GK Research

Social & Market Research

Research report, March 2013:

Practical and process issues in the provision of lifestyle weight management services for adults

Report for:

The Centre for Public Health Excellence (CPHE) at the National Institute for Health and Clinical Excellence (NICE)

Report by:

GK Research

e-mail Graham@GKresearch.co.uk

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Background

The Centre for Public Health Excellence (CPHE) at the National Institute for Health and Clinical Excellence (NICE) is developing draft programme guidance on "Managing overweight and obesity in adults – lifestyle weight management services". The key audiences for this guidance are: commissioners of weight management services; health professionals referring adults to such services; and the providers of weight management services.

The draft guidance is being developed by a multi-disciplinary Programme Development Group (PDG), and will make recommendations for practice based on the best available evidence of effectiveness and cost effectiveness. However the PDG is aware that there are various practical and process issues which are unlikely to be captured by reviews of evidence. For this reason NICE sought out information, using a two pronged approach:

- NICE wrote to the 19 service providers they were aware of, with a list of relevant questions
- NICE wrote to all 558 registered stakeholders for the obese adults work, asking them to forward the questions on to any relevant contacts

It should be noted that the list of registered stakeholders is diverse, containing a variety of public, private and voluntary organisations with a direct or indirect interest in obesity or NICE public health guidance generally. The stakeholder list can be found at: http://www.nice.org.uk/nicemedia/live/13508/60525/60525.pdf

The questions addressed 11 broad themes, namely:

1. Description of service outline
2. Population groups targeted
3. Experience of working with disadvantaged communities
4. Barriers and facilitators around working with commissioners
5. Referral management
6. Non-attendance and drop out
7. Staff
8. Ongoing support (post completion of main programme)
9. Use of incentives
10. Monitoring and evaluation
11. Thoughts on the service's future

The full request for information, including the detailed questions, can be found in appendix 6. The request was sent to stakeholders in the week commencing January 28, 2013, with the deadline for responses set at February 25, 2013. The questionnaire can be found in appendix 7.

A total of 17 responses were received, one of which was judged to be "out of scope", since the service had not yet begun to be delivered.

The data from these free text responses was recorded in a spreadsheet, and providers were then asked to review their own data, providing clarification and amendment where necessary. Draft spreadsheets were sent to each contributor by March 1, 2013, and returned with revisions, by March 7, 2013.

This report has been written on the basis of data in this revised spreadsheet.

Please note that this report is based on what might be best described as a small convenience sample, including only those who were easily and quickly available, and with no special measures taken to encourage responses from non-responders. Responses were diverse. Consequently the reader should exercise caution in relation to the generalisability of the findings to the wider population of providers. For this reason specific percentages are generally not provided, and instead indicated very approximate proportions. Where specific numbers of responses mentioning particular opinions, policies and experiences, are provided these are intended to give very broad indications of the pattern of response, and not to encourage the calculation of specific percentage responses.

The report includes all the information provided by respondents - where explanatory information appears to be missing this is because it was not provided.

Question 1: Service outline

Please give a brief outline of your service. Please provide information on the following (as appropriate):

- *setting and delivery method - eg group, one to one sessions, online etc (if group, please state size).*
- *frequency of sessions*
- *cost of sessions*
- *who delivers the service*
- *age groups covered*
- *tailoring of service for individuals*
- *type of programme and duration*
- *referral criteria*
- *measurements and other key data recorded about participants*
- *any exclusion criteria (eg pregnancy, co-morbidities)*
- *precautions taken to ensure the safety of clients*
- *What components of the service do you consider to be particularly important and why?*
- *Has the service been adapted since its inception and if so, how and why?*

Business context of the provider

Seven of our 16 contributing providers were public sector services, delivering weight management services to single local authority communities. Another was a social enterprise delivering front-line services, but commissioned by a number of different local authority areas.

Two providers were not involved in front-line delivery, but their methods were used by those delivering to the public.

The remaining six were private sector providers. Some delivered "traditional" weight management services, while others offered weight management services involving provision of food/food supplements or monitoring technology.

Programme content

Most programmes were multi-disciplinary, addressing issues around diet, exercise and behaviour change. Four providers offered programmes focused on food and diet, and one provided a service involving new technology to enable the client to monitor their health and behaviour.

Note that one provider specified information about four different programmes, targeted at different groups.

Setting

Across the contributing providers there was a range of different settings/delivery contexts. Around half of programmes were delivered only in community settings, two were delivered

only in clinical settings, and four were delivered in both community and clinical settings. Other providers (particularly those based on provision of food or technology) tended to use telephone or online support, or both. One provider gave clients the option to use face-to-face, online or telephone support.

Frequency
Most programmes were delivered weekly, and in two cases more than once a week. Only two providers said that the programme ran on a fortnightly basis. In some cases the programme ran on a weekly basis initially, but at later stages the frequency of contact reduced. For example, in one case, it began weekly but over the whole 12 month period there were only six contact sessions.

For programmes using online methods, there is a lot more flexibility around what might constitute "contact" with the programme. Clients may have a regular planned session, but can access online advice and discussion throughout the week. Some of the "traditional" programmes also offer the option to access online advice and information outside of session times.

Cost of participation
Public sector programmes tended to be free of charge, or at low cost (e.g. £1 per session), and this was also true of some public sector provision delivered through private sector contractors.

Among other providers there was a wide range of fees for self funders. This is not surprising when we consider that a diverse range of programmes are being provided, some delivered face-to-face, others online, and some providing food/formula food or technology within the price.

In terms of "traditional" group weight management services, weekly fees for self funders are broadly in the £5-£7 range, but the picture is fairly complex, and the precise figure depends on special offers, discounts for payment upfront/direct debit etc. (Note that the figure specified here assumes that the client attends every week within a specified "contract period").

For programmes providing pre-prepared food and/or formula food the price for the client varies, from around £42-£63 per week. The reasons for this range include the sex of the client (females may pay less), and the frequency/intensity/method of support provided.

Who delivers the programme?
The range of staff involved in delivering programmes is diverse. In around half of cases the delivery staff are Health Trainers, Health Improvement staff, or (in one case) Healthcare Assistants. In three cases delivery was by detitians or a qualified clinician, and these tended to be programmes with a more 'clinical' approach, being delivered in healthcare settings and with all, or a high proportion of participants referred by health professionals.

In around six cases the programme was delivered by trained personnel without clinical or health improvement backgrounds, including people who had previously completed the programme successfully.

The technology monitoring service involved online support, delivered by trained customer service personnel, with support from "Scientists".

Groups and one-to-one approaches
Just three providers offered group sessions only in their mainstream provision, two of which were large national commercial organisations (one of which said that one to one sessions could be provided, if requested). The remainder were equally split between those offering only one-to-one, and those offering both groups and one-to-one provision.

Group size varied. Most group providers specified somewhere around the range of 10-20 participants per group, but a minority had groups with much higher numbers, and 50 was said to be typical by one provider.

One-to-one support was delivered online, or by telephone by two providers, and in these cases this support was based around an intervention which supplied the client specific technology or delivered food. A small number of those with one-to-one provision stipulated that this was available "if needed", and "if unable to attend the group".

Age eligibility
All provision specified by contributors was for adults, and this is not surprising, since the adult focus of the information request was clear. There was a fairly equal split between eligibility starting at 16 years, and at 18 years. Just one provider specified that the service was for people aged 17+. Three providers said that they would allow some flexibility around the minimum age in certain circumstances, with two saying that they would go down as young as 13 years, or even 10 years in some cases, if attending with a parent.

Three providers specified an upper age limit, set at 65 years in two cases, and 75 years in the other case.

Tailoring service for individual needs
All of those responding to this question claimed to offer at least some individual tailoring. There was a great deal of variety in the descriptions of personalised features.

Some said that all of their work was individualised, because individuals could set their own goals, and the programme sought to educate them in relation to energy balance, without prescribing any specific diet or exercise activities. Similarly, one provider said that the programme was able to be personalised within its broad framework, and two said that personalised, one-to-one advice/information was provided within the context of the general programme.

One provider specified that the initial introductory consultation was individualised, and two said that they were able to personalise the programme "where appropriate". Another said

that those requiring an individually tailored service would be directed towards their one-to-one programme, though it was unclear as to whether this was a higher tier intervention.

Other forms of individualisation were as follows, with each of these being mentioned by one provider:

- exercise elements of the programme are decided on the basis of the individual's circumstances and needs
- tailored advice can be provided in relation to cultural issues, and on traditional foods
- food supplied with the programme depends on the individual's sex, age, weight and physical activity level
- online advice is tailored according to the individual data uploaded
- advice can be tailored according to allergies, food intolerance and food preferences
- the programme length varies from 8 weeks up to 44 weeks, depending on the individual's circumstances and goals

Programme duration

Programme duration is not, as it might at first seem, a simple concept. It seems clear from the very wide range of answers provided that contributors have made different assumptions, around factors such as whether to include the initial assessment, whether to include the maintenance period, and whether to include optional sessions once a core of the programme has been completed. This complexity needs to be borne in mind when reading the following descriptions of programme durations.

