Optimising Weight Management Services Provision in Kent

Weight Management Strategic Action Plan

May 2024

Version 5.0

Contents

Executive summary

Obesity-related health issues pose a significant risk to local people, increasing the likelihood of chronic diseases and living with co-morbidities. In 2021/22, 65.8% of adults in Kent were overweight or obese, which was higher compared to England (63.8%). It is a national priority with government commitment to tackle obesity building on the Obesity Strategy (July 2020) and the NHS Long Term Plan outlining key commitments in tackling obesity. Partners across Kent County Council and Integrated Care Board (ICB) have been working locally to tackle this in a variety of ways through our individual organisations and efforts, but in recognition of the fact that we are stronger together for this, we have been working together for the last six months to develop this Joint Kent Weight Management Strategic action plan , proposing our plan for driving improvements and equity in weight management services across Kent for our eligible local population. Despite the challenges of the current health and social care context, we believe that it is important to combine our efforts, working together to find ways despite this, to maximally optimise health and equity locally.

The purpose of this paper is to update Executives on the proposed outline for a weight management strategic action plan for adults across Kent, with a focus on tier 1- 4 interventions. It informs Executives of the collaborative work between Kent County Council (KCC) and NHS Kent and Medway (Integrated Care Board, (ICB) to produce a weight management strategic action plan with aspirations to go even further for improving the health and care of local people. It highlights seven key lines of enquiry or 'strategic actions' that will be implemented to address the issue of weight management and incorporates a strong governance structure to ensure successful implementation and sustained results. These are:

- **Strategic Action 1:** Embedding the Weight Management strategic action plan into the wider context of prevention, clinical pathways and whole systems obesity approach, and building strong cross-system collaboration and leadership to oversee and deliver this together.

- **Strategic Action 2**: Use the best of our collective skills across partners to understand in depth the needs of local people and plan together priority action to best meet these needs.

- **Strategic Action 3:** Create a more seamless pathway for flow across the tiers and a single referral form to optimise referral, working across existing pathway areas which are led by different partner organisations to understand the state of play in more detail at each tier of the pathway and factors affecting quality, impact and flow across the tiers.

- **Strategic Action 4:** Improve self-referral access, including information provision for local people and suitability checks by providers.

- **Strategic Action 5:** Improve primary care understanding about the pathway, its needs and their engagement with this.

- **Strategic Action 6:** Enhance our approach to service user engagement and use of insights gained from this by providers to optimise services further.

- **Strategic Action 7:** Ongoing learning, knowledge sharing and innovation across local providers, internal and external stakeholders, national and international approaches to optimise continuous improvement approach to weight management.

Through this strategic action plan, our aim is to empower adults to achieve and maintain healthy lifestyles, enabled by timely quality support as needed, ultimately leading to improved overall well-being and reduced health inequalities locally. Our strategic action plan represents a steadfast commitment to offer the best possible adult weight management services for our Kent population, appropriate to their needs and within the context of the current landscape challenges.

Our aim for Weight Management in Kent

Our aim for this Weight Management strategic action plan is to create the best possible adult Weight Management services for our eligible Kent population, appropriate to their needs and within the context of the current landscape challenges. This includes ensuring equity of access for everyone who needs our services living locally and using the best available evidence from local and external populations. Through collaboration, innovation and a person-centred approach we can empower our population to make healthier lifestyle choices, create environments that promote healthier behaviours and enhance the quality of their life.

We recognise that this will not be easy given the financial, workforce capacity to deliver, and wider challenges faced by the health and care system in Kent, like England more generally. However, we believe it is important to combine our efforts to do what we can within these limitations to ensure the very best possible weight management support for our eligible local people.

Definitions, scope and governance of this Weight Management strategic action plan

Defining healthy weight

Obesity is a complex health and social problem caused by multiple intersectional factors[1]. It can be determined using the BMI, which is a measure. The BMI calculation divides weight in kilograms (kg) by height in meters (m) squared. The result can be classed into the following categories:

[1] Adult obesity: applying All Our Health - GOV.UK (www.gov.uk)

- Underweight – BMI below 18.5 kg/m².
- Healthy Weight Range – BMI 18.5 to 24.9kg/m²
- Overweight – BMI 25 to 29.9 kg/m²
- Obese – BMI 30 to 39.9 kg/m²
- Severely obese – BMI over 40 kg/m²

It is important to note that in South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background the following lower BMI scores should be used to measure overweight and obesity:

- Overweight – BMI 23 to 27.4 kg/m²
- Obese – BMI above 27.5 kg/m²

This is because there is evidence that obesity-related health risks are higher in these ethnic groups compared to others.

The approach and remit of Weight Management services

Weight Management services provide support for people whose BMI puts them in an overweight, obese or severely obese range and, depending on their severity, they can be referred to appropriately tailored support. Weight management services are multi-component interventions that include programmes, courses, clubs and groups provided by a variety of providers in Kent. The aim is to help people to lose weight and to become more physically active, eating healthy diets in order to reduce the risk of obesity-related conditions.

Scope of this Weight Management strategic action plan

This Weight Management strategic action plan aims to address the complex issue of weight management and the strategic action plan is jointly owned, led and overseen by Kent County Council (KCC) and NHS Kent and Medway Integrated Care Board (ICB). Enhanced partnership working on this strategic action plan provides an in-depth focus to this important area for our local population. The focus of this strategic action plan is on adult weight management rather than the wider concept of obesity. The Whole System Approach to addressing obesity more generally is governed by obesity prevention and associated health promotion strategies. Furthermore, in time it is anticipated that these elements will be brought together and included within a wider holistic approach to a healthy weight in Kent as a whole, looking at children as well as adults, sitting within the wider ICB strategy that is currently being developed.

Governance of this Weight Management strategic action plan

This governance structure and approach to this strategic action plan is purposely designed to be one that fosters collaboration between stakeholders, enabling shared decision-making, greater coordinated efforts and more efficient allocation of resources for the successful implementation and ongoing management of the strategic action plan, ensuring a holistic approach to tackling weight management challenges within the region. It aims to link with local systems and ensure dedicated programme/project management resource for weight management with clear reporting and governance mechanisms.

The development of this strategic action plan has been undertaken by an ICB-KCC Task and Finish Group detailed in Appendix B. Following the approval of this strategic action plan from all the necessary parties, the implementation of the strategic action plan will then be led by a new Kent Weight Management Strategic Action Plan Implementation Leadership Group with ICB and KCC staff members representing public health, commissioning, clinicians, ICB managers and other teams also (Appendix C). In KCC this work will be led by the Public Health Consultant and their Healthy Lifestyles team in the Public Health Directorate. In the ICB this work will be led within the out of hospital programmes for implementation jointly with the elective team. The Kent Weight Management strategic action plan Implementation Leadership Group will be jointly chaired by the Public Health Consultant leading Weight Management and an equivalent senior member of the ICB.

It is important to note that at present the governance of this strategic action plan focuses on ICB and KCC reporting and oversight through our teams and executive boards to the Joint Commissioning Management Group (JCMG), within the context of our existing Public Health and healthcare service provision frameworks. Over time, we believe that as the ICB strategy develops further, it will include greater focus on healthy weight across our local population, and it is likely that this strategic action plan will sit within that as a key strategic conceptual framework. It may be that at that time, our governance structure will need to be refined further to optimally work with and fit into this. Our teams will remain aware of local developments around this and are proactively aligned to ensure maximal support overall for improving population health and tackling inequalities locally.

