NHS Croydon

ADULT WEIGHT MANAGEMENT SERVICES IN CROYDON

NEEDS ASSESSMENT AND SERVICE REVIEW 2010

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SEPTEMBER 2010

Adult Weight Management Services Needs Assessment and Service Review 2010

Executive Summary

This report was written in response to the JSNA recommendation that there should be a needs assessment for and service review of adult weight management services in Croydon.

The key findings were:

- In December 2009, GP data indicated that 19% of men and 24% of women aged 16 or over in Croydon were classified as obese (around 59,000 people), and 57% of men and 53% of women were overweight including obese (over 150,000 individuals). However, GP recording of BMI data is patchy and so these figures may over, or (more likely) underestimate the numbers of people who could benefit from a structured portfolio of weight management services.

- Data from the HSE 2006 suggest that over 63,000 people over the age of 16 living in Croydon will be obese (a higher estimate than QOF data), and that more than 95,000 will have a raised waist circumference, which puts them at high risk of developing health problems such as coronary heart disease and diabetes.

- GP data from March 2010 suggest that there are around 10,500 people whose BMI status meets the NICE criteria for bariatric surgery.

- In the Foresight paper modelling future trends in obesity, extrapolations indicate that on current trends, by 2015, 36% of males and 28% of females will be obese. For Croydon this means 49,000 obese males and 41,000 obese females, an increase of 30,000 individuals in less than 5 years, and reversing the present situation where obesity is more common in women than in men. It is also estimated that, by 2025, 47% (68,000) of men and 36% (56,000) of women will be obese.

- The distribution of obesity is not consistent across all sections of the Croydon population:
    - at all ages, more women than men are obese
    - the peak prevalence of obesity is seen in middle to early old age (40-74 years)
    - there is a strong association between socio-economic deprivation and a high prevalence of obesity
    - the prevalence is obesity is highest amongst the black and mixed white/black ethnic groups
    - both people with learning disability and those with severe mental illness are much more likely than the general population to be overweight or obese, particularly women.

- Most of the current weight management service provision funded by NHS Croydon is delivered as part of a wider service funded through generic SLAs. This is particularly true of the Dietetics service, which is fragmented across a number of providers. There are few discretely funded services. There is a general lack of outcome data, and the evidence base for some services is uncertain. Services have not been developed in a systematic or strategic way.

- Current service provision is not entirely consistent with the tiers of need referred to in the NICE clinical guideline, with a major gap in Tier 3, which in turn has implications for access to services in Tier 4.

- Well designed and evidence-based interventions are likely to be applicable to most population groups, but there is also benefit in targeting high risk groups who show a greater prevalence of obesity. Multi-component services should be delivered by a multi-disciplinary workforce working to integrated care pathways. Robust monitoring and evaluation strategies should be in place to enable continuous improvement to take place and ensure a cost effective service.

- Currently, NHS Croydon invests relatively less resource in adult weight management services than other PCTs for whom data have been collected. Some existing services may need to be re-designed or de-commissioned in order to prioritise the resource currently available. At present, services do not necessarily meet the needs of the groups at highest risk from becoming obese, and/or of the adverse consequences of obesity.

- In the medium term, further investment in adult weight management services is recommended. As the programme budgeting approach becomes established, there may be opportunities for releasing resource from other programme groups, for which the prevention and effective management of obesity are important strategies in reducing demand for services. These groups could include the cancer, cardiovascular, genitourinary, and endocrine groups.

Why Obesity Matters

Obesity is a complex, multi-factorial condition and one of the biggest health challenges that we face. It is the second most common preventable cause of death after smoking. Obesity is responsible for more than 9,000 premature deaths per year in England and is a key risk factor for many chronic diseases including heart disease, hypertension, stroke, and some cancers. Estimates suggest that more than 850 deaths amongst Croydon residents in the five years 2004-2008 will have been due to obesity. It is a major cause of the rising prevalence of type 2 diabetes, and the psychological and social burden of obesity can be significant. Social stigma, low self-esteem and a generally poorer quality of life are common experiences for many overweight and obese people.

The Health Survey for England (HSE) data from 2008 indicated that in adults (16+ years) 67% of men and 60% of women are overweight or obese. Worryingly, the same tendency is also true for children: just under a third of boys (31%) and girls (29%) in England aged 2 to 15 years were either overweight or obese. It has been forecast that by 2050, if no action is taken, almost 90% of adults and 66% of children will be overweight or obese.

It has been estimated that the cost of obesity to the NHS is approximately £4.2 billion per year. The Foresight report (2007) estimated that weight problems already cost the wider economy in the region of £16 billion per year, and that this will rise to £50 billion per year by 2050 if left unchallenged.

The Foresight report suggests that to seriously change the current forecasts will require radical, far reaching and long term strategies. The Government has responded by publishing Healthy Weight, Healthy Lives: A cross government strategy (2008) that, amongst other recommendations, aims to support the Public Service Agreement target 'to not only stop the rise in the numbers of children who are overweight or obese but reverse it back to 2000 levels by 2020, as part of a wider strategy to reduce obesity in the population as a whole'.

Strategic Context

Tackling the obesity epidemic is a strategic priority in Croydon. A strategic framework for a local response to Healthy Weight, Healthy Lives was approved by the council cabinet and PCT board in October 2009. The local strategic objective is to reverse the rising trend of overweight and obesity in Croydon by:

- Creating an environment that enables people to make healthier lifestyle choices, for example, walking more, eating more fruit and vegetables;
- Ensuring that people who need support to enable them to achieve and maintain a healthy weight have fair access to appropriate and personalised services.

This document responds to and builds on the *Healthy Weight, Healthy Lives* Joint Strategic Needs Assessment which was completed in December 2009. A specific recommendation to come out of that report was that there should be a needs assessment for and service review of adult weight management services in Croydon.

Data Sources

Health Survey for England
The Health Survey for England (HSE) is an annual survey undertaken since 1991. The HSE is currently commissioned by the Information Centre (and before 2005 was commissioned by the Department of Health) to monitor the health of the population. This is currently the most robust data source to monitor trends in adult obesity in England.

Model Based Estimates using Health Survey for England
Modelled (synthetic) estimates of lifestyle behaviours include estimates of prevalence of obesity among adults. These estimates are based on HSE, Census and other data. Estimates are available at local authority, primary care organisation (PCO) and middle super output area level (MSOA). It is important to note that these estimates are modelled and published as 'experimental data' and should be used and interpreted with caution.

Quality and Outcomes Framework
The Quality and Outcomes Framework (QOF) clinical register on obesity was started in 2006/7 and is based on patients aged 16 and over with a BMI greater or equal to 30 kg/m2. Current prevalence figures are unadjusted, subject to practice compliance and do not capture non-registered or non-attending patients.

In Croydon 24.6% of patients registered with a Croydon General Practice do not have a BMI recorded. 39.4% of patients have had their BMI recorded in the last 15 months, and 9.7% of patients had their BMI recorded over 5 years ago.

Patient Surveys
Croydon patient survey is an annual survey of 10% of Croydon patients and is administered by post. It began in 2002, and the response rate was 36% in 2008. The self-reported survey is a source of lifestyle data, including weight and height data for calculation of Body Mass Index. This data needs to be used with caution, as studies have found that self-reports underestimate weight and overestimate height, resulting in lower estimates of the prevalence of obesity, compared with estimates based on measured data (Gorter et al. 2007).

Measurement of Obesity

Body Mass Index and weight classifications in adults
Body Mass Index (BMI) is a measure of weight status. BMI is a person's weight in kilograms divided by the square of their height in metres. The following cut-offs are used to classify adults:

BMI range (kg/m^2)	Classification
Less than 18.5	Underweight
18.4-24.9	Healthy weight
25.0-29.9	Overweight
30.0-39.9	Obese
Greater than or equal to 40	Morbidly obese

Table 1: World Health Organisation and NICE BMI classification system for adults

BMI is the most widely used approach in the UK, but it is important to note that it is not a direct measure of body fat mass or distribution, and BMI measures may be skewed by high muscle mass. The relationship between BMI and health also varies with ethnicity.

Waist circumference
The circumference of the waist is sometimes used as a simple measure of body fatness, though it can be subject to measurement error. Adult waist circumference cut-off points are:

- Increased risk of health problems: Men≥ 94cm; Women ≥ 80cm
- Greatly increased risk of health problems: Men ≥ 102cm; Women ≥ 88cm

Definitions

In this document the definition of 'overweight' does not include obese. The definition 'obese' includes 'morbidly obese'.

An adult is classed as aged 16+ years.

Adult Obesity in Croydon

HSE data for 2007 estimate that 24% of men and women (aged 16 years and over) are obese, though QOF data from General Practices show that the percentage of adults in Croydon who are obese is lower than this (Table 2).

	Weight Classification (%)				
	Underweight	**Healthy Weight**	**Overweight**	**Obese**	**Morbid Obesity**
Female	3.8	42.5	29.3	20.9	3.5
Male	3.2	39.9	37.8	17.5	1.6

Table 2: Percentage of patients with category of BMI ever recorded, ages 16 and over
Source: Data from Croydon General Practice (31st December 2009)

In December 2009, GP data indicated that more than 59,000 people aged 16+ years had a recorded BMI of over 30 kg/m^2. Overall, approximately 57% of men and 53% of women have a BMI of more than 25 kg/m^2. This equates to over 150,000 individuals. While men are much more likely than women to be overweight, morbid obesity is twice as common amongst women than men.

Data from the HSE 2006 suggest that over 63,000 people over the age of 16 living in Croydon will be obese (a higher estimate than QOF data), and that more than 95,000 will have a raised waist circumference, which puts them at high risk of developing health problems such as coronary heart disease and diabetes.

Trends

Figure 1 shows the changing prevalence of overweight and obesity in adults from Croydon's Patient Surveys. Although the data from the Patient Survey are less robust than GP data, because they rely on respondents providing an accurate BMI, they have been collected since 2002 and therefore provide an indication of local trends. These show a rise in the prevalence of obesity from 13.5% in 2002 to 17.1% in 2008, while the prevalence of overweight remained broadly stable between 2002-2008, at around 31-32%.

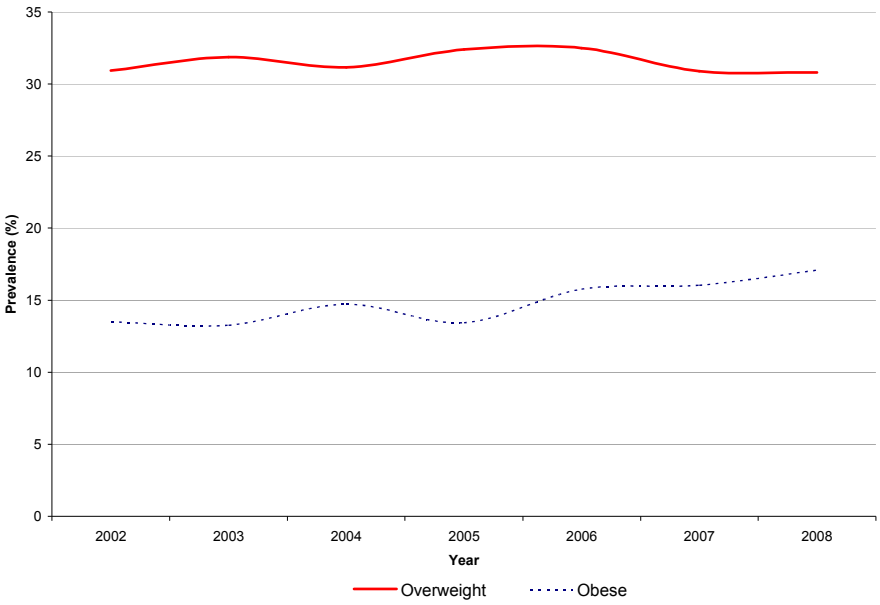

Figure 1: Prevalence of overweight and obesity among adults (aged 16 and over)
Source: Croydon Patient Surveys (2002-2008)

Obesity Prevalence by Age and Sex

At all ages, more women than men are obese or morbidly obese (Figure 2).

