NHS East Sussex Downs and Weald and NHS Hastings and Rother

# Needs Assessment for the Treatment and Prevention of Obesity in East Sussex

September 2010

Compiled by Ottaway Strategic Management Ltd

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## Executive Summary

The policy context to this needs assessment has shifted since it was commissioned. In this time there has been a general election and a new coalition government. The financial environment across the public sector has radically shifted to one which is extremely cautious and expecting severe funding constraints and enforced savings as a result of the Autumn Spending review. Additionally the Health White Paper proposing the increased transfer to General Practice of commissioning budgets and services is likely to impose change to existing PCT commissioning arrangements although at this stage the detail is yet to be released. However against this back drop of change the prevalence of obesity is growing steadily and the need for dedicated responses and interventions are equally critical both for treatment and indeed for the stemming of this growth in prevalence.

In East Sussex the rates of obesity prevalence in the adult population are brought together through a number of data sources. The Health Survey for England based on AHP 09 and 07 population estimates suggest that 24.5% of adults over 16 are obese (BMI+30). Other data from the Health and Social Care Information Centre 2010 shows that the profile of adults with a BMI over 30 is 22.2% in East Sussex, 24.2% in Hastings, 21.6% in Eastbourne, 21.4% in Rother, 21.9% in Lewes and 20.9% in Wealden. In essence just under a quarter of the adult population has a BMI of over 30 which is a comparable level to the region and nationally.

The national Child Measurement Database provides detailed information about the state of childhood obesity and overweight. This data shows that 20.9% of Reception Year Children are overweight or obese across East Sussex; this includes a 1.8% growth of children in Hastings and Rother and 0.6% increase in East Sussex Downs and Weald and 1.1% growth across the East Sussex area as a whole. In Year Six Children 28.1% are either overweight or obese across East Sussex, which when compared to Reception class rates is a real growth, suggesting an increasing problem through childhood development.

2008-09 QOF (GP Practice data) shows that 8.8% of patients are on the obesity register in East Sussex Downs and Weald, with 12.1% in Hastings and Rother and 10.5% across the county. These figures are comparable with figures across the country with the England average being 9.9%, although Hastings and Rother's proportion is high when compared nationally. QOF data is based on those on the register for the last 15 months and hence the lower figure is likely to be a result of the frequency through which patients are measured and the fact that some have moved on through the health system and are either no longer presenting for services of are no longer being measured.

National estimates for weight management/loss prescriptions for the East Sussex area is 12,550, in 2008-09 the actual numbers of prescriptions was 9,264 which was below the estimate, suggesting an under performance in this area of service.

East Sussex Downs and Weald had a growth in approvals for Bariatric Surgery from 77 in 2008-09 to 95 in 2009-10 a 21.1% increase. Hastings and Rother had a growth in approvals for Bariatric Surgery from 23 in 2008-09 to 28 in 2009-10 a 17.9% increase.

Average BMIs for Bariatric Surgery was 47.08 in East Sussex Downs and Weald over these two years and the average BMI in Hastings and Rother was 48.23, suggesting very high BMI counts. The estimated cost of Bariatric Services for both PCT localities is £1,590,000.

Trends in the prevalence of obesity have been used to forecast the likely future needs of the area. Based on existing data and estimates the forecasts shows that Reception children that are either overweight or obese are likely to grow from 19.8% in 2007-08 to 27.5% in 2014-15 if current trends persist. This is a genuine concern as these young people are likely to be presenting for services later in their lives and efforts need to be made to arrest this growth in children who are either overweight or obese. Most startling the growth of adults over 16 with a BMI of over 30 shows growth from 17.3% in 2000-02 to 39.3% in 2014-15 which is a very worrying situation for the county if current trends persist. These trends need to be regularly monitored to secure a more accurate picture of likely service demand.

Services across the county to treat obesity have traditionally been clustered at both ends of the spectrum with GP practice support at Tier 1 and bariatric surgery and other interventions at Tier 4. National policy has sought to address obesity in the whole population although there are still considerable weaknesses in this approach with many people simply not being able to use these services or who are bound up in denial of their needs, lacking in awareness and motivation to address their own weight loss and some who simply have given up. What is clear is that whole population activities to increase exercise and to improve healthy eating have helped to stem some people from slipping into the obese categories but there is still a very strong preponderance of people who are becoming obese and as stated this number is growing. There is a clear fit between obesity and social deprivation and many people are making poor lifestyle choices which are inactive and high in sugar and fat content.

The range of interventions being delivered in East Sussex by the Physical Activity, Health and Food Partnerships and those actions set out in the local commissioning plans and strategies for obesity show that there are some extremely positive interventions, even best practice and there is a consequential development of expertise in this field of public health. However there is little coordination of these resources for obesity and in several cases there could be more informed partnership coordination and targeting of provision.

NHS East Sussex Downs and Wealth and Hastings and Rother PCT localities have not defined a care pathway for obesity. In simple terms this care pathway should address:

- Baseline whole population health promotion and greater focus on healthy eating and increasing exercise
- Tier One services including, Primary care and community advice, GP Nurse lifestyle advice, Wellbeing, Health Strainers, information and sign posting
- Tier Two Primary Care Plus with Community Interventions including Weight Management, Exercise Referral, GP Pharmacology
- Tier Three: Primary Care Specialist Weight Management Service; including dietitians, exercise, psychological and behavioural change (CBT)
- Tier Four: Obesity Surgery and interventions including psychological readiness to change

There are no dedicated services for obesity in East Sussex at Tiers 2 and 3 of this care pathway model. There is some level of activity across mainstream provider services and what is currently being achieved is as much a holding exercise to stem the flood of patient demand. Services are stretched and in particular these relate to community dietitians, paediatric dietitians, mental health support and general weight management provision

Clinicians and practitioners were engaged as part of this review and whilst it was clear that there was a disparate range of views some commonality came through. GP's were primarily concerned that they have no onward referral options for obese patients. Many wanted more dedicated weight management provision citing the strength of dietitians but their general lack of capacity. GP and stakeholders raised genuine concerns about the lack of motivation and acceptance of obese patients of the role they themselves need to play to deal with their obesity. Critically many wanted to press onto surgical options and several GP felt that this was something that for these patients was their only realistic option. School nurses were particularly concerned about the attitude of parents who are either in denial and or aggressively defending their child's weight. They too felt there was a need for more dedicated paediatric weight management but felt that the stigma of obesity made it very hard to work with this group. Both the Physical Activity Health and Food Partnerships felt there was a need for a county wide coordination of resources and to be more dynamic in the publicity and communications of service providers as well as to shape interventions to meet the needs of a diverse range of people with high BMIs.

A set of options were developed through a stakeholder workshop held in July 2010. These Options propose:

- Option 1: Do noting and maintain the status quo
- Option 2: Develop a single referral point for obesity services enabling patients to access existing services more effectively
- Option 3: Development of a virtual Weight Management Service
- Option 4: Development of a dedicated staffed Weight Management Service at Tiers 2 and 3 of service provision

In simple terms the core options recommended from a pure service provision perspective is option 4. However with the high likelihood for financial constraint and with this approach seeking growth in budget, the likely options for realistic evaluation would be options 2 followed by 3 progressing onto 4 when funding is available. Option 2 is a baseline requirement for more effective coordination and delivery of existing service providers (£150,000). Option 3 in effect provides a dedicated commissioning budget (£650,000) for services and Option 4 takes this one stage further with the addition of a dedicated multi disciplinary weight management staff team (£950,000)

The recommendation of the options appraisal state that it would be prudent to start slowly and build services against the increasing trend in prevalence. It is critical however that these options are reviewed and progress is made to achieve option 4 as soon as both feasible and possible.

This needs assessment however makes a number of recommendations, which are set out below:

Overarching

- Develop a commissioning framework for delivering the Healthy Weight agenda
- Develop a comprehensive strategy to address overweight and obesity across East Sussex
- Consider establishing a multi agency cross county strategic group to co-ordinate the Healthy weight, physical activity and healthy eating agenda's
- Ensure evaluation is built into all interventions to assess their effectiveness at a local level
- Ensure that front line practitioners have access to training and support appropriate to their role, to enable them to discuss issues relating to healthy weight with clients

Whole population

- Consider the effectiveness of the role of the HImP working groups in addressing healthy weight and related agenda's
- Ensure that social marketing activities to support the healthy weight, physical activity and healthy eating agenda's are joined up and co-ordinated across East Sussex
- Ensure that the healthy weight agenda is joined up with other related work streams e.g. Active Travel, mental health , sustainability
- Make best use of local free resources in intervention design e.g. by utilising green spaces

Tier 1

- Review exercise referral across East Sussex to consider how this meets the needs of local people and is accessible to vulnerable groups e.g. those on low income

Tier 2

- Commission family based weight management interventions for young people, in line with NICE guidance
- Consider commissioning specific weight management interventions to meet the needs of overweight and obese adults in East Sussex (an options appraisal to inform this is set out in 11.2)

Tier 3

- Commission family based weight management interventions for young people, in line with NICE guidance
- Consider commissioning specific weight management interventions to meet the needs of overweight and obese adults in East Sussex (an options appraisal to inform this is set out in 11.2)

Tier 4

- Specialist commissioning should maintain services and support design and delivery of the proposes Overweight and Obesity Strategy for East Sussex

## Introduction

The purpose of this needs assessment is to identify need relating to obesity in NHS East Sussex Downs and Weald and NHS Hastings and Rother PCTs. The assessment will review current services and treatment commissioned and highlight gaps in services. The needs assessment will also analyse national, regional and local data to establish the current and the projected future prevalence of obesity and propose services and interventions to address obesity across a care pathway for obesity in East Sussex.

Methodologically this report includes a review of quantitative data to assess levels of obesity in East Sussex and model current need and demand. In addition stakeholder perspectives have been collected through the collection and analysis of primary qualitative data included from 1:1 interviews, focus groups and short email surveys with General Practitioners.

### Background

NHS East Sussex Downs and Weald and NHS Hastings and Rother PCTs have been addressing obesity in a wide variety of ways through their work to implement 'Choosing Health'[1] and 'Healthy Weight, Health Lives'[2] and to support partnership approaches to increasing physical activity and improving diet. Analysis and assessment of obesity through the East Sussex Joint Strategic Needs Assessment (JSNA) balanced scorecards indicated that there was a need to explore in more depth the prevalence and treatment of obesity in East Sussex. Consequently in December 2009 Ottaway Strategic Management Limited were commissioned as independent consultants to carry out this needs assessment.