The most commonly stated programme duration was 12 months, mentioned by six of the providers.

The next most common response was to say that there was no fixed duration, with participants staying with the programme as long as they wished. Similarly, one provider stated that the programme was a minimum of 12 weeks, and another specified that it could be from 8 up to 44 weeks. The providers specifying long durations were largely (but not exclusively) in the private sector.

Two providers specified programme durations of 12 weeks, two specified eight weeks, and one had a programme duration of 15 weeks.

Referral criteria

Seven of the contributing providers said that they had no specific referral criteria, and this was typically because most clients were self funded. Five were private sector providers, and two were in the public sector. In two cases, the providers operated a number of contracts for NHS Commissioners, for whom they operated minimum criteria on BMI, and miscellaneous other factors such as not having co-morbidities, not having been on another weight loss programme recently, and not being eligible for bariatric surgery.

Among the others, BMI-based criteria were in place. A BMI of 25 was the minimum requirement specified, applying on three programmes operated by two providers. One provider specified a minimum of 28, and four specified a minimum of 30. In a small number

of cases participants with lower than minimum BMI levels were admitted if they had co-morbidities, and in one case if South Asian.

One provider specified that they would only accept people with high BMI scores if the individual had no co-morbidities. This provider had three different programmes on which they required referral, and the upper limit was around BMI 40 in two cases, and BMI 30 in the other.

A small number of public sector providers specified one or more of the following criteria that participants must meet: to be local residents (or work locally); to be registered with the local GP; to be willing to embrace behaviour change.

Measurement and other key data

The great majority of providers record height and weight, and most also specified BMI. In a very small of cases only two of these three factors were mentioned, and it may be that the contributor assumed that we would infer the third factor.

The next most commonly taken measurements were on the waist (9 providers), physical activity levels (7), hip (5), mental well-being (5), food habits including portion control (5), and blood pressure (3). The following factors were recorded by just one or two providers: bust/chest measurement, arms/size/calves, 6 minute walking test, smoking status, alcohol consumption, attitude towards exercise, fruit and vegetable consumption, CORE, WHO questions, self-efficacy, psychological difficulties, stages of change/motivation, general health, history of anorexia/bulimia, dieting history and experience of undertaking the programme.

A small number of providers also mentioned contact details, management information and demographic information such as name, address, postcode, ethnicity, date of birth, NHS number, GP registration, age, attendance record etc. The majority did not mention such details, though it seems reasonable to infer that such basic information would be collected in most cases, at least when the provision is NHS funded. The same applies with the recording of BMI change and weight loss, i.e. though few mentioned this, it seems reasonable to infer that weight loss is calculated from the regular weight measurement data.

The one provider with a technology-based service delivered this through an armband which measures a range of physical factors - galvanic skin response, skin temperature, heat flux and steps, with algorithms used - to produce data for calorie burn, physical activity, steps, sleep duration and sleep efficiency. The individual client uploads the data online, and tailored advice is provided accordingly.

Exclusions and precautions

The most common exclusions (aside from age and BMI eligibility) were placed on pregnancy, breastfeeding and eating disorders. The latter were sometimes excluded if current, but others broadened the exclusion to those with a history of eating disorders. Each of these were mentioned by about half of those providers who gave us information at this question.

A small number of providers placed exclusions on insulin using diabetics, on substance abuse, and on people with unstable mood/self harming or a psychiatric diagnosis. Beyond these criteria, there was a long list of additional factors, typically specified by only one provider. This largely comprised of specific medical conditions. A comprehensive list is provided in Appendix 1.

In addition to exclusions, the questionnaire asked providers to specify any precautions taken. The most commonly mentioned precautions were risk assessments (e.g. on venues) and screening for medical conditions prior to participation starting. Each of these was mentioned by about one third of providers, but smaller numbers of providers mentioned related precautions such as completing the Physical Activity Readiness Questionnaire, encouraging clients to speak to their doctors about participation, having health and safety policies, and having qualified instructors.

Other specified precautions mentioned by only one provider are detailed in appendix 1.

Particularly important components of the programme
Providers were asked to specify elements of the programme which they regarded as particularly important. There was relatively little agreement, with the 16 providers specifying around 30 important components. Around half of the suggestions were made by only one provider. Those mentioned by two or more are discussed here, and the full list is contained within appendix 2.

The most commonly specified important component was one-to-one/individual support, mentioned by around a third of providers, as was the importance of key staff (expertise, providing support etc). Having a multi-disciplinary/multi-component programme was mentioned by three, with another two providers mentioning the related feature of having a phased/structured programme. Three providers mentioned the importance of a convenient/familiar location, and/or convenient session timing.

The following list of items were mentioned by two providers: having a behavioural change focus; having free/low-cost sessions; using therapy/CBT, particularly with higher BMI clients; group support; having a programme that meets NICE guidance; flexible follow-up and support activities; and control of food/diet - in one case through an eating plan, and in another case through supplied food.

Service adaptation
Providers were asked to describe how their service had adapted, over time. All except four providers answered the question, but the responses were very diverse, with negligible evidence of providers making similar changes, meaning that the 12 answering providers put forward over 30 service adaptations.

Only three specific adaptations were commonly shared by more than one provider. These were the introduction of NHS partnerships/referrals (by commercial providers) and the introduction of a new programme/system - both common to two providers. Three providers talked about introducing special sessions for targeted communities (e.g. learning disabled,

mental health service users, etc), though one of these defined this as working with specialist partner organisations.

The other service adaptations, each mentioned by only one provider, were as follows: introducing a longer initial assessment; having constant minor reviews; dropping the need for health professional referral, and allowing self referral; introducing new support material; acknowledging the importance of weight loss through activities undertaken outside the programme; annual reviews; widening the appeal with a hierarchy of products; operating a research programme to investigate issues such as safety of the programme with specific health conditions; ceasing to offer short taster trials, due to the risk of being seen as a "quick fix weight loss" scheme; introducing a new food plan; introducing an online service; introducing a mobile service; introducing a men only service; introducing enhanced leader training to address the needs of participants with more complex needs; offering a drop-in service (rather than a fixed number of weeks); changing venues; allowing mothers to bring babies.

Question 2: Different population groups

Does your service target any particular groups (eg particular gender, age, social or ethnic groups?) or do you attempt 'blanket' coverage? It would be helpful to know:

- *How do you promote your service to different population groups?*
- *Have you observed any differences in recruitment and retention rates between population groups? If so, what are these.*

Approximately half of the responding providers said that they did not target any particular groups, generally referring to "blanket" coverage. Amongst the other half, three providers specified that they predominantly targeted deprived communities, and another reported focusing its work on workplaces, probation and Black and Minority Ethnic communities.

The remaining providers mentioned their work with targeted group such as South Asians/South Asian women, Black and Minority Ethnic groups, people with learning disabilities and men only groups, but it was not clear whether these were ad hoc initiatives on top of primarily "blanket" mainstream provision.

Targeted promotional activity

From the responses it was clear that targeting of specific communities is mainly done by having partnerships with, or cooperation from relevant local services. For example, services in neighbourhoods with a high proportion of residents from the targeted community may be partnered with, or the weight management service itself may have a visible presence (e.g. based) in such neighbourhoods. These services included GP practices, health trainers, housing associations, probation service, community groups and charities.

There were only a small number of mentions of marketing materials being developed specifically for targeted groups.

Recruitment and retention

Only half of the contributing providers gave us information on this question, and from this limited data no clear pattern was discernible, apart from the fact that females tend to

dominate participation, sometimes by a ratio of 9:1. Nevertheless, one provider asserted that retention/attendance rates amongst males were better than those of females, once the males had been engaged.

Two providers said that retention was better among older participants.

One provider said that the service was most successful in attracting 30-39-year-olds, but another reported that the main age group of participants was 45-55-year-olds.

Two providers reported that they had been particular successful in attracting females from South Asian/Black and Minority Ethnic communities, with one of these also noting that the improved numbers had come about since specific targeted marketing had been implemented.

One provider said that retention rates were higher amongst White British/European participants, than amongst Black and Minority Ethnic participants.

Question 3: Disadvantaged communities

- *What is your organisation's experience of working with disadvantaged groups within the community e.g. adults with learning difficulties, or from black and minority ethnic groups or lower socio--economic groups?*
- *How do you reach these groups?*
- *Do you adapt your service in any way for these groups?*

Half of the contributing providers reported working with people with learning disabilities, sometimes through specially adapted provision, and on other occasions with the help of the caregiver.