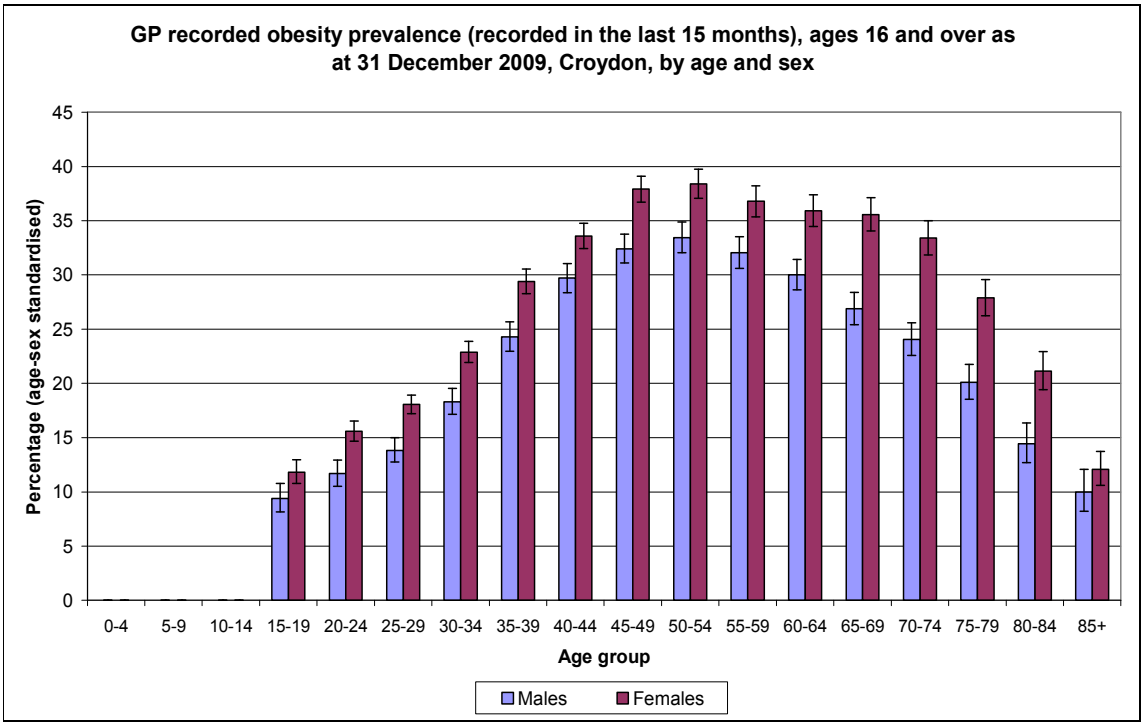

Figure 2: Prevalence of Obesity among Adults in Croydon, by age and sex
Source: General Practice Data 2009

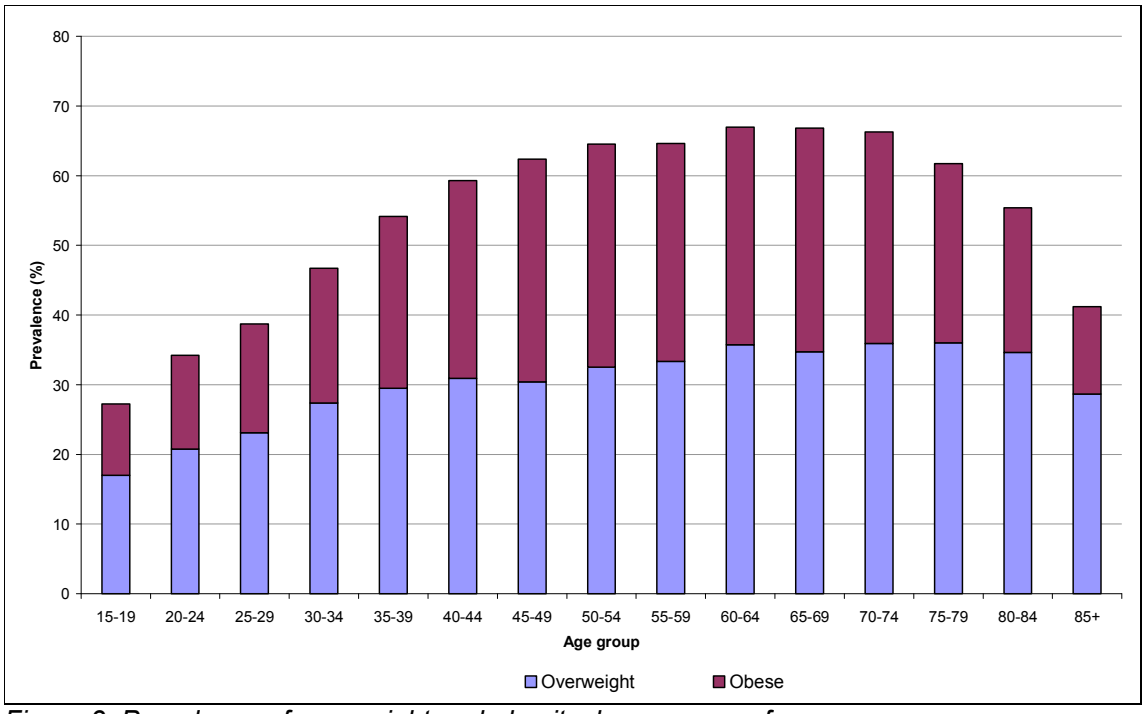

Figure 3: Prevalence of overweight and obesity, by age group for women
Source: Data from Croydon General Practice 2009 (BMI ever recorded)

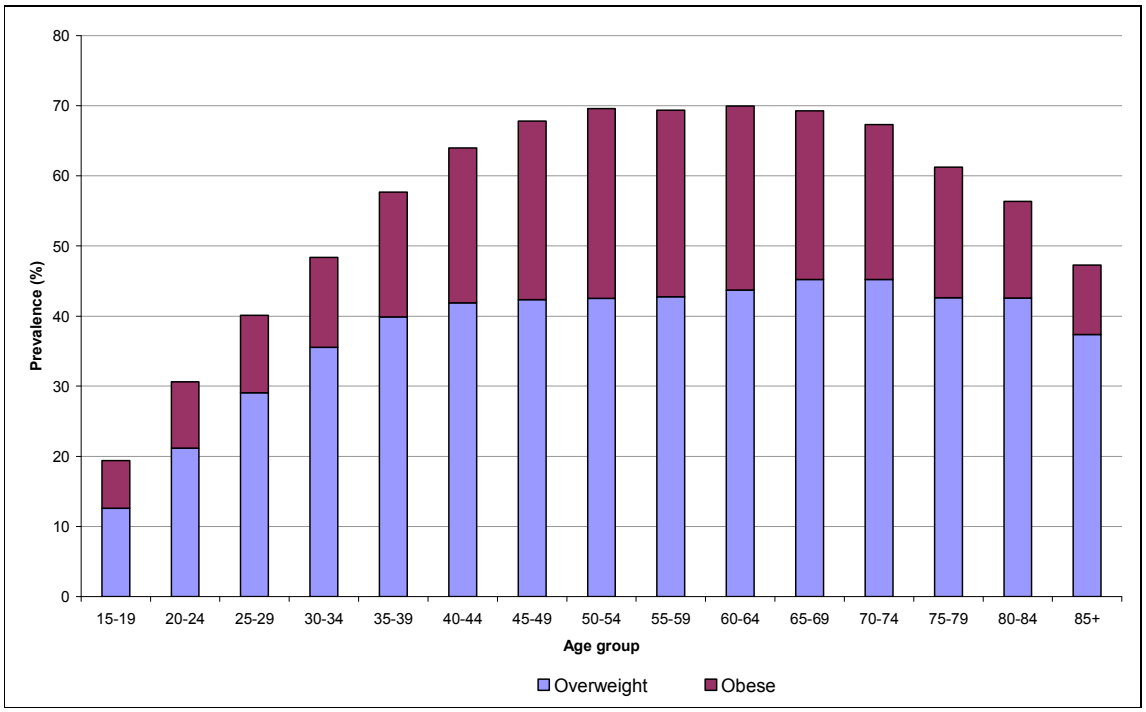

Figure 4: Prevalence of overweight and obesity, by age group for men
Source: Data from Croydon General Practice 2009 (BMI ever recorded)

Amongst women, the peak prevalence of obesity is seen in middle age, after which it declines slowly until early old age. In men the peak prevalence also occurs in middle age, but the decline is much steeper, with the prevalence gap between men and women continuing to widen until age 75. By the age of 85+, the gap between men and women returns to that seen at age 15-19.

From their early twenties, men are more likely to be overweight but less likely to be obese than women. From middle age onwards the prevalence of overweight remains relatively constant for both sexes.

Obesity and Socio-economic Deprivation

High rates of obesity and overweight in adults are unequally distributed across Croydon (Figure 5).

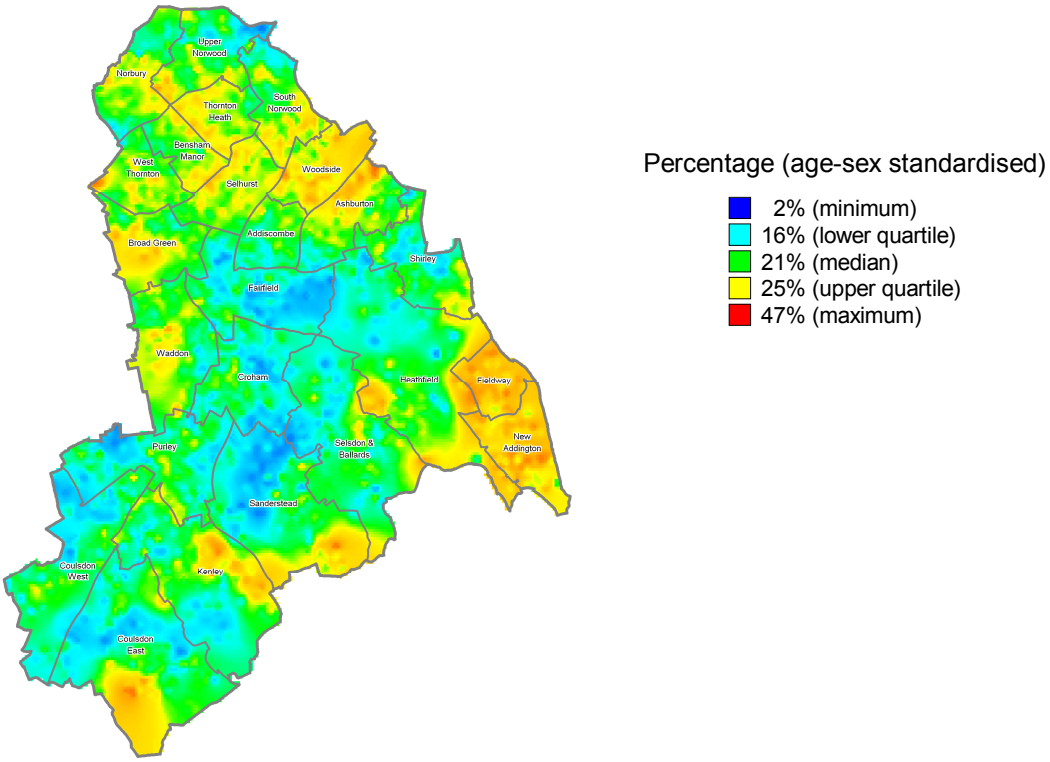

Figure 5: Prevalence of obesity in adults by Super Output Area (Croydon GP data 2009)
Source: Data from Croydon General Practice 2009 (BMI ever recorded)