### Why Obesity is important?

In the first half of the twentieth century it was uncommon for individuals to be overweight or obese. Since then the number of people with persistent, severe weight problems affecting their health has risen steadily. Obese individuals are present in all socio-economic groups, although they are represented to a slightly lesser extent among the most affluent, particularly for women.

Obesity is linked to a large number of health problems, including an increased risk of developing type 2 diabetes, hypertension, cancer, heart disease and liver disease. The risk of developing chronic illness and the likelihood of premature mortality increases with the Body Mass Index (BMI) of an individual[3]. This in turn leads to costs to the NHS, as a direct result of treating these diseases, and also the wider economy through lost working days. A major benefit of weight loss is that it improves not just one risk factor but the entire risk-factor profile and even modest weight loss (5-10% of body weight) can have significant benefits.

Obesity is associated with an increased risk of a number of conditions such as:

- 10 per cent of all cancer deaths among non-smokers are related to obesity
- The risk of Coronary Artery Disease increases 3.6 times for each unit increase in BMI
- 85 per cent of hypertension is associated with a BMI greater than 25
- The risk of developing type 2 diabetes is about 20 times greater for people who are very obese (BMI over 35), compared to individuals with a BMI of between 18 and 25
- Up to 90 per cent of people who are obese have fatty liver. Non-alcoholic fatty liver disease is projected to be the leading cause of cirrhosis in the next generation

[1] Choosing Health, Making Healthy Choices Easier. Department of Health. 2004
[2] Healthy Weight, Healthy Lives. A Cross Government Strategy for England. Department of Health. 2008.
3 WHO 2004

- The health effects of excess weight are increasingly apparent even in children; the incidence of both type 2 diabetes and non-alcoholic fatty liver disease used to be rare in children, but is now increasing
- Obesity in pregnancy is associated with increased risks of complications for both mother and baby
- Social stigmatisation and bullying are common and can, in some cases, lead to depression and other mental health conditions

These illnesses and diseases ultimately curtail life expectancy. Severely obese individuals are likely to die on average 11 years earlier (13 years for a severely obese man between 20 and 30 years of age) than those with a healthy weight, comparable to the reduction in life expectancy from smoking.

**What is obesity**?

A person is considered to be obese if he is so heavy that weight endangers health.[1] Obesity is a growing problem in most developed countries and is responsible for a significant degree of morbidity and mortality in the Western world. There are several facets to the problem of obesity:

- The prevention of obesity
- The correction of obesity
- The population-based approach
- The individual approach

**Measuring Obesity**

The National Institute for Health and Clinical Excellence (NICE) recommends the use of both the Body Mass Index (BMI) and waist circumference to assess overweight and obese individuals, as different health risks have been defined for different combinations of these two measures.[4]

**BMI**

**Table 1: Classifications of underweight, overweight and obesity**[5]

| BMI (kg/m2) | Classification | Risk of obesity related co-morbidities |
|---|---|---|
| <18.5 | Underweight | Low |
| 18.5 to 24.9 | Desirable weight | Average |
| 25 to 29.9 | Overweight | Increased |
| 30 to 34.9 | Obesity I | Moderate |
| 35 to 39.9 | Obesity II | Severe |
| >40 | Obesity III (Morbidly Obese) | Very severe |

In adults, the diagnosis of obesity is most commonly made using BMI levels. BMI is calculated as weight in kilograms (kg) divided by height in metres squared ($m^2$). As a general rule, an ideal BMI is 20 to 25. There are a few exceptions that are worthy of note: A person who is very muscular will have a great weight in muscles and bone to support the muscles and so may have a high BMI without an excess of fat. In the elderly, the lowest morbidity is in the group with a BMI of 25 to 30 rather than 20 to 25.

[4] NHS - The Information Centre; Health Survey for England 2007

5 NICE CG43, 2006

**Waist-hip ratio**
An alternative measure of obesity is the waist-to-hip ratio (WHR). It indicates abdominal fat and is a more accurate predictor for cardiovascular risk than BMI in different ethnic populations, as well as being more valuable in those over 75 years old. The upper limit for acceptable is 0.90 in men and 0.85 in women.

**Measurement of Obesity in Children**
The measurement for children is slightly different. Children between 0-4 are measured through the World Health Organisation Growth Charts, which place children on a percentile based on their weight, length (0-2) height (2-4), head circumference.
As a rule of thumb, in children a BMI of 20 is significantly overweight and the younger the child, the more this is so. However, BMI per se is not generally a suitable way to assess obesity in children although it can be used provided that it is moderated by use of the UK90 charts or equivalent, to be used in children over 2 years old. In this case, a child with a BMI over the 91st BMI percentile is said to be overweight and a child over the 98th BMI percentile is considered obese. For population monitoring purposes, the 85$^{th}$ percentile is used to identify the prevalence of overweight children and the 95$^{th}$ percentile for obesity.
The UK 90 charts do have a component for the measurement of BMI in children and this has been validated.[6] The Royal College of Paediatricians and Child Health have adopted new charts that combine UK90 and World Health Organisation (WHO) data.

**Obesity and Health Inequalities**
Obesity tends to disproportionately affect lower socio-economic groups and the prevalence in social class V is double that in social class I. This effect is particularly noticeable in women. Data on the incidence of obesity in different ethnic groups are limited because national surveys tend to sample only relatively small numbers from minority groups. For many ethnic groups therefore, the sample size is too small to allow for reliable comparisons or predictions. In 2006 1.4% of men and 2.7% of women (approximately 1.2 million in the UK as a whole) were morbidly obese.

**Policy Perspective**
The national policy context to address obesity is described in a number of key government strategies, most recently 'Choosing Health: Making Health Choices Easier. 2004' and 'Healthy Weight, Healthy Lives: a Cross Government Strategy 2008'. In addition, local strategies and action plans to address obesity are outlined in section 4 these include East Sussex Strategic Commissioning Plans, Joint Strategic Needs Assessment, National Service Frameworks, National Institute of Health and Clinical Excellence (NICE) Guidance, and the Marmot Review[7]. Annual Reports of the Director of Public Health and Joint Strategic Needs Assessment balanced scorecards. A summary of relevant policy is included in the Appendix in section 14; current interventions to address obesity are set out in section 5 and 6.

[6] Cole TJ, Freeman JV, Preece MA; Body mass index reference curves for the UK, 1990. Arch Dis Child. 1995 Jul;73(1):25-9. [abstract]
[7] Marmot Review – ' Fair Society Healthy Lives' Feb 2010

## Obesity in the South East and East Sussex

In the South East Coast Region using combined categories of BMI and waist circumference to assess risk, 20% of men are estimated to be at increased risk of co-morbidity[8], 14% at high risk and 21% at very high risk. The equivalent proportions for women are 15% at increased risk, 17% at high risk and 24% at very high risk[9].

Table 2 below shows the estimated prevalence of obesity in the adult population in South East Coast (SEC), based on recently published data[10].

**Table 2: Estimated prevalence of obesity in adults in SEC**

| | Estimated number of obese individuals in SEC | % SEC Population |
|---|---|---|
| **Male** | 404,017 | 25% |
| **Female** | 407,195 | 23% |
| Total | 811,212 | |

Table 3 below shows the estimated prevalence of obesity in the South East Coast (SEC) Strategic Health Authority (SHA) area by Local Authority and indicates that on average around 22% of adults across SEC area are obese. The estimated prevalence of obesity in East Sussex is slightly higher than the SEC average at 24.5%.

**Table 3: SEC Adult Population with Obesity (BMI >= 30kg/m2)**

| PCT | Population[11] | % Obese Adults[12] |
|---|---|---|
| Brighton & Hove | 216,000 | 20.2 |
| **E Sussex Downs & Weald** | **282,600** | **24.5** |
| **Hastings & Rother** | **149,300** | |
| E and Coastal Kent | 613,600 | 23.4 |
| W Kent | 552,100 | |
| Medway | 206,200 | 25.3 |
| Surrey | 901,400 | 20.3 |
| West Sussex | 652,000 | 21.6 |
| SEC | 3,573,200 | 22.3[13] |
| England Worst | | 31.2 |
| England Average | | 23.6 |
| England Best | | 11.9 |

[8] NICE CG43, 2006: Medical illnesses/diseases that are either caused by or contributed to by morbid obesity. These include diabetes, high blood pressure, high cholesterol, sleep apnea, and arthritis (to name a few). Presence of these co morbidities lowers the weight threshold for surgical treatment from a BMI of 40+ to 35+.

[9] Health Survey for England 2008.

[10] Direct estimate from Health Survey for England 2003 – 2005, taken from Area Health Profiles for 2009, APHO and DH, mid-2007 population estimates.

[11] 2009 Population estimates; 2006-based sub national population projections to 2031- Adults

[12] Direct estimate from Health Survey for England 2003 – 2005, taken from Area Health Profiles for 2009, APHO and DH, mid-2007 population estimates.

[13] Calculated figure

## Overweight and Obesity in East Sussex

A variety of local, national and modelled data to describe prevalence and incidence of obesity in East Sussex is available. The following section describes the key data sources and their contribution to understanding demand and need for obesity interventions.

Four data sources used in this report are:

The National Child Measurement Programme, which records the BMI of children in Reception Year and Year 6. This data has been collected since 2005-6 and is recorded by School Nurses and uploaded on to the Child Health Measurement System produced by the NHS Information Centre. Anonymised datasets are available to Public Health Observatories to enable regional-level and local-level analysis to inform delivery of services. In NHS East Sussex Downs & Weald, by 2009, the proportion of Reception Year and Year 6 pupils taking part in the programme was 86% and in Hastings and Rother in 2008 the proportion of Reception Year pupils taking part in the programme was 93%, while participation by Year 6 pupils was 86%.

Quality Outcome Framework (QOF) data collected by General Practice records the number of patients in each practice with a BMI of 30 + recorded in the last 15 months. It is useful as an indicator of obesity at a local level.

The Health Survey for England captures BMI data from across the country. This research is regularly used to model data that can enable local providers to develop estimates of prevalence.

Locally held service intelligence data is collected to review commissioning activity and services at PCT and Strategic Health Authority levels. In particular this provides information on prescribing practice and pharmaceutical interventions for obesity, and Bariatric services which address morbid obesity and or co morbidities associated with obesity.

An examination of these sets of information will be made and reviewed with specific focus on the East Sussex area and in particular to address trends and shifts in the patterns and prevalence of obesity locally.

