 / IND 2020-91	n/a	British Medical Association	<p>We cannot support these indicators. Unless a patient is morbidly obese, GPs do not generally play a major role in this process. In most cases a decision to seek weight management services is patient-led and self-referred. Patients have no impediment to self-referral where CCGs have commissioned these services adequately, but at present there are major concerns about the lack of available, appropriate and convenient services.</p> <p>Talking obesity requires a concerted, multi-system approach, including a public health campaign with patient/public education on healthy eating and school nutrition policies, and promotions on healthy eating options concerning supermarkets/cafes/restaurants/fast-food chains</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	Cancer Research UK	Upper age limit - We have examined this from a cancer risk perspective. In terms of upper age limits to obesity and cancer risk, there is no specific data on this. However, risk accumulates the longer a person is overweight for, so in that sense intervening in younger age groups may be more important. On the other hand, cancer risk increases exponentially with age, so in terms of targeting those at greatest risk of cancer then older groups are still important. We suggest a guideline age (e.g. 65 as suggested in draft) should be given, but clinical judgement also used.
IND 2020-90 / IND 2020-91	n/a	Cancer Research UK	Upper age limit - Widening this beyond cancer risk, CRUK GPs report that they believe 65 years old is a reasonable upper age limit. The best evidence base for interventions around weight loss and reducing morbidity are in diabetes – with both bariatric surgery and low-calorie diet having evidence of putting diabetes into “remission”. Ignoring bariatric surgery, then the DIRECT study is the landmark study in this area. This included patients 20-65y old – the greatest predictor of reversal of diabetes was weight loss with 15kg weight loss having an 86% chance of reversing diabetes. Nearly 50% reversed their diabetes in 12 months – and approximately 36% were still in remission after 24 months. This is the study that says lifestyle is the most fundamental intervention for type 2 diabetes.  <a href="#">Study 1</a>  <a href="#">Study 2</a>
IND 2020-90 / IND 2020-91	n/a	Cancer Research UK	Upper age limit - for the over the age of 65, whilst weight loss would be beneficial for many patients not all will be able to modify their activity due to frailty, poor mobility etc. For this age group, therefore, this should be based on clinical judgement.

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	Cancer Research UK	<p>Patient frailty - We would signpost to the DIRECT study: there were exclusions relating to heart failure, psychotic medication and others. Frailty would be an exclusion because there is no evidence weight loss per se reduces frailty.</p> <p>Exercise in a targeted manner reduces risk of mortality – even in the elderly.  <a href="#">Study</a></p>
IND 2020-90 / IND 2020-91	n/a	Cancer Research UK	<p>24-month timeframe - Patients will attend a programme for 8-12 weeks, but evidence for the effectiveness of programmes is mainly up to 12 months, after which individuals often regain the weight. Therefore a 12-month timeframe might be more appropriate, if it becomes apparent that patient has regained weight or remained obese. However, consideration may need to be given – in line with PH53 guidance - as to why programme was not successful and whether a re-referral would be the right approach or not on an individual patient basis (using clinical judgment).</p>
IND 2020-90 / IND 2020-91	n/a	Cancer Research UK	<p>24-month timeframe - Based on the CRUK GPs' experience of working in general practice, we would advise against such a long and/or rigid timeframe. People may have found circumstances within 24 months which have increased their weight including medication, illness etc</p>
IND 2020-90 / IND 2020-91	n/a	Cancer Research UK	<p>24-month timeframe - Potentially a 12-month timeframe would be more appropriate for a repeat referral to a support service. Many patients, certainly in less deprived areas, can lose weight without support once they know what to do. However, some patients attend practice weight loss clinic either with an increase in weight, or with no weight loss and the surgery is not equipped to sustain this service.</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	East Midlands Bariatric & Metabolic Institute	As patients don't usually just come to their GP to have their weight taken, (unless they need something else) and to join up care processes then the starting age should be the same as cervical screening and end at the same age as bowel screening e.g. 25-74yrs. This way GP's would be expected to weigh at least most women and some men during this time period. This indicator will also work as a nudge to screening services, to record weight in patient records. The frequency should also be the same as for other screening services e.g. every 3yrs.
IND 2020-90 / IND 2020-91	n/a	East Midlands Bariatric & Metabolic Institute	We are concerned that to reach this quality indicator, patients will be referred to services without the patient having the motivation to attend. Thus, weight management services will be sent lots of referrals, but very few people would attend. NICE do need to consider means of preventing mass referral to weight management services for patients that do not wish to attend a weight management service.
IND 2020-90 / IND 2020-91	n/a	Fosse Medical Centre	<p>Working age people would majorly struggle to get time off just to get diet advice and for the lifestyle advice to actually have an intended effect – it should be a proper consultation, agreeing a diet plan and regular, best weekly follow ups – it is a full time job in itself and there is no capacity for that in primary care.</p> <p>Otherwise – we will pretty much tell them: 'eat healthy, exercise more, off you go' – it becomes a box ticking exercise for the sake of achieving qof. And it's guaranteed that there isn't a single person in this world who lost any amount of weight following 10 min consultation with GP. Diet plans and proper consultation about lifestyle must be personalised to different cultures and religions as well.</p> <p>I think advice on healthy eating would be appropriate at any age but wouldn't make it compulsory for every single person. More money should be invested in teaching children about.</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	Health Behaviors Research Team - University of Oxford	We strongly support the change in the QOF to incentivise GPs to refer patients with obesity to weight management programmes. There is strong evidence that such programmes are effective as documented in NICE guidance on lifestyle weight management.
IND 2020-90 / IND 2020-91	n/a	Health Behaviors Research Team - University of Oxford	We suggest specifying that the referral should be made in-person. Practices aiming to fulfil the requirement on making smoking referrals have done so by writing letters, which is far less effective than in-person. Compare in-person <a href="https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31893-1/fulltext">https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31893-1/fulltext</a> with by letter <a href="https://bjgp.org/content/66/645/e258">https://bjgp.org/content/66/645/e258</a> In addition, there is evidence that by-letter invitations produce inequalities in uptake by lower SES groups <a href="https://bjgp.org/content/66/645/e258">https://bjgp.org/content/66/645/e258</a> that could worsen inequalities in health. In-person invitations lead to greater uptake by the lower SES groups than higher <a href="https://bmcmmedicine.biomedcentral.com/articles/10.1186/s12916-019-1284-y">https://bmcmmedicine.biomedcentral.com/articles/10.1186/s12916-019-1284-y</a>
IND 2020-90 / IND 2020-91	n/a	Individual 2	Barrier – this will become a meaningless tick box exercise unless effective evidence-based weight management programmes are made widely available Equity – any programme needs to be easily accessible to people of different languages, incomes, physical ability (high rate of painful MSK conditions affecting exercise) and differing digital access Is there any evidence of effective lifestyle change and weight loss in the over 80s?

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	Individual 3	Who will we be able to refer these patients too? If this started tomorrow our local obesity service would be overwhelmed in weeks.
IND 2020-90 / IND 2020-91	n/a	Individual 3	Needs a good exclusion criterion for those that refuse strongly.
IND 2020-90 / IND 2020-91	n/a	Individual 3	Threshold feels very low meaning we'd be referring a huge proportion of the population.
IND 2020-90 / IND 2020-91	n/a	Individual 3	Why 24 months, if you have a bad year the previous year, you can never catch up the next year and so will miss payment. So does not incentivise year on year improvement.
IND 2020-90 / IND 2020-91	n/a	Individual 3	Will this stop practices doing BMI's in the first place if referral is becoming problematic?