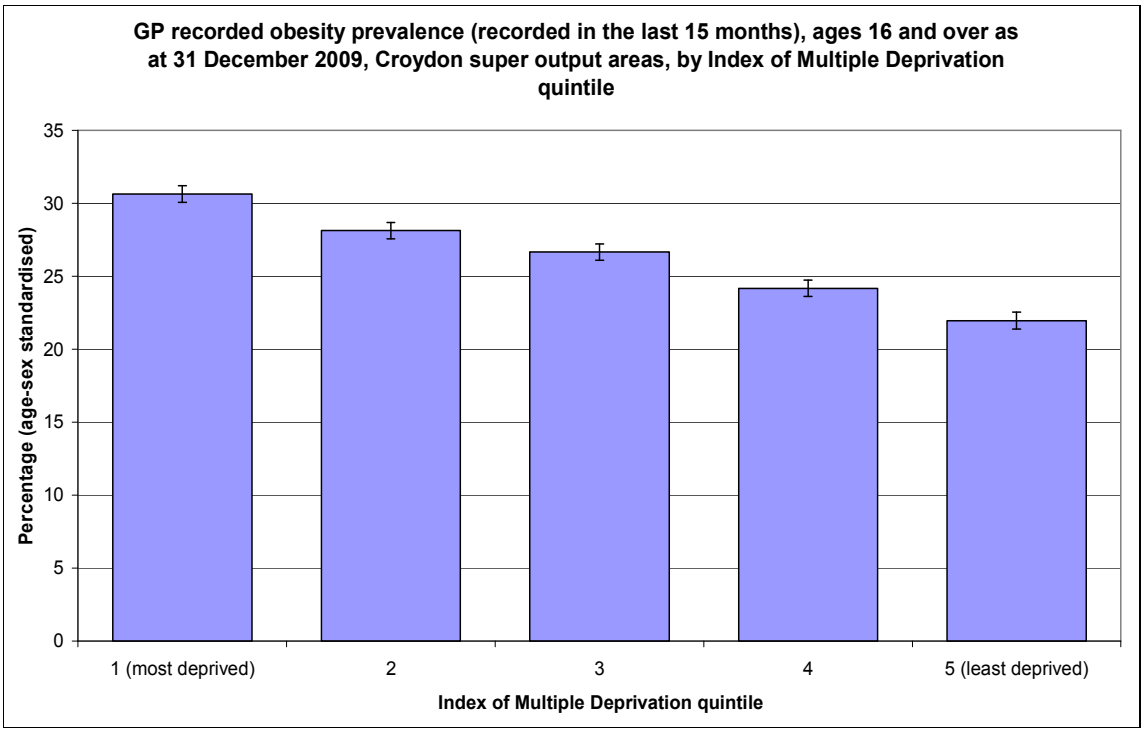

Figure 6: Prevalence of Obesity by Deprivation Quintile

Fieldway (30.7%), New Addington and Woodside have the highest recorded prevalence of obesity in the borough. The wards Croham, Sanderstead and Fairfield (16.9%) have the lowest recorded prevalence of obesity in the borough. Analysis of General Practice data by deprivation quintile shows a clear gradient, with higher levels of socio-economic deprivation being strongly associated with higher prevalence of obesity.

Using data from the Croydon Patient Surveys, Figure 7 compares trends in obesity prevalence among adults in quintile 1 (most deprived) and quintile 5 (least deprived). The overall trend for increasing rates of obesity is seen in both quintiles, and the gap between the quintiles is large and widening.

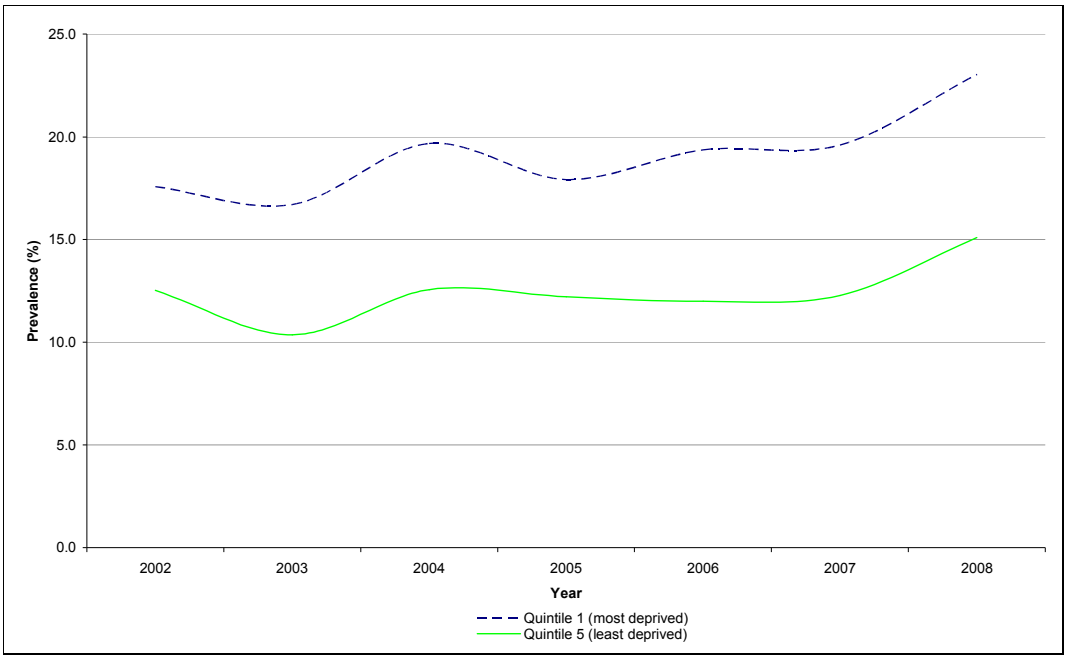

Figure 7: Obesity prevalence in adults by index of deprivation quintiles, 2002-2008
Source: Croydon Patient Surveys 2002-2008

Obesity and Ethnicity

There is a varied distribution in obesity prevalence by ethnicity, as shown in Figure 8. Black and mixed White and Black ethnic groups have the highest rates, compared with the Chinese group which has the lowest.

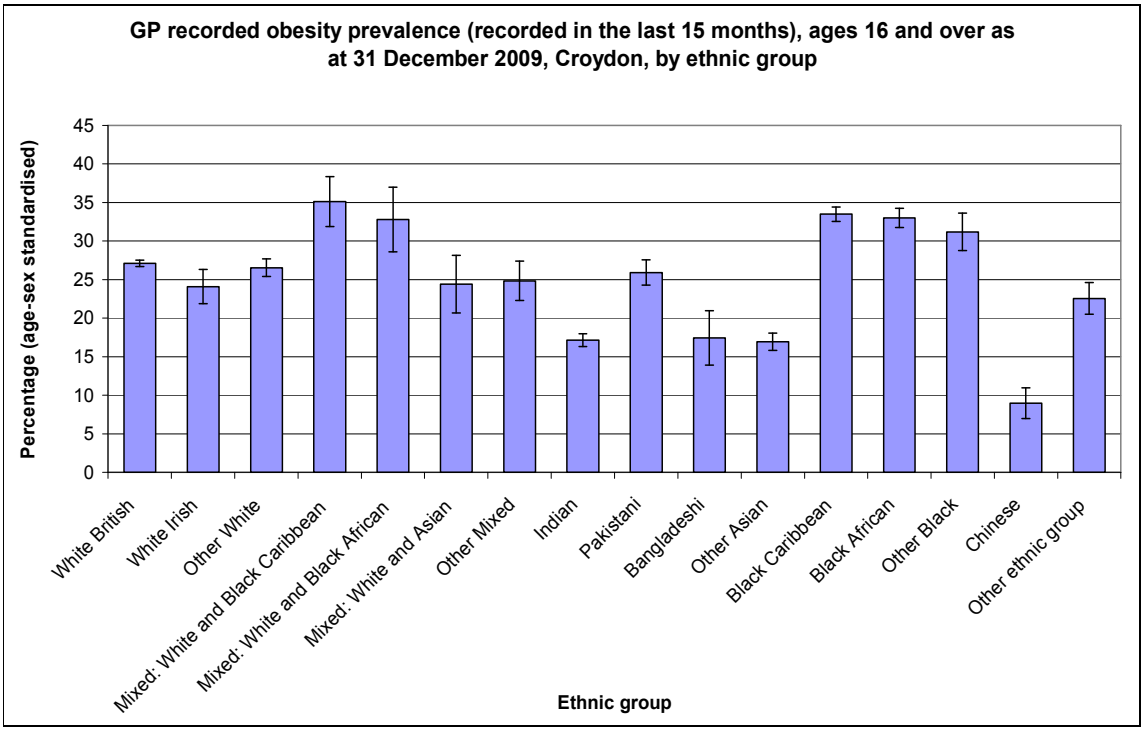

Figure 8: Prevalence of obesity in adults (aged 16 and over) by ethnic group (including 95% confidence intervals)
Source: Data from Croydon General Practice December 2009

High Risk Groups

Because of the requirement to maintain practice-based registers of people with learning disabilities and severe mental illness, and to offer them an annual health review, it is possible to extract data on the prevalence of obesity and overweight in these groups.

Adults with a learning disability are much less likely to be of a healthy weight than their counterparts in the general population (Table 3 and Figure 9). A greater proportion of people with a learning disability are underweight, obese, or morbidly obese, compared with the general population.

Weight status category	2009 (%)		
	Male	Female	ALL
Underweight	8.5	5.6	7.3
Healthy Weight	37.5	21.9	31.1
Overweight	29.7	28.8	29.4
Obese	22.1	35.7	27.7
Morbidly Obese	2.1	7.9	4.5

Table 3: Weight status among adults with a learning disability (aged 16 and over)
Source: Croydon General Practice Data December 2009

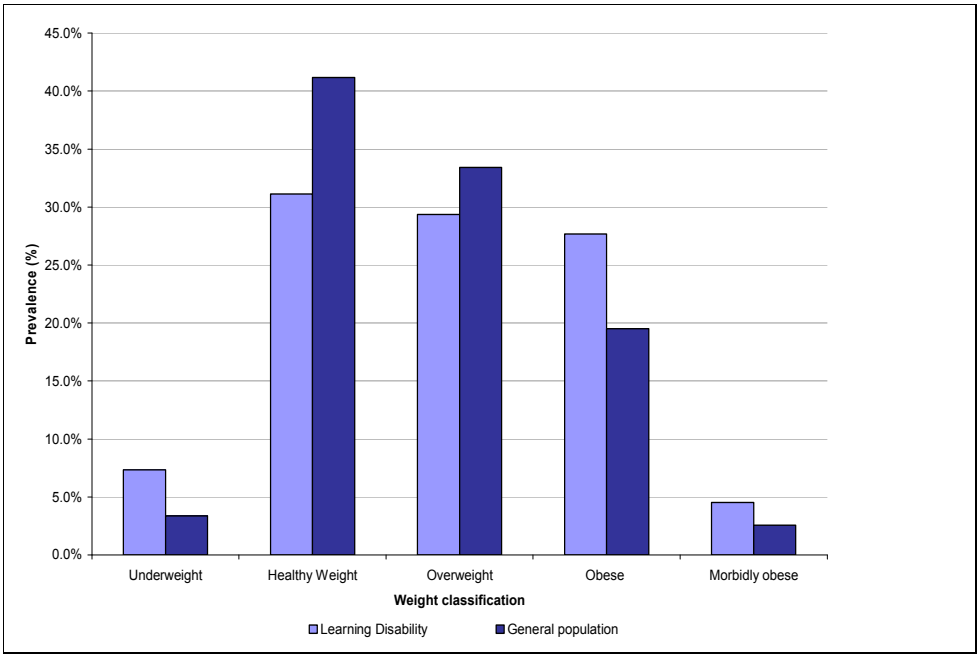

Figure 9: Distribution of weight status amongst adults (aged 16+) with learning disability compared with the general population
Source: Croydon General Practice Data December 2009