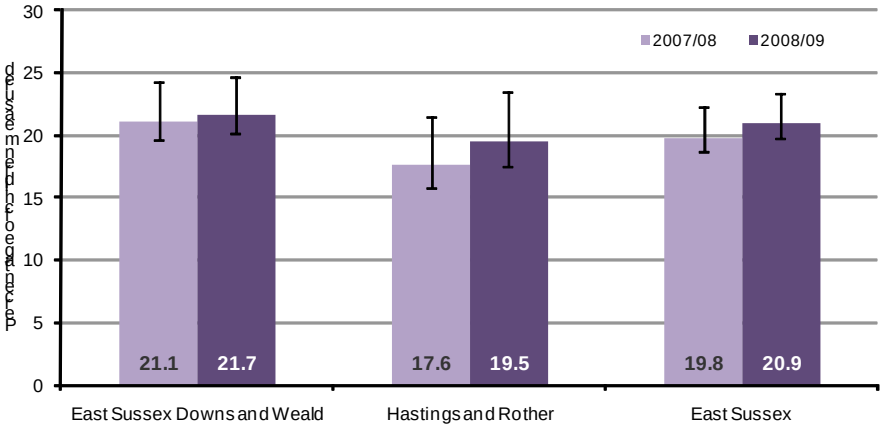
Data Limitations: A comprehensive data set of individual height and weight is not available, either at a local or national level; consequently attempts to quantify the burden of obesity in East Sussex are not straightforward. Modelling from national data may over or underestimate obesity, GP QOF registers provide a snapshot, but only include those patients who have presented at their practice in the last 15 months and have then been assessed. Over time information gathered through the Child Measurement Programme together with QOF data may provide a more accurate indication of obesity levels in adults and children at a local level.

### National Child Measurement Programme in NHS East Sussex Downs and Weald and NHS Hasting and Rother PCT s

The National Child Measurement Programme collects data on the weight and height of children in Reception Year and Year 6. The full data set can be found in Appendix 16. Data

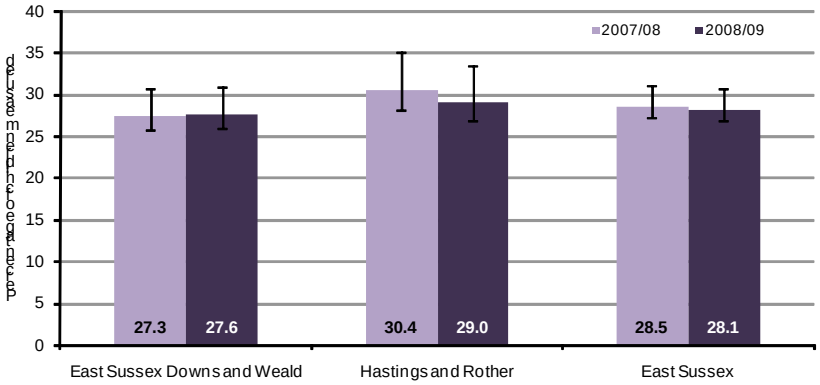
from this programme indicates that for Reception Year the proportion of children taking part in the programme in 08/09 that fell into the obese and overweight categories was greater than that in 07/08, however caution should be applied in interpreting this as indicating a trend, as it represents only 2 years of data

**Figure 1: Percentage of children in Reception overweight or obese with 95% confidence intervals, East Sussex PCTs, 2007/08 and 2008/09**




For Year 6 the proportion of children taking part in the programme who fall in the overweight category is 28.1%, this is higher that the Reception Year (20.9%). Participation data shows an increase in recording from 2007-08 to 2008-09. However as before caution should be used in interpreting this as survey response participation rates vary between the year groups.

**Figure 2: Percentage of children in Year 6 overweight or obese with 95% confidence intervals, East Sussex PCTs, 2007/08 and 2008/09**




### Obesity in adults

Table 4 below shows obesity prevalence estimated from data collected through the **Health Survey for England (HSE)**[14]. This data has been modelled by the PCT's Public Health Intelligence Team (PHIT). This information is broken down by local authority.

[14] Health Survey for England 2004-2008 (NB 2010 as yet not published)

**Table 4: Estimated prevalence of obesity 16 years and over, 2003 to 2005**[15]

| Area | Count | % |
|---|---|---|
| East Sussex | 98,932 | 22.2 |
| Hastings | 18,083 | 24.2 |
| Eastbourne | 18,405 | 21.6 |
| Rother | 16,608 | 21.4 |
| Lewes | 17,983 | 21.9 |
| Wealden | 26,265 | 20.9 |

HSE data suggests that 22.2% of adults in East Sussex are obese, which is broadly consistent with the South East regional average of 22.3%. However rates across East Sussex vary between the District and Borough Council's, with Hastings having the highest rate of 24.2% and Wealden and Lewes the lowest at 20.9%.

Information on the prevalence of obesity is collected at General Practice (GP) level through the **Quality and Outcome Framework (QOF)**. QOF records patients over 16 years with a BMI of 30 or more recorded in the previous 15 months. This data shows some interesting findings for the East Sussex area as a whole and Table 5 describes this in the context of other localities in South East Coast SHA. The Quality and Outcomes Framework includes an indicator which rewards GP practices for maintaining a register of patients with obesity. At both a national and local level prevalence of obesity recorded through QOF is significantly lower than that predicted through modelling e.g. using HSE data. QOF data for 08/09 indicates that 8.5% of practice adult populations in the South East Coast SHA and this is lower than the England average of 9.9%. The difference in obesity prevalence described by these two methods is to be expected as QOF data only includes those patients assessed in the last 15 months. Consequently this provides a useful proxy measure of obese people who have visited their GP practice in the period and whose health is being monitored. The proportion of Patients with a BMI above 30 recorded in the relevant period increased slightly in ESDW between 07/08 and 08/09, however it is not clear whether this growth represents an increase in prevalence, or better recording in GP Practices.

**Table 5: National obesity prevalence rates recorded on GP practice registers**[16]

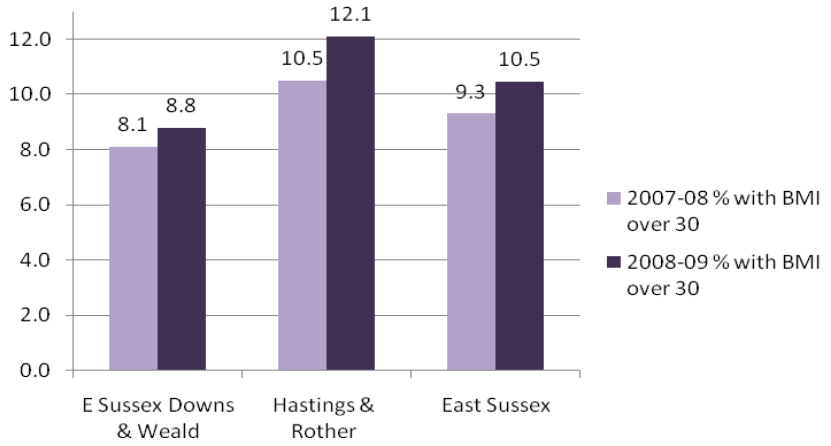
| SHA | QOF 07/08 (%) | QOF 08/09 (%) |
|---|---|---|
| North East | 9.3 | 12.3 |
| North West | 8.2 | 10.8 |
| Yorkshire and Humber | 8.2 | 10.7 |
| East Midlands | 8.1 | 10.2 |
| West Midlands | 8.4 | 10.9 |
| East of England | 7.4 | 9.3 |
| London | 6.7 | 9.0 |
| **South East Coast** | **6.8** | **8.5** |
| South Central | 7.1 | 9.4 |
| South West | 7.3 | 9.3 |
| **England** | **7.6** | **9.9** |

[15] Taken from JSNA Scorecard 107
[16] Health and Social Care Information Centre; Statistics on Obesity, physical activity and diet; England, 2010.

**Table 6: SEC PCT obesity prevalence rates recorded on GP practice registers**[17]

| Primary Care Trust | QOF 07/08 (%) | QOF 08/09 (%) |
|---|---|---|
| Brighton & Hove | 6.0 | 6.6 |
| **E Sussex Downs & Weald** | **8.1** | **8.8** |
| **Hastings & Rother** | **10.5** | **12.1** |
| **East Sussex** | **9.3** | **10.5** |
| E and Coastal Kent | 10.1 | 10.9 |
| Medway | 12.1 | 12.9 |
| W Kent | 9.1 | 9.1 |
| Surrey | 6.7 | 6.7 |
| West Sussex | 7.7 | 7.8 |

**Figure 3:**
**Figure 3 2007-08 and 2008-09 QOF data for East Sussex Compared**[18]




Data on pharmaceutical prescribing for obesity provides a source of information on levels of non medical interventions for obesity. Data from the Office of National Statistics Health and Social Care information Centre (Prescriptions Dispensed in the Community Statistics for 1998 to 2008)[19] indicates a prescribing rate of 1.3 million prescriptions for England in 2008, which equates to an average of 25.3 prescriptions per 1000 population. Applying this rate to an East Sussex population would suggest 8,231 prescriptions in East Sussex, Downs and Weald and 4,319 prescriptions in Hastings and Rother (12,550 overall). However this is considerably higher than the number seen in Table 7 below.

**Table 7: PCT Pharmacy data 2008-09 for East Sussex**[20]

NB. Data relating to small numbers has been suppressed where relates to n<5

| PCT area | Orlistat number | Orlistat total cost | Sibutramine number | Sibutramine total cost | Rimonabant number | Rimonabant cost | Total Pres-criptions | Total Cost |
|---|---|---|---|---|---|---|---|---|
| Bexhill and Rother | 990 | £ 35,100 | 380 | £ 10,700 | 90 | £ 3,675 | 1460 | £ 49,450 |
| Crowborough and Uckfield | 745 | £ 22,950 | 320 | £ 8,500 | - | - | 1070 | £ 31,500 |
| Eastbourne and Hailsham | 1790 | £ 53,925 | 720 | £ 16,975 | - | - | 2510 | £ 70,900 |
| Hastings and St Leonards | 1725 | £ 53,700 | 730 | £ 19,125 | 265 | £ 10,975 | 2720 | £ 83,800 |
| Lewes | 340 | £ 10,125 | 80 | £ 1,875 | - | - | 420 | £ 12,000 |
| Seaford and the Havens | 820 | £ 24,575 | 265 | £ 7,200 | - | - | 1085 | £ 31,800 |
| Total East Sussex | 6405 | £ 200,400 | 2500 | £ 64,350 | 355 | £ 14,675 | 9265 | £ 279,425 |

[17] NHS Comparators. At individual practice level, QOF prevalence ranges from 2% to 49% with a mode of 8%.
[18] QOF Obesity Register East Sussex Downs and Weald and Hastings and Rother PCT
[19] Prescriptions Dispensed in the Community Statistics for 1998 to 2008: England; The Health and Social Care Information Centre; Prescribing Support unit; 2009
[20] PCT pharmacy data from general practice East Sussex Downs and Weald and Hastings and Rother PCTs- Data 09-10

The number of Bariatric Surgery referrals and approvals has increased in the last three years. Figure 4 shows that between 2008-09 and 2009-10, 286 people were referred for Bariatric surgery of which 223 (78%) were approved for surgery. This represents an increase across both PCTs.