The next most commonly mentioned category was deprived communities. This was specifically mentioned by about a third of the providers, although a small number of others also mentioned that their work was spread across the country, and many of the localities in which they deliver are disadvantaged, though they did not suggest that they set out to target any particular type of locality.

About a quarter of providers mentioned their work with Black and Minority Ethnic participants, though most said they did not specifically target these groups. The exception was one provider which did specifically target South Asian females.

One provider said that they work with partner organisations from faith communities. Another provider said that its (semi-independent)consultants do adapt their normal working practice if required, doing more home visits to participants living in isolated locations, or with limited mobility.

Reaching disadvantaged groups

Most providers used at least one of the three main methods of reaching disadvantaged groups. Firstly, using referrals through primary care (and sometimes Health Trainers) serving

the relevant communities and neighbourhoods. Secondly, forging links with local community groups and key figures in the target communities, to publicise the service. Thirdly, by locating the service in the deprived neighbourhood, and thereby having a visible presence and providing a convenient and familiar point of delivery.

Two providers said that they employed (or work with) outreach workers, to develop links with relevant faith groups and community groups. One provider said that they worked with the Learning Disability service in the local authority, and one national provider said that the marketing for local programmes was always designed specifically with the target community in mind.

Adapting the service to better serve disadvantaged groups

A range of service adaptations were specified, though in some cases it was clear that these adaptations had been made in exceptional circumstances, such as one-off contracts, where the commissioner had particular targeted objectives. These experiences should not be taken to demonstrate incorporation of such methods into mainstream, ongoing provision.

Three providers mentioned adaptation of programme delivery methods to accommodate the needs of participants with learning disabilities. This could include attendance with their caregiver, use of visual aids, or using techniques such as role-play within the sessions.

Two providers said that they made language and cultural alterations to their programme delivery to optimise the appeal and usefulness for certain groups (sometimes specified as South Asian females), such as single sex aqua sessions, female instructors etc.

Two providers said that they used translated materials and/or interpreters when the participant group contained people with limited English.

Two providers said that the food they provided, or the information about appropriate foods, was tailored as required, for minorities including vegetarians and South Asians.

No other service adaptation was mentioned by more than one provider. These single mention adaptations were as follows: cook and eat sessions for homeless participants; community development teams with embedded health trainers; “piggybacking” on existing groups, e.g. women’s groups; mobile services serving isolated communities; varying the price to make it affordable in specific communities; special provision for wheelchair users, e.g. being weighed in the wheelchair; large print support materials; training in cultural awareness for programme leaders; allowing a helper to attend alongside a hearing-impaired participant.

<u>Question 4: Working with Commissioners</u>

What is your experience of working with commissioners of lifestyle weight management services for adults? In particular:

- *What are the key barriers?*
- *What are the key facilitators?*
- *What are the key performance indicators and are these linked to payment?*
- *Have you been involved in setting or negotiating goals required by commissioners?*

Six of the contributing providers had no current relationships with public sector commissioners. Some dealt only with self funders, and others sold their proprietary weight management methods to local organisations which run programmes for the public. These local organisations had contracts with local commissioners, but the contributing provider had no direct relationship with commissioners. These providers made very limited comments, and where commented on in this chapter, they are explicitly identified in the sections below, in order that this context can be understood.

Key barriers/unhelpful factors

In this section we describe the barriers identified by more than one provider. A more comprehensive list can be found in appendix 3.

Around half of the providers with existing Commissioner relationships said that lack of funding or budget constraints was a key barrier. This tended to result in limited opportunities for service development and the training/support of practitioners. One provider said that the absence of lifestyle services from the Quality and Outcomes Framework (QOF) was unhelpful in this respect.

About one third of these providers said that Commissioners were excessively focused on short-term weight loss outcomes, not recognising the need to spend time equipping participants with the skills and knowledge that would enable sustainable weight loss and behaviour change. One provider criticised the practice of having outcome measurement over 12 months, following a programme only funded for 12 weeks.

Similarly, around one third of these providers were critical of the Commissioner's lack of help in influencing primary care and other potential partners into supplying a strong pipeline of referrals.

Some commercial providers observed that Commissioners often finalise tender specifications without having a dialogue with potential tenderers, and without the aid of a "toolkit" to inform them of best practice in specification content. There was also some concern that some Commissioners could be biased against the private sector, though it should also be noted that we also had some indication of public sector providers feeling disadvantaged when in competition with large commercial providers.

One of the providers which had no direct commissioner relationships itself reported some feedback from its local delivery agencies. This was the view that small, local providers find the tendering process complex and time-consuming, and feel at a disadvantage compared with large, national commercial competitors.

Key facilitators/helpful factors

The most commonly cited facilitating factor was good communication. Around half of those commenting mentioned this, using terms such as "the Commissioner listens to us", "openness and transparency" and mentions of regular meetings.

The importance of the strategic role was underlined by those commenting on the Commissioner's help with identifying target populations, integrating related services and promoting the service with stakeholders and potential partners.

Some of the commercial providers commented that it helped if the Commissioner was not biased towards public sector providers.

Key performance indicators (KPIs)
Only nine of the 16 contributing providers specified the KPIs to which they worked. In total they specified 18 different factors on which KPIs were based.

The most commonly cited factor was weight loss or BMI reduction, being mentioned by seven providers, and typically described as based on the proportion having at least a 5% weight loss. The period over which this had to be achieved was not always specified, but could be as long as 12 months, and in some cases the target applied over a shorter period and was expected to be maintained over 12 months.

Four providers said that they had a KPI based on increased physical activity levels. Three providers had targets on increased well-being.

Three providers had been set a KPI on the proportion of participants completing the programme, and three specified that the target was based on attendance, or "patients seen". The definition of completion, and the threshold for attendance were not specified.

Three providers said that customer feedback (either comments or level of satisfaction) was a key performance indicator, but no detail was provided on how this applied.

Three providers mentioned key performance indicators based on addressing inequalities. For example this might include the proportion of residents in deprived areas (postcode defined), from Black and Minority Ethnic groups, or aged over 50.

No other specified KPI factors were mentioned by more than one provider. These single mention factors were as follows: "18 week wait"(presumably a target relating to a participant waiting list); number of referrals; change in healthy eating habits; success with participants with a BMI over 40; proportion of men; proportion of women; fruit and vegetable consumption; cost per patient; disability adjusted life years; the achievement of individually set goals.

The provider relaying feedback from its delivery agencies made a number of comments about KPIs. They said that there is a lot of confusion over what constitutes completion/success, e.g. is it at the end of the programme, or after a maintenance period? They also reported uncertainty over what will happen when public health moves into the new structures after April2013. Finally, they mentioned the requirement to take measurements after 12 months, commenting that providers find it difficult to get participants to re-engage after such a long time, and that this would be a major cause of concern if 12 month outcomes were linked to payment.

Linkage between key performance indicators and payment
Only two providers were currently operating with payment linked to KPIs, though a small number did say that they expected this to be introduced in the foreseeable future.

The two providers with current experience of payment linkage were large commercial operators, with linkage on some of their public sector contracts. One said that this took the form of no payments being made for non-attendance. The other said that that such linkage has increased over the last 18 months, typically through non-payment for non-attendance, or through a bonus system based on the proportion achieving a 5% weight loss over a specified time. Both expressed concerns about the setting of targets without reference to relevant evidence.

Involvement of providers in goal setting
Only around half of the contributing providers gave us a response on this question. Amongst those answering, experience was divided fairly evenly between "yes" and "no".

Two large commercial providers reported that involvement happens on some contracts, but not others.

Question 5: Referrals
How does your organisation manage referrals from NHS, local authority or other organisations? It would be helpful to know:

- *How do you promote your service and where do referrals come from*
- *Do participants receive a different service according to their referral source, e.g. are self referrals treated differently from those from eg primary care.*
- *Are there any differences in the referral process, or referral rates, according to participants' characteristics (e.g. age, or ethnicity).*
- *Is a GP or other health professional required to approve an individual to participate in your programme(s)?*
- *Do you provide any training or support for agencies making referrals to your service?*

Source of referral
Three of the private sector providers did not receive referrals in the conventional sense, dealing directly with the public, though one commented that GPs would sometimes signpost their patients to the service (i.e. an informal referral). Another provider was the developer and owner of a weight management method, and not involved directly in front line services.

Only one provider had no participants via self referral, recruiting only through primary care referrals.

Promoting the service to the referral source
This question was interpreted inconsistently, partly due to the varying business contexts of our providers. There were three types of response:

1. how they promoted the service to individual referral agencies (e.g. GP Practices, health improvement teams), to raise awareness of both the service and the process for making referrals

2. how referral agencies promoted the service to potential participants
3. how the organisation promoted the service to potential contract letting commissioners, e.g. organisations publicising their services to NHS commissiners

Information covered by the second interpretation has been addressed earlier in this report, and the third interpretation is not relevant to this information gathering exercise. Consequently information in this section relates to the first interpretation, which was the original purpose of this question.