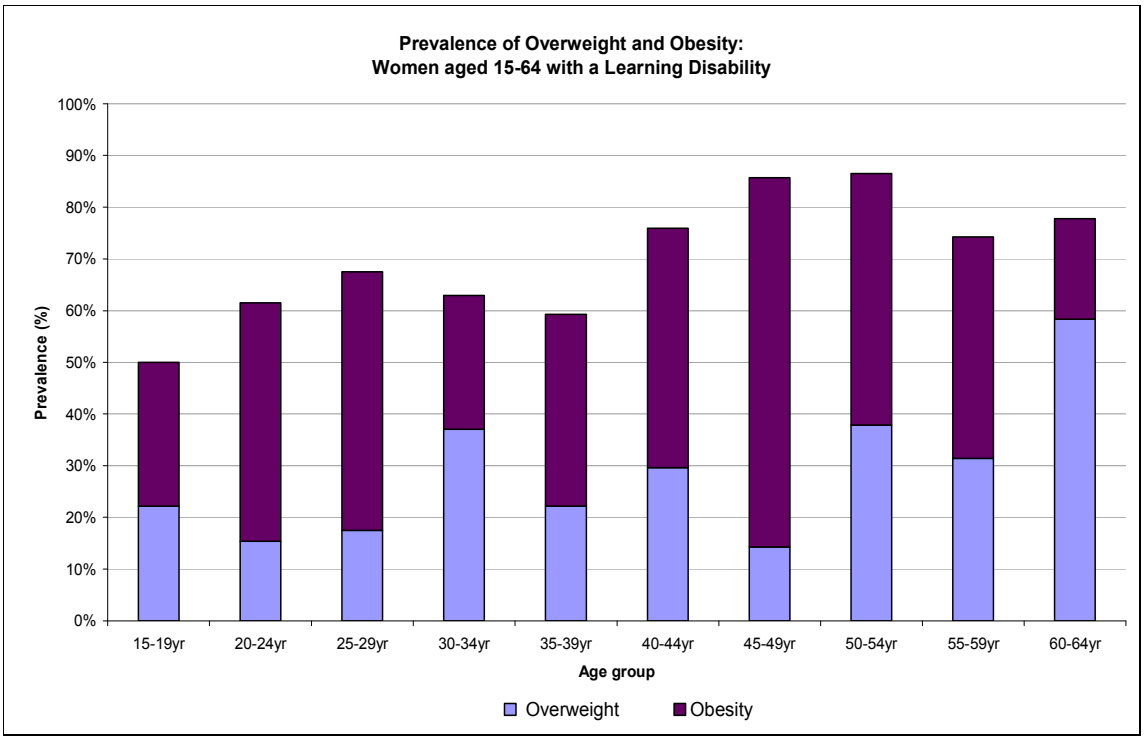

Figure 10: Prevalence of overweight and obesity in women with a learning disability
Source: Croydon General Practice Data December 2009

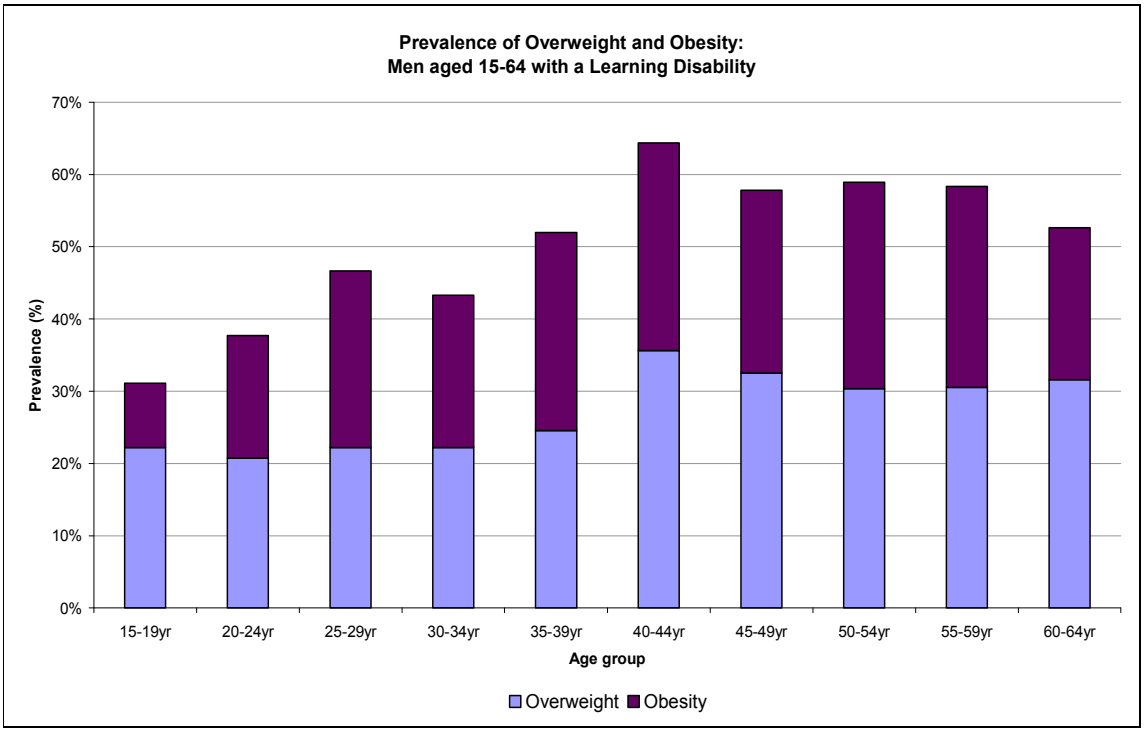

Figure 11: Prevalence of overweight and obesity in men with a learning disability
Source: Croydon General Practice Data December 2009

Women with a learning disability are much more likely than their male counterparts to be overweight or obese, and this holds true at all ages up to 64. (Numbers of people in the older age groups are too small for meaningful comparison.) Nearly half of women with a learning disability aged 40-64 have a recorded BMI of more than 30 kg/m^2, compared with only a quarter of the men. Though numbers are relatively small, these differences are striking, especially when compared with the general population.

Adults with severe mental illness are also more likely to be obese or morbidly obese, compared with the general population (Table 4 and Figure 12)

Weight status category	2009 (%)		
	Male	Female	All
Underweight	1.4	2.7	2.1
Healthy Weight	31.4	24.8	27.9
Overweight	38.1	28.9	33.3
Obese	27.0	35.6	31.5
Morbidly Obese	2.1	8.0	5.2

Table 4: Weight status among adults with severe mental illness
Source: Data from Croydon General Practice 2009 (BMI ever recorded)

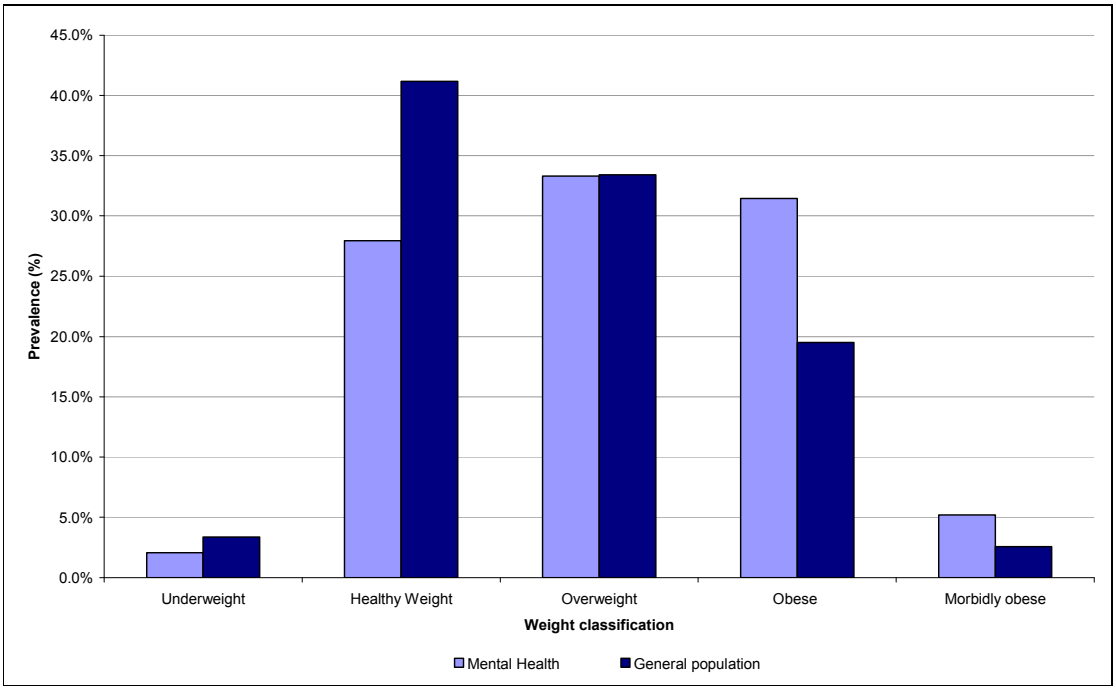

Figure 12: Prevalence of overweight and obesity amongst adults on the mental illness register
Source: Data from Croydon General Practice 2009 (BMI ever recorded)

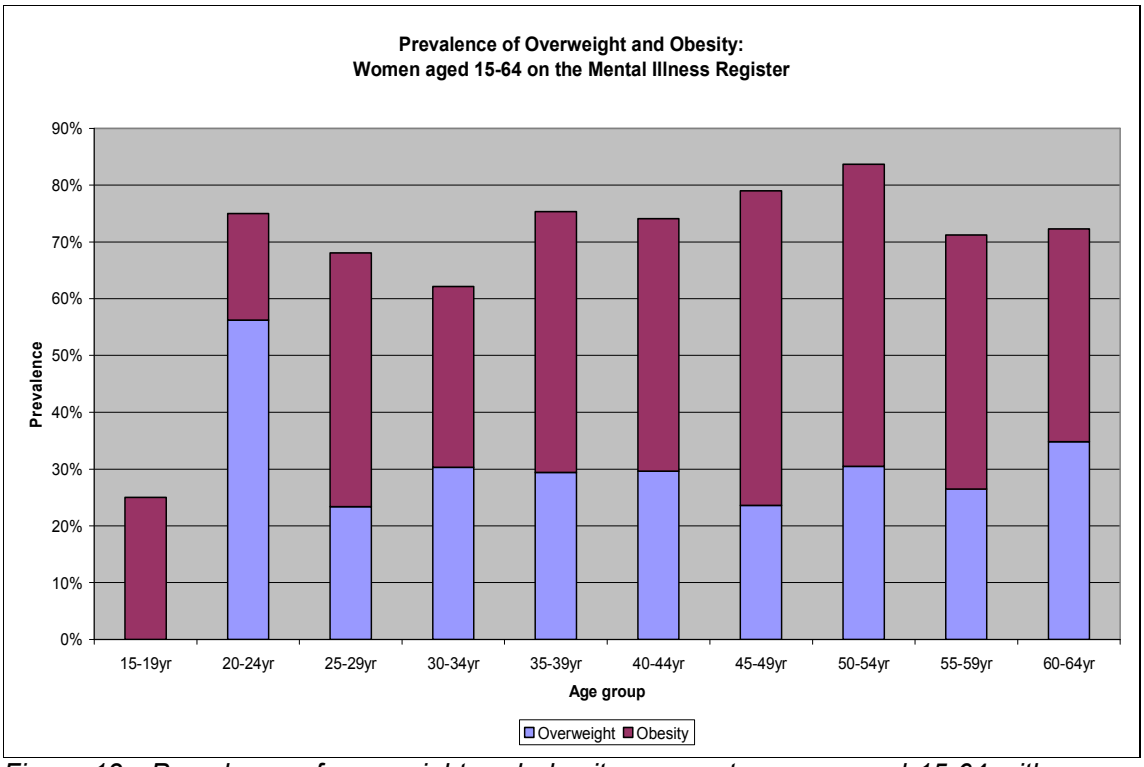

Figure 13: Prevalence of overweight and obesity amongst women aged 15-64 with severe mental illness

