North Yorkshire Adult Weight Management Service

Update report for Scarborough and Ryedale CCG Primary Care Co-Commissioning Committee

Meeting date: Wednesday 27th June 2018

Report author: Ruth Everson (Health Improvement Manager, NYCC)

1.0 Background to the Adult Weight Management Service

1.1 North Yorkshire Healthy Weight, Healthy Lives Strategy

Obesity is widespread. Nationally two thirds of adults, a quarter of two to ten year olds and one third of 11-15 year olds are overweight or obese. The challenge in North Yorkshire is very real with over 60% of adults being overweight and obese. Over 20% of four to five year olds and just under 30% of 10-11 year olds in our local communities are measured as having excess weight.

The resulting NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year.

In 2016 a North Yorkshire Healthy Weight, Healthy Lives Strategy (2016-2026) was launched. The Strategy has been signed off by the Health and Wellbeing Board and supports a whole-system approach to tackling obesity across the County. The Strategy details the issue of obesity in North Yorkshire, why and where action is needed and how different stakeholders can contribute. Six key priorities are presented, which include:

- Supporting children’s healthy growth and healthy weight
- Promoting healthier food choices
- Building physical activity into our daily lives
- Providing the right personalise, accessible weight management services
- Ensuring people have access to the right information and resources to make healthy choices that support weight loss
- Building healthier workplaces that support employees to manage their weight
In line with these priorities, key stakeholders are delivering action to create change to the food and physical activity environment in North Yorkshire and to ensure residents have access to high quality weight management services. A multi-agency steering group has been established to ensure actions within the Strategy Implementation Plan reflect current and planned activity in relation to the Strategy priorities and effectively report progress against action.

1.2 Evidence based weight management services

The provision of weight management services is crucial in supporting people make positive behaviour changes associated with food and physical activity. Clinical guidelines recommend a stepped approach to weight management depending on the severity of a patient’s obesity and whether they have weight-related co-morbidities.

North Yorkshire Public Health provided grant funding to the seven district councils across North Yorkshire to pilot tier 2 lifestyle weight management programmes for individuals aged 18 and over with a BMI over 25. The pilot programme ran from August 2014 to December 2017.

Teesside University was commissioned to deliver an academic evaluation of the pilot weight management programmes (tier 2) across the County. The evaluation was initiated on 1st October; a final evaluation report was presented at the beginning of April 2016. The final report presented key findings in relation to similarities and differences in service provision across the County, the impact of the service provision in relation to the demographics of those accessing the services and their outcomes at the end of the 12 week programme and at a 6-month follow up. The findings from the evaluation and the recommendations for service provision in the future made by Teesside University provided the information needed to further develop the service model of delivery and high quality service specification for future service provision.

A new North Yorkshire Adult Weight Management Service (tier 2) was formally procured with the Service launching in Selby in July 2017 and the remaining 6 lots (districts areas) in January 2018. An overview of the providers delivering the Service in each district area is illustrated:
<table>
<thead>
<tr>
<th>District</th>
<th>Name of service</th>
<th>Service provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Craven</td>
<td>Healthy Lifestyles</td>
<td>Craven District Council</td>
</tr>
<tr>
<td>Hambleton</td>
<td>Take That Step</td>
<td>Hambleton District Council</td>
</tr>
<tr>
<td>Harrogate</td>
<td>Fit 4 Life</td>
<td>Harrogate Borough Council</td>
</tr>
<tr>
<td>Richmondsh</td>
<td>Healthy Futures</td>
<td>Maple Health Group</td>
</tr>
<tr>
<td>Ryedale</td>
<td>NHS Weight Management Service</td>
<td>Humber NHS Foundation Trust</td>
</tr>
<tr>
<td>Scarborough</td>
<td>NHS Weight Management Service</td>
<td>Humber NHS Foundation Trust</td>
</tr>
<tr>
<td>Selby</td>
<td>Move It, Lose It</td>
<td>Inspiring Healthy Lifestyles</td>
</tr>
</tbody>
</table>

More information on the service providers can be accessed on the NYCC website [https://www.northyorks.gov.uk/adult-weight-management-service](https://www.northyorks.gov.uk/adult-weight-management-service)

### 2.0 The Adult Weight Management Service delivery model

The new Service incorporates a structured assessment process from referral; triaging clients to assess eligibility and readiness to change, and supporting clients to set and review weight loss plans and physical activity agreements with their weight management advisor at an initial health assessment, 12 week and 24 week assessments. Clients are supported to achieve a 5% weight loss at 12 weeks and sustain 5% weight loss at 24 weeks. The Service provides weekly weigh-ins, structured nutritional advice and a free facilitated physical activity offer.