The most commonly specified method was for the provider to have a partnership approach with the primary care practice, for example by having a presence in the surgery, or in a pharmacy. Similarly, one provider service was part of the wider Health Trainer service, receiving most of its referrals from the Health Trainers and their partners.

One provider said that they give all referral agencies a resource pack with all relevant information and an explanation of how to make a referral. One might have expected more providers to mention such a resource, and it is perhaps the case that this sort of material is not considered "promotion", and was therefore not considered when answering the question.

One provider said that they employed an outreach worker to liaise with referral agencies, and another said that they obtain slots on GP academic days and in departmental meetings, to talk about the service with potential referrers. Another provider said that they respond to requests to do talks for health professionals.

Tailoring the service according to referral source
No provider reported any difference in the service provided on the basis of referral source, apart from limits on programme duration specified by the commissioner, e.g. only a limited number of weeks funded on programmes which are not of limited duration for self funders.

Differences in referral rates by participant characteristics
This question was unanswered by most providers. The small number of answers were written from diverse perspectives, with some mentioning participant age and some mentioning ethnicity, and within these topics some referred to current proportions, whilst others referenced trends. Consequently no meaningful analysis was possible, due to the diversity of focus.

The requirement for approval from a health professional
As noted above, a number of the contributing providers dealt directly with the public, and received no referrals. Four providers did not answer the question.

Amongst the remainder, only two answered an unqualified "yes" to this question, but another one said that it could be required if exercise was involved, and another required GP approval for participants with certain medical conditions.

A small number said that approval from a health professional was needed on certain contracts/programmes, depending on Commissioner requirements. One said that GP

approval could be problematic because health professionals may have limited knowledge of the programme, and may be reluctant to approve the case this is interpreted as endorsement of a commercial service.

Training and support provided to referral agencies
Only around half of the contributors answered this question, in some cases the absence of an answer was because they did not work with referral agencies, but in other cases it was simply left blank despite potentially being relevant.

Amongst those answering all did some work with referral agencies, though it was not always clear whether this was an ongoing programme of activity, or as specified in one case, an initial one off visit when the programme started.

In six cases there did appear to be some form of ongoing training and support. This could be through a dedicated development team, local contract launch events, refresher training on assessment and obesity, regular training on Making Every Contact Count, or regular links with relevant professional such as Health Visitors, Health Trainers etc.

Question 6: Attendance and dropout
Please describe your organisation's policy and practice when individuals fail to attend or drop out of the programme. In particular:

- *Please describe your policy on non attendance or drop-out.*
- *Are some people more likely to drop out than others? If so, please explain who is more likely to drop out.*
- *Have you observed any differences in attendance or drop-out according to whether participants self fund or are referred from eg primary care.*
- *What is particularly important in reducing non attendance or drop-out?*

Policy on non-attendance and dropout
Most providers did have a policy on non-attendance, but a small number of the providers operating self funded services without face-to-face contact did not see this as particularly relevant and, for example, pre-paid for food continues to be sent even if telephone/online consultation appointments are missed.

For those with a policy it was the norm to contact non-attenders after each unexplained absence, usually by telephone, to investigate the reason and encourage future attendance. In just one case, the provider only attempted this contact after three missed sessions.

Some programmes are ongoing, all year round, and self funding participants are not expected to attend every session. However for public sector funded/referred participants, one of these providers indicated a process of contacting non-attenders similar to the one described above.

In one case participants are discharged from the programme if they fail to lose at least 1 kg in the first four weeks. This was a community programme delivered by detitians in healthcare settings

Are some people and families more likely to drop out than others?
Only around half of contributing providers responded to this question. None of the responders provided any data to support their suggestions, which were diverse, with little cohesion across the responses.

Time constraints seem to lay behind the suggestions that dropout rates are greater amongst people aged under 50, full-time workers, those with caring responsibilities, and new mothers who had to return to work during the programme.

One provider specified people with chaotic lifestyles, and another suggested those with depression, as being more likely to drop out of the programme.

One provider said that South Asian females have less regular attendance than other groups (though not necessarily greater drop out levels), and another suggested that certain ethnic groups were more likely to drop out because exercise was not part of their culture.

Another provider said that those not fully complying, and not being completely honest, were more likely to drop out of the programme. Failure to complete food diaries was given as an example of non-compliance more likely to lead to drop out.

Self funding versus referred and funded participants
Very little information was obtained in response to this question. Some providers have no referred/funded participants, and others have no self funders, so they cannot compare. Of the remainder, most said that they had no information/did not collect the data.

Only two providers directly answered the question. Both were large commercial providers. One noted that it had been hypothesised that NHS referrals would have lower attendance levels than self funders, because they were not personally paying for the service. However actual attendance levels have proved to be similar between the two groups. This may partly be explained by the information from the other provider, stating that NHS referred participants (compared with self funders) tended to have a higher starting BMI, and were more likely to have a medical motivation for participation, often on the basis of very firm advice from their GP.

What is important in reducing non-attendance and drop out rates
The response to this question was varied, reflecting the fact that there is no strong consensus around the most important issues.

The most commonly mentioned factors, each specified by four providers, were convenient session times, and having participants who were ready to change and understood what the programme involved (e.g. they had been screened/inducted effectively).

There was a cluster of related factors around the role of the programme leader/facilitator. Three providers mentioned the need for a programme leader who was enthusiastic and fully understood the programme, and two mentioned the importance of the programme leader developing a rapport with the participants. Another two mentioned the value in having consistent staff delivering the programme (i.e. the same staff in each session).

Enjoyable/welcoming sessions were mentioned as particularly important by three providers.

Two providers emphasised the value of reminding participants about the upcoming session (e.g. text messages). Another two providers said that the programme needs to address individual needs, with an approach that is more than "one size fits all".

Other factors considered important by only one provider included the following: avoid excessive pressure to lose weight, as this can lead to demoralisation and dropout; the group dynamic/social benefits of participation; clients who are prepared to use formula food are already highly motivated; communicate creative ways of dealing with "pitfalls" (e.g. special occasions, social eating etc); providing appropriate support; good quality educational tools; local delivery sessions.

Question 7: Staff

What is your organisations policy and practice in relation to staff (or peer) support? (Please do not include normal staff meetings, or standard features of management supervision). In particular:

- *What sort of experience, qualifications or personal characteristics (eg personal experience) do you require from staff (or peers)?*
- *What training do you offer staff (or peers)?*
- *Do you evaluate the performance of staff (or peers) and if so how and using what criteria?*

There was a diverse range of responses to these questions. No single qualification or characteristic was common to even half of providers. This would seem to be the result of differences between the types of programmes provided, but also differences in terms of the specialist staff they were considering when answering the question. For example, some included staff with nutrition qualifications who may have been involved in support and development of the programme, whilst others seemed to focus their answers on frontline delivery staff.

Required experience, qualifications and characteristics

In terms of qualifications and skills, the most commonly mentioned requirement was for relevant qualifications/training in subjects such as nutrition and physical activity. This was sometimes expressed in terms of a specific qualification (e.g. degree level, or City and Guilds). Only five contributing providers mentioned such specific requirements.

Communication skills/listening skills were mentioned by three providers.

Other qualifications and skills included the following, each of which was mentioned by only one provider: a minimum of 2 A-levels with one in a related subject; safeguarding training; motivational interviewing; basic counselling; behaviour change; English language; IT skills.

In terms of experience, three providers required staff to have successfully lost weight through their programme in the past. Two providers mentioned the need for having experience of data collection/record-keeping. Experience in advice giving, group facilitation and community working where each mentioned by one provider.

A long list of personal characteristics was put forward by the providers, with emotional awareness/empathy clearly topping the list with six mentions. Three providers looked for a personal interest in food/health/science. Social skills, the ability to influence/develop rapport and enthusiasm, time management, and sensitivity to diversity were each mentioned by two providers. The remaining characteristics were each mentioned by one provider, namely: team working; flexibility; confidence; the ability to empower and support.

Training provided for staff

Most had a basic training programme which was compulsory for those leading the programme delivery on the frontline. The intensity of this varied significantly, and this may in part have been due to the wide variation in qualifications required of new staff. The minimum "core" training was a one-day session, and the maximum initial duration was two weeks of training. However, this is not a simple issue to quantify, since related periodic training also varied, with many delivering ad hoc/refresher type sessions and continuous development training, which in one case involved taking four examinations.

Beyond the basic introductory requirement, the most common subjects on which training was provided were nutrition, weight management, behaviour change and exercise (each with three or four providers specifying).