Source: Croydon General Practice data December 2009

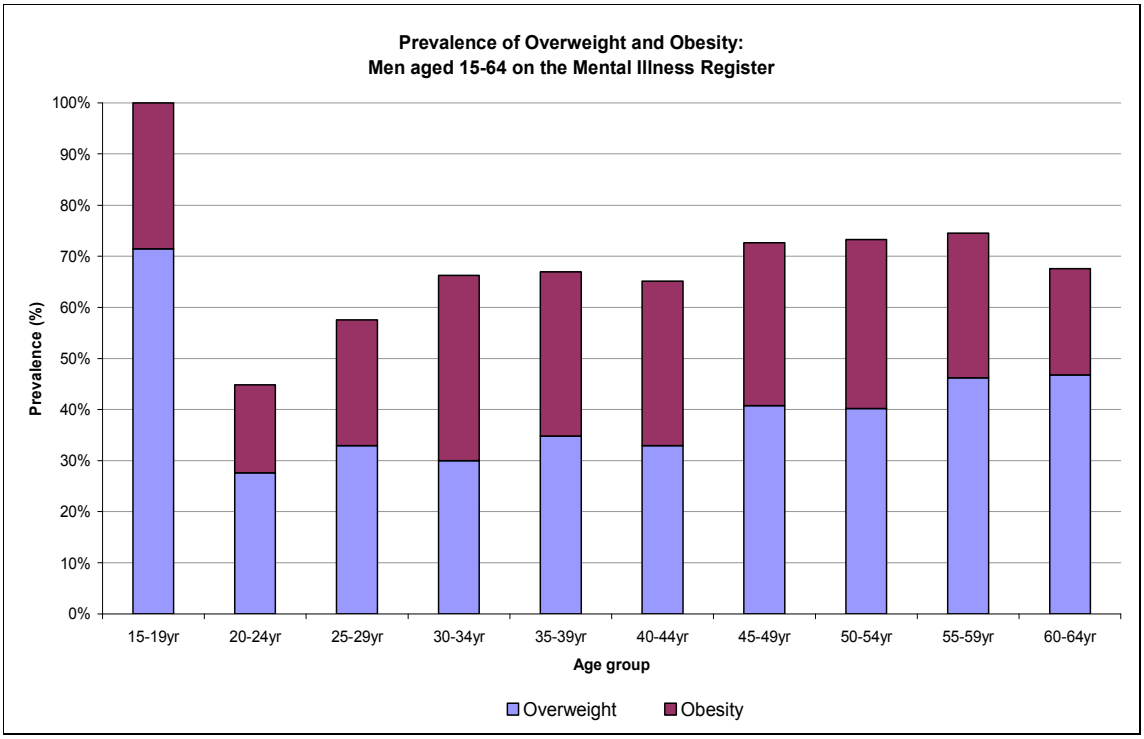

Figure 14: Prevalence of overweight and obesity amongst men aged 15-64 with severe mental illness

Source: Croydon General Practice data December 2009

Women with severe mental illness are much more likely than men with severe mental illness to be obese or morbidly obese; over 50% of those aged 45-54 had a recorded BMI of 30 kg/m^2 or more.

Summary

The distribution of obesity in adults is not consistent across all sections of the Croydon population:

- at all ages, more women than men are obese
- the peak prevalence of obesity is seen in middle to early old age (40-74 years)
- there is a strong association between socio-economic deprivation and a high prevalence of obesity
- the prevalence of obesity is highest amongst the black and mixed white/black ethnic groups
- both people with learning disability and those with severe mental illness are much more likely than the general population to be overweight or obese, particularly women

Numbers of People Requiring Services

Current figures suggest that there are:

- around 59,000 people in Croydon who meet the NICE criteria for Tier 2 services (i.e. a BMI of 30 kg/m^2 and existing co-morbidity); this figure is projected to rise to 90,000 over the next five years
- about 1,200 women and 1,100 men with a severe mental illness who are registered with general practices in Croydon, and of these, the majority are already overweight or obese
- around 560 men and 390 women with a learning disability are registered with general practices in Croydon, of whom a majority is overweight or obese, especially women in middle age
- approximately 150,000 adults in Croydon who have a BMI of more than 25 kg/m^2, of whom a significant proportion either have or are at significant risk of developing an obesity related condition
- around 10,500 people whose BMI status meets the current NICE criteria for bariatric surgery.

However, GP recording of BMI data is patchy and so these figures may over, or (more likely) underestimate the numbers of people who could benefit from a structured portfolio of weight management services.

Projections

A recent report from the National Heart Forum contains future projections for adult obesity (Brown, 2009). The projection is for the number of normal weight individuals to inexorably fall, while the numbers of people who are overweight remain broadly steady and those who are obese continue to rise. There is projected to be a significant rise in rates of morbid obesity (i.e. a BMI ≥40 kg/m^2) which carries an extremely high risk of associated disease.

In the Foresight paper modelling future trends in obesity, extrapolations indicate that on current trends, by 2015, 36% of males and 28% of females will be obese. For Croydon this means 49,000 obese males and 41,000 obese females, an increase of 30,000 individuals in less than 5 years, and reversing the present situation where obesity is more common in women than in men. It is also estimated that, by 2025, 47% (68,000) of men and 36% (56,000) of women in Croydon will be obese.

Proposed Service Model

Adult weight management services are most commonly delivered in a tiered approach, with four levels of multi-component treatment options and weight maintenance support and entry based on BMI (Figure 15).

- **Tier 1** (BMI 25+; overweight) is delivered in Primary Care and offers general advice on diet, physical activity and behaviour change. For many people, brief intervention and signposting to appropriate self help options is sufficient.
- **Tier 2** is a more intense specialist service with community based interventions, which NICE guidance recommends should be considered for all people with a BMI 30+ (obese).
- **Tier 3** for individuals with a BMI 35+ involves multi-disciplinary team specialist management and possible drug therapy.
- **Tier 4** services offer bariatric surgery (BMI 40+). If co-morbidities exist, the BMI threshold is reduced.

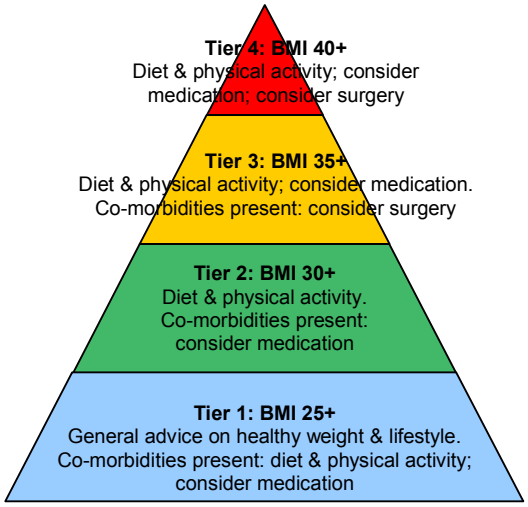

Figure 15: Tiers of need and a guide to deciding the initial level of intervention to discuss (interpretation of NICE clinical guideline 43)

In addition to the NICE clinical guideline 43 (Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children) published in 2006, other relevant NICE and DH guidance includes:

- NICE PH2: Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling, March 2006
- NICE PH6: Behaviour change at population, community and individual levels, October 2007
- NICE PH17: Promoting physical activity, active play and sport for pre-school and school-age children and young people in family, pre-school, school and community settings, January 2009
- NICE PH25: Prevention of cardiovascular disease at population level, June 2010
- Department of Health statement on Exercise Referral (March 2007). Gateway reference 7930

Current Service Mapping

Table 5 shows the current weight management services provision funded by NHS Croydon. There are few discretely funded services; most are delivered as part of a wider service funded through generic SLAs. This is particularly true of the Dietetics service, which is fragmented across a number of providers.

There is a general lack of outcome data, and the evidence base for some services is uncertain.

Table 5: Current service mapping

Provider	Summary of service	Description of service	Funding	Budget	Budget holder	Contract start & end dates	Output and outcome data	Evidence and effectiveness/ comments
Tier 1								
Primary Care Teams (e.g. GPs, Practice Nurses, Health Care Assistants)	Record BMI and brief intervention with patients as required	Brief intervention and general advice on diet, physical activity and behaviour change. Signposting to appropriate self help options. Self referral service	GMS contract. QOF - 8 out of a total of 1000 points are awarded for an obesity register (recording BMI 30+). In practice this provides little incentive for primary care to prioritise weight management delivery and achieve the aim of the NICE guideline to stem the rising prevalence of obesity and associated diseases	Recording BMI is part of core service; it is not possible to separate out a budget	Primary Care		Output and outcome data not available	There are a further 177 QOF points influenced by providing appropriate advice and treatment for weight management for the management of cholesterol, hypertension, CHD secondary prevention, diabetes and kidney disease. These patients with pre-existing obesity related disease would benefit from effective evidence-based weight management interventions to improve disease outcomes. Many practitioners prioritise the treatment of patients with disease secondary to obesity, yet do not consider treating obesity
Primary Care Healthcare Professionals	PCT Weight Management Guidelines	Croydon PCT Weight Management Guidance (2007) developed by dietitians for primary care includes evidence based guidance for weight management	No allocation	No allocation	n/a	n/a	None available	The guidance is poorly used by primary care and lacks information regarding physical activity. The guidance needs to be reviewed, updated in line with recent guidance and proactively implemented

Provider	Summary of service	Description of service	Funding	Budget	Budget holder	Contract start & end dates	Output and outcome data	Evidence and effectiveness/ comments
Health and Social Care Professionals	Public Health training 'Identifying and managing obesity in adults' which includes brief intervention advice for health and social care professionals	To raise awareness of the issue of adult obesity in Croydon and how this can be approached from a multi agency perspective. Participants will be able to understand their role in the prevention and management of this issue					This course has poor uptake, although healthcare professionals report a lack of training and support regarding weight management. Frontline staff lack training on raising the issue of obesity	Training should go hand in hand with implementing the Weight Management Guidance in primary care. Informal feedback - how do health care professionals address weight management with patients when it may be a sensitive personal issue?
Pharmacists	Record BMI	Pharmacists increase the recording of BMI. Aim to reach patients who have not had a weight check with their GP in the last year. There was concern that BMI recording would be introduced as a target	LES contract for pharmacies. Funding for 2009/10 from Lipid Management budget - non recurrent. Any cost incurred for 2010 likely to come from Practice Based Registers budget - also non recurrent	Spend for 2009/10 was £9,075. No recurrent allocation	Pharmacy for 2009/10; PBC for 2010/11. No recurrent allocation	1/11/08 - 30/11/10	BMI recorded for 2807 patients between Nov 2008 and July 2010; 1815 in 2009/10 which equates to £5 per measurement. BMI records (which include appropriate READ codes) are sent by pharmacies to GP practices, but require inputting on to the GP clinical system to feed into performance indicators. Pharmacists have now been given notice on this service which will cease on 30 Nov 2010	There is a performance indicator that shows how many people have BMI recorded in the last 15 months (aged 16+): April 2008 = 35.5%; March 2009 = 40.2%; March 2010 = 39.4%. BMI recorded at anytime = 75.8% as at March 2010