Individuals who are eligible to access the Adult Weight Management Service include those:
- aged eighteen years or over
- BMI equal or greater than 25
- resident or registered with a GP practices in North Yorkshire, or working or an organisation based in North Yorkshire

Individuals meeting the following criteria should be excluded from this service:
- under the age of eighteen
- have a BMI of less than 25
- are pregnant, or breastfeeding
- have a diagnosed eating disorder
- have an underlying medical cause for obesity and would benefit from more intensive clinical management from a tier 3 service
- have a significant unmanaged co-morbidity* or complex needs as identified by
their GP or other healthcare professional
• have had bariatric surgery in the last two years.

*e.g. type 2 diabetes, cardiovascular disease, chronic obstructive pulmonary disease (unmanaged meaning not on medication and/or not subject to regular clinical review, or not completed a management programme such as diabetes management or cardiac rehabilitation). Each referral where a co-morbidity is identified should be assessed case by case and advice sought from the client’s GP where appropriate.

The Provider must ensure that clients who do not meet the eligibility criteria are managed appropriately, which may include a referral back to the GP/healthcare professional, referral into a tier three weight management service (where available), and/or signposting to local tier one community activities.

3.0 Progress to date
3.1 Adult Weight Management Service performance update

The Service has only been launched in the majority of the district areas for 4 months therefore there is limited data available at this stage.

The Service is delivered as a rolling programme in each district area so clients accessing the Service are at different stages of attendance and completion.

The key performance measures of the service include:

- Clients starting\(^{\text{a}}\) a programme but not completing
- Clients completing\(^{*}\) a programme
- Clients completing\(^{*}\) the 12 week programme and achieving a 5% weight loss
- Clients completing\(^{*}\) the 12 week programme, achieving a 5% weight loss and sustaining that 5% weight loss at 24 weeks.

\(^{\text{a}}\) defined as attended a minimum of 2 sessions but less than 9
\(^{*}\) defined as attending 9 out of the 12 sessions of the 12 week programme

With the majority of the providers initiating the first 12 week programme less than 12 weeks ago, the only data we can report on at this stage is the number of referrals into the service and those that have started a 12 week programme. To date (across all districts):

- 1,559 clients have been referred into the Service (258 Scarborough and Ryedale districts combined)
- 788 clients have started the 12 week structured programme (173 Scarborough and Ryedale districts combined)

Please note, it is not currently possible to disaggregate Whitby resident data from all clients accessing the Service in Scarborough district.

3.2 Linkages to other local programmes

Humber, Coast and Vale STP are in the early stages of implementing and mobilising the Healthier You: NHS Diabetes Prevention Programme. The contract awarded to Pulse Healthcare Limited in April 2018. The programme will start to take referrals from June 2018 with identified trailblazer practices.

The Adult Weight Management Service supports Scarborough and Ryedale CCG’s Health Optimisation policy, which states that clients requiring surgical specialties, who have a BMI of ≥ 35 to 40, are advised and given appropriate information to address lifestyle factors to optimise their health outcomes for surgery. A referral into the Adult Weight Management Service is an option where clients meet the inclusion criteria and are committed and motivated to attend the Service and work towards agreed weight loss targets. Pathways and literature on the Adult Weight Management Service should be clear and accurate to enable clients to access the support they need at the most appropriate time of readiness.

4.0 Issues to highlight

Clients are triaged at the point of referral and in some Districts, patients are being referred with limited information on the service they are being referred to. Good quality referrals into the Adult Weight Management Service are needed. It is essential that health care professionals provide consistency in the brief advice offered regarding weight and that they have the information they need to effectively refer into the Weight Management Service.

There is a need to link the Adult Weight Management Service with the newly launched National Diabetes Prevention Programme to ensure the primary reason for referral is acknowledged and patients are referred into the most appropriate service depending on their need. The pathway between the two services needs to be clarified to ensure referral between the two services is available where appropriate.
5.0 Recommendations

It is recommended that the Committee note:

- the update on the procurement of the North Yorkshire Adult Weight Management Service.
- the opportunity to contribute to the whole system approach to obesity and support the notion of making the healthy choice the easy choice for the residents of Scarborough and Ryedale.

and,

- consider how the CCG and the Committee would like to receive further updates on the performance of their local weight management services.