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	Individual 4	<p>Laudable but if the weight management services are not in place or have limited capacity this then becomes a false exercise.</p> <p>This indicator will fail for a practice, if a practice for whatever reason decides to batch code BMI using in built BMI calculation tools – similarly it could drive patient weight to be captured but BMI not to be fully coded (for the reason above – why calculate BMI if you know the waiting list for weight management is 12 months?)</p>
IND 2020-90 / IND 2020-91	n/a	Individual 5	<p>A BMI of 27.5 is practically normal for the town I work in. To achieve the QOF target would mean referring the majority of my patients for weight management to a service which does not exist. I was involved in recruiting patients for the BWEL study which showed the value of weight reduction programmes and we recruited I believe more patients than any other GP practice. Without a massive investment in services and a change in attitude from the public this is imply unachievable.</p>
IND 2020-90 / IND 2020-91	n/a	Obesity Group of the British Dietetic Association	<p>We welcome the proposal to include obesity in adults as a QOF indicator. In particular we support the requirement for action to be taken on the basis of BMI status (not just recording of the BMI). For women who are pregnant this will have additional benefit for their infants,</p>
IND 2020-90 / IND 2020-91	n/a	Obesity Group of the British Dietetic Association	<p>We welcome the proposed cut-off points for BMI based on ethnicity, which recognises the increased risk at lower BMI among those who are not Caucasian.</p>



ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	Obesity Group of the British Dietetic Association	We suggest that the reason for the referral needs to be discussed with the patient and that these discussions should be documented. It is important for example to ascertain whether they are already engaged with weight management services, in which case another referral is unlikely to be necessary. Where patients are already engaged with weight management services, this should be documented.
IND 2020-90 / IND 2020-91	n/a	Obesity Group of the British Dietetic Association	We do not think that age is sufficient justification for decisions about whether or not to refer. Clinical judgement should be used on the basis of an appropriate assessment, including age but also the wishes of the patient and their health status.
IND 2020-90 / IND 2020-91	n/a	Obesity Group of the British Dietetic Association	In those with more severe obesity, it may be that referral to specialist weight management services would be more appropriate (as per NICE CG189; BMI at or above 35kg/m <sup>2</sup> with co-morbidities, BMI at or above 40kg/m <sup>2</sup> without co-morbidities) Diabetes Remission services should be considered for indicator IND 2020-91 for people with BMI >27.0kg/m <sup>2</sup> – note these may be offered under diabetes treatments services rather than weight management services.
IND 2020-90 / IND 2020-91	n/a	Obesity Group of the British Dietetic Association	All discussions about weight status should be sensitive and patient-centred. The social and psychological drivers behind excess weight gain are well documented however obesity remains a stigmatised disease. British Psychological Society documents on obesity may be useful resources for healthcare practitioners.
IND 2020-90 / IND 2020-91	n/a	Obesity Group of the British Dietetic Association	Where patients choose not to be referred to weight management services, or diabetes remission services in IND 2020-9, this should be recorded in the notes.

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	Obesity Group of the British Dietetic Association	We would like to see a requirement for follow-up included e.g. if a referral is made but the patient chooses not to accept it, or their weight status after engaging with weight management services. Where a patient engages with weight management services it is likely that progress reports will be shared with the referring agent, but at subsequent appointments it would be useful to note whether patients have engaged or not.
IND 2020-90 / IND 2020-91	n/a	Obesity Group of the British Dietetic Association	All referrals should be made to evidence-based weight management provision i.e. including diet, activity and behaviour change.
IND 2020-90 / IND 2020-91	n/a	Obesity Group of the British Dietetic Association	We also note that there may be a lack of local evidence-based weight management / diabetes remission (IND 2020-91) services in some areas. This may be exacerbated by weight gain in some people as a consequence of the lockdown. There is likely to also be an impact on availability of psychological services and social care prescribers, and this needs to be considered both from a service provision perspective and from a personalised care perspective.
IND 2020-90 / IND 2020-91	n/a	Obesity Group of the British Dietetic Association	In recognition of the sensitivity of weight and the stigma associated with obesity, we would like to see People First language used throughout this document (e.g. 'people with obesity', rather than 'obese people').
IND 2020-90 / IND 2020-91	n/a	Rotherham Institute for Obesity (RIO)	The Rotherham Institute for Obesity (RIO) welcomes the review and update to the NICE indicators on Obesity, as the current Indicator do NOT achieve their intended aim of leading to improvements in care and outcomes for patients living with this chronic relapsing progressive disease.

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	Rotherham Institute for Obesity (RIO)	The current Indicators, NM128 and NM121 merely incentivise primary care to record weight, without further assessment of associated medical conditions, or further management such as advice on leading a healthy lifestyle or referral into local weight management services. Furthermore, NM128 has encouraged primary care to bring in otherwise healthy individuals (i.e. those with Metabolically Healthy Overweight/Obesity, or MHO) just for a weight check when primary resources are already stretched.
IND 2020-90 / IND 2020-91	n/a	Rotherham Institute for Obesity (RIO)	NICE should incentivise primary care to treat manage the problems of overweight and obesity in both adults and children and feel that the new proposed Indicators only address the issue of just obesity and in only adults.
IND 2020-90 / IND 2020-91	n/a	Rotherham Institute for Obesity (RIO)	The proposed NICE Indicators only reference the use of Body Mass Index (BMI) to estimate obesity instead of including other proxy measures of carrying unhealthy excess fat that can cause harm to health, such as waist circumference.
IND 2020-90 / IND 2020-91	n/a	Rotherham Institute for Obesity (RIO)	It is important to incentivise primary care to screen patients that have been identified as suffering with obesity, for other important and associated medical conditions such as diabetes, cardiovascular disease, including hypertension and dyslipidaemia, non-alcoholic fatty liver disease, obstructive sleep apnoea, and hypothyroidism etc. There are 236 medical conditions associated with obesity (Yuen MM et al 2018) and obesity is considered to be a public health priority. Therefore, RIO would have expected there to be many more than the proposed 2 new NICE Indicators to relate to managing obesity, and for them to be apportioned a significant amount of QOF points.

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	Rotherham Institute for Obesity (RIO)	All of primary care, whether the GP, nurse or allied healthcare professional should be incentivised through the use of appropriate NICE Indicators, and QOF points to give weight management advice at the time of identification, and to refer into appropriate weight management services. Patients, who are not appropriate, on an individual basis, after clinical assessment, should be allowed to be exempt from inclusion in these Indicators.