- East Sussex Downs and Weald had a growth in approvals from 77 in 2008-09 to 95 in 2009-10 a 21.1% increase. Hastings and Rother had a growth in approvals from 23 in 2008-09 to 28 in 2009-10 a 17.9% increase.
- Average BMIs for these procedures was 47.1 in East Sussex Downs and Weald over these two years and the average BME in Hastings and Rother was 48.2.

Table 8 below describes referrals and approvals for revision of bariatric surgery, which is coordinated through the South East Coast Specialised Commissioning Group, who act on behalf of PCTs in the South East. There has been an increase in referrals for revision bariatric surgery in 2009-10, and this may be due to:

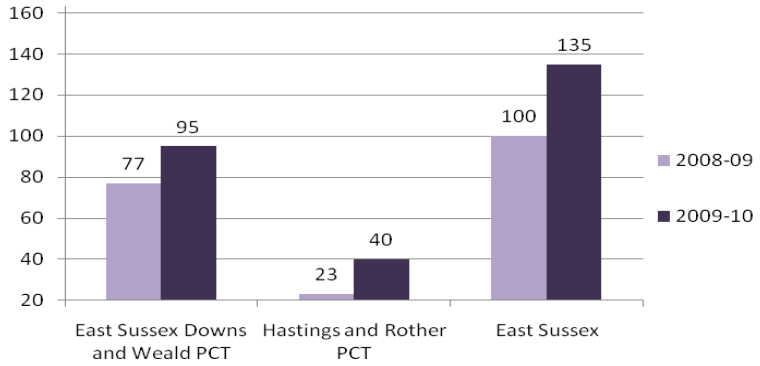
- Increased prevalence in obesity
- Higher referral rates
- Surrey/Sussex is the only region which has fully instituted NICE guidelines – other regions are keeping referral rates lower by raising the benchmark for qualification for surgery.

**Table 8: Bariatric Surgery Referrals and Approvals for Revision 2008-09/2009-10 for East Sussex[21] (this includes both primary surgery and revisions hence BMI may differ from NICE guidance for primary surgery)**

| PCT | Year | Bariatric Operation Approved/ (Yes/No) | Count of Approved/ (Yes/No) | Average of BMI | Min of BMI | Max of BMI2 |
|---|---|---|---|---|---|---|
| East Sussex Downs & Weald | 08-09 | No | 23 | 44.77 | 38.00 | 57.40 |
| | | Yes | 77 | 48.16 | 27.00 | 72.40 |
| | 08-09 Total | | 100 | 47.40 | 27.00 | 72.40 |
| | 09-10 | No | 24 | 43.73 | 35.10 | 55.70 |
| | | Yes | 95 | 47.92 | 27.00 | 79.00 |
| | 09-10 Total | | 119 | 47.08 | 27.00 | 79.00 |
| East Sussex Downs & Weald Total | | | **219** | **47.22** | **27.00** | **79.00** |
| Hastings & Rother | 08-09 | No | <5 | 44.85 | 44.30 | 45.40 |
| | | Yes | 23 | 48.23 | 40.00 | 62.00 |
| | 08-09 Total | | 27 | 47.94 | 40.00 | 62.00 |
| | 09-10 | No | 12 | 44.90 | 35.20 | 54.40 |
| | | Yes | 28 | 48.23 | 27.00 | 68.00 |
| | 09-10 Total | | 40 | 47.23 | 27.00 | 68.00 |
| Hastings & Rother Total | | | **67** | **47.49** | **27.00** | **68.00** |
| Grand Total | | | **286** | **47.28** | **27.00** | **79.00** |

[21] Bariatric Surgery Database SEC April 2010 M. Lander

**Figure 4: Approvals for Bariatric Services 2008-09-2009-10 for East Sussex**[22]




This growth in both referrals and approvals for surgery is significant and will if maintained place a heavy burden on the NHS. The local average cost estimate of bariatric services is £10,000 per intervention, excluding ongoing costs of patient care and management post surgery[23]. Based on this the estimated cost of bariatric services across East Sussex was £1,590,000 in 09/10. This represents an estimated increase of £1,300,000 over the period. Predicted trends in population weight suggest that levels of need for bariatric services are likely increase if effective interventions at Tiers 1, 2 and 3 are not in place.

**Table 9: Approvals for Bariatric Services and their cost 2008-10 for East Sussex**[24]

| Year | Number of Referrals | Number of Approvals | Cost of Approved Treatment |
|---|---|---|---|
| **East Sussex Downs and Weald** | | | |
| 2008/9 | 98 | 77 | £770,000 |
| 2009/10 | 109 | 119 | £1,190,000 |
| **Hastings and Rother** | | | |
| 2008/9 | 27 | 23 | £230,000 |
| 2009/10 | 34 | 40 | £400,000 |
| **East Sussex** | | | |
| 2008/9 | 125 | 100 | £1,000,000 |
| 2009/10 | 143 | 159 | £1,590,000 |

A summary review of the data set out in this section would suggest that:

- 24.5% of adults over 16 are obese in East Sussex Downs and Weald and Hastings and Rother PCTs
- East Sussex profile of the adult community with a BMI over 30 is 22.2% which is broadly consistent with the South East regional average of 22.3% and the National mid point average of 23.6%.
- 20.9% of Reception Year children are either overweight or obese across East Sussex.
- 28.1% of Year Six Children are either overweight or obese across East Sussex.
- 2008-09 QOF (GP Practice data) shows 8.8% of patients on the obesity register in East Sussex Downs and Weald and 12.1% in Hastings and Rother and 10.5% across the County. The East Sussex average is broadly comparable with national rates, however Hastings and Rother is somewhat higher than that of ESDW.

[22] Bariatric Surgery Database SEC April 2010 M. Lander
[23] Strategic Commissioning Plan Specialised Weight Management Services April 2010/11 to 2015/16: M. Lander
[24] Strategic Commissioning Plan Specialised Weight Management Services April 2010/11 to 2015/16: M. Lander

- Prescribing rates for pharmacological interventions for obesity are lower in East Sussex than national estimates suggest would be expected.
- East Sussex Downs and Weald had a growth in approvals for Bariatric Surgery from 77 in 2008-09 to 95 in 2009-10.
- Hastings and Rother had a growth in approvals for Bariatric Surgery from 23 in 2008-09 to 28 in 2009-10.
- In 2009 the rate of referrals per 1000 population (0.32/1000) in East Sussex Downs and Weald was almost double the rate for Hastings and Rother (0.18/1000)[25]
- Average BMI for Bariatric Surgery was 47.1 in East Sussex Downs and Weald over these two years and the average BMI in Hastings and Rother was 48.2.
- Crude cost estimates for Bariatric Services across East Sussex are £1,590,000, this has steadily increased over the last three years.
- Obesity prevalence estimates suggest that Hastings and Rother PCT is likely to have higher rates of obesity than East Sussex Downs and Weald, however referral for Bariatric Services in ESDW are twice those of H&R

## 3. Modelling Need

Population estimates which have been used for this needs assessment are from the NHS which models population growth based on the Office for National Statistics data set for 2006. Tables 10, 11 and 12 below set out the population increases for East Sussex Downs and Weald, Hasting and Rother and East Sussex based on ONS projections used by the PCT.

Population estimates for East Sussex as a whole predict a sizeable growth in population between 2006 and 2016 (circa 40,000). The adult population is expected to increase by some 28,000 whereas the child population is expected to increase by 2,000.

**Table 10: East Sussex Downs and Weald Population Estimates 2006-2016**

| 2006-based sub national population projections, Table 7: Population for SHAs and PCOs Quinary age groups, persons | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (000) | | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
| ALL AGES | | 330.2 | 332.5 | 335.0 | 337.5 | 340.7 | 343.6 | 346.4 | 349.0 | 351.9 | 354.6 | 357.5 |
| Adult | 16-85+ | 270.7 | 273.0 | 275.6 | 278.0 | 281.0 | 283.7 | 286.3 | 288.8 | 291.4 | 293.8 | 296.2 |
| Child | 0-15 | 59.5 | 59.5 | 59.4 | 59.5 | 59.7 | 59.9 | 60.1 | 60.2 | 60.5 | 60.8 | 61.3 |

**Table 11: Hastings and Rother Population Estimates 2006-2016**

| 2006-based sub national population projections, Table 7: Population for SHAs and PCOs Quinary age groups, persons | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (000) | | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
| ALL AGES | | 176.1 | 176.7 | 177.5 | 178.3 | 179.2 | 180.2 | 181.2 | 182.3 | 183.4 | 184.5 | 185.7 |
| Adult | 16-85+ | 144.4 | 145.3 | 146.2 | 147.2 | 148.2 | 149.3 | 150.4 | 151.6 | 152.8 | 153.8 | 154.8 |
| Child | 0-15 | 31.7 | 31.4 | 31.3 | 31.1 | 31.0 | 30.9 | 30.8 | 30.7 | 30.6 | 30.7 | 30.9 |

**Table 12: Population Estimates East Sussex (Adult Population 16+)**

| 2006-based sub national population projections, Table 7: Population for SHAs and PCOs Quinary age groups, persons | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (000) | | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
| ALL AGES | | 506.3 | 509.2 | 512.5 | 515.8 | 519.9 | 523.8 | 527.6 | 531.3 | 535.3 | 539.1 | 543.2 |
| Adult | 16-85+ | 415.1 | 418.3 | 421.8 | 425.2 | 429.2 | 433.1 | 436.7 | 440.4 | 444.2 | 447.6 | 451.0 |
| Child | 0-15 | 91.2 | 90.9 | 90.7 | 90.6 | 90.7 | 90.7 | 90.9 | 90.9 | 91.1 | 91.5 | 92.2 |

[25] GP Practice registered population aged 15+ October 2009, Exeter data,

Forecasting trends is another way to establish potential demand for services. The forecasts below have been completed by taking historic and current data for, QOF, HSE and forecasting the trend line beyond the current data. In the case of the Child Measurement Programme it is not possible to do this as there are only two reliable years of data to base this trend on. Whilst 3 data points have been used to forecast QOF and 7 for HSE data these indications, whilst being more robust, still need to be treated with caution as differences could be due to random variation. However early indications are that local data indicates increased prevalence of obesity and therefore suggests that demand for obesity services may increase.