Aspiration of this Weight Management strategic action plan

It is intended that through collaborative partnership efforts, the implementation of the strategy will make a positive impact on local service provision and in the development of a new model of care. Learning from implementation will inform future strategic and collaborative actions.

The current local context – the case for change

In Kent, the percentage of adults classified as overweight or having obesity increased from 63.1% in 2020/21 to 65.8% in 2021/22. While the percentage of adults classified as obese only increased from 26% in 2020/21 to 27.3% in 2021/22, this increase was statistically significant. The majority of Kent districts had higher prevalence of overweight and obesity compared to the South East regional average (62.7%) and England average (63.8%) however Folkestone and

Hythe (72.8%), Thanet (72%), Dover (69.4%) and Gravesham (68.3%) had the highest overweight and obesity prevalence. The prevalence of overweight and obesity was below the England average in Tunbridge Wells (57%), Sevenoaks (58.5%) and Ashford (62.1%). Figure 1 illustrates the percentage of adults (aged 18+) classified as obese (2021/22) by district, compared to Kent and England average.[2].

Figure 1: Percentage of adults (aged 18+) classified as obese (2021/22) by district, compared to Kent and England average.

Area	Recent Trend	Count	Value
England	–	-	25.9
Kent	–	-	27.3
Dover	–	-	36.1
Thanet	–	-	32.4
Swale	–	-	32.1
Canterbury	–	-	29.5
Gravesham	–	-	29.1
Folkestone & Hythe	–	-	29.1
Ashford	–	-	28.1
Dartford	–	-	23.6
Maidstone	–	-	23.4
Tunbridge Wells	–	-	21.9
Tonbridge and Malling	–	-	21.1
Sevenoaks	–	-	18.9

Source: Office for Health Improvement and Disparities (based on the Active Lives Adult Survey, Sport England)

This is particularly important as obesity is a significant risk factor for many chronic diseases including type 2 diabetes, other metabolic diseases, cardiovascular disease (mainly coronary artery disease and stroke), liver disease, some forms of cancer and osteoarthritis, posing a high burden to health and social care. As a result, there is an increased risk of disability and premature death for individuals living with overweight and obesity[3]. Obesity can also be a risk factor for psychological problems such as depression, low self-esteem and can impair a person's well-being, quality of life and ability to earn. Approximately nine years of life is prematurely lost to obesity-related conditions. Obesity is strongly associated with deprivation and health inequalities.

QOF and hospital episode data: Other relevant data include the Quality Outcome Framework (QOF), which is a reward and incentives programme for GP surgeries. QOF recorded obesity as the 3rd highest (9.52%) health condition for Kent and Medway ICB in

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[2] Obesity Profile - Data - OHID (phe.org.uk)

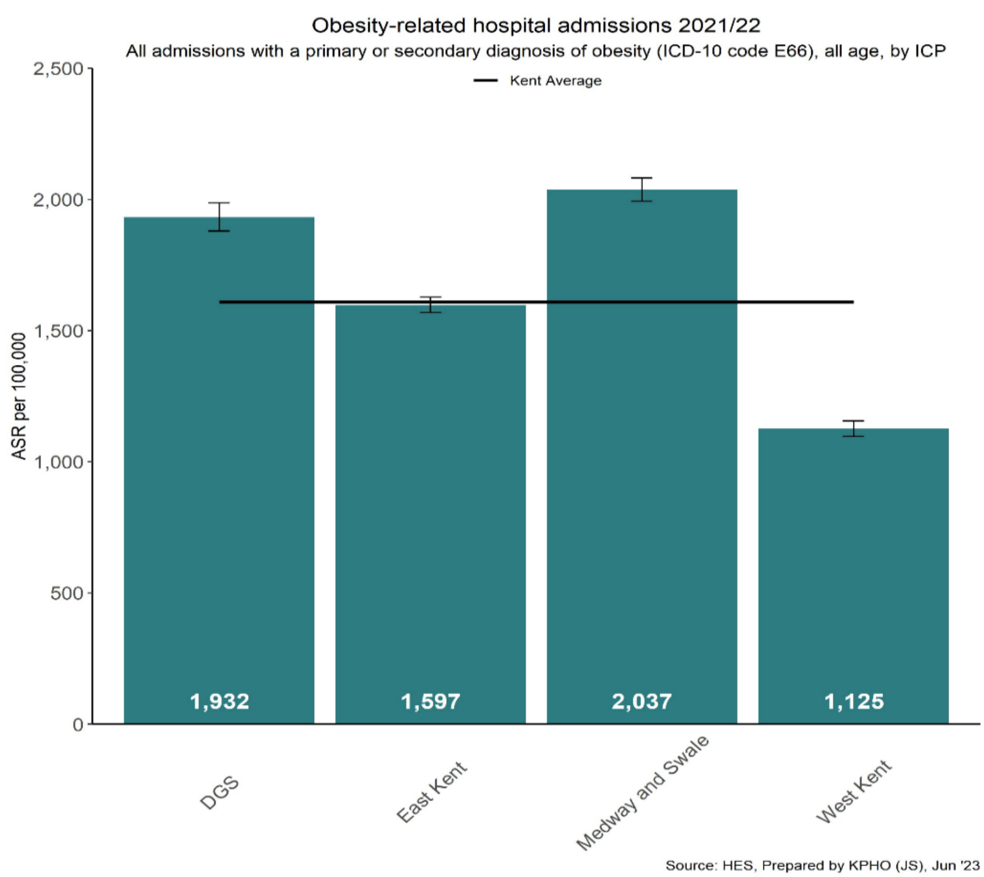
[3] Adult obesity: applying All Our Health - GOV.UK (www.gov.uk)

2021/22 compared to England 9.72%[4]. This data is likely to underrepresent the scale of the problem in Kent because it is only recorded for those that have regular contact with primary care/GP services.

Hospital admission related to obesity: Across Kent and Medway in 2021/22, the number of admission episodes related to obesity data indicate that admissions are higher in Medway & Swale and Dartford, Gravesham & Swanley Health and Care Partnerships (HCP) compared to the Kent average. East Kent is similar to the Kent average, while West Kent is lower than Kent average. Overall, this suggests greater Public Health need in the areas of Dartford, Gravesham, Swanley, Swale and East Kent. Figure 2 shows the 2021/22 obesity related hospital admission data.

NHS Digital reports admissions directly attributable to obesity, which are admission episodes with a primary diagnosis of obesity. Admissions directly attributable to obesity, were higher within Medway & Swale HCP in comparison to Kent. Figure 3 illustrates hospital admissions with a primary diagnosis of obesity.