No other subject was specified by more than one provider. These other subjects were as follows: shadowing of the programme leaders; peer reviews; safeguarding training; personal development training; clinical supervision sessions; NHS mandatory training; Health Trainer training; smoking cessation; alcohol; working with men; diabetes; NHS information governance.

Performance evaluation

Almost all providers responded to this question but it is difficult to interpret and compare, because of the diverse range of methods used, and the inconsistent focus of information provided.

Three providers assessed staff on the basis of quantitative participant information, such as attendance, assessments conducted, weight loss criteria etc. One of these providers said that this data was used only on contracts where it was specified by the Commissioner.

Two providers mentioned one-to-one assessments, one of which was in the form of monthly meetings with the line manager.

Two providers mentioned using observation of staff. In addition, one said that they carried out "spot checks", and another referred to "unannounced reviews". These may also have been observations, but it is not possible to be certain from these descriptions.

No other evaluation method was common to two providers. Methods specified by just one provider were as follows: evaluation through a competency framework; evaluation through the Trust's standard appraisal; user satisfaction ratings; best practice reviews; monitoring non-compliance; using a scorecard; Q&A tests.

Question 8: Ongoing support

- Please describe any maintenance period activity, once the main intervention has finished.
- Please describe any other ongoing support (over and above the standard maintenance period).
- For each of the above, please tell us:
  - how long the activities last
  - the level of uptake
  - any barriers and facilitators to provision and uptake.

The nature of ongoing support

On 10 of the 16 programmes the maintenance provision is in the form of periodic progress checks (e.g. monthly, quarterly or six monthly) after programme completion, usually up to a 12 month endpoint. One of those providing ongoing support up to 12 months said that it was extending this period for participants identified as requiring longer-term support.

Four of the programmes were not time-limited, being all year round rolling programmes, which participants were able to attend for as long as they wished and were willing to pay for.

One programme (based on delivered food) operates a maintenance phase once the individual's goal is achieved. The maintenance support is in the form of monthly telephone calls.

The technology-based programme operates by participants signing up for six week programme, with the option for further purchases from the website, on a discount basis. Clients are entitled to ongoing support through the website.

One provider supplied some interesting thoughts on what ongoing support means for the participants. This provider runs an ongoing, all year round programme for self funders, on which those individuals can agree a personalised targets and timetable with the programme leader, moving towards a healthy weight in a series of stages which do not have prescribed durations. Alongside the self funders they have public sector funded participants who are typically restricted to 12 sessions, and whilst there is good evidence to show that such a short intervention can deliver weight loss of around 5%, there is no clear evidence on what "maintenance" means in this scenario. It could possibly mean maintaining weight at the 12 week achievement, or continuing the rate of progress towards a healthy weight, or to consolidate before resuming weight loss. In the opinion of this provider, a better service could be provided if the public sector were to have a genuine partnership approach, allowing the provider to agree personalised strategies based on an individual's needs.

Other ongoing support

There was a very diverse range of other forms of ongoing support. The only form of other support common to a number of providers was information/advice/forum discussions on the website, which was mentioned by four providers. On a similar theme, another provider said that those achieving their target weight were given a free resource pack, containing advice and practical tips.

Two providers said that those with specified achievement levels could become members for life, using the service for free thereafter. In one case this level was defined as completion of

the programme, and in the other it was the achievement and maintenance of a healthy weight.

Two providers said that they encouraged participants to continue to meet, though it was unclear whether the provider took any steps to facilitate such meetings.

Two providers said that they offered fun days/themed reunions (e.g. Christmas and Easter).

Other forms of ongoing support, mentioned by only one provider, were as follows: encouraging regular weight checks at the GP surgery; signposting to physical activity options; if struggling, ex-participants are welcome back to the programme; Consultants are encouraged to keep in touch with the participant, who may or may not choose to continue purchasing formula food; higher-level weight loss protocols are available.

Take-up of ongoing support
Very few providers responded to this question. Only two providers supplied specific information, with one citing a take-up rate of one quarter, and the other citing 30%.

Other responses were less specific. One provider said that take-up was “generally good”, but another said it was “low”. Another provider said that they had noticed a gradual decrease in take-up, but it was not clear whether this was within individual programmes (e.g. 12 month take-up lower than 6 month take-up) or across programmes (e.g. 2013 take-up lower than 2010 take-up).

Barriers to the take-up of ongoing support
Only a minority responded to this question, and they suggested a variety of potential barriers, without views coalescing around any particular reasons.

- Time constraints due to work and childcare (including mothers returning to work)
- Lack of cooperation from GP surgeries in assisting with the periodic weight checks
- Some GP surgeries do not have good quality scales
- Ex-participants can feel that they should not “waste time” of the Consultant, once they have achieved their goal
- The ability to continue paying for the service
- Lack of familiarity with the technology (re-online support)

Facilitators of the take-up of ongoing support
Only two providers put forward their thoughts on facilitating factors. One said that take-up was better if the Practitioner involved was the same one that led the programme. On a similar theme, another suggested that the quality of rapport between the staff and participants was key to a good level of take-up of ongoing support.

Question 9: Incentives

Do you have any experience of providing incentives or rewards to users (for example, for achieving a specific goal)? If so:

- *What incentives do you use?*
- *Do incentives differ between referrals from eg primary care and other users?*

Do you have any reports or other written evaluations that indicate the success or otherwise of incentives?

Eight of the 16 contributing providers said that they did not use incentives. Three said that the practice varied according to the policy of the delivery agent using their method, across different locations. One provider did not respond to the question.

In the remainder of this section we discuss the responses from the four providers from whom we received descriptions of their policies around incentives, none of which were public sector organisations. These providers tended to see the use of incentives as very important, describing them in terms such as "vital" and "a key part of the programme".

The nature of rewards

Verbal praise in front of the group was considered a reward in face-to-face sessions. Other awards for achievements included the following: exercise equipment (e.g. resistance bands); healthy recipe books; packets of vegetable seeds; baby bibs (from a provider with provision targeted at new mothers); water bottles; pedometers; stickers; text messages; keyrings; certificates.

Major achievements could receive rewards such as a change in membership status, privilege cards for the use of leisure facilities, discounts/free sessions and the opportunity to have a one-to-one session with a specialist adviser. There were no examples of cash being offered as an incentive.

Variation in policy on incentives according to referral source

Only one provider answered this question, stating that there was no difference between the two types of participants in terms of incentives. Some providers had either only self funded, or only public sector funded participants, so would be unable to make a judgement.

Evaluation of the use of incentives

Only a very small number of providers answered this question. One reported that, on the basis of limited feedback, they believe that their incentives are viewed positively. The other provider had conducted qualitative research which found that "the weight loss journey is perceived to be a massive challenge, and great value is placed on rewards for small successes".

Question 10: Monitoring and evaluation

How does your organisation monitor and evaluate the programme(s) you offer? In particular:

- *What data do you record?*
- *Do you evaluate the programme according to whether participants self referred or were referred from eg primary care.*

- *How do you define 'completers' or successful weight maintenance.*
- *What are your success criteria (eg X% weight loss at 1 year)*

All of our contributing providers reported some form of evaluation activity.

What data is recorded?
Note that there is some inconsistency between measurements specified at question 1, and data recorded at this question. This may be due to human error, or may reflect the fact that some measurements are taken for individual record-keeping and context setting, but are not part of the wider evaluation procedure.

All except one provider recorded weight, and the exception was the technology-based service. Most recorded height, and most specified BMI. In a very small number of cases only two of these three factors were mentioned, and it may be that the contributor assumed that we would infer the third factor. Similarly, some providers specified that they recorded change in weight/BMI (e.g. weekly, pre- and post etc), but it seems very likely that those not specifically mentioning this would assume that we would infer that this calculation is made from the time series data.

The next most commonly taken measurements were on demographics (7 providers), waist (6) physical activity levels (5), an identifier for residents of deprived areas (4), blood pressure (3), customer satisfaction/experience feedback (3), number of participants attending (3), number of sessions attended (3), ethnicity (3), goal setting/achievement (2), referral motivations (2), co-morbidities (2), well-being (2).

The following each factors were recorded by one provider: educational attainment, smoking status, number of new assessments, self efficacy, Rosenberg self-esteem questions, WHO questions, quality-of-life questions, CORE, and attitude to exercise.

On the theme of diet, two providers recorded information on food habits, two recorded fruit and vegetable consumption, and one recorded alcohol consumption.

Only two providers said that they recorded the referral source. This seems a very low figure given the number known to recruit from different sources.

A number of more clinical factors were recorded by one or both of the two more clinically focused providers.