Quality Outcomes Framework data for the prevalence of patients on the obesity register is set out in Figure 5 below. This data would seem to indicate an increase in the number of patients on practice obesity registers in future years, however due to the small number of data points it should be treated with some caution.

**Figure 5: QOF Obesity Register Forecast to 2015**

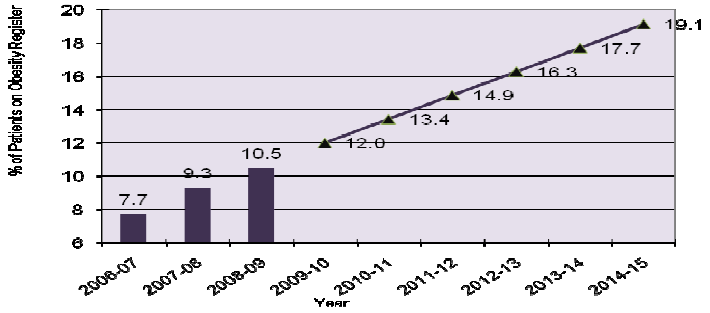
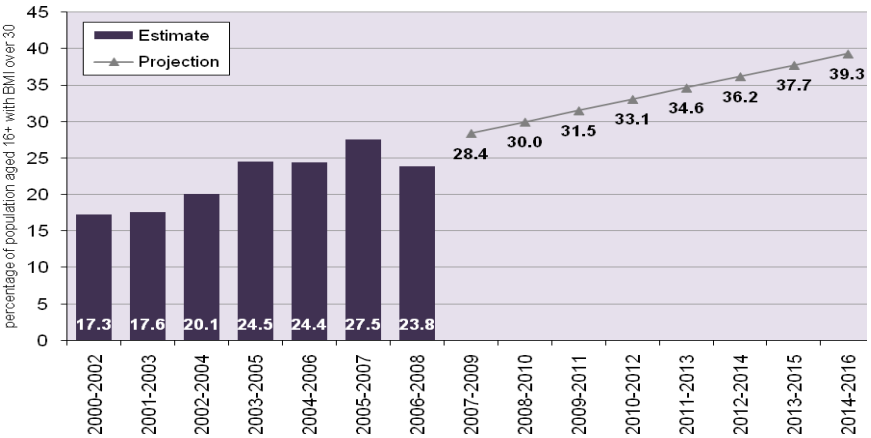



Figure 6 below is based on a range of obesity estimates for 2000-2008. These have been projected to 2015 the volume of estimates makes this forecast more reliable. It shows a growth from 15.5 % increase in people with a BMI of over 30 between 2008 and 2016.

**Figure 6: Rate of BMI Growth in 16+ Population in East Sussex to 2015**[26]




[26] Data sourced from *APHO - Health Profiles for 2007, 2008, and 2010 www.healthprofiles.org.uk - JSNA - JSNA scorecards based on aggregating Ward and MSOA synthetic estimates www.esdw.nhs.uk or www.hastingsandrother.nhs.uk – and NCHOD - Published on www.nchod.nhs.uk*

The Government Office for Science's Foresight Programme[27] has modelled expected prevalence of obesity up to 2050. Table 13 below takes national assumptions from the Foresight Report and applies these to the East Sussex population. Whilst this is a crude application of the complex modelling undertaken by Foresight (e.g. it does not take account of variations in population structure such as age profile) it does give some indication of potential future numbers of obese people in East Sussex.

**Table 13: Table 13 Foresight projections to 2026 applied to East Sussex population forecasts**

| Foresight Model BMI over 30 | 2007/08 | | 2015/16 | | 2025/26 | |
|---|---|---|---|---|---|---|
| Applied to East Sussex | Foresight% | East Sussex | Foresight% | East Sussex | Foresight% | East Sussex |
| Adult Male | 26.7% | 51861 | 36% | 73767 | 47% | 98614 |
| Adult Female | 24.0% | 52936 | 28% | 64488 | 36% | 85511 |
| Total | | 104,797 | | 138,255 | | 184,125 |

Table 14 below takes the forecasting set out above and moulds this to the population estimates for the key child and adult groups set out below. It estimates that by 2015 there will be some 1,641 reception age children who are either obese or overweight and 2,119 Year 6 children in the same position, however over this period there is a slight drop in the numbers of young people in the population and hence whilst this growth in proportion is some 7% and 6% respectively the overall numbers of children are not a great increase.

However the data for QOF shows a strong growth in adults on the obesity register from 43,585 in 2008-09 to 83,128 in 2014-2015 almost half the number and data from the Health Survey for England prevalence estimates for Obesity show a steady growth of 23.8% of the population with a BMI of over 30 to 40.6% by 2015-16 which represents some 176,701 people. Interestingly with respect to this last figure this is significantly higher than the Foresight Report's estimate of Obesity in males and females, which when added together gives a figure of 138,255 a differential of 38,446 people or 22%

**Table 14: Modelling Demand against service and population forecasts for East Sussex**

| Modelling demand against population growth | 2008-09 | | 2011-12 | | 2014-15 | |
|---|---|---|---|---|---|---|
| Child | % Overweight & Obese | Count | % Overweight & Obese | Count | % Overweight & Obese | Count |
| Receptions Age | 20.9% | 1,270 | 24.2% | 1,447 | 27.5% | 1,641 |
| Year 6 | 28.1% | 1,792 | 35.2% | 2,101 | 35.5% | 2,119 |
| Adult | % Obese | Count | % Obese | Count | % Obese | Count |
| QOF GP Obesity Registers | 10.5% | 43,585 | 14.9% | 63,516 | 19.1% | 83,128 |
| HSE Obesity | 23.8%[28] | 98,792 | 30.9% | 134,484 | 40.6% | 176,701 |

Table 15 below maps current interventions available to East Sussex residents against the 4 Tier of provision set out in the model described in Section 8. This is based on an approach used by West Sussex PCT to estimate the number of interventions needed for a local population. The West Sussex approach is set out in more detail in Section 5 BMI thresholds

[27] Foresight, together with the Horizon Scanning Centre, produce challenging visions of the future (www.foresight.gov.uk) Tackling Obesity: Future Choices Project Oct 2007

[28] 2009/10 HSE data forecasted

for access to intervention at each Tier should be determined locally, however proposed thresholds for West Sussex are presented here for information.

Tier 4 Bariatric Services are commissioned on an SHA wide basis by the South east Coast Specialised Commissioning Group. Referrals for bariatric surgery in East Sussex are forecast to grow to 345 from the 2009/10 level of 123. However additional interventions at lower Tiers may of course reduce both need and demand for Tier 4 interventions over time.

**Table 15: Modelling Services required by 2015 for NHS East Sussex Downs and Weald PCT and NHS Hastings and Rother PCT**

| Model of Services Required by 2015 | Current Numbers | Estimated Numbers | BMI level | New Service requirement | Unit Cost | Current Cost | Estimated Cost |
|---|---|---|---|---|---|---|---|
| Tier 4 (Surgery & Other interventions) | 135 | 345 | 40 or 35+ with other co morbidities | No | £10,000 | £1,350,000 | £3,450,000 |
| Tier 3 (Weight Management Service) | 0 | 690 | 40-49.9 | Yes | £1,200 | £0 | £828,000 |
| Intensive support | 0 | 173 | 40-49.9 | Yes | £1,452 | £0 | £250,470 |
| Tier 2 Primary Care + Community Interventions | 0 | 2760 | 35-39.9 + co-morbidities | Yes | £600 | £0 | £1,656,000 |
| Referral Management | 0 | 1 | | Yes | £50,000 | £0 | £50,000 |
| | | | | | | | |
| Total | | | | | | | £6,234,470 |

**Modelling need for Bariatric Services**

NICE guidance estimates that annual referrals to a bariatric surgical service will be at 0.01% of population (or 10 per 100,000 pop) by 2011, equating to 432 adult patients across the whole SEC area in 2011. This figure is derived from a total prevalence of patients who fall within NICE criteria, of approximately 2.2% of the population. NICE adjusts this figure for those who are considered eligible for surgery and again for those who would take up surgery if offered. This algorithm results in an adjusted "pool" of 23,040 people within SEC. NICE has then estimated that due to capacity only approximately 1.6% of this population could actually be treated each year.

NICE guidance [29]suggests that only a small proportion of morbidly obese patients are currently offered surgery. The reasons for this are unclear, however it may be that patients are happy with their health and lifestyle; are not aware of the availability of interventions; feel that they are not supported in their desire to lose weight; do not wish to undergo the procedures or are otherwise clinically unsuitable. NICE estimates do not represent the optimum rate of procedures, but the expected rate. NICE guidance suggests that based on need surgical provision may need to rise beyond the current level.

Other methods of estimating prevalence and demand exist, resulting in different figures. SSNDS - The Specialised Services National Definition Set (SSNDS) for Morbid Obesity (3rd edition) estimates that the group of patients requiring access to a Bariatric Surgery and or Specialist Weight Management Services amounts to approximately 120,000 adults nationally. This grouping is derived from a tighter set of criteria than used by NICE and includes all

[29] National Institute for Health and Clinical Excellence: Obesity (morbid) – Surgery CG43

patients with a BMI over 50kg/m2 and patients with a BMI over 40kg/m2 who have the following co-morbidity (note: this is not an exhaustive list):

- endocrine conditions
- genetic conditions (rare causes of severe obesity)
- organ failure and are being considered for transplantation, e.g. renal, heart
- awaiting major surgery (with the attendant anaesthetic risk)
- women seeking infertility treatment
- Failure with other methods of weight-loss management.

For South East Coast PCTs (assuming an equal distribution to that seen nationally) this represents approximately 10,000 adults and is represented in Table 16 below.