Figure 2: Obesity Related Hospital Admission Data



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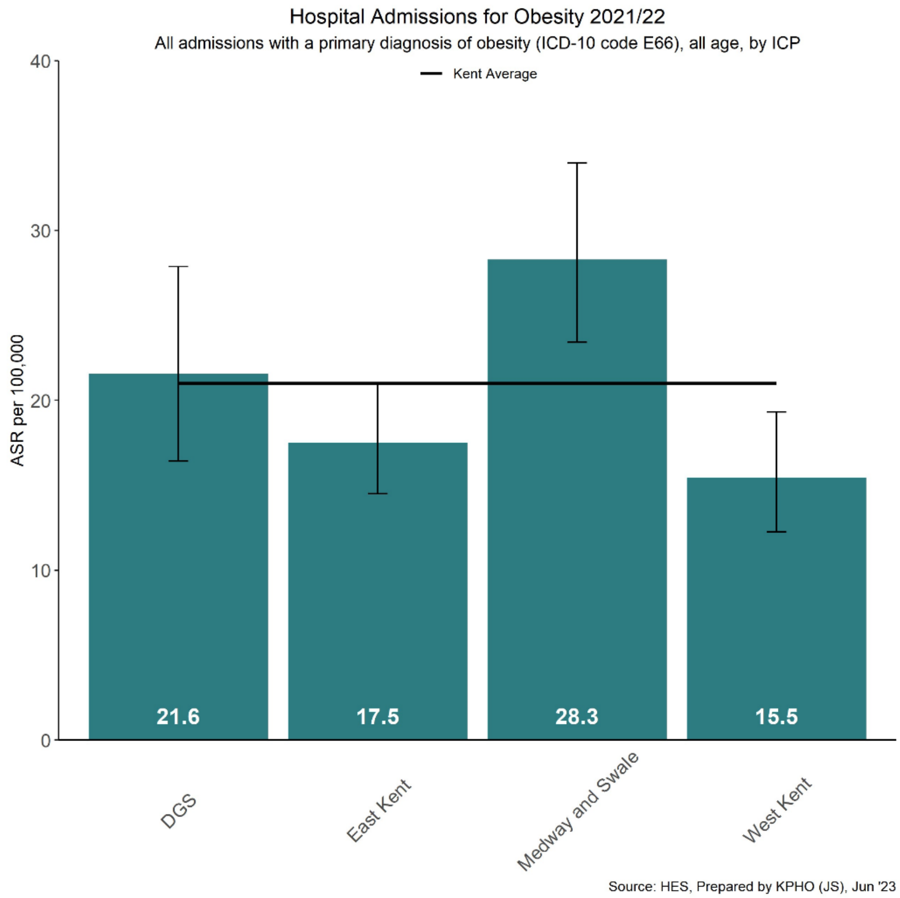
4 Microsoft Power BI

Figure 3: Hospital Admissions for obesity 2021/22 (ASR, age standardised rate)



It is also important to note that although anyone can develop excess weight, there are some people at higher risk and having increased risk of comorbidities at lower BMI classifications. Some of these groups are described below:

Deprivation: There is a strong association between deprivation and obesity. Nationally, the gap in obesity rates between women from the most and least deprived areas was 17%, while for men the deprivation gap was 8%. According to Health Survey for England 2021, in Kent, obesity prevalence was lowest among adults living in the least deprived areas (20%) and highest in the most deprived areas (34%). 12.3% of the obese population in Kent and Medway are in the 10% most deprived segment of the population compared to 6.5% in the 10% least deprived segment.

Coastal effect: Obesity prevalence was 22% higher in Kent coastal towns compared to Kent non-coastal towns. To be clear, this does not mean there is an absolute gap of 22% between coastal and non-coastal towns but rather the proportion is 22% higher. The coastal effect remains after adjusting for demography and deprivation but reduces to 16%. Sheerness and Minster (Swale) had 52% and 54% respectively higher prevalence of obesity compared to non-coastal towns. At the other end of the scale, Hythe and Whitstable had 6% and 5% respectively higher prevalence of obesity compared to non-coastal towns.

Age: Obesity increased with age, from 8% of adults aged 16-24 to 32% of those aged 65-74, before decreasing in those aged 75 and over to 26%.

Ethnicity: Nationally, the prevalence of obesity was highest among black women (53.6%) compared to their white counterparts (27.5%). A greater percentage of Black and Asian adults compared to white and mixed ethnic groups have lower BMI (27kg/m^2) at increased or high risk of comorbidities such as hypertension and type 2 diabetes[5]. A Joint Strategic Needs Assessment (JSNA) on the Gypsy, Roma and Traveller population in Kent reported a higher prevalence of unhealthy behaviours such as obesity among the Gypsy and Traveller communities and a greater proportion of Roma men and women between 18-55 with an obesity diagnosis than their counterparts in non-Roma populations[6].

Education: The odds of those with no qualifications having all four risk factors (smoking, excessive alcohol use, poor diet and low levels of physical activity) were five times greater than for those with higher education.

Mental health conditions: In Kent, there was a 24.6% obesity prevalence recorded on GP records among people with a mental health condition. The above 24.6% obesity prevalence are only people with mental health conditions based on the GP record. The QOF record indicates 9.5% obesity prevalence for the Kent and Medway ICB[7].

Disabilities: There is currently no available data on obesity and disability, however national data indicate that the prevalence of overweight and obesity was 72.2% among those with disabilities compared with 61.7% for people with no disabilities in 2021/22[8].

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[5] Ethnicity-specific BMI cutoffs for obesity based on type 2 diabetes risk in England: a population-based cohort study (thelancet.com)

[6] https://www.kpho.org.uk/__data/assets/word_doc/0003/154803/Gypsy-Roma-Traveller-HNA-2023.docx

7 Microsoft Power BI. Mental-Health-NA-Kent-2019.pdf (kpho.org.uk)

[8] Public health profiles - OHID (phe.org.uk)

Policy context – opportunity for change

The government has articulated a commitment to tackle obesity, building on the Obesity Strategy (July 2020). The NHS Long Term Plan outlines key commitments in tackling obesity. There is a clear emphasis on working collaboratively alongside local partners to establish effective, whole systems approaches to tackling obesity and improving population health.

In 2023, the Office for Health Improvement and Disparities set up various initiatives to start to tackle preventable conditions including obesity more proactively[9]. This includes work to restrict placement of less healthy products in stores and online to reduce impulse purchases, to introduce greater levels of calorie labelling in restaurant menus, creating a new diet for people with Type 2 Diabetes and researching new treatments and digital technologies to support people to achieve a healthier weight. They are working with NHS organisations and local authorities to support people living with obesity reach a healthier weight by developing effective preventative care plans for those at high risk of weight gain and diet-related illness through weight management services ranging from behavioural weight management programmes to consideration of weight loss drugs and bariatric surgery. It is therefore an opportune time to focus on optimising weight management services across Kent through this strategic action plan.

In Kent, good work had already begun in individual organisations, and collectively. For example, the KCC Public Health team have been working with other council departments and partner organisations to review Tier 1 and 2 services to ensure they are optimally in keeping with national guidance and best practice, as part of the Public Health Service Transformation Programme. Work by the council has been recognised as innovative and there is much learning from the work of the Whole Systems Obesity Approach programme which started in 2020 and aims to make tackling obesity everyone's business. Across the wider system, obesity is also a priority. For example, it is included as part of the ICS's Inequalities, Prevention and Population Health group's priority area and features in the Integrated Care System strategy.

Current Weight Management services in Kent – arrangements and resources

In Kent, all four Tiers of weight management services are provided for local people. KCC commissions Tier 1 and 2. The ICB commissions Tier 3 and 4. This includes:

[9] Government plans to tackle obesity in England - Department of Health and Social Care Media Centre (blog.gov.uk)

Tier 1 services (commissioned by KCC Public Health Team) are provided within the One You Kent service help to support the service's mission statement "to *motivate people to achieve and maintain a healthy lifestyle by supporting them to make positive lifestyle choices".* The service is designed to assess an individual and holistically provide them with the tools to make long lasting behaviour change allowing them to achieve a healthier lifestyle. Interventions are evidence-based and are based on the individual's strengths rather than their deficits.