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	Rotherham Institute for Obesity (RIO)	<p>It would be more appropriate to consider having the following obesity Indicators (not the proposed final wording) based upon the following principles:</p> <p>Medical Record Keeping:</p> <p>OB1 – The Practice can produce a register of adults living with obesity, using the criteria of BMI<math>\geq</math>30 and/or waist circumference of &gt;102cm (men) or 88cm (women), allowing for a lower threshold for patients from a BAME background</p> <p>OB2 – The Practice can produce a register of children, aged 5-17, living with obesity, using the criteria of a BMI&gt;95th centile</p> <p>Diagnosis and Initial Management:</p> <p>OB3 - The percentage of patients with newly diagnosed obesity where the medical notes record weight management advice, or inclusion in a weight management programme, has been offered at least once</p> <p>Ongoing Management:</p> <p>OB4 – The percentage of obese patients whose medical notes contain a record of BMI and/or waist circumference in the previous 18 months</p> <p>OB5 – The percentage of patients with obesity where the medical notes reflect that they have had a BP recorded in the previous 18 months</p> <p>OB6 – The percentage of patients with obesity where the medical records reflect that they have had appropriate blood tests to screen for co-morbidities (such as, but not only, HbA1c and lipids) in the previous 18 months</p> <p>With each Indicator and in total having a large proportion of QOF points allocated to them to ensure that weight management is prioritised</p> <p>The lack of including the above points in the NICE Indicators on obesity will lead to barriers implementing adequate care for those patients living with Overweight/Obesity.</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	Royal College of General Practitioners	<p>Obesity is a cyclical chronic relapsing condition that requires shared decision making and person-centred care. Not all patients want or will consent to a referral and this must be taken into account.</p> <p>Building a relationship with patients may be detrimentally harmed by repeatedly calling patients in for review of their weight and sending a referral that patient does not want</p> <p>Adding an exclusion of patient dissent should be considered in each indicator to fulfil patient-centred care, patient choice and shared decision-making policies</p> <p>Potential unintended consequences/ Potential barriers to implementation:</p> <p>Repeated conversations could damage the GP-patient relationship, preventing longer term help, and may mean people with high BMIs avoid GP care for fear of stigmatization</p> <p>Lack of consistent and available services across the country so an increase in service commissioning will be required to ensure evidence-based services are available for GPs to refer into</p> <p>Weight management services may be difficult to access if elderly, disabled or patients have mental or physical illness, are living in poverty (travel costs, lack of IT), or have language barriers. Pregnant women (and other groups) may need more tailored care and commissioners should be encouraged to look at all options, taking into account health inequalities.</p>
IND 2020-90 / IND 2020-91	n/a	Royal College of Nursing	We support this addition to the QOF indicators.

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	Royal College of Physicians (RCP)	<p>People with overweight and obesity experience significant weight related stigma often from HCPs it is therefore critical that all language in documents going forward uses a person first approach. For example a person with obesity not an obese person (see publication March 2020 <a href="https://www.nature.com/articles/s41591-020-0803-x">https://www.nature.com/articles/s41591-020-0803-x</a>).</p> <p>Suggest change “have been identified as obese based on their BMI measurement” to “ have on obesity based on their BMI”</p>
IND 2020-90 / IND 2020-91	n/a	Royal College of Physicians (RCP)	<p>All conversations about weight need to be sensitive and person-centred</p> <p>It is important that there is a discussion with the patient about reasons for referral and that this is documented. Referral may not be appropriate for all people with a BMI &gt; 27.5 or &gt; 30kg/m<sup>2</sup>, for instance, for people who have already achieved &gt;10% weight loss and are successfully sustaining this but are still in the above BMI category, onward referral may not be appropriate Whether referral is necessary or appropriate should not be made on grounds of simple measures such as age. It should be based on clinical judgement that should include assessment of the patients co-existing health conditions and their own needs and wishes.</p> <p>If someone is already attending weight management services and happy to continue to do so, that should be documented.</p> <p>If referral to weight management services is offered but the patient chooses not to accept this, this should be recorded in the notes.</p>
IND 2020-90 / IND 2020-91	n/a	Royal College of Physicians (RCP)	<p>All weight management services that patients are referred to should be evidence-based i.e. include diet, activity and behaviour change.</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	Royal College of Physicians (RCP)	We would like to see more than a requirement to make a referral but to follow up on progress, including whether the patient has actually attended weight management services. If they have then progress reports on their progress will presumably be shared with the referring agent.
IND 2020-90 / IND 2020-91	n/a	Royal College of Physicians (RCP)	There should be an additional focus on people with severe and complex obesity (In general BMI > 40 or > 35 with co-morbidity, and certainly for those with a BMI > 50kg/m <sup>2</sup> ). These people may benefit from referral to specialist (tier 3) weight management services (as per NICE guideline CG189) and this should be specified for this group.
IND 2020-90 / IND 2020-91	n/a	Royal College of Physicians (RCP)	We are pleased that the proposed QOF moves further than simply recording BMI status, to taking action based upon it but this should be nuanced depending on weight status.
IND 2020-90 / IND 2020-91	n/a	Slimming World	We welcome the proposal for these new QOF indicators to include obesity in adults. We feel it's a positive step to include a requirement for action to be taken on the basis of BMI status (not just recording of the BMI which has previously been the focus).
IND 2020-90 / IND 2020-91	n/a	Slimming World	We have an overall concern that there may be an incentive to refer a patient to a service but no emphasis on raising the issue sensitively, assessing patient motivation and discussing what service might be best for the individual patient. We'd suggest more emphasis be given to the appropriateness of referrals and ensuring 'quality' of the referral ie taking care to ensure patients are offered a service that suits their needs and is most likely to be engaged with.



ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	Slimming World	In response to the question asking if the proposed indicators will lead to improvements in care and outcomes for patients - Overall we feel yes, if patients are referred to programmes highlighted by NICE as evidence based, effective services. It's also key that services are available across all areas to allow GPs to refer to them. Currently there is a postcode lottery in terms of where services are commissioned. It's vital that all areas have access to services to refer to and to offer patients a choice to ensure they can select what will best suit them and their needs.
IND 2020-90 / IND 2020-91	n/a	South Sefton Clinical Commissioning Group	For patients who have non-diabetic hyperglycaemia and are obese referral to the NHS Healthier You programme, normal circumstances, should be performed within 12 months of a blood result in the eligible range.

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	The All-Party Parliamentary Group on Obesity	<p>The All-Party Parliamentary Group (APPG) on Obesity is a group of cross-Party members of the House of Commons and House of Lords working to improve the prevention and treatment of obesity.</p> <p>The APPG welcomes both proposals to increase the proportion of referrals to weight management services for obesity. These proposals will lead to improvements in care and outcomes for patients but only provided there are weight management services available to refer onto.</p> <p>In order for these proposals to be fully effective, the full range of digital and non-digital weight management options must be available in every area of the country. The APPG found in its 2018 inquiry that just 57% of CCGs commissioned Tier 3 services (multidisciplinary specialist weight management services in secondary care) and 73% commissioned Tier 4 services (bariatric surgery). These services must also be resourced effectively for example by ensuring there are enough bariatric surgeons to deliver the services, to ensure that any increases in demand for services can be accommodated.</p> <p>The APPG also found that 82% of local authorities commissioned Tier 2 services. Public Health England found in 2015 that for adults, respondents from 61% of local authorities reported providing or commissioning a Tier 2 service.</p> <p>If weight management services are not universally available to refer patients onto these indicators will have severely limited effectiveness. The current lack of weight management provision is a significant barrier to implementing the care described. This may cause frustration for patients who are not able to receive the treatment they need. Similarly, the lack of services to refer patients on to may cause GPs to avoid talking about weight with their patients entirely as they may feel unable to help.</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	The All-Party Parliamentary Group on Obesity	In order to relieve the pressure on GPs, wider staff in primary care including community pharmacists should be trained and utilised to refer patients to the range of available weight management services and deliver these services where required. Furthermore, considering the large numbers of patients with obesity for which the quality indicators will apply, the option of self-referral should be considered (but not the only option).
IND 2020-90 / IND 2020-91	n/a	The All-Party Parliamentary Group on Obesity	<p>These indicators should be expanded to cover increasing the proportion of referrals to weight management services and achieving clinically significant weight loss and/or improved quality of life. In other words, GPs should be incentivised to deliver improved outcomes for their patients rather than just increasing the number of referrals to weight management.</p> <p>In practice this could be structured as follows: GPs could be paid a proportion of the incentives when they refer a patient to a weight management service, and could receive the remainder of the incentives once the patient has achieved their goal in terms of reduced BMI/waist circumference or improved quality of life. Incentives could also be provided for timely referral i.e. if a patient is referred and attending the weight management service without delay.</p> <p>The amount of incentives received by GPs could also be structured so that GPs receive more reward for more successful outcomes. I.e. if a patient maintains weight loss over a period of 12 months, the GP will receive more than if the patient-maintained weight loss for only 3 months.</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	The All-Party Parliamentary Group on Obesity	<p>Indicators of obesity additional to BMI should be considered for use within clinical practice and appropriate tests for obesity such as body fat calculators could be considered where they have clinical value. Height and weight can be easily, cheaply and reliably measured in large numbers of people using simple equipment with minimal training, so BMI is a valuable measure for population surveillance.</p> <p>However, BMI does not distinguish between weight from fat and weight from muscle or bone which makes it less suitable for use at individual level. Other measures of obesity including waist circumference should be considered additionally to BMI as part of these indicators. For example, a person with a BMI of 31 or 32 with high muscle mass should not necessarily be told to lose weight.</p> <p>The Edmonton Obesity Staging System is a staging and prognostic tool for obesity which is based on BMI and the implementation of this system should be considered.</p> <p>GPs should also be encouraged to weigh children in pre-school years on a regular basis, for example every 6 months, and to discuss nutrition, mental health and concerns patients and families may have relating to their own or their child's weight.</p>