**Table 16: SSNDS 35 population estimates of surgical demand, compared to NICE benchmark prediction of annual presentation at surgical centres**

| PCT | 2009 Population[30] | Estimated population derived from thresholds in SSNDS 35 | Estimated population derived from NICE criteria (NICE)[31] | Estimated Population Eligible and willing (NICE)[32] | Estimated surgical benchmark (NICE 0.01%)[33] |
|---|---|---|---|---|---|
| Brighton & Hove | 216,000 | 605 | 4,795 | 1,151 | 25 |
| E Sussex Downs & Weald | 282,600 | 791 | 6,274 | 1,506 | 34 |
| Hastings & Rother | 149,300 | 418 | 3,314 | 795 | 18 |
| E and Coastal Kent | 613,600 | 1,718 | 13,622 | 3,269 | 74 |
| Medway | 552,100 | 577 | 12,257 | 2,942 | 25 |
| W Kent | 206,200 | 1,546 | 4,578 | 1,099 | 68 |
| Surrey | 901,400 | 2,524 | 20,011 | 4,803 | 110 |
| West Sussex | 652,000 | 1,826 | 14,474 | 3,474 | 78 |
| **SEC Total** | **3,573,200** | **10,004** | **79,325** | **19,038** | **432** |

Table 16 above indicates that the SSNDS predicts lower demand for Tier 4 interventions than applying the NICE algorithm to the East Sussex population. What this table shows is that in 2009 the SSNDS 35 combined estimate for East Sussex Downs and Weald and Hastings and Rother was 1,209 which is significantly lower than the NICE estimates (9,588 ) of prevalence based on the 2.2% of the population. Those eligible and willing to proceed to surgery based on the NICE algorithm that determines the potential demand (without assumptions for access rates) is 2,301 and the surgical benchmark (NICE 0.01%) for East Sussex Downs and Weald and Hastings and Rother is 52. In 2009 the number of actual approvals for Bariatric Surgery in East Sussex was 100 which is almost double the level of those set out in the NICE estimates. This is a concern as there would seem to be a higher level of approvals for surgery compared to that which is set out in the NICE estimates.

[30] 2009 Population estimates; 2006-based sub national population projections to 2031- Adults
[31] 2011 estimated prevalence using NICE 2.22% Population
[32] NICE CG43 algorithm to determine potential demand, with no assumptions for annual access rates
[33] NICE CG43 estimated appropriate annual provision benchmark

In summary data suggests that:

- The need and demand for obesity services in East Sussex is likely to increase
- Population growth in East Sussex is projected to increase, ONS data projects show a 40,000 person increase to 2016 and East Sussex CC data shows an increase of 18,500
- Predictions for increase in prevalence suggest strong rates of growth that will place significant demand on services
- There are positive trend increases in both projections for QOF Obesity Register patients and the adult population post 16 in East Sussex
- Modelling need in Bariatric Surgery shows the East Sussex area is performing above the current NICE estimate with 100 approvals as compared to 52 projected by NICE

## 4. Obesity, the National and Local Policy Context

This section summarises the main national and local policy drivers and strategies that contribute to the obesity agenda

National Policy and Strategy

**'Healthy Weight, Healthy Lives' A Cross Governmental Strategy for England** was published in Jan 2008 sets out the Governments aspirations of sustained programme to support people to maintain a healthy weight. Its ambition is for England to be the first major nation to reverse the rising tide of obesity and overweight in the population by ensuring that everyone is able to achieve and maintain a healthy weight. The Strategy's initial focus will be on children: by 2020, it aims to reduce the proportion of overweight and obese children to 2000 levels. The strategy recognises that being overweight or obese is associated with increased risk of diabetes, cancer, heart disease. Costs to society as a whole as a result of obesity are forecast to £50 billion per year by 2050.

**Fair Society, Healthy Lives, the Marmot Review 2010** is an independent review into health inequalities in England which Professor Sir Michael Marmot was asked to chair by the Secretary of State for Health. This review identifies that health inequalities that are preventable by reasonable means are unfair, and that putting them right is a matter of social justice and that:

- There is a social gradient in health – the lower a person's social position, the worse his or her health.
- Action to reduce health inequalities should focus on reducing the gradient in health.
- Action on health inequalities requires action across all the social determinants of health.
- Interventions should be proportionate to the scale of disadvantage
- There are economic costs to society from health inequalities.

Local strategies and policies

**NHS East Sussex and NHS Hastings and Rother: Strategic Commissioning Plan (SCP) 2009/2010 to 2014/15**. This joint Strategic Commissioning Plan identifies the PCTs strategic goals and aims over the next five years. Obesity is identified in the SCP as a key health challenge.

**Choosing Health Strategies and Action Plans**; Each PCT has developed strategies and Action plans to deliver the Choosing Health agenda around obesity. Delivering the primary prevention elements of Healthy Weight, Healthy Lives has now been incorporated into these Strategies. A summary of key actions is included in Section 20 in the appendix.

## 5. Development of an Obesity Care Pathway for East Sussex

NICE Guidelines

**NICE** [34] through its guideline 43 sets out the prevention, identification, assessment and management of overweight and obesity in adults and children. The guidelines set the key priorities for implementation. It states that 'The prevention and management of obesity should be a priority for all, because of the considerable health benefits of maintaining a healthy weight and the health risks associated with overweight and obesity. It sets roles for Public health providers including the NHS and Local Authorities and partners. It states that 'managers and health professionals in all primary care settings should ensure that preventing and managing obesity is a priority, at both strategic and delivery levels. Dedicated resources should be allocated for action'. The guidelines set responsibilities for Local authorities and partners, Early years settings, Schools, Workplaces and Self-help, commercial and community settings.

The guidelines set priorities for Clinical care:

Children and adults

- Multi component interventions are the treatment of choice. Weight management programmes should include behaviour change strategies to increase people's physical activity levels or decrease inactivity, improve eating behaviour and the quality of the person's diet and reduce energy intake.

Children

- Interventions for childhood overweight and obesity should address lifestyle within the family and in social settings.
- Body mass index (BMI) (adjusted for age and gender) is recommended as a practical estimate of overweight in children and young people, but needs to be interpreted with caution because it is not a direct measure of adiposity.
- Referral to an appropriate specialist should be considered for children who are overweight or obese and have significant co morbidity or complex needs (for example, learning or educational difficulties).

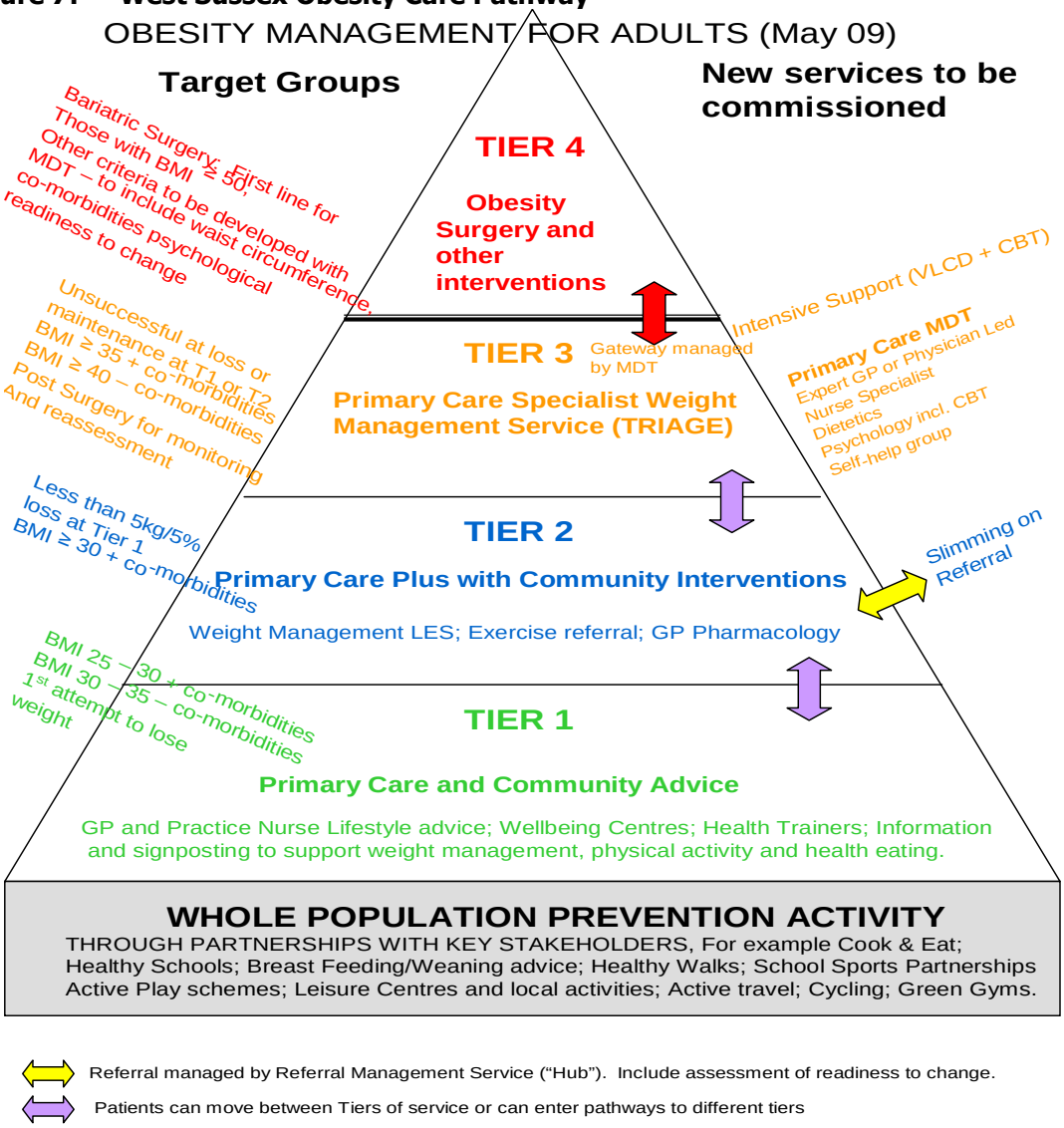
Adults

[34] NICE Clinical Guideline 43: On the prevention, identification, assessment and management of overweight and obesity in adults and children Dec 2006

- The decision to start drug treatment, and the choice of drug, should be made after discussing with the patient the potential benefits and limitations, including the mode of action, adverse effects and monitoring requirements and their potential impact on the patient's motivation. When drug treatment is prescribed, arrangements should be made for appropriate health professionals to offer information, support and counselling on additional diet, physical activity and behavioural strategies. Information about patient support programmes should also be provided.
- Bariatric surgery is recommended as a treatment option for adults with obesity if all of the following criteria are fulfilled:
    - they have a BMI of 40 kg/$m^2$ or more, or between 35 kg/$m^2$ and 40 kg/$m^2$ and other significant disease (for example, type 2 diabetes or high blood pressure) that could be improved if they lost weight
    - all appropriate non-surgical measures have been tried but have failed to achieve or maintain adequate, clinically beneficial weight loss for at least 6 months
    - the person has been receiving or will receive intensive management in a specialist obesity service
    - the person is generally fit for anaesthesia and surgery
    - the person commits to the need for long-term follow-up
- Bariatric surgery is also recommended as a first-line option (instead of lifestyle interventions or drug treatment) for adults with a BMI of more than 50 kg/$m^2$ in whom surgical intervention is considered appropriate.