Provider	Summary of service	Description of service	Funding	Budget	Budget holder	Contract start & end dates	Output and outcome data	Evidence and effectiveness/ comments
Midwifery Team	As part of the antenatal booking appt, height, weight and BMI should be routinely measured and recorded electronically	BMI should be routinely measured. Any woman with a BMI 30+ should have a detailed history taken and be referred to consultant-led care at 20 weeks gestation as per the Mayday Maternity Guideline 2009	Mayday SLA				Support for pregnancy related issues, but treatment pathway for underlying obesity unclear	NICE public health guidance 27: Weight management before, during and after pregnancy issued July 2010 needs review and possible action
Tier 2								
Pharmacy Weight Management Service	BMI assessment and lifestyle guidance offered by pharmacist	The service involves weekly consultations with a pharmacist for 12 weeks. Aim to reduce body weight by 10% by 12 wks. If not achieved, Orlistat to be prescribed with regular monitoring	LES contract for pharmacies. Funding for 2009/10 from Lipid Management budget - non recurrent. Any cost incurred for 2010/11 likely to come from Practice Based Registers budget - also non recurrent	Spend for 2009/10 was £947.40. No recurrent allocation	Pharmacy for 2009/10; PBC for 2010/11. No recurrent allocation	PGD valid Jan 2009 to Feb 2011	Total number of patients who have accessed the pharmacy weight management service from Jan 2009 to June 2010 = 24; during 2009/10 = 21 which equates to cost of £45.11 per patient. Two patients have received Orlistat through this pharmacy service. No outcome data currently available; evaluation due to be undertaken end of 2010	Service specification detailed 50 pharmacies would offer this service – only 5 pharmacies do

Provider	Summary of service	Description of service	Funding	Budget	Budget holder	Contract start & end dates	Output and outcome data	Evidence and effectiveness/ comments
Mayday Hospital Dietetics Service	- Dietetics outpatients as part of general clinic and mental health specialist clinics - Antenatal dept - Eye Unit - Purley Hospital	Delivery method is to send first line diet sheet & appt sheet with time once triaged. Opt-in service to reduce DNA rate. 1:1 first appt 30mins, with 15mins follow up. Acute dietetic service of 7 dietitians band 5-7 and assistant with varied caseload of acute and outpatient clinics. Core competency of behaviour change facilitation and band 7 dietitians have Cognitive Behaviour Therapy & Motivational Interview training. Referral via GP or Mayday consultants; criteria BMI 30+ or BMI 28 with 2 or more co-morbidities or rapid weight gain	Mayday SLA budget. Dietetics at Mayday are split into 4 categories, each with planned activity and cost: adults' direct access, children's direct access, outpatient first attendance and outpatient follow up (OP is adult and children combined). More work required to determine what resources are spent on obese patients	General dietetics contract; not possible to break out spend on weight management work			More work required to determine exact resources attached to weight management activity. Average age 50yrs (16-88yrs). 83% women, 17% men. 37% White British, 9% Black British, 8% Caribbean, 4% Indian, 4% Pakistani, 15% any other background, 12% not stated. 267 referrals for 2009/10. <8 wk waiting time for 1st appt; approx 10 wks between appointments. DNA data 30%. Average loss of 2.4Kg (range of up to 23Kg weight loss and 9Kg weight gain). 2 appts – av. 1.4Kg loss/person. 3 appts – av. 2.6Kg loss/person. 4 appts – av. 4.78Kg loss/person. 5 appts – av. 10.7Kg loss/person	Low capacity as there is no dedicated weight management dietitian. Payment is made for outputs i.e. activity on a per attendance basis rather than funding the dietetic post

Provider	Summary of service	Description of service	Funding	Budget	Budget holder	Contract start & end dates	Output and outcome data	Evidence and effectiveness/ comments
Mayday Hospital Maternity Service	- Dietetics outpatients as part of general clinic and mental health specialist clinics - Antenatal dept. These sessions were organised for every 2 weeks. Information includes risks of being overweight, healthy eating, specific pregnancy nutrition (additional calories in 3rd trimester, vitamins and minerals) and diet related problems, increasing knowledge of fat, sugar, calories in food and barriers to change and strategies (as per NICE guidance)	Delivery method is to send first line diet sheet & appt sheet with time once triaged. Opt-in service to reduce DNA rate. One off group session for those with a pre-pregnancy BMI >30kg/m2 or rapid weight gain. Individual appointment with the Dietitian for those who have a poor intake, language difficulties, poor weight gain or who don't want to attend a group session. Follow up appointments offered on an individual basis	Mayday SLA budget. Dietetics at Mayday are split into 4 categories, each with planned activity and cost: adults' direct access, children's direct access, outpatient first attendance and outpatient follow up (OP is adult and children combined). More work required to determine what resources are spent on obese patients	General dietetics contract; not possible to break out spend on weight management work			Unclear of outcomes for maternal dietetic service. More work required to determine exact resources attached to activity	Difficult to quantify as there is not a specific obesity dietitian within service
Obstetricians & Anaesthetics, Mayday	Medical service for pregnant women with a BMI 30+	Any woman with a BMI 30+ is referred to consultant-led care at 20 weeks gestation as per the Mayday Maternity Guideline 2009 - The Management of Obesity in Pregnancy	Mayday SLA budget	Anticipated total obstetric spend for 2010/11 based on last year is £14,808,000 pa. Query: what % activity is for obese patients?			Unclear of output and outcomes	

Provider	Summary of service	Description of service	Funding	Budget	Budget holder	Contract start & end dates	Output and outcome data	Evidence and effectiveness/ comments
Dietetics at CCHS	Provide assessment, intervention and treatment for dietary health in the community	1:1 first appt 30mins, with 15mins follow up. Dietetic outpatients at GP surgeries; home visits also possible. Dietitians band 7. 3x dietitians (<3.0wte) have Cognitive Behaviour Therapy & Motivational Interview training. Referral via GP or Mayday consultants; criteria BMI 30+ or BMI 28 with 2 or more co-morbidities or rapid weight gain	Croydon Community Health Service contract	Full contract value £148,000 pa. ESTIMATED 0.5 wte band 7 dietitian on weight management work, therefore estimated spend is £24,500 (salary and on-costs)	CCHS	1/4/10-31/3/11 ongoing	Total of 1586 contacts for weight management in 2009/10 (627 new; 959 follow-up). Age 16-24yrs – 8%; 25-34yrs – 11%; 35-44yrs – 20%; 45-54yrs – 30%; 55-64yrs – 30%. Female 54% / Male 46%. Ethnicity data: 46% White British; 8% Black or Black Caribbean; 6% Black or Black African; 6% Asian or British Asian. 12% DNA for all dietetic clinics. Waiting times not known. Low capacity for weight management service	Low capacity for weight management element of service
Exercise Referral Scheme (ERS) and phase 4 cardiac rehabilitation	To promote the benefits of exercise in relation to tackling coronary heart disease	The ERS is aimed at encouraging people will medical conditions who would gain health benefits from regular physical activity and who are at risk of CHD. A CHD register pathway separates those individuals who join ERS as part of their phase 4 cardiac rehab programme. 12 session exercise scheme and encourage to maintain lifestyle sessions for 'low' or 'medium' risk patients	PCT funding	ERS £50,000 pa plus phase 4 cardiac rehab £7,000 pa, totalling £57,000 pa	Primary Care	SLA 1/4/10-31/3/11	Targets for activity and outcomes have been agreed for 2010/11. Output data for 2009/10 is incomplete and difficult to interpret. There is a 50% drop out rate between referral and assessment and only a small number of individuals classed as 'completers'. There is no long term follow up data.	The evidence from two RCTs suggests that ERS can have positive effects on physical activity levels in the short term (6-12 weeks). However evidence from four trials indicates that such referral schemes are ineffective in increasing physical activity levels in the longer term (over 12 weeks) or over a very long time frame (over 1 year). The evidence base for phase 4 cardiac rehabilitation is weak and the local uptake and completion rates are very poor

Provider	Summary of service	Description of service	Funding	Budget	Budget holder	Contract start & end dates	Output and outcome data	Evidence and effectiveness/ comments
Specialist Mental Health Service – Dietetics Service	South London and Maudsley (SLAM) provide a dietetic led Obesity & Metabolic Syndrome service for mental health users	Opt-in service to reduce DNA rate. 1:1 first appt 45mins and 2nd appt 30mins. 0.4WTE Band 7 Mental Health Dietitian. Referral criteria BMI 25+. User must express motivation to change behaviour	SLAM	Budget is within overall SLAM block contract and is not possible to break out. ESTIMATE 0.4 wte band 7 dietitian = £19,500 pa (salary and on-costs)	Commissioning	1/4/10-31/3/11	Typically 50 new referrals per year for weight and metabolic disorder referral (according to 2008/09 data provided by Mental Health Dietitian). SLAM unwilling to share data - not available to people who are not in the care of SLAM services (Head of Dietetic SLAM). Unable to quantify output and outcomes	Budget is within the overall block contract with SLAM which is not broken down

Provider	Summary of service	Description of service	Funding	Budget	Budget holder	Contract start & end dates	Output and outcome data	Evidence and effectiveness/ comments
MIND - 'Buddying' Scheme for Mental Health Users	A pilot project for a 'buddying service' with the aim of increasing the number of people with a history of mental health problems engaging with local physical activity services. Provided by MIND in Croydon	MIND in Croydon recruited volunteer buddies to work with identified mental health users to support them make use of a range of physical activity services including ERS and Boxercise. Buddies usually worked with service users for approx 14 weeks, starting off in a very supportive role and moving to telephone support as required	PCT funding for pilot. No further funding identified	£30,000 funding for pilot - non recurrent and no funding identified for 2010/11	Public Health	Pilot project only - ran April 2009 until March 2010	The buddying service was accessible to diverse group of people. 70 referrals to pilot service 2009-10. Ethnicity data: 42% White British; 20% Black Caribbean; 5% Black African. Age: 32% 18-29 yrs; 57% 30-49 yrs; 9% 50-64yrs. Outcomes included: sustained weight loss of 0.6Kg (end of 12wk session); at 6 months follow up sustained weight loss of 0.4Kg. Majority of users stated a large increase or moderate increase in physical activity levels at end of programme and sustained at 3mths and 6mths. Service users reported an improvement in mental wellbeing. Of the 24 volunteer buddies, 16 had current or past experience of using mental health services - they also reported an improvement in mental wellbeing and demonstrated better employment outcomes after the experience of being a buddy	Positive outcomes from evaluation of the one-year pilot buddying scheme. This was a section 64 grant / Third Sector Investment Programme

Provider	Summary of service	Description of service	Funding	Budget	Budget holder	Contract start & end dates	Output and outcome data	Evidence and effectiveness/ comments
MIND - Boxercise	A pilot project that uses boxing training techniques to improve the physical and mental wellbeing of people with mental health problems. It is also intended that the project will improve confidence and social inclusion by encouraging people to take part in training, education and employment	A weekly two-hour exercise session for 10 weeks at Duke McKenzie's fitness academy in West Croydon. Average 10-12 participants in a cohort. Participants are also be given advice and information about healthy lifestyles, in particular diet and exercise. Referral through GP, MIND or self referral	PCT funding for pilot. Pilot is averaging 2 cohorts per year	Pilot: £3,000 per cohort; recurrent funding not identified. June 2010 cohort commissioned from unallocated funds previously applied to Asian Cookery Club, which was decommissioned in 2009/10	Public Health	Pilot	Participants have lost weight, reduced waist circumference and mean BMI is lower. Reported improvements in mood and enthusiasm and commitment to adopting healthier lifestyles - 30% have continued training at the gym. Developed in other life areas too with a participant on work placement, one on college course, one volunteer leader of horticulture project and a number who have become 'buddies'. User satisfaction surveys rate the project as excellent. Work underway to investigate whether there have been cost savings in OP, DC and IP activity. Cost per client is approx £300	Excellent outcomes and lots of anecdotal evidence from service users and psychiatric professionals about the benefits of the pilot. The service has featured on Sport Relief, and has won a number of awards, both regional and national.