Tier 2 Healthy Weight services (commissioned by KCC Public Health Team) are provided within the One You Kent service and aim to help support individuals to reach and maintain a healthy BMI, whilst also promoting the benefits of being a healthy weight. Services use motivational techniques over a 12-week course of interventions to help individuals set and achieve manageable goals around physical activity, diet and implementing behavioural change techniques. As part of this, KCC was awarded grant funding to meet the needs of harder to reach groups of people who may not readily access the existing Tier 2 weight management services already in operation. Due to insufficient funding, the provision of these additional services from the grant funding has now ceased.

Tier 1 and Tier 2 services are delivered by Kent Community Health Foundation Trust (KCHFT) in East Kent and the six Borough/District Councils in West Kent (Maidstone Borough Council, Tonbridge & Malling Borough Council, Tunbridge Wells Borough Council, Sevenoaks District Council, Dartford District Council and Gravesham Borough Council). At Tier 2 level, there is also a digital weight management programme that is nationally commissioned available for eligible local people. Further information about this national offer for our local residents can be found at: https://www.england.nhs.uk/digital-weight-management/how-to-access-the-programme/.

Tier 3 services (commissioned by the ICB) are delivered by TBC Ltd for eligible people in Kent and Swale. These services provide a face-to-face service over a 12-month period, including dietician and psychiatric support. This service also delivers access to weight management medication.

Tier 4 services (commissioned by the ICB) are delivered by Maidstone & Tunbridge Wells NHS Trust for non-complex cases. These are delivered by a number of London borough Trusts and are based on their treatment needs as well as choice.

These tiers are described in further details with eligibility criteria in appendix A.

It is increasingly recognised that there are inter-dependencies and a need for creating more seamless flow across the four tiers. Currently there is a waiting list for Tier 3 services which is causing bottlenecks and impacting on flow and access to support through the stages, mainly attributed to the pandemic back log. Work is being undertaken by the ICB to better understand the composition of this backlog both in terms of size, duration of waiting times, reason for any delays and appropriateness of referrals to this service. It is likely that the waiting times are a combination of these factors and understanding this will help to inform not only the work of the ICB in addressing these waiting lists, but also in the team delivering on this strategic action plan to optimise delivery at all parts of the Weight Management pathway locally for Kent residents. It provides an opportunity to review the whole pathway as there is feedback from primary care and other colleagues across the county that they would like greater clarity about the referral pathway and criteria, particularly in light of the latest NICE guidelines and opportunity afforded by the digital capabilities for increasingly simplified and automated triage processes.

Given the importance of this work for meeting the current and future needs of our local population, KCC and ICB partners came together in September 2023 to commence work scoping opportunities for improving local services through our joint efforts. This strategic action plan, which has been built on insights through this phase so far and in collaboration with wider partners and stakeholders, outlines actions that we plan to take to deliver on our vision for Weight Management services across Kent.

As part of this, a phased strategic action plan has been developed. Following phase 1 (August 2023 to strategic action plan launch in March/April 2024), we will continue with efforts to deepen understanding and build plans for implementing improvements against each of the strategic actions outlined. In the section that follows the strategic actions (key lines of enquiry) are outlined, including those that have been started through this process already (Phase 1), what more is needed (Phase 2), and how this will be achieved and measured.

The Tier 3 service waiting lists have been through a process of validation to confirm peoples' needs and whether they still need to be on the waiting list.

Unlocking a healthier future for our local people – seven strategic actions

To achieve our aim for weight management services in Kent, we have established the need for seven strategic weight management actions (key lines of enquiry). These were identified through a comprehensive study of existing research and reviewing successful weight management strategies, and communication and engagement with key stakeholders helped us to better understand the challenges faced by local communities and gather their perspectives on potential solutions, as well as gaps needing further work. Also, the strategic action plan has tapped into the learning from the KCC Public Health Service Transformation Programme and workshops. Through this collaborative approach, we refined the seven strategic Weight Management actions (key lines of enquiry) that we believe will be instrumental in helping us to deliver better Weight Management services for the people of Kent.

It is important for us to adopt the principle of equity as we review our approach to the weight management pathway. This includes ensuring that our actions take a proactive focus on understanding and tackling existing health inequalities. This also means ensuring that any interventions taken take care not to widen health inequalities further.

The seven key strategic actions (key lines of enquiry) are:

Figure 4

Strategic Action 1: Embedding the Weight Management strategic action plan into the wider context of prevention, clinical pathways and whole systems obesity approach, and building strong cross-system collaboration and leadership to oversee and deliver this together.

Strategic Action 2: Use the best of our collective skills across partners to understand in depth the needs of local people and plan together priority action to best meet these needs.

Strategic Action 3: Create a more seamless pathway for flow across the tiers and a single referral form to optimise referral, working across existing pathway areas which are led by different partner organisations to understand the state of play in more detail at each tier of the pathway and factors affecting quality, impact and flow across the tiers.

Strategic Action 4: Improve self-referral access, including information provision for local people and suitability checks by providers.

Strategic Action 5: Improve primary care understanding about the pathway, its needs and their engagement with this.

Strategic Action 6: Enhance our approach to service user engagement and use of insights gained from this by providers to optimise services further.

Strategic Action 7: Ongoing learning, knowledge sharing and innovation across local providers, internal and external stakeholders, national and international approaches to optimise continuous improvement approach to weight management.

These seven areas will now be outlined in more detail. In the development of this strategic action plan, we have commenced some of the work in these actions to ensure that we do not delay progress in the meanwhile. The actions underway in this interim period are classified as Phase 1 and will likely need to continue to be completed before moving into Phase 2 actions on the launch of this strategic action plan.

It is also important to note, although not an action in itself, the thread of maximising equity, understanding, and reducing health inequalities and ensuring that actions do not widen inequalities further runs throughout all the strategic actions (key lines of enquiry).

It is envisaged that the implementation group will look at every strategic action (key lines of enquiry) to take a proactive focus on understanding what more is needed, including for tackling health inequalities, and for each of these they will establish and start to implement concrete actions for change. Proposed steps and updates about progress will be provided through the governance routes articulated above, including measurement and evidence of impact. Where actions designed by this group signify considerable changes to services, at that stage the implementation group will design optimal methods for engagement and involvement specifically to inform this, including any public consultation as necessary going forwards also.