Figure 7 below describes the care pathway for the management of Obesity for Adults in West Sussex. Developed by Versha Talati a commissioning manager at West Sussex PCT. The tiers describe the ways of unlocking provision and intervention and the opportunity for patients to move between the tiers of provision. However from a commissioning perspective these services have been established and this provision is dedicated a resource for the treatment of obesity in that locality. Both the target groups and the new services to be commissioned presented in Figure 7 are specific to West Sussex PCT, thresholds indicated for movement between tiers are locally determined criteria for West Sussex. East Sussex may wish to address this kind of programme of interventions and relevant thresholds and to consider ways in which services can be commissioned locally to reflect local need.

**Figure 7: West Sussex Obesity Care Pathway**[35]




The care pathway described above has foundations based on a range of whole population activities which should include interventions to reduce the likelihood of individuals becoming obese. Whole population activities should not be confused with the more formalised actions of health professionals in identifying weight concerns and developing programmes of response and intervention for specific cases and individuals who are either obese or overweight. The two have a strong and clear beneficial relationship, however what is clear, through the consultation and research carried out by this assessment, is the need for a defined care pathway for the treatment of obesity in East Sussex.

Tier One interventions are based on initial engagement with Primary Care and Community Advice. Tier Two takes these interventions further forward with higher levels of interventions including weight management and exercise referral. Tier Three takes these interventions

[35] West Sussex Obesity Care Pathway. Talati, V. 2008

further still with Specialist Weight Management Services and Tier Four includes Surgery and other targeted interventions.

A review of care pathways used across England has identified some key components of care pathways for obesity. These are set out below:

- Primary care should be the initial interface where individuals are identified, initial assessment carried out and treatment plans developed.
- Lifestyle advice (physical activity, diet) including behavioural interventions should be provided in primary care but may also be components of more specialist services.
- Drug therapy may be managed either in primary or secondary care depending on the severity of the level of obesity.
- Community weight management services (sometimes defined as specialist care) may include physical activity based (e.g. exercise on referral), diet based (e.g. diet groups, specialist dietetics) or multi component and may be provided through a variety of provider services.
- Secondary services should exist for those with more severe obesity or complex needs and include specialist management of drug therapy, psychological therapies, management of co-morbidities, specialist paediatrics, specialist dietetics services etc.
- Tertiary services: primarily surgical interventions and associated supporting therapies including psychological/behavioural/dietetics etc. This would also include pre and post operative support.

There are many individual initiatives being undertaken across East Sussex to prevent and treat weight gain and obesity. However co-ordination between the individual Tiers of provision is limited because a formal care pathway is absent.

Section 9 sets out stakeholders perspectives of current services to prevent and treat obesity and their views on potential gaps in services and interventions to address obesity in East Sussex.

Section 10 sets out services in East Sussex in relation to the West Sussex model described in Figure 7. This indicates that whilst primary prevention services are reasonably well developed, and there are well developed services at Tier 4 there is limited availability of services at Tiers 2 and 3.

## 6. A Summary of Obesity interventions In East Sussex

### Prevention services in East Sussex Downs and Weald

Whilst there is no formal care pathway within East Sussex this section is seeking to identify services by their position against a widely recognised care pathway for Obesity.

### Whole Population Services

Physical Activity promotion across ESDW is co-ordinated through the PCT led Health Improvement Partnerships which are sub groups of each District and Borough Local Strategic Partnership (LSP). Priorities for improving physical activity are set out in the PCTs Choosing Health Strategies and Action Plans (see section 20 in the appendix).

The Food in Schools Programme

Co-ordinated by East Sussex Community Health Services (ESCHS) the Food in Schools programme aims to improve the health of school children by implementing a specialist programme for East Sussex primary schools adopting a whole school approach focused on healthy eating and actively involving all stakeholders – pupils, teachers, governors, caterers, mid day supervisors, school nurses etc.

East Sussex, Downs and Weald Health Trainer Service

The PCT has commissioned a Health Trainers service from ESCHS. Health Trainers were first proposed in the 'Choosing Health' White Paper. They are members of local communities who are trained and paid to act as links between health professionals and marginalised social groups, and support people to set and achieve realistic health-related lifestyle and behaviour change goals. Health Trainers offer 1:1 evidenced based behaviour change interventions to enable people to change their health related behaviour and improve their lifestyles. Health Trainers refer clients into specialist services e.g. smoking cessation services, health walks etc. The Health Trainer Programme in the ESDW is currently in its developmental phase, and will ultimately offer a full Health Trainer service in priority wards in ESDW from January 2011.

Healthy Start

'Healthy Start' is a Department of Health scheme established to improve the diets of pregnant women, new mothers and young children. It entitles eligible families to access fresh fruit, vegetables, cow's milk and infant milk. The scheme is promoted through the network of integrated Children's Centres for 0-5 year olds, currently being developed across East Sussex.

Play Pathfinders

Play pathfinders are nationally determined pilots which seek to improve the availability of safe play environments for 8-13 year olds. The availability of play space is an important contributor to improving levels of physical activity in this group.

Community cookery training

Action in Rural Sussex is funded until 2011 by the National Lottery Well-being project to improve cooking skills of vulnerable groups living in rural areas. The project provides Cookery Club Leader training to key staff groups across agencies to enable them to offer cook and eat session, given healthy eating advice and be aware of impact of diet and health.

Health Improvement Partnership Small Grants programme
Four District and Borough level Health Improvement Partnerships across East Sussex (Lewes and Wealden have a combined partnership). Each HImP has a physical activity working group which allocates small grants to the value of £10, 000 per partnership per year

Physical Activity Taster Days:
Lewes and Wealden Food and Physical Activity Action Group have supported physical activity taster days in both Lewes and Wealden during summer 2008. These days encouraged a whole family approach to physical exercise with the aim of encouraging parents and children to take part in new activities

Walking
Health Walks are offered from Leisure Centre sites in Lewes, Seaford, Peacehaven and Newhaven.

East Sussex County Council
ESCC offers a programme of leisure walks, guided Walks and a 'Walking for Wellness' programme across East Sussex. In addition short themed walks are included in it's children's Summer Activities Programme.

Age Concern Eastbourne
Offer a programme of health walks aimed at older people.

Cycling
Between April and September ESCC offers a programme of graded guided cycle rides across East Sussex, with rides for adults and families.

**Tier One Services**

Specialised Health Improvement Support
East Sussex Community Health Services (ESCHS) are commissioned by the PCTs to provide Physical Activity and Health, Food and Health and Food in Schools Specialist services and support and form part of the ESCHS Healthy Weight Team who provide specialised health promotion advice, support and interventions to take forward the healthy weight agenda across East Sussex.

East Sussex, Downs and Weald Exercise on Referral Scheme
ESDW PCT does not have a Locally Enhanced Service for exercise referral. However local GPs have worked in partnership with leisure service providers to develop an informal scheme to enable GPs to refer people to local leisure providers and organizations providing targeted physical activity and weight loss support e.g. 20/20 Leisure. The ESDW scheme incorporates a range of physical activity opportunities including gym based, swimming and health walks.

White Hart Health Club, Lewes.
In addition to taking part in exercise referral the health club at the White Hart Hotel also offers self funded weight management interventions which are promoted to GPs to encourage them to recommend their patients.

## Tier Two Services

Mind Exercise Nutrition Do it (MEND)
Hailsham Community College offer a MEND programme as part of their further education programme. MEND was developed at the Institute of Child Health, University College London, and the Great Ormond Street Hospital for Children, the MEND Programme is a family-based weight management intervention aligned to the NICE guidelines for children aged 7-13.

## Tier 3 services

The PCTs do not currently commission specific stand alone Tier 3 services for obesity. Tier 3 interventions are provided through referral to the generic dietetics service provided by East Sussex Community Health Services.

## A summary of Prevention services in Hastings and Rother

Whilst there is no formal care pathway within East Sussex this section is seeking to identify services by their position with a traditional care pathway for Obesity.

## Whole Population Services

Hastings and Rother Community Fruit and Vegetable Project
The Community Fruit and Vegetable Project is a social enterprise which aims to improve access to and consumption of affordable locally grown fruit and vegetables, in the Hastings and Rother area.

Active Hastings
The *"Active Hastings"* programme aims to increase participation levels among low participating or inactive people, and targets both men and women that are over 45, plus disabled and ethnic minority groups. It is jointly funded by Hastings Borough Council who provide the service, and the PCT. Active Hastings provides targeted physical activity sessions designed to meet the needs and preferences of priority groups. Evaluation of Active Hastings suggests that most participants are new to sport/physical activity; however the majority do not continue to be active following participation in an Active Hastings activity. The most commonly cited reason for this is cost.

Hastings Active Attitude: Children
This programme is funded by the British Heart Foundation and offers schools based physical activity across Hastings and St Leonards, using a whole school approach. The programme is funded until 2012. The project is managed by Hastings Borough Council through the Active Hastings Project. In addition to school based interventions the project seeks to engage Hastings Borough Council members in the physical activity agenda.

Hastings and Rother Health Walks Programme
The British Trust for Conservation Volunteers are commissioned by the PCT to develop and provide a programme of Health Walks in Hastings and Rother, aimed at promoting walking to inactive people

Active Rother Programme; Adults and Children
Active Rother is a partnership project between Rother District Council and NHS Hastings and Rother. It aims to increase participation in physical activity and active lifestyles in target groups in the Rother area by providing low cost physical activity sessions

Health Improvement Partnership Small Grants programme
Four District and Borough level Health Improvement Partnerships across East Sussex (Lewes and Wealden have a combined partnership). Each HImP has a physical activity working group which allocates small grants to the value of £10, 000 per partnership per year.