- calorie burn, calorie intake, macronutrient intake (carbohydrate, protein, fat and alcohol), minutes of physical activity (vigorous and moderate), steps, sleep duration and sleep efficiency - using the monitoring technology on the participant's body
- Total Energy Expenditure, Basic Metabolic Rate, Physical Activity Level, blood pressure, resting heart rate, body fat, and the main blood measurements include - lipids, glucose, HbA1C, etc. Additional data may be recorded about previous dieting and weight loss history, current lifestyle goals recorded, etc.

Evaluation by referral source
No providers said that they compared outcomes between different referral sources, though it was noted earlier in this report that one had compared the attendance records of self funders with those of NHS funded participants. This may have been a one-off comparison, and not part of ongoing monitoring/evaluation.

Many providers had only self funders, or only had public sector referrals. Amongst those with significant numbers of both types of participant, the potential for comparison would be limited by the fact that different Commissioners require different data to be collected.

Defining programme completion
All but one of the providers were able to answer this question. Eight of the 16 had a definition based on "attendance" (i.e. sessions attended, appointments completed etc). Seven of these eight shared remarkably similar definitions, with six setting the definition of completion within the range 66%-70%, and the other setting it at 75% attendance, which they said was in line with the Standard Evaluation Framework from the National Obesity Observatory. Just one of the eight stood out by having a much lower threshold for completion, set at a minimum of three weekly sessions out of eight (i.e. 37.5%). In the case of the technology-based service, this definition was based on the number of times the participant uploaded data onto the provider website.

Three providers defined completion as the achievement of a personal goal, with one of these adding the caveat that this would need to be maintained over 12 months.

Two providers could not provide a definition, as their service is delivered by local agencies, each operating to different definitions of completion, as set by different Commissioners. Variation across different contracts and areas was also mentioned by other national providers, though these others were able to report their own company's definition.

One provider said that they had no definition of completion, since they operated an open access, rolling weekly programme, and participants were welcome to attend whenever they like, with no endpoint. One provider defined completion as reaching the end of the 12 month phase, on a face-to-face programme that was initially weekly for 12 weeks, and then monthly until 12 months had passed.

Defining success
Twelve of the 16 supplied an answer to this question. Six of the 12 said that the definition varies, either by the goals of individual participants (3) or the targets set by public sector commissioners (3).

Four providers defined success as a weight loss of 5% or more, with two of these specifying the range 5%-10%. Some of these had supplementary criteria on maintenance over a longer period such as 12 months. Another provider defined success as 10% weight loss after a 12 month period.

The technology based service provider defined success as the achievement of sustainable behaviour change.

Question 11: The future of the service

- *What are your thoughts on the future of your service in light of the planned move from NHS to local authority commissioning in 2013?*
- *Do you have any particular concerns about the impact on your service?*

Thoughts on the planned move from NHS to local authority commissioning
Amongst the public sector bodies, there was a fairly even split between the expression of concerns, and more reassuring observations.

The concerns were as follows:

- It will be harder to persuade councillors to invest in obesity than it would be to persuade GPs
- The NHS brand is useful to have, and this will be lost to the service
- Uncertainties over new policies and procedures, and possibility of reduced service quality in service delivery
- Potential loss of knowledge as responsibilities transfer from NHS managers to local authority managers

The more positive observations were as follows:

- In the short term funding is secured/ring fenced (2 providers)
- The expectation of more joint working with sport and education
- The service is already based in the local authority, so there will be no change/disruption

Non-public sector providers also had a mix of concerns and positive observations.

The concerns were as follows:

- Concern about possible loss of public health expertise as departments merge and new Commissioners takeover (4 providers)
- Responsibility falling in between the Clinical Commissioning Group and Public Health within local authority, because the benefit of improved weight management is a benefit to the CCG, but the cost of achieving this sits with the local authority
    - The organisation raising this concern did say that the Public Health Outcomes Framework may go some way to address this
- Some existing contracts need to go through a due diligence process when transferring to local government - the implication being that this introduced administrative burden and some uncertainty for the contractor
- Concern that service priorities will be influenced by a desire for popularity with voters, for example with resources shifted away from community-based services, and towards high-profile public campaigns

The more positive comments were as follows:

- Greater potential for addressing the wider determinants of health, with more cooperation from local authority professionals in planning, schools, procurement etc

- A hope that the new Commissioners will be more open-minded about the type of services that they commission
- A belief that this may create an opportunity for the provider to demonstrate the cost effectiveness of their service

Other particular concerns for the future
There was a wide range of concerns expressed, with relatively little agreement across providers. The concerns were as follows:

- Funding – the short-term is generally secured, but significant risk in the longer term
    - Lifestyle services may be given a low priority because weight gain is seen as an individual responsibility, with more priority being given to environmentally focused prevention services
    - Weight management may find it difficult to compete with other issues for limited public health resources
- Commissioning
    - More localised commissioning, resulting in more contracts with lower average tender values, thus increasing the tendering burden
    - Continuing confusion about the role of local authorities in public health, and in particular around who the decision-makers are in commissioning processes
    - Loss of knowledge in the transfer to local authorities may result in new, inexperienced Commissioners specifying unrealistic outcomes
    - Concern that political influence will lead to the emphasis shifting from outcome measures to numbers of participants going through the system
- New commissioning guidelines are coming in, and this creates uncertainty for those who have designed their services around evidence, e.g. what will be the new "gold standard"?
- The tendering process
    - A small, local public sector provider worried about competition with large scale commercial providers
    - Commercial providers are worried about Commissioner bias against the private sector
    - An NHS provider expressed concern that local authorities will prefer to commission local authority providers
- Conflicts of interest on Health and Well-Being Boards and Clinical Commissioning Groups
    - For example, GP representatives having interests in local community primary care services - such potential conflict should be acknowledged, and measures put in place to ensure transparency and integrity
    - CCGs should not commission services from their own GPs

Positive comments about the future
One (commercial) provider noted that it would be a positive development if Clinical Commissioning Groups can commission services which take account of the local population. This provider added that they are hoping that there will be opportunities for providers of discretionary services (such as weight management services) to be commissioned to provide both prevention and treatment interventions.

Another provider (public sector) said that they were confident about their future, on the basis of reassurance provided by the Commissioner. They believe that their service provides a cost-effective gateway into higher tier clinical treatment.

The technology-based provider expressed the view that traditional weight loss methods have failed, and their economic viability is in doubt as the eligible population grows. This provider believes that technology enabled feedback and information can assist the NHS, and to this end they are currently conducting research with a UK university, and developing products with the UK employee, insurance and healthcare markets in mind.

Appendix 1
The full list of exclusions and precautions, from question 1

The most commonly mentioned exclusions were as follows:

- Pregnant or breastfeeding women (7)
- Eating disorder - sometimes specified as current, but in other cases specified as having a history of this condition (6)
- Diabetic patients using insulin (3)
- Psychiatric conditions, e.g. unstable mood, self harming, DSM-based diagnosis (2)
- Certain co-morbidities (2)

Other exclusions mentioned by only one provider included the following:

- Any client with serious uncontrolled disease e.g. Angina, Diabetes, COPD, Asthma
- People on Haemodialysis, recent complicated MI or awaiting further investigation
- Uncontrolled Arrhythmia which compromises cardiac function
- Uncontrolled Hypertension
- Acute infection
- Unstable psychiatric disorder
- Clients who in their Healthcare Professional's opinion are not medically fit to take part in twelve weeks of physical activity
- Patients who have had chronic back pain for over 6 months, who have not previously had a physiotherapy assessment
- Coeliac disease
- Porphyria
- Severe allergies
- Kidney problems
- Chronic back pain for over six months without having physiotherapy assessment
- Using certain medications (unspecified)
- Recent severe illness or surgery
- Patients qualifying for bariatric surgery
- People with criminal records that would make them unsuitable for inclusion

The most commonly mentioned precautions were as follows:

- Risk assessments (5)
- Screening for medical conditions prior to participation starting (5)
- Using the Physical Activity Readiness Questionnaire (2)
- Having qualified instructors (2)
- Health and safety policies/protocols (2)
- Safeguarding policy for vulnerable adults (2)

Other precautions mentioned by only one provider included the following:

- Having excellent communication between practitioners and GPs
- Signposting participants to relevant services e.g. smoking cessation
- Restricting the choice of programmes according to identified health conditions
- Restricting the starting calorie level
- Monitoring participants with particular conditions e.g. diabetes

- Prioritising any medical advice that the participant has received, and tailoring the programme around that advice
- Noticing if weight loss is too rapid, and taking action
- Using proven, evidence-based programmes, defined centrally, using centrally produced support materials, and allowing no local variation
- Thorough training of programme delivery staff, ensuring that they all know that they should not become involved in discussions relating to medical conditions - instead they should encourage participants to see their GP
- Having health professionals available to support frontline delivery staff
- Having clear quality assurance procedures

Appendix 2

Full list of particularly important components specified at question 1.