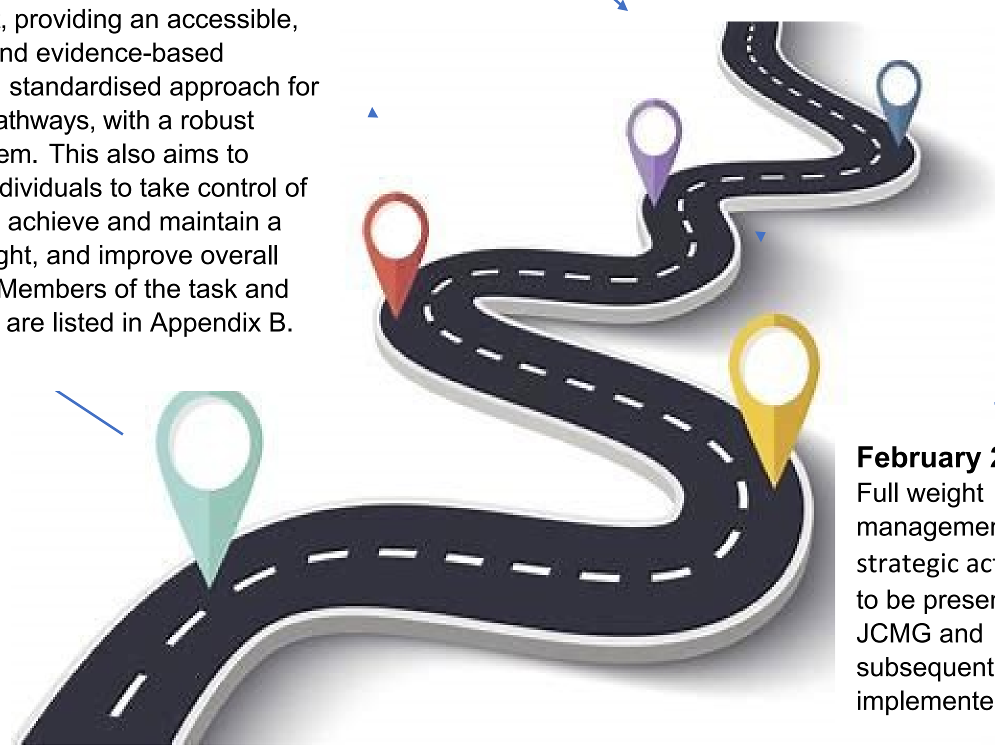
Strategic Action 1

Embedding weight management efforts into the wider context of prevention, clinical pathways and whole systems obesity approach and building strong cross-system collaboration and leadership to oversee and delivery this together.

This includes identifying, developing and strengthening partnerships with regional leaders and local networks to create a shared vision for change, which in turn will enable and support the right people to lead local change.

KCC and the ICB have been working together since September 2023 to build the foundation blocks for this strategic action plan (Phase 1 of this strategic action). We have developed a core group across both our organisations (and with input from others, including primary care) to commence work to plan the path to delivering the vision (illustrated below in Figure 5)

Figure 5 : Roadmap: starting well for success



For Phase 2, the cross-system core group will be reviewed and be refined to focus on implementation of the strategic action plan and provide longer-term oversight to create and sustain efforts for effective weight management services for our local population.

This action there will be focus on building greater strategic discussion with providers to build clarity to support the operational detail ensuring greater sharing of learning and insights about challenges as well as feedback from service users. This action will also ensure that weight management services are linked in with other services or stakeholders to maximise prevention, equitable provision and links to the Whole System Approach to Obesity programme. This also ties in with the aims of the ICS strategy where there is an emphasis on tackling the wider determinants to prevent ill health. Commissioned services to tackle the problem of excess weight will not reach the number of people required, which is why ensuring collaboration with the Whole System Approach to Obesity and wider determinants is extremely important.

For Tiers 1 and 2, an initial holistic assessment is undertaken to ascertain what support can be delivered by One You Kent services and what other support needs the individual may have. With consent, they would refer the individual to other services that meet other identified needs such as Drug and Alcohol services, Mental Health support, Debt and Housing services. In phase 2, KCC and the ICB will work together to identify potential joint commissioning opportunities.

Strategic Action 2

Use the best of our collective skills across partners to understand in depth the needs of local people and plan together priority action to best meet these needs.

Obesity is a complex health and social problem caused by many intersectional factors that requires a long-term plan and partnership across the system. The current local context around what we currently know has been described in an earlier section in this strategic action plan , but further work still needs to be done to understand the complexities around local needs. This is especially important as the trends in obesity are predicted to continue upwards, nationally, not just in Kent.

Based on national modelling and the increasing prevalence of overweight and obesity in Kent, it is clear that we need to do more to maximise the potential of the current Weight Management service, explore new methods of delivering a cost-effective service, and promote healthy weight among Kent residents.

In phase 1, the Public Health team at KCC will explore commissioning a multi-year survey that aims to understand more fully prevalence of obesity, associated risk factors (including physical activity and eating habits) and attitudes to weight related behaviours. With the research team within KCC Public Health, we are also exploring collaborations with academic institutions or submissions for calls for research that will help us understand specific cohorts that are affected by health inequalities within our population better (for example, specific ethnic groups or deprived geographical areas) or improve our weight management services.

The Kent Public Health Observatory (KPHO) are in the early stages of trialling the use of a system dynamic modelling tool, which can model or simulate population health impacts of behavioural determinants and specific outputs, for example the effect on services, disease prevalence or financial resources. As part of phase 2, we can explore how this modelling can help us understand the needs of the population better and plan specific changes to our services to the greatest benefit. To get the maximum benefit from the modelling, it would be pertinent to try to ensure the data from the services is linked to the NHS shared care records. This can help us to consider for example the proportion of people currently supported within the service and the number of people experiencing excess weight in Kent, and help us to explore questions such as:

- Are we doing enough to tackle the problem?
- What is the current reach?
- How could we take a more Proportionate Universalism approach to this work and what are the options for doing this (through options modelling and prioritisation)
- Consider the opportunity to link the dataset and tabulate the current services data.
- Reviewing the Tier 4 data available within the strategic action plan.

The task and finish group has already commenced preliminary conversation with KPHO leads to scope options for their involvement using SDM and so this is something that the Implementation Leadership Group should pick up following necessary strategic approvals.

Further discussion on gathering intelligence from stakeholders, service users and metrics to measure the services, and therefore improve our knowledge of gaps issues with the service, are addressed in strategic actions 5, 6 and 7.

This work will include establishing greater clarity about the data picture across all tiers (needs, service activity and how well they are meeting local needs, health inequalities that exist, experience, and impact on outcomes for people in the short, medium and longer term in terms of health and wellbeing). This is especially necessary for Tier 4 where at present there is paucity of data at this level due to commissioning arrangements to an external provider. This data picture will inform a process of ongoing review and improvement, supported by the work articulated on system dynamic modelling and thinking. This inform will then help to inform commissioning and delivery discussions about targeting of services to optimise equity including optimal models of delivery for maximum benefit for local people.

Strategic Action 3

Create a more seamless pathway for flow across the tiers and a single referral form to optimise referral, working across existing pathway areas led by different partner organisations to understand the state of play in more detail at each tier of the pathway and factors affecting quality, impact and flow across the tiers.

In Phase 1, the core group have commenced mapping local providers and data about service use across our organisations to establish a picture across the entire pathways from Tiers 1-4 (see table 1).

Table 2 below shows the number of individuals supported in 2022/23 across the tiers of Weight Management support. For Tier 2, data has also been shared around those who have successfully completed the Weight Management programme, lost weight and also those that have lost 5% of their original body weight.

A draft single referral form has been developed by KCC and the ICB for Tiers 1-3. The form will require further refining in Phase 2 and user acceptance testing to ensure all services have the relevant information to accept these referrals onto their programme. A link to the draft form is included here:

https://kentcc-self.achieveservice.com/AchieveForms/?form_uri=sandbox://AF-Form-7ea9d684-1680-48e5-a1f2-a20a76abd8d8&category=AF-Category-8a1487bd-7362-458b-97f5-c8cfdce1e5f7&isPublished=false

The service criteria for each tier have been reviewed through looking at various models for best practice from other Integrated Care Systems. Conversations have begun with providers to test these.