<p>IND 2020- 90 / IND 2020- 91</p>	<p>n/a</p>	<p>The Association for the Study of Obesity ASO (UK)</p>	<p>The Association for the Study of Obesity (ASO) welcomes the review and update to the NICE indicators on Obesity. We feel that the current NICE Indicators for obesity (listed immediately below) do NOT achieve their intended aim of leading to improvements in care and outcomes for patients living with this chronic relapsing progressive disease.</p> <p>Current NICE indicators:</p> <p>NM128 – the contractor established and maintains a register of patients aged 18 or over with a BMI <math>\geq 25</math> in the preceding 12 months</p> <p>And</p> <p>NM121 – the percentage of patients with coronary heart disease, stroke or TIA, diabetes, peripheral arterial disease, heart failure, COPD, asthma and/or rheumatoid arthritis who have had a BMI recorded in the preceding 12 months</p> <p>NM128 and NM121 merely incentivise primary care to record weight, without further assessment of associated medical conditions, or further management such as advice on leading a healthy lifestyle or referral into local weight management services. Furthermore, NM128 has encouraged primary care to bring in otherwise healthy individuals (i.e. those with Metabolically Healthy Overweight/Obesity, or MHO) just for a weight check when primary resources are already stretched.</p> <p>ASO believes that NICE should incentivise primary care to:</p> <ul style="list-style-type: none"> <li>• Identify those at an unhealthy weight (by clinical assessment, whether done by Body Mass Index (BMI), Waist Circumference (WC) or Bio-impedance) – in both adults and children</li> <li>• Start recording at least waist circumference in addition to BMI, and equivalent thresholds for increased and/or significant risk be included in the NICE Indicators whenever BMI is</li> <li>• Screen those patients at an unhealthy weight for common co-morbidities associated with weight, including (but not exclusively) hypertension, type 2 diabetes, dyslipidaemia, Non-Alcoholic Fatty Liver Disease (NAFLD) and hypothyroidism, by performing a Blood Pressure (BP) check and basic blood screening such as glycosylated haemoglobin (HbA1c) or Fasting blood Sugar (FBS) as appropriate, lipid profile, Liver Function Tests (LFTs) and Thyroid Function Tests (TFTs).</li> </ul>
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ID	Proforma question no.	Stakeholder organisation	Comment
			<ul style="list-style-type: none"> <li>• Give basic advice at the time of the consultation (“make every consultation count”) by given brief interventions and advice on achieving a healthier lifestyle</li> <li>• For those considered at risk, refer into local weight management services</li> </ul> <p>The above should be expected of, and delivered by, all General Practitioners and associated healthcare colleagues in a primary care setting that have consultations with the patients, including nurses, healthcare assistants etc, and also be extended to include those patients identified by other allied healthcare professionals, such as local pharmacists, social workers, health visitors, school nurses, and those working in the leisure services that may liaise with primary care.</p> <p>The lack of including the above points in the NICE Indicators on obesity will lead to barriers implementing adequate care for those patients living with Overweight/Obesity.</p> <p>Given the importance of Obesity as a disease, and the fact that it is such a high public health priority, being associated with an estimated 236 different conditions (Yuen MM et al, 2018) we would have expected more Indicators to have been dedicated to Obesity.</p>
IND 2020-90 / IND 2020-91	n/a	The Association for the Study of Obesity ASO (UK)	<p>People with overweight and obesity experience significant weight related stigma often from Health care professionals. It is therefore critical that all language in documents going forward uses a person first approach. For example a person with obesity not an obese person (see publication March 2020 <a href="https://www.nature.com/articles/s41591-020-0803-x">https://www.nature.com/articles/s41591-020-0803-x</a> and <a href="https://www.thelancet.com/journals/landia/article/PIIS2213-8587(20)30102-9/fulltext">https://www.thelancet.com/journals/landia/article/PIIS2213-8587(20)30102-9/fulltext</a> ).</p> <p>Suggest change “have been identified as obese based on their BMI measurement” to “have on obesity based on their BMI”</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90 / IND 2020-91	n/a	The Challenging Behaviour Foundation	It is known that obesity is a significant issue for many people with learning disabilities. When discussing known inequalities, the guidance needs to recognise this client group as particularly vulnerable to obesity. If digital and/ or non- digital weight management programmes are deemed appropriate for the individual, then they need to be delivered consistently and in conjunction with appropriate support from other services. Weight management plans should also be carefully discussed with family carers and all those who support the individual.
		<b>General comments IND 2020-90 Obesity: all patients</b>	
IND 2020-90	n/a	British Medical Association	We cannot support this indicator, as outlined in our general comments on obesity.
IND 2020-90	n/a	Individual 1	Referring to weight management services is overly simplistic if we want to properly address this problem and lower risks associated with obesity. Utilising health coaches, personalised health plans and addressing patient activation measures would offer a more productive solution to addressing this problem. PCNs would play a role in this. As a public health issue, an area-based approach would be more appropriate than GP practice-based approach

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90	n/a	Peninsula Cancer Alliance	Obesity is a significant risk factor for several cancers, and we support the intention to assist patients to lose weight. There is increasing concern that patients with a high BMI feel stigmatised by repeated focus on their weight in a GP consultation. There is also concern that offering patients intervention may be counterproductive if the support services around this are inadequate. For this reason, recommend 1. That the numerator should be those patients whose notes indicate that an offer of referral to weight management services has been made within 90 days of their BMI being recorded, and 2. That this indicator only be enacted if guidance and resource is at the same time provided to organisations commissioning weight loss services.
IND 2020-90	9 / 10	Pfizer	For the purposes of a performance measure, we see no reason why the indicator should include a reason to restrict by age or frailty; it should be a case by case clinical decision.
IND 2020-90	n/a	Rickleton Medical Centre	We feel that this proposed indicator may have quite a number of patients who fit this group and referrals could potentially overwhelm any existing service in the community
IND 2020-90	n/a	Rotherham Institute for Obesity (RIO)	RIO welcomes the focus on referral into weight management services and the fact that certain patients, e.g. BAME have the same risks at lower BMI but notes that this indicator will only incentivise the appropriate management of patients with significant risk (as determined by BMI) and does not help prevent obesity by appropriately managing those living with Overweight who are at risk of developing Obesity.
IND 2020-90	n/a	Rotherham Institute for Obesity (RIO)	By incentivising primary care to refer into local weight management services, this may encourage more commissioners to provide adequate local services.
IND 2020-90	n/a	Rotherham Institute for Obesity (RIO)	This proposed new Indicator does not incentivise the screening of these high-risk patients for any of the co-morbidities associated with obesity and also notes that this Indicator excludes patients under the age of 18 years.



ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90	n/a	Rotherham Institute for Obesity (RIO)	This Indicator suggests that the Quality Outcomes Framework (QOF) will be determined by the percentage of appropriate patients referred to weight management services, rather than offered referral. Can it be assumed that patients who decline the offer of referral are allowed to be excluded from QOF, otherwise GPs will be potentially penalised financially for patients who decline the referral.

<p>IND 2020- 90</p>	<p>9 / 10 / 11</p>	<p>Royal College of General Practitioners</p>	<p>Obesity: all patients</p> <ul style="list-style-type: none"> <li>· Can the committee consider rephrasing the indicator to add “appropriate” so it reads “to an appropriate weight management programme...”. For example, a patient with a BMI of 50 is likely to be inappropriate for digital weight management services and is better directed to a secondary care level 3 service, someone with an eating disorder may be more appropriately referred to an eating disorder service and for some, psychological/ CBT referral may be more appropriate. It is essential that clinicians are given the autonomy to choose the best treatment for their patients with them with a shared decision-making approach.</li> <li>· Can the committee consider rephrasing the indicator to “referral considered/ offered” rather than “referred” to take into account patient preferences and shared decision making to read: “...in the preceding 24 month who have been offered a referral to an appropriate weight management service”.</li> <li>· Weight management programme needs to be defined. Which services are “appropriate”?</li> </ul> <p>Question 9: We believe that exceptions should be based on patient choice or clinical indication and not related to age. The performance status of adults varies based on clinical presentation and is often not simply age related.</p> <ul style="list-style-type: none"> <li>· Weight management can be helpful in appropriately selected older adults (<a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5387759/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5387759/</a>)</li> </ul> <p>Question 10:</p> <ul style="list-style-type: none"> <li>· We are not aware of evidence that actively suggests this indicator should have exclusions based on patient frailty. However, the majority of trials of behavioural weight management programmes or intensive interventions have excluded the most frail patients (recent MI, CVA, active cancer treatment, etc).</li> <li>· There is some evidence that suggests that weight management can improve frailty (<a href="https://pubmed.ncbi.nlm.nih.gov/16636211/">https://pubmed.ncbi.nlm.nih.gov/16636211/</a>)</li> </ul> <p>Question 11:</p>
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ID	Proforma question no.	Stakeholder organisation	Comment
			<p>The timeline to reengage with patients is dependent on their wish and current interaction. If a patient is continuing to lose weight, then reengagement at 24 months would be inappropriate. For example, if their BMI started at 45 and is now 32, they would, according to the indicator require referral to a weight management programme, however a BMI of 32 in this instance would be a positive outcome for them. For this reason, the committee should consider adding “if appropriate” to the indicator. If a patient has not engaged with services and continues to have an elevated BMI, then 24 months is a reasonable timeline.</p>
IND 2020-90	n/a	Royal College of Paediatrics and Child Health	<p>These indicators sound relevant to adults and are not all appropriate (or are absent) for children. The reviewer would recommend including indicators based on NICE obesity guidelines including:</p> <ol style="list-style-type: none"> <li>1. Recognition of overweight/obesity – unless GPs have access to NCMP and Health visitor data, they should weigh children routinely and opportunistically, and certainly if there is a suspicion of overweight (which should be at least 15% of children, based on national data) – just as they would for adults.</li> <li>2. Overweight children should be assessed for possible causes and comorbidities as per NICE guidance – just as they would for adults.</li> <li>3. Such children/families should be referred to local weight management services where available or offered some form of follow up for their condition – just as they would for adults. (Given the other QOF indicators (largely for adults), it is hard to think of why childhood obesity would not be on this list.)</li> </ol>
IND 2020-90	n/a	Royal College of Paediatrics and Child Health	<p>The title is misleading as this indicator relates only to adult patients who are known to be obese. Perhaps at least change the title to “Obesity: all adult patients”</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90	n/a	Royal College of Paediatrics and Child Health	Clinical judgement should be used to exclude certain patients. However, this decision needs to be reviewed every few months. Every effort should be made to refer a patient to a suitable programme. For e.g. A patient with disability should be referred to an appropriate programme.
IND 2020-90	n/a	Slimming World	It doesn't feel clear in this document that it's important that the weight management services being referred to should be in line with the core components outlined in the NICE guideline PH53. We'd suggest this is specified to ensure that the services referred to are evidence based and effective.

IND 2020- 90	n/a	The Association for the Study of Obesity ASO (UK)	<p>IND 2020-90: the percentage of patients with a BMI<math>\geq</math>27.5 (or 30 if ethnicity is recorded as white) in the preceding 24 months who have been referred to a weight management programme within 90 days of the BMI being recorded</p> <p>ASO welcomes the focus on referral into weight management services, which may also drive commissioners to provide adequate local services as currently there is big variations in the provision of the different tiers of weight management nationally and equal provision of those services across all Tiers is required. ASO also welcomes the fact that certain patients, e.g. BAME have the same risks at lower BMI but notes that this indicator will only incentivise the appropriate management of patients with significant risk (as determined by BMI) and does not help prevent obesity by appropriately managing those living with Overweight who are at risk of developing Obesity. The time period of 24 months is preferable to a time period of 12 months, and patients with MHO that were previously just being called in specifically for a weight check will now at least be offered a referral to a weight management service. However, this time-frame has been chosen to align with other health promotion activities such as smoking cessation, rather than be aligned with NHS CVD health checks, which are offered to adults in England, aged 40-74 years, and every 5 years.</p> <p>ASO notes that this proposed new Indicator does not incentivise the screening of these high risk patients for any of the co-morbidities associated with obesity and also notes that this Indicator excludes patients under the age of 18 years.</p> <p>This Indicator suggests that the Quality Outcomes Framework (QOF) will be determined by the percentage of appropriate patients referred to weight management services, rather than offered referral. Can it be assumed that patients who decline the offer of referral are allowed to be excluded from QOF, or will GPs be potentially penalised financially for patients who decline the referral, as the British Medical Association (BMA) has previously and openly expressed concern about this.</p>
		<b>Question 9:</b> For the purposes of a performance measure, should the indicator	