- One-to-one/individual support (5)
- Staff expertise and support (4)
- Convenient location/time (3)
- Multi-disciplinary/multi component programme (3)
- Gradual weight loss/phasing of the programme (2)
- Free/low-cost services (2)
- Use of therapy/CBT especially with higher BMI (2)
- The support of the group (2)
- Programme meets NICE guidance (2)
- Having a behavioural change focus (2)
- Flexible follow-up/support activities (2)
- Food intake is controlled by the food supplied/eating plan (2)
- Rapid early weight loss increases motivation (1)
- Face-to-face contact (1)
- NHS branding (1)
- Non-dieting approach (1)
- Individual assessment/treatment/support (1)
- Weekly groups (1)
- Working with partner organisations (1)
- Rolling programme/can join any time (1)
- BME worker networking with mosques, community groups etc (1)
- Babies can attend with the mother (1)
- Wide variety of behaviour change tools, to increase weight loss skills achievable by inexperienced advisers, (1)
- Shared protocols between community and hospital practitioners, to enable joined up service (1)
- Formula food weight loss programmes are very cost-effective (1)
- Having a visible presence in the targeted community (1)
- Informal/fun sessions (1)
- Having a buddy system (1)
- Client led/setting their own goals (1)
- Supporting information/documentation (1)

Appendix 3

Full list of perceived key barriers in relation to working with commissioners, specified at question 4

- Budget restraints/lack of funds, e.g. limiting programme expansion, improvement, training and support etc (4)
    - Lifestyle services are not part QOF so limited funding available (1)
- Lack of Commissioner support in encouraging referrals from partner organisations (e.g. primary care and others) (2)
    - Primary care staff not sufficiently aware of available services - implication that this is the responsibility of the Commissioner (1)
- Excessive focus on short-term weight loss (e.g. in 12 weeks), not recognising the evidence/ the need to develop skills which enable sustainable outcomes (2)
    - Excessive focus on BMI outcomes without regard to other outcomes, e.g. diabetes management, psychological improvement in centre (1)
    - Setting targets over a 12 month period is unreasonable for a 3 month programme (1)
    - 12 week limit on programme duration/membership is not enough for some individuals (1)
- Excessively strict BMI criteria on eligibility for the programme (1)
- Poor practice in contract specification (2)
    - Commissioners don’t have a standard toolkit, e.g. to help them develop specifications and set realistic targets
    - Commissioners don’t discuss specifications with potential tenderers, before finalising and issuing
    - Commissioners not well informed about evidence-based approaches
    - Commissioners lack of understanding of evaluative criteria, e.g. intermediate outcomes demonstrating commitment to good practice in behaviour change

Appendix 4

Full list of perceived key facilitating factors in relation to working with commissioners, specified at question 4.

- Regular meetings/openness/good communication between the commissioner and provider (6)
    - the Commissioner listens to us
    - having a dialogue with providers, e.g. on the development of specifications
- Supporting the programme by influencing partners and stakeholders (2)
    - Helping to find suitable venues, e.g. GP surgeries (1)
- Strategic role of commissioners
    - Commissioner's population surveillance identified the need for the service, and target groups (2)
    - Commissioners are well placed to integrate/coordinate local services (2)
    - Commissioners are keen to introduce and support cost-effective, sustainable local services (1)
- Not putting unrealistic pressure on providers (1)
- Flexibility/willingness to try new approaches (1)
- Long-term relationship between commissioner and provider (1)
- Understanding that national commercial organisations can deliver on a large-scale basis (1)
- Focusing on data around cost effectiveness (1)
- Assisting with training provision for staff (1)
- Assisting with referral criteria, service guidelines etc (1)
- Supporting the welfare and care of participants, e.g. safeguarding training (1)

Appendix 5

Full list of key required staff attributes specified at question 7.

- Empathy/emotional awareness/non-judgemental attitude (6)
- Professional registration, accreditation or formal qualifications in relevant subjects, e.g. nutrition, physical activity, behaviour change etc (6)
- Interest/experience in health/science/food (3)
- Good communication/listening skills (3)
- Social skills (2)
- Sensitivity to diversity/able to support diverse participants (2)
- Having been successful slimmers (3)
- Ability to influence/empower/develop rapport (3)
- Passionate/enthusiastic (2)
- Good time management (2)
- Experience in data collection/keeping records (2)
- Motivational interviewing (1)
- Basic counselling (1)
- English language (1)
- Team working (1)
- Flexibility (1)
- IT skills (1)
- Experience of advice giving (1)
- Understanding professional boundaries (1)
- Experience of community working (1)
- Ability to critique scientific data/ think laterally (1)
- Confidence (1)

Appendix 6:
Request for Information

As you are aware, the Centre for Public Health Excellence (CPHE) at the National Institute for Health and Clinical Excellence (NICE) is currently developing programme guidance on lifestyle weight management services for adults. The guidance will provide recommendations for good practice, based on the best available evidence of effectiveness and cost effectiveness. It is aimed at commissioners, health professionals and providers of lifestyle weight management services. It will also be of interest to managers in local authorities, overweight and obese adults and other members of the public. The scope for the work is here http://guidance.nice.org.uk/PHG/67

NICE has commissioned evidence reviews that will address the key questions outlined in the final scope. However, we are aware that there are gaps in the published literature. NICE is therefore seeking more detailed information about the current provision of lifestyle weight management services for adults in England (particularly services provided by commercial companies or social enterprises). We would be grateful for your responses to the questions in the table below. Your responses will be considered in confidence.

The guidance is being developed by a Programme Development Group (PDG) which is a multi-disciplinary group consisting of academics, practitioners and community members. The PDG will make recommendations for practice based on the best available evidence of effectiveness and cost effectiveness. However there are various practical and process issues the PDG would like to consider which are unlikely to have been captured by reviews of the evidence.

For this reason, the NICE team is writing to stakeholders to invite **the providers of lifestyle weight management services for adults** to contribute to an information gathering exercise to help the PDG address a number of questions. These are listed in the attached document. The responses to these questions will be collated and synthesised into a report by an independent researcher, who will then present the findings to the PDG in April 2013. The report will be made available on the NICE website, alongside the other evidence considered by the PDG, during the consultation on the draft guidance from mid-October to mid-December 2013 and again when the guidance is published in May 2014.

Your responses to these questions will be very helpful in informing the development of the guidance.

Participants should note the following:

- This process relates to the guidance in development on **weight management services for adults**. It does not relate to the guidance in development on weight management services for children and young people.
- The questions are particularly aimed at commercial providers or social enterprises.
- NICE has issued a call for evidence which closes on the 1st February (see http://guidance.nice.org.uk/PHG/67/2ndCallForEvidence) .

Appendix 7: the questionnaire

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE
PUBLIC HEALTH GUIDANCE

Managing overweight and obesity in adults: lifestyle weight management services
QUESTIONS FOR PROVIDERS OF LIFESTYLE WEIGHT MANAGEMENT SERVICES FOR ADULTS

Responses to be received no later than noon on 25th February

Background

The National Institute for Health and Clinical Excellence (NICE) has been asked by the Department of Health (DH) to develop guidance on lifestyle weight management services for adults.

This guidance will provide recommendations for good practice, based on the best available evidence of effectiveness and cost effectiveness. It is aimed at commissioners, health professionals and providers of lifestyle weight management services. It will also be of interest to managers in local authorities, overweight and obese adults and other members of the public.

NICE has commissioned evidence reviews that will address the key questions outlined in the final scope. However, we are aware that there are gaps in the published literature. NICE is therefore seeking more detailed information about the current provision of lifestyle weight management services for adults in England (particularly services provided by commercial companies or social enterprises).
We would be grateful for your responses to the questions in the table below. Your responses will be considered in confidence.

Please respond by inserting your answers in the space below each question. The space will expand if necessary.

Information of interest

The scope of the guidance describes what it will cover. See http://guidance.nice.org.uk/PHG/67/Scope/pdf/English

Please note that we are only interested in programmes that meet our criteria of lifestyle weight management:

Multi-component lifestyle weight management approaches which focus on adults who are overweight or obese and aim to change someone's behaviour to reduce their energy intake and make them more physically active.

It may include weight management programmes, courses or clubs that:

- accept adults through self-referral or referral from a health practitioner
- are provided by the public, private or voluntary sector
- are based in the community, workplaces, primary care or online.

This questionnaire is particularly aimed at commercial providers or social enterprises.

Please note that the following are outside the scope for this work:

- Weight management services and primary prevention programmes for children and young people.
- Clinical management of overweight or obese adults (for example, pharmacological or surgical treatment).
- Management of medical conditions associated with being overweight or obese (such as cardiovascular disease).
- Complementary therapies to reduce or manage overweight or obesity (for example, acupuncture or hypnotherapy).
- Assessment of the definitions of ‘overweight’ and ‘obese’ in adults.