As can be seen from this data:

- For Tier 2, data indicates a higher than national average percentage of people who enrol onto the 12-week programme completing it and achieving weight loss (62%). 22% of people who completed the programme lost more than 5% of their body weight which compares positively to the national average of 16%.

- However, from this data is seems that there is locally a lower percentage of enrolments compared to national average. There is also still a low update from target groups (BAME, LD, males).
- However, further work across all the Tiers 1-4 would be helpful to understand the local situation more clearly as part of this strategic action plan . For example, the following areas:
    - Trends in the level of activity
    - Comparison with other weight management programmes
    - Breakdown of activity by provider locally
    - Data about waiting times – including source of referral, time on waiting list, reason for waiting, intervention and impact to reduce excess waiting, data about unwarranted variation
    - Provider performance and growth
    - Tier 4 data (currently none available)

In Phase 2, focus will be given to these areas and also considering the potential for further growth and innovation. This includes closer work with the KPHO to consider pathway modelling and scenario testing for improving flow through the pathways and seeking opportunities to better target under-represented groups using population segmentation and mapping methods. This will also include building more proactive review of this data between commissioners and providers to review areas of high performance and areas needing more attention.

Table 1: Overview of current Tier 1-4 specialist weight management in Kent and Medway

Kent and Medway ICS Adult Weight Management Services							
Tier 1		**Tier 2**		**Tier 3**		**Tier 4**	
Provider	**Which districts have access?**	**Provider**	**Which districts have access?**	**Provider**	**Which districts have access?**	**Provider**	**Which districts have access?**
Better Health - NHS (www.nhs.uk) Digital online resources, also available via One You Kent - Kent County Council NHS	All Kent	• National Diabetes Prevention Programme (Kent and Medway ICB) • Lifestyle intervention for people with non – diabetic hyperglycaemia (NDH). • Referral via healthcare professional (HCP) • Kent & Medway ICB	Kent & Medway	TBC Website | Home (tbchealthcare.co.uk) A fully comprehensive clinically led service that incorporates a dietetic, activity and behaviour change support program that all face and lasts for 12 months The service also provides a patient pathway for preparation and referral to weight loss surgery	All Kent	Maidstone & Tunbridge Wells NHS Trust	All Kent
Exercise - NHS (www.nhs.uk) Free online physical activity resources NHS	All Kent	Kent and Medway Marketing Engagement | Xyla Health & Wellbeing (xylahealthandwellbeing.com) • Low Calorie Diet – 12 weeks total diet replacement for people with type 2 diabetes • Kent & Medway ICB	Kent & Medway			Lewisham & Greenwich NHS Trust	All Kent
The Eatwell Guide - NHS (www.nhs.uk) Online resource on Healthy nutrition NHS	All Kent	NHS England » The NHS Digital Weight Management Programme 12 - Week online support for adults having obesity plus either diabetes, or hypertension, or both, to help manage their weight and improve their health. Referral from GP	Kent & Medway			Imperial College London NHS Trust	All Kent
Everyday Active Active Kent and Medway website providing information on locally available physical activity resources.	Kent &Medway	Healthy weight - Kent County Council • 12-week multicomponent community weight management service • Health professional and self-referrals • Kent County Council	All Kent			Chelsea & Westminster NHS Trust	All Kent
One You Kent - Kent County Council Kent One You Kent Healthy lifestyle for advisers provide brief interventions between 1 and 4	All Kent					Kings College Hospital London NHS Trust	All Kent
						St Georges Hospital NHS Trust & UCLH NHS Trust	All Kent

NB: Whilst this table provides a high level overview it is designed to be indicative (to give an idea of the rich mix of services on offer) rather than exhaustive. The production of a comprehensive catalogue of services available may form part of the next stage of this work.

Table 2: 2022/23 data on numbers supported and outcomes of weight management services (tier 2, 3 and 4)

	Numbers supported	Enrolled	Completed intervention	Participants who lose weight	Participants that lost at least 5% of the body weight
Tier 1	3,787 Diet and physical activity support	No data available	24% complete their exit goal within 6 months of finishing the service	No data available	No data available
Tier 2					
Kent - Core	2,038	38%	63%	62%	22%
National - All	85,605	65%	37%	43%	16%
Tier 3	2723	1111	92%	89%	66%
Tier 4	No data available				

For Tier 2, further information about OHID target groups is provided below -

		Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
% from Target Group (BAME)	%	7.4%	13.4%	13.3%	14.7%
% from Target Group (Males)	%	11.0%	10.6%	9.4%	14.6%
% from Target Group (LD)	%	2.4%	1.4%	1.5%	1.8%

In Phase 2, there will be a commitment to jointly review services, identify any gaps in data and undertake user engagement activities to ensure that services meet the needs of the Kent population. For Tiers 1 and 2, there will be a review of the data collected, in order to ensure that reporting evidences outcome achievement, value for money and service impact.

As part of Phase 2, we plan to finalise and implement referral routes, pathways between Tiers and the criteria for each.

Strategic Action 4

Improve self-referral access including information provision for local people and suitability checks by providers.

For Tiers 1 and 2 people can self-refer through the OYK referral form, hosted on the KCC website. Social media campaigns occur throughout the year to promote access to these services, with a dedicated weight management newspaper, social media and radio campaign occurring every January.

In Phase 1, we have commenced conversation with the providers of the Tier 2 services to establish current approaches to self-referral and ways to optimise this. In particular we are seeking to understand:

- awareness about self-referral and promotion of this to local people who may wish to access services
- current use of the forms and people's experiences about its ease of use
- current processes in place by providers to check the suitability of potential service users who are self-referring
- review of the criteria being used and to ensure both service safety by testing this against national guidelines and also other models of practice, as well as working with primary care to assess suitability, and working with the various providers and some service users to test ease of use
- over time developing automated methods for filtering people to the relevant tiers but ensuring manual checks for safety

Strategic Action 5

Improve primary care understanding about the pathway, its needs, and their engagement with this

Research has shown that brief, opportunistic interventions delivered in primary care can result in a five-fold increase in the proportion of eligible people engaging in weight management services. Simple advice from a health or care professional to lose weight increases people's' intentions to lose weight. However, referring people to weight management services can more than double the amount of weight they lose. This requires that referral to weight management services needs to be simple and effective. Hence it is important that we make the referral processes smooth and simple.

In Phase 1 we have started working with primary care professionals in the ICB and in local GP practices to understand their current experiences and to help shape our plans for improvement. This will help prevent any confusion around referrals to different tiers as, for example, people already on weight loss medications being referred to Tier 2 inappropriately, or people being referred to multiple tiers.

In Phase 2 we plan to conduct more widespread engagement with primary care and to create a more live dialogue about the ongoing oversight of weight management services in Kent. This includes understand more about the opportunity to link with Integrated Neighbourhood Teams and Health Alliances and the role that they can play in this plan. This action will include focus on how partners can work together to consider best ways of utilising existing resources and opportunities to work together to increase system capacity through existing resourcing to maximise positive impact for local people.