ID	Proforma question no.	Stakeholder organisation	Comment
		include an upper age limit, or should clinical judgement be used to exclude certain patients? Are you aware of evidence or case studies that indicate an upper age limit should be applied to this indicator?	
IND 2020-90	9	Highcliffe Medical Centre	Not aware of any evidence/case studies which suggest an upper limit.
IND 2020-90	9	PC24 Social Enterprise	No cap to age, frailty should be factored in and appropriate interventions must be offered.
IND 2020-90	9	Rotherham Institute for Obesity (RIO)	Re Question 9) RIO does not believe there should be an upper age limit on this Indicator, and clinical judgement should be used to exclude certain patients. It would however be essential to offer the same facility to exclude patient from the QOF is not suitable clinically or otherwise (i.e. unable to easily be weighed and measured)
IND 2020-90	9	Royal College of Paediatrics and Child Health	There need not be an upper age limit for this indicator though it is important that clinical judgement be used to exclude certain patients. Weight management is extremely important for older adults, taking into consideration the typical fat re-distribution during aging and the co morbid conditions. Dangers and benefits of weight loss in this population is filled with challenges and implications. For instance, the dangers of sarcopenia, increased risk of hip fractures etc. Though BMI is the traditional metric used, is inexpensive and quick , it should also be kept in mind that the BMI is a sub optimal measure for obesity in older adults as it does not account for age related changes in adipose tissue specifically, the ratio between fat mass and fat free mass. In older individuals, in addition to BMI and weight, other anthropometric measures such as waist circumference and waist hip ratio, should be considered. NCBI – pmc (LE gill et al 2016).

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90	9	Slimming World	<p>In response to question 1, regarding an upper age limit, we feel there should not be an upper age limit and that clinical judgment should be used. Each patient should be assessed as an individual and a discussion had with them to see what's most appropriate for them. None of our current 65 weight management referral schemes across the UK impose an upper age limit. Some areas might target specific age groups as they've been identified locally as a key group for the intervention but no schemes set upper age limits at present.</p> <p>Looking at our attendance and outcome data, there is no suggestion that those in older age categories see poorer outcomes*. While further, more detailed, analysis looking at age specifically hasn't yet been presented in the public domain we do have this data available and would be willing to discuss if this would be useful.</p> <p>*Toon, J. et al. 2019. Levels of engagement: a predictor of long-term weight loss in over 1 million adults attending a community weight management programme. Obesity Facts, 12(suppl 1), p176)</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90	9	South Sefton Clinical Commissioning Group	<p>Question 9:</p> <p>There should be benefits at all ages but it is the co-morbidities which come with older age that need to be considered. Taking this into consideration clinical judgement should be used to exclude certain patients, age may be one of the criteria used but not the only one. The older patient might not be able to access a digital service and there may be other issues making it difficult for patients to access community services in certain areas</p> <p>For the very elderly the prevention of sarcopenia, which is important at all ages, becomes more important to reduce the risk of falls. The available evidence to prevent sarcopenia concentrates on exercise but there is also mention of healthy eating.</p>
IND 2020-90	9	SweatCo Ltd	<p>For the purposes of a performance measure, should the indicator include an upper age limit, or should clinical judgement be used to exclude certain patients? Are you aware of evidence or case studies that indicate an upper age limit should be applied to this indicator?</p> <p>This may be the case with “one size fits all” programmes. The argument for the use of programmes such as SweatCo’s is to achieve the required sustained improvement in fitness levels across all demographic and social-economic groups. Hence the customised nature of the offering to develop fitness programmes and incentives that are customised and targeted on specific populations to suite age and frailty. To date there have been no such age limit restrictions nor should they be required. See below in the response to question 12, re the demographics of the Diabetic fitness trial in SW London which was able to embrace all demographics.</p>



ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90	9	The Association for the Study of Obesity ASO (UK)	ASO does not believe there should be an upper age limit on this Indicator, and clinical judgement should be used to exclude certain patients. Any patient who is even 1 day older than any arbitrary upper age limit should not be excluded from being offered the same level of care and would be discriminatory by definition. However, clinical judgement is needed to assess whether a patient is appropriate for a weight management programme, not to mention the lack of evidence to suggest that weight loss in the elderly is as beneficial as in the young (ie the "obesity paradox"). It would however be essential to offer the same facility to exclude patient from the QOF is not suitable clinically or otherwise (ie unable to easily be weighed and measured).
		<b>Question 10:</b> Are you aware of evidence or case studies that indicate that this indicator should have exclusions based on patient frailty?	
IND 2020-90	10	Highcliffe Medical Centre	Not aware of any evidence/case studies which suggest an upper limit.
IND 2020-90	10	PC24 Social Enterprise	No.
IND 2020-90	10	Rotherham Institute for Obesity (RIO)	Re Question 10) RIO believes that patient frailty may become an issue in terms of being able to weigh and measure appropriately, but also in terms of how the patient may cope with attending a weight management programme. Providing that the facility to exclude unsuitable patients still existed this could be managed on an individual basis.

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90	10	Royal College of Paediatrics and Child Health	<p>While uncertainties about obesity reduction in later life continues to hamper intervention, the fact is that obesity has become a significant concern in this population. The study of geriatric obesity and its management is a relatively new area of research especially pertaining to those who are seriously ill, those residing in long term care facilities, those with complex and physical health concerns. Frailty in the elderly also poses difficulty in obtaining accurate weight and height.</p> <p>Challenges in the management of geriatric obesity in high risk population. Kathryn N. Porter Starr et al NCBI, NIH, May 2016</p>
IND 2020-90	10	South Sefton Clinical Commissioning Group	<p>Question 10:</p> <p>I cannot recall evidence or case studies regarding exclusions based on patient frailty. There has been concern that patient frailty may be made worse as a result of weight reduction on its own without any advice on how to protect muscle mass to reduce the risk of falls and fractures.</p>
IND 2020-90	10	SweatCo Ltd	<p>Are you aware of evidence or case studies that indicate that this indicator should have exclusions based on patient frailty?</p> <p>As above; with the inherent customisability of programmes and campaigns, allowed through the digital app based on the “irrational economic theories”, such as SweatCo’s , frailty can be taken into account.</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90	10	The Association for the Study of Obesity ASO (UK)	<p>ASO believes that patient frailty may become an issue in terms of being able to weigh and measure appropriately, but also in terms of how the patient may cope with attending a weight management programme. Providing that the facility to exclude unsuitable patients still existed this could be managed on an individual basis, especially that some evidence suggest that lifestyle interventions could improve frailty</p> <p>(<a href="https://pubmed.ncbi.nlm.nih.gov/16636211/">https://pubmed.ncbi.nlm.nih.gov/16636211/</a> and <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2650077/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2650077/</a> and <a href="https://bmjgeriatr.biomedcentral.com/articles/10.1186/s12877-019-1196-x">https://bmjgeriatr.biomedcentral.com/articles/10.1186/s12877-019-1196-x</a> and <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4023554/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4023554/</a>)</p>
		<b>Question 11:</b> Is 24 months an appropriate timeframe for the repetition referral to a weight management programme?	
IND 2020-90	11	Highcliffe Medical Centre	Yes, we feel this is appropriate.
IND 2020-90	11	Obesity Group of the British Dietetic Association	We agree that 24 months is a pragmatic timeframe.
IND 2020-90	11	PC24 Social Enterprise	24M interval to re-refer to weight management seems reasonable but I would advise a pre referral screen/assessment where by an individual's position with regards to their ability to make change is undertaken. Patients who are pre-contemplation should perhaps be referred to a different intervention and patients in contemplation or change phase of behaviour change should be referred to a good (based on outcome measures) weight management programme