Using the highlighter tool in MS Word, please highlight any information that you would like us to treat as ‘commercial in confidence’. See Appendix A for more details.

We are unable to accept any attachments whether published or unpublished reports, reference lists or promotional material.

Name/ Organisation
NICE has commissioned an independent consultant to collate the findings of this information gathering exercise. The consultant has no connection with any provider of weight management services and will abide by NICE confidentiality processes. Only NICE and the independent consultant will see your individual submission and this will be considered in confidence. Our report will describe what contributors have told us, but no contributor will be identified in that report. If you are content for your contact details to be passed on to the consultant and for them to contact you to check that your contribution has been accurately represented, please provide your email address in the space below. If you do not wish to be contacted by the consultant or for your contact details to be passed on to them, please state this below.
Question 1: service outline
Please give a brief outline of your service. Please provide information on the following (as appropriate): • setting and delivery method - eg group, one to one sessions, online etc (if group, please state size). • frequency of sessions • cost of sessions • who delivers the service • age groups covered • tailoring of service for individuals • type of programme and duration • referral criteria • measurements and other key data recorded about participants • any exclusion criteria (eg pregnancy, co-morbidities) • precautions taken to ensure the safety of clients What components of the service do you consider to be particularly important and why? Has the service been adapted since its inception and if so, how and why?
Question 2: different population groups
Does your service target any particular groups (eg particular gender, age, social or ethnic groups?) or do you attempt ‘blanket’ coverage? It would be helpful to know: • How do you promote your service to different population groups? • Have you observed any differences in recruitment and retention rates between population groups? If so, what are these.
Question 3: disadvantaged groups

- What is your organisation's experience of working with disadvantaged groups within the community e.g. adults with learning difficulties, or from black and minority ethnic groups or lower socio--economic groups?
- How do you reach these groups?
- Do you adapt your service in any way for these groups?

Question 4: working with commissioners

What is your experience of working with commissioners of lifestyle weight management services for adults? In particular:

- What are the key barriers?
- What are the key facilitators?
- What are the key performance indicators and are these linked to payment?
- Have you been involved in setting or negotiating goals required by commissioners?

Question 5: referrals

How does your organisation manage referrals from NHS, local authority or other organisations? It would be helpful to know:

- How do you promote your service and where do referrals come from
- Do participants receive a different service according to their referral source, e.g. are self referrals treated differently from those from eg primary care.
- Are there any differences in the referral process, or referral rates, according to participants' characteristics (e.g. age, or ethnicity).
- Is a GP or other health professional required to approve an individual to participate in your programme(s)?
- Do you provide any training or support for agencies making referrals to your service?

Question 6: attendance and drop out

Please describe your organisation's policy and practice when individuals fail to attend or drop out of the programme. In particular:

- Please describe your policy on non attendance or drop-out.
- Are some people more likely to drop out than others? If so, please explain who is more likely to drop out.
- Have you observed any differences in attendance or drop-out according to whether participants self fund or are referred from eg primary care.
- What is particularly important in reducing non attendance or drop-out?

Question 7: staff

What is your organisations policy and practice in relation to staff (or peer) support? (Please do not include normal staff meetings, or standard features of management supervision). In particular:

- What sort of experience, qualifications or personal characteristics (eg personal experience) do you require from staff (or peers)?

- What training do you offer staff (or peers)?
- Do you evaluate the performance of staff (or peers) and if so how and using what criteria?

Question 8: on-going support

- Please describe any maintenance period activity, once the main intervention has finished.
- Please describe any other ongoing support (over and above the standard maintenance period).
- For each of the above, please tell us:
  - how long the activities last
  - the level of uptake
  - any barriers and facilitators to provision and uptake.

Question 9: incentives

Do you have any experience of providing incentives or rewards to users (for example, for achieving a specific goal)? If so:

- What incentives do you use?
- Do incentives differ between referrals from eg primary care and other users?
- Do you have any reports or other written evaluations that indicate the success or otherwise of incentives?

Question 10: monitoring and evaluation

How does your organisation monitor and evaluate the programme(s) you offer? In particular:

- What data do you record?
- Do you evaluate the programme according to whether participants self referred or were referred from eg primary care.
- How do you define 'completers' or successful weight maintenance.
- What are your success criteria (eg X% weight loss at 1 year)

Question 11: service future

- What are your thoughts on the future of your service in light of the planned move from NHS to local authority commissioning in 2013?
- Do you have any particular concerns about the impact on your service?

We would be grateful if you could send your responses to: Overweightandobeseadults@nice.nhs.uk by noon on 25th February 2013.

Paper copies can be sent to: Rukshana Begum, Project coordinator, Centre for Public Health Excellence, National Institute for Health and Clinical Excellence
10 Spring Gardens, London SW1A 2BU.

We look forward to receiving your information and thank you in advance for your help.

Annex A

The use of 'commercial in confidence' and 'academic in confidence' data in the development of public health guidance: statement of principle

1. NICE is under obligations of transparency and fairness to all stakeholders, among others, in the development of its guidance

2. The rights of the owners of the data provided to NICE must be respected.

Definitions

3. Commercial in confidence information is information provided in confidence relating to the commercial interests of the owner of the information.

4. Academic in confidence information is information provided in confidence in circumstances where disclosure could prejudice future publication of the information in a scientific publication. It would be expected that any information marked as academic in confidence is going to be published at some stage and that a timeline for publication can be given.

Submission of data

6. The amount of information submitted on an 'in confidence' basis should be kept to a minimum. The whole submission should not be marked as confidential. It is likely to be unacceptable to mark complete sections as confidential.

7. Only information that is genuinely confidential, such as actual numbers, should be marked as in confidence. NICE will only treat information in confidence if the material is in fact either 'commercial in confidence' or 'academic in confidence'.

8. When marking data as confidential, organisations should indicate if this status will apply at the time NICE anticipates publication/presentation of the data. The last opportunity for organisations to review the confidential status of information is during the consultation on the draft guidance and its supporting evidence.

9. For all unpublished data submitted as 'academic or commercial in confidence' the minimum that should be made available for release is that which normally would be included in a CONSORT (or PRISMA) compliant abstract (http://www.consort-statement.org/?o=1011) and be suitable for public disclosure. An equivalent approach is required for all data and studies which underpin and are included in economic analyses and models, and for the economic model included in the submission if that is marked 'academic or commercial in confidence'.

Presentation of data at PHAC or PDG meetings

10. Data that contributes to evidence of effectiveness and cost effectiveness can be presented to a PDG meeting or to a PHAC meeting provided the information is factual, accurate and not misleading.

11. 'Academic in confidence' information may be presented during the PDG and PHAC meetings, even if the meetings are conducted in public. However, the data owner retains the right to make a final decision in relation to the release of confidential information into the public domain

12. The data owner retains the responsibility for the release of 'commercial in confidence' data into the public domain. With the exception of presentation of data at PDG or PHAC meetings, the data owner retains the right to make a final decision in relation to the release of confidential information into the public domain.

Publication of data

13. In circumstances where NICE wishes to publish data regarded by the data owner as academic or commercial in confidence, both NICE and the data owner will negotiate in good faith to seek to find a mutually acceptable solution, recognising the need for NICE to support its recommendations with evidence and the data owner's right to publication. However the data owner retains the right to make a final decision in relation to the release of confidential information into the public domain.

Economic models

14. NICE will normally disclose in full economic models provided by manufacturers/sponsors to NICE as part of a submission of evidence, together with the data on which such models are based. Exceptionally, data within a model can be treated as confidential if they contain or make practical the reverse engineering of confidential data inputs which are credibly specified as confidential by the organisation or company.

15. Model structures will not be accepted as confidential information, and by submitting a model the manufacturers/sponsor will be taken to have agreed that the model structure may be put into the public domain.

Disclosure of confidential data

16. NICE is challenged that confidential information it has received should be released in the interests of fairness, during the guidance development process or otherwise, data owners must on request promptly reconsider whether it is in fact necessary to maintain confidentiality.

17. NICE does not intend to make repeated requests for a prima facie tenable claim of confidentiality to be abandoned or modified, and it will accept the data owner's judgement in that regard.

18. NICE cannot ‘second guess’ the motives of a data owner. If a data owner would not agree to the specific request for disclosure made, but would agree to some more limited disclosure (for example to a “confidentiality club”,) then it is asked itself to suggest the disclosure it would find acceptable, rather than wait for NICE to propose the specific formula it may have in mind and discuss and agree a potential solution with NICE.

19. If disclosure is not possible the data owner must be prepared to assert publicly that the information is considered to be confidential, and must submit evidence giving the justification for maintaining confidentiality in defence of NICE's maintenance of that confidentiality. In the absence of any such assertion and evidence, NICE shall be entitled to conclude that the information is no longer confidential.