Provider	Summary of service	Description of service	Funding	Budget	Budget holder	Contract start & end dates	Output and outcome data	Evidence and effectiveness/ comments
Specialist Learning Disability Service (Joint Community for Learning Disability Team)	Croydon Joint Community Learning Disability Team arranging support and specialist health services for adults with learning disabilities	Multi-agency and multi-disciplinary service. 0.8wte band 7 dietitian supported with MDT for mixed caseload (obesity competes with other dietetic referrals). Referral via GP or Care Manager from residential care home. Safeguarding within the care plan raises obesity as an issue for referral. Referral criteria BMI 30+ or BMI 28 with 2 or more co-morbidities. Dietitian & physiotherapist from MDT joint manage obesity referrals. Aim is to stabilise weight, and reduce weight long term. Dietitian provides 1:1 support with user and carer and provides meal plan to care homes. Physiotherapist provides suitable exercise for user. Team involved in person centred plans and health action plans	TBC - Surrey Oaklands SLA or Mayday Hospital?	Not possible to break out spend on weight management work	Commissioning	1/4/10-31/3/11	12 referrals from GPs in 2009/10 (anecdotal evidence from Learning Disability dietitian). Most referrals are generated from the Care Manager bi-annual review of the care plan	Valuable service for this group at high risk of obesity. No guidelines for Croydon patients with Learning Disability

Provider	Summary of service	Description of service	Funding	Budget	Budget holder	Contract start & end dates	Output and outcome data	Evidence and effectiveness/ comments
Foodlink Community Food Project (Foodlink)	Providing people who are living in socio-economically deprived areas of Croydon with improved access to affordable fruit and vegetables	Attend 4 markets per week in New Addington and Shrublands selling fruit and veg at wholesale prices. Also free home delivery on orders over £3 and visits to schools to promote healthy eating. Foodlink co-ordinator and 4x volunteers	PCT funding	£37,549 pa (outturn for 2009/10 was £20,393)	Public Health	Ends 31/3/12	Service accessed by approximately 45-50 customers per week; service sells approximately £200 worth of fruit and vegetables per week (anecdotal evidence from Foodlink co-ordinator August 2010). Home delivery reaches elderly people and those with mobility difficulties. Visits to schools to promote healthy eating to children and their parents. Numbers accessing the service vary during the year, with more at Christmas and Easter and less during school summer holiday	Although this is a project people value, its priority in the context of weight management services is unclear. Formal evaluation of the service is recommended (last evaluation was in 2005)
Asian Cookery Club	To prevent coronary heart disease in the Asian community through improvements in diet	6 to 8 once-weekly sessions delivered at two community centres	PCT funding	£32,936 pa. Service now decommissioned	Public Health	1/4/10-31/3/11	Individuals accessing service in 2009/10 = 23. Asian Cookery Club has been decommissioned and it is proposed the budget be invested in other weight management services	£3,000 previously applied to Asian Cookery Club budget was used to fund June 2010 Boxercise cohort
Tier 3								
n/a	Specialist multi-disciplinary team offering more intense weight management services and possible drug therapy	No specialist obesity service in Croydon. Elements of tier 3 service by tier 2 dietetics and pharmacotherapy by GP or LES pharmacist	n/a	No budget	n/a	n/a		Elements of a Tier 3 service are provided but not in a coherent and systematic way.

Provider	Summary of service	Description of service	Funding	Budget	Budget holder	Contract start & end dates	Output and outcome data	Evidence and effectiveness/ comments
Tier 4								
St George's Hospital	Specialist bariatric surgical service	South West London Bariatric Service Effective Commissioning Initiative (ECI) criteria. Referral via GP	SLA via ACU	??		ongoing	2007/08 = 20 procedures at estimated spend £95,000; 2008/09 = 35 procedures at estimated spend £202,000; 2009/10 = 55 procedures at estimated spend £260,000 (note HRG coding change to HRG4 this year with the aim that with more HRG codes available, costing is more accurate). This is more than 2.5-fold increase in both activity and cost in 2 years. No outcome data available to determine effectiveness of surgery in short or long term. No weight maintenance data.	The SW London ECI criteria for bariatric surgery 2010/11 requires patients to have participated in an intensive multi-disciplinary weight management programme for at least 6 months. Such a service is not currently commissioned by NHS Croydon. The prevalence of obesity is increasing, suggesting demand for surgery will continue to rise.

Evidence Base

The evidence available to support and inform service development and delivery includes:

- NICE CG43: Obesity: prevention, identification, assessment and management of obesity in adults and children, published 2006
- NICE PH2: Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling, March 2006
- NICE PH6: Behaviour change at population, community and individual levels, October 2007
- NICE PH17: Promoting physical activity, active play and sport for pre-school and school-age children and young people in family, pre-school, school and community settings, January 2009
- NICE PH25: Prevention of cardiovascular disease at population level, June 2010
- NICE PH27. Weight management before, during and after pregnancy, July 2010
- Department of Health statement on Exercise Referral (March 2007). Gateway reference 7930.

Gap Analysis

Table 6 provides a comparative analysis of the current service provision against the evidence and best practice.

Table 6: Comparative analysis of the current adult weight management service provision against evidence and best practice

Gap analysis based on need, demand & supply. Key: Red = no service provision; Amber = limited; Green = complete service provision

Level of pathway	Evidence and best practice	Current service provision	Gap analysis
Identification, assessment & classification	Service provided by all frontline staff. Training should be provided to relevant professionals to provide brief intervention advice to raise the issue of BMI (NICE 2006). Health professionals should discuss weight, diet and activity with people at times when weight gain is more likely, such as during and after pregnancy, the menopause and while stopping smoking (NICE 2006). There is good evidence for the effectiveness of brief interventions in primary care in promoting physical activity and these may be useful components of any coordinated obesity prevention intervention (Let's Get Moving 2009). Providing advice for overweight and obese patients. For example, 'Why Weight Matters' a leaflet for overweight patients who are not yet committed to losing weight. It discusses the risk associated with overweight, the benefits of modest weight loss and practical tips for people to consider (Department of Health 2008). Health professionals should discuss willingness to change with patients and then target weight loss intervention according to patient's willingness around each component of behaviour required for weight loss e.g. specific dietary and/or activity changes (SIGN 2010).	This is provided by a range of services e.g. provided by PCT, Council, Education, Leisure Services, Sports Clubs, and Voluntary Sectors. Croydon PCT Weight Management Guidance (2007) developed by dietitians for Primary Care includes evidence based guidance for weight management. This guidance is poorly used by Primary Care, and the guidance lacks information regarding physical activity. Public Health training provides 'Identifying and managing obesity in adults' which includes brief intervention advice for health and social care professionals. This course has poor uptake from health care professionals. Health care professionals report a lack of training and support regarding weight management.	Amber
Tier 1 Prevention and early intervention BMI equal to or greater than 25 kg/m2	Universal service provided by frontline staff, such as practice nurses and health care assistants (NICE 2006). Brief intervention training provided to ensure health and social professionals can raise subject of obesity and signpost accordingly (NICE 2006).	This is provided by a range of services e.g. provided by PCT, Council, Education, Leisure Services, Sports Clubs, and Voluntary Sectors. Frontline staff lack training on raising the issue of obesity and lack support in Primary Care. Primary Care professionals report on the unknown	Amber Service development requires more human resource than financial input

Level of pathway	Evidence and best practice	Current service provision	Gap analysis
		efficacy of dietetics and therefore may not refer patients to dietetics. Also there is a long waiting list for the Exercise Referral Scheme and health professionals may not refer for this reason.	
Tier 2 Community weight management service Multiple referral routes including self-referral BMI equal to or greater than 30 kg/m2 or BMI>28 with increased risk (co-morbidities) or Waist circumference >80cm -Female Waist circumference >94cm - Male Plus those who have not achieved tier 1 treatment objectives	Multi-component (nutrition, physical activity and behavioural change) weight management interventions and possibly pharmacotherapy supporting individuals who are 'ready to change'. Community based, and available outside 9-5. NICE 2006 guidelines recommend "regular, non discriminatory long term follow up by a trained professional should be offered". PRODIGY guidelines on managing weight suggest "regular review is necessary e.g. every two weeks" (PRODIGY, 2002). Dietary Intervention in Adults Dietary interventions for weight loss should be calculated to produce a 600Kcal/day energy deficit. Programmes should be tailored to the dietary preference of the individual patient (SIGN 2010). Physical Activity in Adults Overweight and obese individuals should be prescribed a volume of physical activity equal to approximately 1,800 to 2,500 kcal/wk. This corresponds to approximately 225-300 min/wk of moderated intensity physical activity (which may be achieved through five sessions of 45-60 mins per week, or lesser amounts of vigorous physical activity) (SIGN 2010). Pharmacological Treatment in Adults (NICE 2006): Orlistat should be considered as an adjunct to lifestyle interventions in the management of weight loss. Patients with BMI ≥ 28 kg/m² (with co-morbidities) or BMI ≥ 30 kg/m² should be considered on an individual case basis following assessment of risk and benefit. Weight management interventions should include behaviour change strategies to: increase people's physical	Acute and community dietetics provide nutrition advice with behavioural change in their intervention. Data available from Acute Dietetics shows high DNA rate (30%) and long waiting periods between appointments. Data from Community (CCHS) Dietitians show a lower DNA rate (12%); the wait between appointments is not known. Dietitians are highly trained in use of motivation and counselling skills. Exercise Referral Scheme provides physical activity intervention. Pharmacotherapy is prescribed by GP or pharmacist as part of a Local Enhanced Service. Poor follow up and co-ordination of services for patients.	Amber Robust monitoring and evaluation strategies should be in place to ensure cost effective services

Level of pathway	Evidence and best practice	Current service provision	Gap analysis
	activity levels and/or decrease inactivity; improve eating behaviour and the quality of the person's diet; reduce energy intake (NICE 2006). Among both children and adults, interventions in non-clinical settings that are shown to be effective in terms of weight management, are likely to demonstrate significant improvements in participants' dietary intakes (most commonly fat and calorie intake) or physical activity levels.		
Tier 2 / Tier 3 Community weight management – Mental Health	There is a lack of evidence base for effective weight management services for mental health. Well designed and evidence-based interventions are likely to be applicable to most population groups. However, there are some population groups that may require specific tailored interventions (NICE 2006).	0.4WTE mental health dietitian with a varied and considerable workload. The weight management service is provided on a 1:1 service with an experienced dietitian, with post-qualification training in cognitive behaviour therapy and motivational interviewing. A letter is sent to user asking if they would like an appointment with the dietitian with the rational to reduce DNA rates in the service. One questions whether this is appropriate with clients who maybe lacking in motivation. Exercise Referral Scheme provides physical activity intervention. The outcomes suggest the service is not meeting the needs of the user and the evidence-base for ERS is weak. MIND had funding from Croydon PCT for a pilot project for a 'buddying service' with the aim of increasing the number of people with a history of mental health problems engaging with local physical activity services. Croydon PCT also piloting a Boxercise course in West Croydon.	Amber
Tier 2 / Tier 3 Community weight management – Learning Disability	There is a lack of evidence base for effective weight management services for learning disabilities. Well designed and evidence-based interventions are likely to be applicable to most population groups. However, there	No health promotion guidance including physical activity and provision of healthy meals and snacks for day specifically for residential homes and day centres providing supported living with learning disability users.	Amber