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90	11	Rotherham Institute for Obesity (RIO)	Re Question 11) The time period of 24 months is preferable to a time period of 12 months. However, this time-frame has been chosen to align with other health promotion activities such as smoking cessation, rather than be aligned with NHS CVD health checks, which are offered to adults in England, aged 40-74 years, and every 5 years.
IND 2020-90	11	Royal College of Paediatrics and Child Health	“In the preceding 24 months who have been referred to a weight management programme within 90 days of the BMI being recorded.” - 12 months would be preferable.
IND 2020-90	11	Royal College of Paediatrics and Child Health	24 months would be acceptable timeframe for the repetition referral to a weight management programme, even 18 months.
IND 2020-90	11	Royal College of Physicians (RCP)	We agree that 24 months is a reasonable timeframe for re-referral to a weight management programme

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90	11	Slimming World	<p>In response to question 3, as to an appropriate timeframe for the repetition of referral to a weight management programme, we'd suggest this is judged on an individual basis (as some may benefit from a re-referral in a shorter timeframe) and also that there is consideration given to offering a repeat referral/continuation straight after the original referral has been completed.</p> <p>Some patients may, for example, have been referred to a programme for an initial 12 weeks and be making good progress towards their weight loss goals but would benefit from a further referral to allow them to continue with the progress being made towards a healthier BMI.</p> <p>This also needs to be considered for those patients with higher starting BMIs i.e. those patients with BMIs over 35/40kg/m<sup>2</sup> as they may benefit from a longer duration of support as their journey to reach a healthier BMI will take more time.</p> <p>It's also worth noting that there is often a preconception that for those people with higher BMIs &gt;35/40 kg/m<sup>2</sup> a community weight management service may not be the right course of action. It's reassuring to see that there is no upper BMI limit being imposed here. Our data* has repeatedly highlighted that Slimming World's programme is as effective for people with high BMIs (who might usually be seen as candidates for bariatric surgery) as well as those who are moderately overweight.</p> <p>*Toon, J. et al. 2019. Weight outcomes, by baseline BMI category, in patients referred to a commercial weight management programme. <i>Endocrine Abstracts</i>, doi: 10.1530/endoabs.61.CD1.3</p> <p>Toon, J. et al. 2019. Longer term weight outcomes following a 12-week referral to a multi-component lifestyle weight management programme across high BMI patients. <i>Obesity Facts</i>, 12(suppl 1), p177</p>

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-90	11	South Sefton Clinical Commissioning Group	Question 11:  24 months is probably an appropriate timeframe for the repetition of referral of patients who continue to meet the criteria for referral
IND 2020-90	11	SweatCo Ltd	Is 24 months an appropriate timeframe for the repetition referral to a weight management programme? Weight and diabetes management programmes would be considered as lifetime challenges that need continuous reinforcement. The key measure of successful programmes, is sustainability. In the past didactic programmes and media campaigns have been seen to have very poor sustainability. In Canada, compliance and engagement with fitness programmes, based on “irrational economic theory” behavioural modification, have independent published evidence of less than 27% attrition after 18 months compared to 90% for traditional education and media programmes. It should be noted that sustainability after the gains are achieved is the vital measure. thus the QOF should where possible continue to reward and incentivise sustainability.
IND 2020-90	11	The Association for the Study of Obesity ASO (UK)	As mentioned previously, a time-frame of 24 months for this Indicator is preferable to 12 months, but it could be argued that those at higher risk of the health consequences of obesity will be picked up by the other proposed Indicator (IND 2020-91) or at other long term condition monitoring, and so those patients with MHO may only require mandatory weighing and measuring every 3-5 years (to align more closely with public health activities like NHS CVD risk assessments) as those motivated for weight loss will still be able to present to primary care at any intervening period. Given the stretched time and resources in primary care, there is an argument for the longer time period.
		<b>General comments IND 2020-91 Obesity: patients with hypertension or diabetes</b>	

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-91	n/a	British Medical Association	We cannot support this indicator, as outlined in our general comments on obesity.
IND 2020-91	n/a	Obesity Group of the British Dietetic Association	We agree that 12 months is a reasonable timeframe given the additional health risks faced by this group and the need for timely action.
IND 2020-91	12 / 13	PC24 Social Enterprise	Not aware.
IND 2020-91	12 / 13	Rickleton Medical Centre	We feel this indicator does not need an upper age limit and should be based on clinical judgment. We are not aware of any case studies or evidence that there should be exclusions based on frailty
IND 2020-91	n/a	Rotherham Institute for Obesity (RIO)	RIO welcomes the focus on referral into weight management services the fact that certain patients, e.g. BAME have the same risks at lower BMI but notes that this indicator will only incentivise the appropriate management of patients with significant risk (as determined by BMI) and does not help prevent obesity by appropriately managing those living with Overweight who are at risk of developing Obesity. The time period of 12 months is understandable given that this cohort of patients with these co-morbidities should be being seen every year for a medication review. However, in reality, patients do not always come in to primary care when they are due, so some leeway needs to be given with regards to any annual review, and so a time-scale of 18 months is preferable, and more realistic.
IND 2020-91	n/a	Rotherham Institute for Obesity (RIO)	RIO notes that this proposed new Indicator does not incentivise the screening of these high-risk patients for any of the other co-morbidities associated with obesity but assumes that this should be picked up in their annual chronic disease management.

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-91	n/a	Rotherham Institute for Obesity (RIO)	This Indicator suggests that the Quality Outcomes Framework (QOF) will be determined by the percentage of appropriate patients referred to weight management services, rather than offered referral. Can it be assumed that patients who decline the offer of referral are allowed to be excluded from QOF, otherwise GPs will be potentially penalised financially for patients who decline the referral.
IND 2020-91	12 / 13	Royal College of General Practitioners	<p>Obesity: patients with hypertension or diabetes</p> <p>Question 12: We believe that exceptions should be based on patient choice or clinical indication and not related to age. The performance status of adults varies based on clinical presentation and is often not simply age related.</p> <ul style="list-style-type: none"> <li>· Weight management can be helpful in appropriately selected older adults (<a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5387759/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5387759/</a>)</li> </ul> <p>Question 13: · We are not aware of evidence that actively suggests this indicator should have exclusions based on patient frailty. However, the majority of trials of behavioural weight management programmes or intensive interventions have excluded the most frail patients (recent MI, CVA, active cancer treatment, etc).</p> <ul style="list-style-type: none"> <li>· There is some evidence that suggests that weight management can improve frailty (<a href="https://pubmed.ncbi.nlm.nih.gov/16636211/">https://pubmed.ncbi.nlm.nih.gov/16636211/</a>)</li> <li>· There is a potential risk of sarcopenia in frail patients, and increased risk of hypoglycaemia with dietary changes if medication not reduced so clinical judgement and patient choice should be used as the exclusion criteria rather than frailty.</li> </ul>
IND 2020-91	n/a	Royal College of Physicians (RCP)	We are pleased to see lower BMI cut-off points proposed for groups other than Caucasians, in light of their increased health risks at lower BMI cut-off points.



ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-91	n/a	The Association for the Study of Obesity ASO (UK)	<p>IND 2020-91: The percentage of patients with hypertension or diabetes and a BMI<math>\geq</math>27 (or <math>\geq</math>30 if ethnicity is recorded as white) in the preceding 12 months who have been referred to a weight management programme within 90 days of the BMI being recorded.</p> <p>ASO welcomes the focus on referral into weight management services (which may also drive commissioners to provide adequate local services) and the fact that certain patients, e.g. BAME have the same risks at lower BMI but notes that this indicator will only incentivise the appropriate management of patients with significant risk (as determined by BMI) and does not help prevent obesity by appropriately managing those living with Overweight who are at risk of developing Obesity. The time period of 12 months is understandable given that this cohort of patients with these co-morbidities should be being seen every year for a medication review. However, in reality, patients do not always come in to primary care when they are due, so some leeway needs to be given with regards to any annual review, and so a time-scale of 18 months is preferable, and more realistic.</p> <p>ASO notes that this proposed new Indicator does not incentivise the screening of these high-risk patients for any of the other co-morbidities associated with obesity but assumes that this should be picked up in their annual chronic disease management. ASO also notes that this Indicator excludes patients under the age of 18 years.</p> <p>This Indicator suggests that the Quality Outcomes Framework (QOF) will be determined by the percentage of appropriate patients referred to weight management services, rather than offered referral. Can it be assumed that patients who decline the offer of referral are allowed to be excluded from QOF, or will GPs be potentially penalised financially for patients who decline the referral, as the British Medical Association (BMA) has previously and openly expressed concern about this.</p>

ID	Proforma question no.	Stakeholder organisation	Comment
		<p><b>Question 12:</b> For the purposes of a performance measure, should the indicator include an upper age limit, or should clinical judgement be used to exclude certain patients? Are you aware of evidence or case studies that indicate an upper age limit should be applied to this indicator?</p>	
IND 2020-91	12	Highcliffe Medical Centre	Not aware of any evidence/case studies which suggest an upper limit.
IND 2020-91	12	Rotherham Institute for Obesity (RIO)	Re Question 12) RIO does not believe there should be an upper age limit on this Indicator, and clinical judgement should be used to exclude certain patients. It would however be essential to offer the same facility to exclude patient from the QOF is not suitable clinically or otherwise (i.e. unable to easily be weighed and measured)
IND 2020-91	12	Slimming World	As referred to above, in response to question 4, regarding an upper age limit, we feel there should not be an upper age limit and that clinical judgment should absolutely be used. Each patient should be assessed as an individual and a discussion had with them to see what's most appropriate for them.

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-91	12	South Sefton Clinical Commissioning Group	<p>Question 12:</p> <p>There should be benefits at all ages but it is the co-morbidities which come with older age that need to be considered. Taking this into consideration clinical judgement should be used to exclude certain patients, age may be one of the criteria used but not the only one. The older patient might not be able to access a digital service and there may be other issues making it difficult for patients to access community services in certain areas</p> <p>For the very elderly the prevention of sarcopenia, which is important at all ages, becomes more important to reduce the risk of falls. The available evidence to prevent sarcopenia concentrates on exercise but there is also mention of healthy eating.</p>

<p>IND 2020- 91</p>	<p>12</p>	<p>SweatCo Ltd</p>	<p>For the purposes of a performance measure, should the indicator include an upper age limit, or should clinical judgement be used to exclude certain patients? Are you aware of evidence or case studies that indicate an upper age limit should be applied to this indicator?</p> <p>As mentioned above the underlying principles of behavioural modification solutions, such as Sweatco's is to harness and customise "gamification" (nudge) and "irrational economic" theories to engage the full spectrum of the target cohorts and reflect the range of individuals to drive, monitor and sustain behaviour change.,</p> <p>Importantly SweatCo recently completed a pilot to address obesity and fitness of diabetic patients. It was undertaken initially in South West London with a grant from the Health Innovation Network AHSN. The SweatCo approach replaced the traditional NHS Diabetes Programme (NDPP), which is a didactic education programme, offered over a period of nine months. The Sweatcoin results are stunning in comparison to NDPP, both in their immediate and more importantly, sustained improvements, including compliance and weight loss. The pilot was written up in the Digital Health Blog by the projects lead and reported in the Sunday Times.</p> <p>In summary the benefits have been:</p> <ul style="list-style-type: none"> <li>- Average 1.1kg weight loss per participant on the relatively short life of the pilot programme (10 weeks)</li> <li>- 35%+ change in step count</li> <li>- 87% programme completion (retention) rate, compared to 25% for the NDPP</li> <li>- 9.4/10 average customer satisfaction score</li> </ul> <p>The pilot was about to be extended to a larger cohort when the corona virus struck. It should be noted that the demographics of the initial pilot group are predominantly elderly including patients 85+ which are recognised as the most challenging group to engage in exercise and the dietary modification required to achieve sustained behavioural change.</p>
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ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-91	12	The Association for the Study of Obesity ASO (UK)	ASO does not believe there should be an upper age limit on this Indicator, and clinical judgement should be used to exclude certain patients. Any patient who is even 1 day older than any arbitrary upper age limit should not be excluded from being offered the same level of care and would be discriminatory by definition. However, clinical judgement is needed to assess whether a patient is appropriate for a weight management programme, not to mention the lack of evidence to suggest that weight loss in the elderly is as beneficial as in the young (ie the “obesity paradox”). It would however be essential to offer the same facility to exclude patient from the QOF is not suitable clinically or otherwise (ie unable to easily be weighed and measured).
		<b>Question 13:</b> Are you aware of evidence or case studies that indicate that this indicator should have exclusions based on patient frailty?	
IND 2020-91	13	Highcliffe Medical Centre	Not aware of any evidence/case studies which suggest an upper limit.
IND 2020-91	13	Rotherham Institute for Obesity (RIO)	Re Question 13) RIO believes that patient frailty may become an issue in terms of being able to weigh and measure appropriately, but also in terms of how the patient may cope with attending a weight management programme. Providing that the facility to exclude unsuitable patients still existed this could be managed on an individual basis.
IND 2020-91	13	South Sefton Clinical Commissioning Group	Question 13:  I cannot recall evidence or case studies regarding exclusions based on patient frailty. There has been concern that patient frailty may be made worse as a result of weight reduction on its own without any advice on how to protect muscle mass to reduce the risk of falls and fractures.

ID	Proforma question no.	Stakeholder organisation	Comment
IND 2020-91	13	SweatCo Ltd	<p>Are you aware of evidence or case studies that indicate that this indicator should have exclusions based on patient frailty?</p> <p>This question assumes that solutions are based on a “one size fits all” solution.</p> <p>One of the philosophes underpinning nudge and irrational economic theories, and behind these more recent digital app. solutions, is its ability to address a wide range of demographic, ethnic and behavioural health challenges.</p> <p>As an example, obese Hypertension Patients would become a separately targeted group with specific customisation to address the cohort’s clinical requirements, frailty, and the local health determinants, ethnicity and socio-economic issues.</p>
IND 2020-91	13	The Association for the Study of Obesity ASO (UK)	<p>ASO believes that patient frailty may become an issue in terms of being able to weigh and measure appropriately, but also in terms of how the patient may cope with attending a weight management programme. Providing that the facility to exclude unsuitable patients still existed this could be managed on an individual basis, especially that some evidence suggest that lifestyle interventions could improve frailty</p> <p>(<a href="https://pubmed.ncbi.nlm.nih.gov/16636211/">https://pubmed.ncbi.nlm.nih.gov/16636211/</a> and <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2650077/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2650077/</a> and <a href="https://bmcgeriatr.biomedcentral.com/articles/10.1186/s12877-019-1196-x">https://bmcgeriatr.biomedcentral.com/articles/10.1186/s12877-019-1196-x</a> and <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4023554/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4023554/</a>)</p>

