EVIDENCE TO THE NICE PDG ON ADULT OBESITY BY DR. STEPHEN WATKINS DIRECTOR OF PUBLIC HEALTH FOR STOCKPORT JULY 2013
OBESITY AND COMMISSIONING

The Context

When the NHS was first established Nye Bevan intended that it should address the determinants of health as well as provide healthcare. The local authority Health Departments were the wing of the NHS which was to carry out this function. It is often said that the NHS has never addressed the determinants of health and that it is not structured to do so, but this is not true for, as part of the NHS, the local authority Health Depts. in the NHS's first quarter of a century cleared the slums and cleaned the air. What is true is that the separation of the NHS and local government from each other in 1974 left the NHS with no structure to address the determinants of health.
That changed in April of this year when public health was transferred back into local government as part of the health service, restoring the pre-1974 situation where local government managed part of the health service. Whatever one's general views on the Health & Social Care Act 2012 this is one part of the Act that was not only desirable but indeed was essential to restore the original vision of the health service.
It is unfortunate that s66 (4) of the Act defines the NHS in a way which excludes part of the health service – specifically the new local authority functions and PHE. The health service therefore now consists of the NHS, local authority health service functions and PHE. I doubt if many people will find it helpful that the terms "the NHS" and "the health service" have been given different meanings for the first time ever. The statement "public health in local authorities is part of the health service but not part of the NHS" is not a statement that resonates with clarity of meaning.
In considering the role of local authorities in commissioning lifestyle services we have to set that in the context of the total duty of local authorities to the health service, a duty which entails, indeed is primarily intended for, the pursuit of the determinants of health. Lifestyle services must fit into a strategy for improving health, sitting alongside issues like active travel.
We see commissioning as part of an overall strategy which also includes taking steps to address food supply in towns, cycle network, walking networks etc. These are outside the remit of PDG but it is pointless to commission services unless we make it easy for people to make the changes we advise. If losing weight were easy I wouldn't be the shape I am and wouldn't have to put "potential consumer" on the declaration of interests form. We need a strategy which understands the difficulty in making sustained change.
We will be spending money from public health grant on promoting active travel. It would be wrong if a local authority spent all its money on the wider determinants but it would be equally wrong if it spent none and only provided services. Our statutory duty is to contribute, within our areas of responsibility and available resources, to the maintenance of a comprehensive health service and that requires balance between different approaches not the pursuit of one to the exclusion of others.

How can we encourage local areas to keep on commissioning lifestyle weight management services?

Firstly it is necessary to understand that many authorities, including Stockport, are now commissioning integrated lifestyle services. We have a service that includes a website covering smoking cessation, alcohol, physical activity and weight management and is supported by health trainers and a service that amalgamates the previous different services.
Secondly it is necessary to understand the link to physical activity – weight management services should have a clear pathway to physical activity services. In Stockport our lifestyle services make referrals to PARIS, our exercise referral service.

Within that context it would be useful to have effectiveness evidence, to have material emphasising the importance of obesity as a health problem, and to have evidence of demand.

The impact of tier definition for commissioning / referral to lifestyle weight management services (we observed variation in definition of tier 2)

There are two different tier definitions in common use as follows

	Classification by Severity	Classification by Service needed
Tier 1	Normal weight	Universal services e.g. campaigns
Tier 2	Overweight	Lifestyle services
Tier 3	Obese	Specialist services
Tier 4	Morbidly obese	Surgery

The two definitions do not correspond. Not everybody who is obese needs specialist services and not everybody who is morbidly obese needs surgery. The use of the same words for different concepts is confusing.
The boundary between NHSE and local government in funding preparation for surgery has also caused confusion, although now clarified. .
Need to know where tier 2 fits so there is a pathway that runs through general promotion like good food to brief intervention to role of health trainer or lifestyle or weight management service. A term like "tier2" isn't really very precise. Does it include brief interventions and health trainers?

What recommendations would most support local commissioning – where can NICE add most value?

We would like you to tell us what works and tell us what the evidence is. But you need to understand, and welcome, that we will apply that in our local context. On the whole services do not work in isolation; they impact only as part of a collaborative endeavour.
There is a risk that what is recommended will drive out what you have not addressed. It would be unfortunate, for example, if the clear guidance that now exists on specialist weight management diverted resources from more upstream elements.

NHS v commercial providers – are there any issues around meeting the needs of a local population?

Both are needed – the health service alone cannot do the whole of the work.
The health service cannot charge for services. This is true even though there is evidence of reduced compliance without charges. This evidence, of course, may reflect only the fact that, if charges are made, only the most committed attend.

As well as the health service and commercial providers there is also the voluntary sector and the community sector. We can facilitate set up of local support groups. Nature of support will vary from group to group but it is definitely part of our remit to provide a degree of support to such groups. Not same as a course but could, for example, help find premises

Just as some free newspapers are not provided in certain postcodes which advertisers are not interested in, so commercial companies may not set up groups in deprived areas. Commercial providers do what is profitable and treat those who pay for it. There is a question how far we can legitimately counter by putting countervailing gradient in service. That is an issue that is debated –

where does prioritisation become the failure to provide a service universally to all. In our lifestyle service we have a universal service but we also have criteria for accessing a higher level which could be the severity of the problem but could also be the area where the patient lives. So to that extent there is a post code lottery that provides a higher level of service to deprived areas. The justification is that in those areas people face a more difficulty in adopting healthy lifestyle because of the commercial market and these market factors influence need.

Are you aware of any flexibility in the number of weeks referral or is it always 12? Our review work has indicated that most weight management referral programme are 12 weeks in duration however evidence also suggests that programmes of a longer duration can be more effective.

We do not offer this at present but are looking at it. However one of our programmes Keep It Off for Good facilitates people coming together into support groups if they feel they need this at the end of the programme.

Are there any local rules on re-referral to programmes?

We permit re-referral after consideration of individual circumstances. Losing weight is not easy and it is wrong to say that people should only have one chance.

Diversity

There is value in things like men-only courses and courses for people with learning difficulties.

How can we best ensure continued support from GPs following referral.

We aim to focus on building commitment to public health in general practice. Pathways are important. So is understanding of the value of brief intervention.

Including evaluation in contracts – is it possible?

It certainly isn't easy.

I have twice said that losing weight isn't easy, but actually it is. I have lost three quarters of a stone several times in the last two years. Unfortunately it has been the same three quarters of a stone each time. It is making sustained change which is difficult and this is the problem with evaluations that do not address the long term effect.

Weight loss may not be the only end point – mental health could be another.

There are data problems –routine data is limited and providers are reluctant to produce non-routine data.

It is too early to be sure how well our integrated service is working.

Role of scrutiny committees – do we need to make recommendations directly to them to support on-going monitoring?

Yes you should, but be aware that scrutiny committees vary considerably in their approach and their impact on local decisions. Some scrutinise broader outcomes, others focus on limited specialist reviews, and others have an eclectic agenda.

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