Strategic Action 6

Enhancing our approach to service user engagement and use of insights gained from this by providers to optimise services further

We believe that core to building optimal weight management services locally is in partnership with local service users, residents and communities. As part of this strategic action plan, we plan to:

- establish what the current practice and information held amongst providers is
- Consider the gaps and ways to fill them across the entire pathway (including under-represented groups)
- Use opportunities afforded by the KCC Public Health Services Transformation Programme to engage with a wide range of stakeholders, including service users.
- Build a plan for service user engagement for the medium and long term also to help ensure the services we commissioned are user informed (increasingly thinking about digital for this too plus keeping in mind minimising digital exclusion)

As mentioned in section 3, certain groups are at higher risk of having excess weight, for example those with learning disabilities or those with medication conditions. It would be important to ensure that services are considering their specialist needs, for example managing their weight in the context of medications that may make it more difficult for them to lose weight.

Services should also be inclusive and adaptive where possible, for example those with learning disabilities, those with different cultural background or do not speak English may need specific adaptations.

Strategic Action 7

Ongoing learning, knowledge sharing and innovation across local providers internal and external stakeholders, national and international approaches to optimise a continuous improvement approach to weight management

We know from our work already that we have a good, diverse range of providers locally delivering weight management services. However, we also know that they vary greatly in terms of size, strengths and also the challenges they face.

In Phase 1, we have engaged with over 40 stakeholders from the KCC Public Health Transformation Programme across our range of geographies locally, interest areas and sectors. We have heard about the opportunity to create a learning community amongst our providers to learn and grow together, share good practice, and unblock issues as they emerge, supported and enabled by us as the commissioners. We also know from our Whole Systems Obesity work that there is great value in creating and sustaining a network like this. However, we recognise that this takes careful planning and resource to do well.

In Phase 2, we will start to scope the options for supporting providers to develop together and start work to implement this in practice for the benefit of our local people. It is likely that we can use and share learning for other areas as well, and it may also be that we can combine our efforts. We will consider the use of digital media to support this and also consider the research and funding opportunities for unlocking innovations in so doing.

We are also keen to ensure that we are also aware of good practice and learning from other regional, national, or even international models, including academia.

In Phase 1, exploring different case examples, learning about good practices, and connecting with regional and national communities are vital steps towards achieving the best practices in weight management services. By examining successful interventions, adopting evidence-based approaches, considering community needs, and working together, we can effectively address weight management challenges and improve the overall health and well-being of individuals across diverse communities. This collective effort will pave the way for a healthier future and contribute to the advancement of weight management services on a broader scale.

Exploring case examples

Exploring different case examples provides valuable insights into effective strategies and approaches employed in weight management services. It allows us to examine diverse scenarios, including successful interventions and programs that have yielded positive outcomes. Through careful analysis, we can identify common factors that contribute to success and learn from the experiences of others. Case examples offer practical guidance and serve as a foundation for developing evidence-based practices.

Learning about best practice

Learning about best practice is essential for effective Weight Management services. These practices may include comprehensive lifestyle interventions, personalised dietary plans, regular physical activity, behavioural therapy, and creating supportive environments. Understanding best practice allows us to establish guidelines and standards to ensure consistent and high-quality care for individuals seeking weight management services.

Connectedness to regional and national communities

Effective weight management services must be contextually relevant and tailored to the unique needs of communities. It is crucial to actively engage with regional and national communities throughout the process. By doing so, we foster a sense of connectedness and gather diverse perspectives, enabling us to consider cultural and environmental factors that influence weight management practices.

Working together to achieve best practice

Working together is the key to achieving best practices in weight management services. Collaboration facilitates the exchange of knowledge, expertise and resources among stakeholders. Regional and national communities can come together to share successes, lessons learned, and challenges faced in implementing weight management programs. Through collective problem-solving and open dialogue, innovative solutions can be developed, tailoring best practices to specific community needs and resources.

7. Measures of Success

For us to measure success and understand progress against our key objectives and targets, it is crucial to establish clear metrics and regularly evaluate outcomes. By setting specific objectives and targets, and by analysing interpreting relevant data, such as weight loss metrics, improvements in health care, with a focus on health inequalities, and service user feedback, we can measure progress accurately.

Adapting a Donabedian approach as a basis to the framework of metrics, Table 3 shows measures used for tier 2 and tier 3. These metrics can also be analysed by demographics to determine and monitor inequalities, as well as working with providers to share or collect data on other populations that we know to have higher risks from excess weight such as those with mental health conditions or learning disabilities. However, having a consistent dataset will also need to be agreed across providers. We are currently not aware of any KPIs for tier 4.

Table 3: Key measure for success for tier 2, 3 and 4 weight management services based on current KPIs for the services.

	Process	**Outputs**	**Outcomes**
Tier 1	No metrics or data available	No metrics or data available	No metrics or data available
Tier 2	100% of participants enrolled in the service meet the eligibility criteria.	60% of participants complete the active intervention.	75% of participants will have lost weight at the end of the active intervention
	Referrals to the service	% of individuals enrolled in the service are from identified high risk groups (BME; men; people with learning difficulties)	30% of all participants will lose a minimum of 5% of their (baseline) initial body weight, at the end of the active intervention
		100% of enrolled participants are invited to provide feedback at the end of the active intervention.	50% of completers will lose a minimum of 5% of their (baseline) initial body weight, at the end of the active intervention.
		Patient satisfaction	35% of completers provide a weight measure at 6 months
			20% of completers provide a weight measure at 12 months
			% of completers at 12 months have a body weight which is lower than their baseline body weight

Tier 3	Number of individuals referred to the service	% of people attending and who are referred to the Multi Disciplinary Team (MDT) within 6 weeks	Referrals to Tier 4 based on pathway recorded at MDT.
	Inappropriate referrals to the service	Number of people who have attended within 6 weeks of referral	% participants who successfully achieve weight loss
		Number of people attending MDT within six weeks of referral	Reduction in medication use after active intervention
		Patient satisfaction (by patient questionnaires or surveys)	
Tier 4	No metrics or data available		

We will work together in the early part of Phase 2 with colleagues from KPHO to review these metrics and to create a wider dashboard to capture the impact of our work and contribution to improving the health and wellbeing of the local population and tackling inequalities locally. For example, we will consider the indicators that are measured nationally and locally within our public health team including those from the Public Health Outcomes Framework relating to obesity and obesity related conditions:

- Percentage of adults classed as overweight or obese (excess weight)
- Percentage of physically active and inactive adults
- Percentage of adults meeting '5-a-day' fruit and vegetable consumption recommendations
- The Quality & Outcomes Framework (QOF) includes an indicator for obesity as recorded in general practice disease registers, in those aged 18 and over.
- Hospital admissions for obesity
- Newly diagnosed type 2 diabetes
- Percentage of people with type 2 diabetes, as recorded on practice in general practice registers, in those aged 18 and over
- Percentage of people with type 2 diabetes who are of minority ethnic group
- Percentage of people with established hypertension, as recorded in general practice disease registers, in those aged 18 and over.