Level of pathway	Evidence and best practice	Current service provision	Gap analysis
	are some population groups that may require specific tailored interventions (NICE 2006). The service needs to reduce barriers to physical activity specific to the Learning Disability population including transport needs, staffing ratios, and provide clear policy health promotion guidance (including physical activity and healthy eating) to day and residential service provision (Messant and Cooke, 1998).	Referral rate from GP to dietitian for weight management advice is very low for learning disability population, despite high rates of obesity. Lack of capacity for weight management advice from Learning Disability dietitian, as large and varied caseload. The service lacks innovation as traditional model of 1:1 with client, and user. Supported living staff have a qualification for basic level nutrition (1 day course). Although there is no prerequisite for staff to have this course. Current lack of resources associated with community care deny many people with learning disability real choices to live a physically active lifestyle.	
Tier 2 / Tier 3 Community weight management – Maternity	Specific interventions should be considered for women who have gained weight following childbirth. Diet combined with exercise or diet alone compared to usual care seem to enhance postpartum weight loss (Cochrane 2007). NICE public health guidance 27 - Weight management before, during and after pregnancy issued July 2010	There is no specific service targeted for women post-pregnancy. Referred to community/acute dietetics or Exercise Referral Service if appropriate. New NICE guidance requires review and potential implementation.	Amber
Tier 3 Specialist services BMI equal to or greater than 35 kg/m2 or BMI>30 with increased risk (co-morbidities) or Waist circumference >88cm -Female Waist circumference >102cm -Male Plus those who have not achieved tier 2 treatment objectives	Specialist Obesity Service The service will provide treatment and a package of care for those individuals who are morbidly obese with a view to improved patient outcomes, help to reduce the number of patients progressing to bariatric surgery and work closely with primary care to develop a range of other services and treatments that will prevent individuals becoming obese and morbidly obese in the first instance (NICE 2006).	There is no specialist obesity clinic for morbidly obese patients in Croydon. Current physical activity programmes (e.g. Exercise Referral Scheme) assume a certain level of mobility and many obese patients are immobile requiring physiotherapy and specialised physical activity programmes. There may be aspects of tier 3 provision from dietetics and exercise on referral but there is no co-ordination between services.	Red
Tier 4	NICE Guidelines (2006)	Croydon does not commission a 12-week multi-	Amber

Level of pathway	Evidence and best practice	Current service provision	Gap analysis
Specialist secondary care: bariatric surgery (South West London - Effective Commissioning Initiative 2010/11) Criteria as below: PCTs will fund bariatric surgery for morbidly obese patients aged 20-65 who meet all of the criteria within one of the following groups: Group 1 Patients with a BMI >50 kg/m2; OR Group 2 Morbidly obese patients with a BMI >35 kg/m2 and with a significant obesity-related co-morbidity that could be improved if they lost weight; AND Have participated and complied with the following unless contraindicated: > 12-week multi-component weight management programme which includes support to change behaviour, increase physical activity, improve eating behaviour and diet quality and reduce energy intake and three months of anti-obesity medication. AND Have failed to maintain a clinically significant weight loss for at least 6 months (at least 5% of their initial weight loss); AND Have received intensive obesity management at a specialised obesity clinic for at least 6 months	Consider surgery for people with severe obesity if: – they have a BMI of 40 kg/m2 or more, or between 35 kg/m2 and 40 kg/m2 and other significant disease (for example, type 2 diabetes, high blood pressure) that could be improved if they lost weight – all appropriate non-surgical measures have failed to achieve or maintain adequate clinically beneficial weight loss for at least 6 months – they are receiving or will receive intensive specialist management – they are generally fit for anaesthesia and surgery – they commit to the need for long-term follow-up. Consider surgery as a first-line option for adults with a BMI of more than 50 kg/m2 in whom surgical intervention is considered appropriate; consider Orlistat before surgery if the waiting time is long.	component weight management programme so it is excluded when agreeing bariatric surgery funding for Croydon patients. Care Pathway – South Thames Bariatric Service 3 part assessment for bariatric surgery by Highly Specialist Psychologist, Dietitian and Surgeons. If patient is appropriate for bariatric service there is dietetic follow-up at 6 months, 1 year and 2 years post-surgery for specialist advice on supplements. Assessments and long term support for patients undergoing bariatric surgery is limited because of the lack of tier 3 service.	
Maintenance	Variety of services provided via existing or new services within the borough. Interventions aimed at people who have been obese and	Health Hub, leisure centres and voluntary sector providing healthy eating and physical activity initiatives.	Amber

Level of pathway	Evidence and best practice	Current service provision	Gap analysis
	have lost weight should emphasise that it may be necessary to be active for 60–90 minutes a day to avoid re-gaining weight (SIGN 2010).	No formal follow-up with healthcare professional at regular intervals to maintain healthy weight.	

Aim of Adult Weight Management Services

The overarching aim of adult weight management services is to reduce the burden of obesity and its impact on health inequalities. Moving forward the intent is to:

- promote and support whole population prevention activity in line with initiatives including "more people, more active, more often" and "making healthy choices easier"
- ensure there is capacity and capability in primary care so frontline healthcare professionals can offer consistent and appropriate weight management advice and support so individuals achieve and maintain a healthy weight
- ensure that individuals at high risk of adverse consequences of obesity have access to specialist, personalised advice and support to achieve and maintain a healthy weight.

Conclusions

The service review and gap analysis have identified that current service provision for adults who are obese is not entirely consistent with the tiered approach recommended within the NICE clinical guideline, with a major gap in Tier 3, which in turn has implications for access to services in Tier 4.

Well designed and evidence-based interventions are likely to be applicable to most population groups, but there is also benefit in targeting high risk groups who show a greater prevalence of obesity. Multi-component services should be delivered by a multi-disciplinary workforce working to integrated care pathways. Robust monitoring and evaluation strategies should be in place to enable continuous improvement to take place and ensure a cost effective service.

Services should meet the needs and expectations of motivated adults, but also need to have the skills and capacity to work with high risk groups. For a variety of reasons, individuals in high risk groups may not have the motivation or personal resources to achieve sustained lifestyle change without continuing support.

Service Objectives

The services to be commissioned need to be

- high quality and based on the best available evidence, to deliver the desired patient outcomes
- cost effective, with the capacity to treat a minimum percentage of the potential patients per annum
- delivered by integrated multi-disciplinary teams from skilled providers
- flexible, timely and responsive, delivered at multiple sites around the borough close to where patients with the highest need are
- able to assess and manage the needs of complex patients with co-morbidities
- able to provide long term follow up to support individuals maintain a healthy weight, particularly following specialist treatment, e.g. bariatric surgery.

Outcomes

Proposed outcomes for patients include:

- weight loss – aiming for a 10% weight loss within 12 months
- reduced waist circumference
- improved emotional health and wellbeing
- sustained increase in levels of physical activity
- reduction in co-morbidities and medication requirements.

Commissioning a portfolio of services across the four tiers should deliver:

- a greater spread of demand
- an opportunity to offer patients more appropriate options and a greater level of specialised, personal support
- a means of preparing patients for surgery if this is the most appropriate option, and the capability to provide long term follow up to support individuals maintain a healthy weight.
- an increase in the number of adults able to safely and effectively manage their weight loss without the need for surgical intervention.

Currently, NHS Croydon invests relatively less resource in adult weight management services than other PCTs for whom data have been collected. Some existing services may need to be re-designed or de-commissioned in order to prioritise the resource currently available. At present, services do not necessarily meet the needs of the groups at highest risk from becoming obese, and/or of the adverse consequences of obesity.

In the medium term, further investment in adult weight management services is recommended. As the programme budgeting approach becomes established, there may be opportunities for releasing resource from other programme groups, for which the prevention and effective management of obesity are important strategies in reducing demand for services. These groups could include the cancer, cardiovascular, genitourinary, and endocrine groups.

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Appendix 1: Motivators and Barriers to Achieving a Healthy Weight

The report 'Maximising the appeal of Weight Management Services' (Department of Health, 2010) found that individuals often expressed frustration about the current NHS services on offer, which were described as unappealing, 'for someone else' and unreflective of their needs or experiences. This report was intended to represent a first step towards understanding the needs of individuals and in supporting better service provision across England. The findings clearly highlight a strong need for commissioners to think beyond the services that are currently on offer, and identify ways to promote the development of new and innovative approaches to effectively target those who are most at risk.

Broad differences of appeal emerged across different socio-demographic groups:

- Male and female
- Older and younger
- More and less affluent
- Size (e.g. overweight – morbidly obese)

Nine 'People Segments' were devised to encapsulate these differences more clearly:

Women

Segment	Young Women	BME Women (traditional role)	Older Women (more affluent)	Lower Income Women (just coping)
Motivations	Physical attractiveness Fashion Clothes size	Health and wellbeing Energy Vitality	Physical attractiveness Long term health issues Mobility	Physical attractiveness Being a good parent Self-esteem
Barriers	Tendency to overemphasise the impact of diet Prone to quick fixes	Too little information Care giver for extended family	'Weight management' fatigue Snobby about public leisure facilities	Cost of services Child care issues Self esteem Physical limitations
Ideal Service	Glamorous, aspirational service Combining nutrition and exercise	Culturally tailored Basic nutritional info Female only service	Need motivation and support New innovative services Run by experts	Family based activities Affordable Fun

Men

Segment	Young Men	Physical Men	More Affluent Man	Lower Income Man	BME Man (Traditional role)
Motivations	Physical attractiveness Health	Strength and fitness Physical prowess	Long term health concerns Managing health issues	Desire to be fit and healthy A second chance…	Strong connection to cultural identity Fitness and strength
Barriers	Lack of confidence, poor Adjustment to lifestyle changes	Want to remain a 'physical presence' Not interested in being 'smaller'	Not responsible for food preparation Lack of time	Unhealthy lifestyle patterns Lack of awareness	Poor knowledge of nutritional information Reliance of others to prepare food
Ideal Service	Focused on fitness Competition	Health Check MOT Support of active lifestyle	Professional, expert advice Actionable goals	Designed for men Nutritional info Basic into level exercise	Whole household solutions Basic nutritional information

Appendix 2: Learning from other PCTs

Examples of other adult weight management interventions in London

Tier 2 services

NHS Bromley

A weight management programme combining dietary advice and exercise. Weekly 2-hour sessions are held in local venues and are led by qualified Exercise Advisers, Nutrition Assistants and PCT Dieticians.

Providing 'Lite 4 Life' weight management / exercise referral programmes with a combination of physical activity and nutrition advice, using behavioural change technique. Upon completion of the Lite 4 Life programme, participants are offered the opportunity to join 'Fresh Start' to continue their exercise programme, whilst regular programme reunions are arranged to help keep up the good work.

NHS Kensington and Chelsea

Commission a 10 week programme of weight management and behaviour change, helping participants to develop key skills to manage their weight in everyday situations. The sessions are facilitated by a registered dietitian who uses evidence based advice and creates a relaxed, interactive environment. Each session is followed by 30 minutes of physical activity.

Tier 3 services

NHS Wandsworth

Commission a specialist obesity management clinic prior to assessment and/or referral to bariatric obesity services.

Levels of Investment by other PCTs in Tier 2 services

PCT	Population	Ethnicity	Tier 2 contract value	Comments
Croydon	342,816	White 65%; Black 15%; Mixed 4%; Asian 14%	£57,000 pa plus non-recurrent funding for pilot projects Some funding tied up in SLAs for provision of dietetic services – not possible to separately identify	GP Exercise on Referral Scheme, incorporating Phase IV Cardiac Rehabilitation funded recurrently Boxercise and the Buddying Scheme funded as pilots Dietetics services provided in a fragmented way; referral pathways and treatment programmes need further work.
Tower Hamlets	234,765	White 55%; Black 5%; Mixed 3%; Asian 34%	£333,000 pa; 3 year contract	Awaiting further information
Kirklees	406,750	White 84%; Black 2%; Mixed 2%; Asian 12%	£144,000 pa	Exercise Referral Scheme, Cook & Eat Programme, Walking Groups, etc, are funded in addition to this contract value. These services are available universally in Kirklees
Bristol	433,087	White 88%; Black 3%; Mixed 2%; Asian 5%	£175,000 pa; 2 year contract	Exercise Referral Scheme, Cook & Eat Programme, Walking Groups, etc, are funded in addition to this contract value
West Sussex	792,948	White 94%; Black 1%; Mixed 1%; Asian 3%	£113,000 pa	Exercise Referral Scheme, Cook & Eat Programme, Walking Groups, etc, are funded in addition to this contract value