In addition to this we will also consider other metrics available, which together will help us to understand the impact of our work overall (accepting that given the multiple initiatives in some of these areas that it may be hard to attribute specifically to our work in places, but we would at least like to monitor trends and contributions to the best of our abilities):

1. Reduction on overall obesity rates in K&M and those of obesity related conditions – in year, and over time modelling the impact of this on the estimated disease prevalence locally also
2. Reduction in the gap of obesity prevalence between the most and least deprived areas
3. Reduction in number of people with hypertension utilising primary care datasets such as reduction of mmHg and the cost of prescribed medicines also (thus estimating financial savings and the creation of a more sustainable and quality model of care delivery)
4. Reduction in patients with Diabetes again both clinically and in savings of prescribed medicines
5. Reduction in number of people with acute disease prevalence and impact on service utilisation, for example people presenting with stroke or TIA
6. Shifting in the model of care from investment and focus on reactive care delivery to prevention and proactive care
7. Quality of care provision and engagement for planning delivery at all parts of the pathway as evidenced by staff and service user feedback
8. Measurement of the equity of service and the specific effectiveness against weight loss in terms of equity and completers.

We recognise that metrics are not only quantitative, and also include testimonials and success stories from service users. By sharing these and, in conjunction with the stories derived from quantitative figures, we can inspire and motivate others on their weight management journey. We also recognise that the formulation of this dashboard will in itself be an opportunity to strengthen relationships across the system as we will start by collating metrics that are currently collected by partners but also work to understand aspirations and build a dashboard that can enable the capture of not just activity but also delivery against these wider aspirations for and with local people.

Furthermore, staying informed about current models of weight management allows us to tap into best practices and innovative strategies that can enhance our programs. Regularly assessing progress and adapting approaches based on data and participant feedback enables us to continuously improve and achieve optimal outcomes in weight management services.

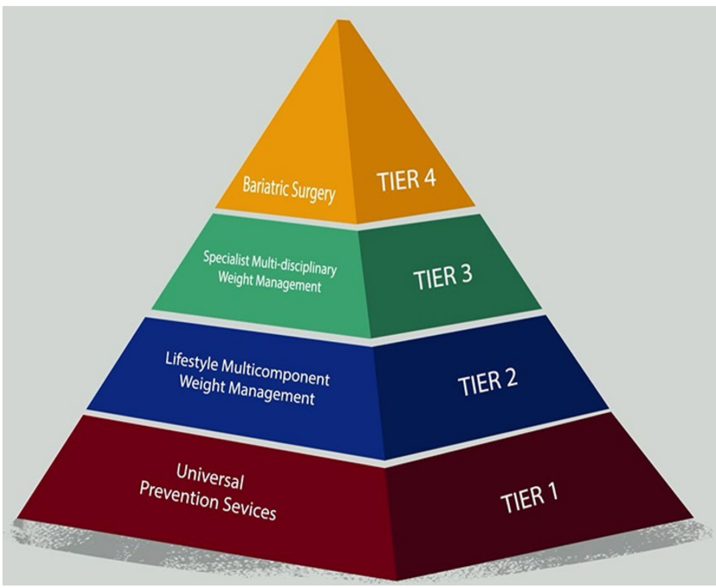
8. Appendices

A: Overview of current provision for weight management and obesity

B: Core members of the task and finish group

Appendix A: Overview of current provision for weight management and obesity

A stepped-care approach to tackling obesity



Treatment

Prevention

Classification	BMI (kg/m ^{2})
Healthy weight	18.5–24.9
Overweight	25–29.9
Obesity I	30–34.9
Obesity II	35–39.9
Obesity III	40 or more

From prevention to treatment:

When individual support or treatment is required for those who are overweight or obese, they are referred to weight management services.

There are different levels, or tiers, of weight management services.

Description of the tiered system of weight management services based on NICE guidelines

Tier 4

Type of service

- Surgical and non-surgical interventions
- Typically, bariatric surgery, with multidisciplinary lifestyle support pre- and post-op

Who can benefit/ who should be referred

- NICE guidelines (2016) state that bariatric surgery is the option of choice for adults with a BMI of more than 50 kg/m2 when other interventions have not been effective. Adults with BMI of ≥40, or ≥35 with other significant disease (e.g., Type 2 diabetes or high blood pressure) that could be improved if they lost weight, should also be considered for referral.
- Typically, referral to a Tier 4 is only considered if the person has already tried all appropriate non- surgical measures and received intensive management in Tier 3 service.
- See https://www.nice.org.uk/guidance/qs127 for further details.

Tier 3

Type of service

- Specialist weight management services. Provide non-surgical, intensive lifestyle management programmes, delivered by a multidisciplinary team, typically including specialist physicians, nurses, dieticians, psychologists, and physiotherapists/ exercise therapists.

Who can benefit/who should be referred

- NICE guidelines (2016) state that adults with a BMI of ≥30 for whom Tier 2 interventions have been unsuccessful should discuss the choice of alternative interventions for weight management, including Tier 3 services.
- Referral criteria for Tier 3 varies depending on locality. See https://www.nice.org.uk/guidance/qs127 for further details.

Tier 2

Type of Service

- Community-based lifestyle, weight management services. These are typically group-based and are focused on behavior change including diet, nutrition, and physical activity.
- Typically, limited time, up to 12 weeks

Who can benefit/who should be referred

- Anyone with BMI >= 25 (or lower for those from black and minority ethnic groups) or with other risk factors (comorbidities such as type 2 diabetes).
- May be particularly beneficial for those with BMI > 30 or from BAME groups or with other risk factors.

Tier 1

Type of Service

- Universal, behavioural interventions focused on obesity prevention and promotion of healthy eating and physical activity (for example through public health campaigns and providing brief advice in primary care/community settings)

Who can benefit/who should be referred

- The aim is to benefit the whole population through healthy lifestyle and physical activity public health strategies.
- In parallel, those who are overweight or at risk of becoming overweight may be identified within primary care/ community settings and offered brief advice (for example, from GPs, school nurses etc), together with support from local organisations, leisure centres and/or community-based groups through social prescribing.

Appendix B: Core members of the task and finish group

Name		Role	Organisation
Malti	Varshney	Director of Strategic Change and Population Health	NHS Kent and Medway ICB
Jules	Bole	Senior Programme Manager	NHS Kent and Medway ICB
Luke	Edwards	Senior Commissioner	Kent County Council
Abimbola	Ojo	Public Health Specialist	Kent County Council
Amrit	Matharu	GP Fellow with Public Health Team	Kent County Council
Durka	Dougall	Interim Consultant Public Health	Kent County Council
Dan	Coleman	Deputy Director of Elective Care	NHS Kent and Medway ICB
Constance	Wou	Consultant in Public Health	Kent County Council
Chris	Beale	Commissioner	Kent County Council
Lynette	Merry	Strategy Team Administrator	NHS Kent and Medway ICB

Appendix C: Core members of the Implementation Leadership group

Name		Role	Organisation
Ashwani	Peshen	Deputy Chief Medical Officer (Primary Care)	ICB
Sukhbir	Singh	Director of Primary Care Commissioning	ICB
Luke	Edwards	Senior Commissioner	Kent County Council
Abimbola	Ojo	Public Health Specialist	Kent County Council
Durka	Dougall	Interim Consultant Public Health	Kent County Council
Rutuja	Kulkarni-Johnston	Consultant in Public Health	Kent County Council
Chris	Beale	Commissioner	Kent County Council
Rachel	Parris	Deputy Director Out of Hospital Care	ICB

Version	Date	Changes/commentary	Agreed
1.0		Interim Weight Management strategic action plan for agreement presented to JCMG Group in December 2023	
2.0		Weight Management for strategic action plan agreement presented to JCMG Group in March 2024	
4.0	8 March 2024	Changes made by Prof D Dougall and Dr Abimbola Ojo (Public Health, KCC)	