East Sussex County Council
ESCC offers a programme of leisure walks, guided Walks and a 'Walking for Wellness' programme across East Sussex. In addition short themed walks are included in it's children's Summer Activities Programme

Food in Schools Programme
There is a developing evidence-base that these schemes do improve the diet and nutrition of children in schools. The following points are from the national evaluations:

- Teachers reported that children had improved attendance, attention, behaviour and levels of concentration as a result of healthier foods being provided in the morning. In addition, it has been suggested that this provision can also contribute to improved academic performance.
- It was demonstrated that a school community working together could provide food and drink in tuck shops and vending machines that was healthier, popular with pupils and profitable for schools.
- 82% of primary and 65% of secondary schools in the water provision pilot reported increased consumption of water.
- It was demonstrated that changes in the physical environment of the school dining room had an immediate, significant and (potentially) sustainable impact on health eating.
- Healthier lunchbox and cookery clubs pilots used fun and social activities that successfully engaged pupils and their families in selecting and preparing healthier choices.
- Gardening interventions found positive benefits, particularly in increasing younger children's likelihood to try new fruit or vegetables and support all pupils' understanding of healthy eating.

Since the East Sussex Food in Schools programme was launched in September 2006 the following key results have been achieved.

- Over 40% of all East Sussex primary schools have now benefited from the Food in Schools programme which has now involved over 6,000 pupils and over 1,200 parents
- School meal uptake has increased in some schools by as much as 50%
- Lunch boxes including a healthy sandwich and dairy product increased on average by 12% as a result of auditing them both before and after the Food in Schools programme.
- Over 80% of all East Sussex schools have now achieved National Healthy School Status many of whom have used the Food in Schools programme as evidence or a

case study for their submission. The East Sussex Healthy Schools team is now the second highest performing team in the South East Region.
- Some schools have reported a significant drop in the numbers of lunchtime incidents and an improvement in pupil concentration and behaviour after lunch.

**Tier One Services**

Specialised Health Improvement Support

East Sussex Community Health Services (ESCHS) are commissioned by the PCT to provide Physical Activity and Health, Food and Health and Food in Schools Specialist services and support and form part of the ESCHS Healthy Weight Team who provide specialised health promotion advice, support and interventions to take forward the healthy weight agenda across East Sussex.

Hastings and Rother Health Trainer Service

The PCT has commissioned a Health Trainers service from ESCHS. Health Trainers were first proposed in the 'Choosing Health' white paper. They are members of local communities who are trained and paid to act as links between health professionals and marginalised social groups, and support people to set and achieve realistic health-related lifestyle and behaviour change goals. Health Trainers offer 1:1 evidenced based behaviour change interventions to enable people to change their health related behaviour and improve their lifestyles. Health Trainers refer clients into specialist services e.g. smoking cessation services, health walks etc.

**Tier Two Services**

Hastings and Rother Exercise on Referral Scheme

Hastings and Rother PCT has develop a pilot Locally Enhanced Service (LES) to refer appropriate patients to exercise schemes. The LES has a two tier approach where patients are referred either to an 'in house' pedometer scheme provided by practice nurses, or to the local leisure provider for structured exercise.

Cardiac Rehabilitation Programme

This is provided by the local leisure provider as a Phase 4 of the local Cardiac Rehabilitation programme. It is based on Exercise referral principles targeted to those who are on Cardiac Rehabilitation.

**Tier 3 services**

The PCTs do not currently commission specific stand alone Tier 3 services for obesity. Tier 3 interventions are provided through referral to the generic dietetics service provided by East Sussex Community Health Services.

## 7. Current Commissioning Arrangements for Bariatric Surgery (Tier 4)

South East Coast Strategic Commissioning Group (SECSCG) carries out the Strategic Commissioning function for Bariatric surgery and other Tier 4 services on behalf of its constituent PCTs, with the exception of Surrey. All PCTs in SEC use NICE thresholds for referral, but there are sub-regional differences in the management of funding applications. Sussex applications are assessed by SCG staff using a protocol based system; Kent patients are also assessed against a protocol system but use a panel approach to discuss more complex patients. The panel will also make referral recommendations to local services, whereas Sussex patients are returned to the referring GP. Surrey PCT assesses patients using a panel approach.

NICE criteria for surgery state that patients must have exhausted all avenues of non-surgical management, and have been unable to lose weight using conventional non- surgical weight loss programmes for at least 6-months, prior to referral to a specialised centre. Following publication of these criteria, the SEC HPSU issued policy recommendation that patients should meet the NICE thresholds and also have attempted to lose weight for minimum 12-months prior to referral to a specialised weight management service. This recommendation is in operation in Sussex and Surrey, but has not been adopted in Kent, who follow the NICE guidance of 6-months. Neighbouring PCTs have developed obesity management services e.g. Coastal Kent PCT has community services and operates a dedicated weight management service. West Sussex PCT has developed a Tiered approach to obesity interventions which includes community weight management interventions procured through competitive tender. In comparison East Sussex PCTs do not have any dedicated obesity management and treatment services below Tier 4 in place, and patients currently access generic services such as dietetics and exercise referral.

Expenditure on Bariatric surgery is currently split between a Kent, Medway and Sussex cost per- case budget amounting to approximately £8.1million held by the SCG, small amounts contained within acute contracts at some of the providers listed above and a budget held by Surrey PCT. Table 18 below shows the cost-per-case budget for 09/10. Surrey PCT currently manages the budget directly and the figure for Surrey is derived from expected outturn in 09/10.

**Table 17: Operating Plan budget for Specialised Weight Management 2009/2010**

| PCT | 2009 Population[36] | 09/10 operating Plan (£,000) | Budget per 100,000 Pop (£,000) |
|---|---|---|---|
| Brighton & Hove | 216,000 | 1,022 | 473 |
| E Sussex Downs & Weald | 282,600 | 923 | 327 |
| Hastings & Rother | 149,300 | 433 | 297 |
| E and Coastal Kent | 613,600 | 632 | 103 |
| Medway | 552,100 | 192 | 35 |
| W Kent | 206,200 | 556 | 270 |
| Surrey | 901,400 | 1,138 | 126 |
| West Sussex | 652,000 | 4,407 | 676 |
| Total | **3,573,200** | 9,313 | 261 |

[36] 2009 Population estimates; 2006-based sub national population projections to 2031- Adults

## Current Bariatric service provision

The Bariatric Surgery Service Preferred Provider Selection Project was carried out in 2006/7. This project, tasked with ensuring that specialised providers carrying out Bariatric Surgery met clinical effectiveness and safety standards ensuring good outcomes for patients, resulted in twenty two bids from hospitals in the private and public health sectors. Nine met the essential quality criteria/standards in the specification and were awarded preferred provider status. The units providing services to SEC area PCTs are currently located in the western part of the health economy or outside SEC boundaries. There are no preferred providers in Kent or East Sussex and many eligible patients have to travel in order to access services. The providers used are shown in the Table 18 below.

**Table 18: List of SEC, London and East of England preferred providers**

| Provider | |
|---|---|
| Chelsea & Westminster Healthcare NHS Trust | |
| Homerton University Hospital NHS Foundation Trust | |
| Imperial College NHS Foundation Trust | |
| Kings Healthcare & Guy's & St Thomas' NHS Foundation Trusts | Joint bid |
| Luton & Dunstable NHS Trust | |
| Royal West Sussex NHS Trust *(now Western Sussex Hospitals NHS Trust)* | |
| St George's & Ashford & St Peter's NHS Trusts | Joint bid |
| University College London NHS Foundation Trust & UK Hospitals | Joint bid |
| Whittington Hospitals NHS Trust | |

The rates of referral by PCT do not appear to reflect the relative proportions of obesity within the local populations *(see Table 3 SEC Adult Population with Obesity).* It is not clear why this is the case but the variation may be influenced by availability of Primary or Community services, location of Specialised Weight Management Services and patient knowledge.

Table 19 below shows the number of referrals received by PCT area since April 2008 and shows that observed referral levels are significantly higher than the benchmark estimated by NICE.

**Table 19: Number of referrals, for bariatric surgery, received for prior authorisation since April 2008.**

| Month of referral | Brighton & Hove | East Sussex Downs& Weald | Hastings & Rother | West Sussex | Medway | Eastern& Coastal Kent | West Kent | Surrey | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Total** | **119** | **163** | **46** | **493** | **81** | **255** | **180** | **227** | **1564** |
| **08/09 total** | **80** | **96** | **27** | **359** | **44** | **146** | **111** | **171** | **1034** |
| **09/10 forecast** | **78** | **134** | **38** | **268** | **74** | **218** | **138** | **112** | **1060** |

Table 20 below shows the current referral rate for Bariatric Surgery as identified through the prior approvals process in SEC.

**Table 20: Current referrals for Bariatric Surgery, compared to NICE benchmark estimates**

| PCT | Population[37] | Estimated Benchmark (NICE 0.01%) | Estimated rate referrals Adult[38] | Current Annual Observed referrals[39] | Current rate Observed referrals[40] |
|---|---|---|---|---|---|
| Brighton & Hove | 216,000 | 22 | 1.0 | 78 | 3.6 |
| *E Sussex Downs & Weald* | *282,600* | *28* | *1.0* | *134* | *4.7* |
| *Hastings & Rother* | *149,300* | *15* | *1.0* | *38* | *2.5* |
| E and Coastal Kent | 613,600 | 61 | 1.0 | 218 | 3.6 |
| Medway | 552,100 | 55 | 1.0 | 74 | 1.3 |
| W Kent | 206,200 | 21 | 1.0 | 138 | 6.7 |
| Surrey | 901,400 | 90 | 1.0 | 112 | 1.2 |
| West Sussex | 652,000 | 65 | 1.0 | 268 | 4.1 |
| **SEC Total** | **3,573,200** | **357** | **1.0** | **1,060** | **3.0** |

The increase in Bariatric Surgery in the South East Coast Region places a cost burden on the NHS. In addition further pre and post operative interventions and support are estimated to cost approximately £18-20,000 per patient However NICE has determined that bariatric services are cost effective if offered to the appropriate patient group, and will reduce the cots burden on the NHS of treating co- morbidities associated with obesity.

Partnerships are effective in delivering local change and in supporting a multi agency approach to addressing specific health needs. Strong and sustained partnership with local providers of sport and physical activity support and encourage increased uptake and availability of physical activity. In addition partnership working can expand opportunities for incorporating physical activity into everyday life, and making best use of the wealth of natural resources in East Sussex, such as green spaces. Creating partnerships with communities themselves can also improve healthy eating options and in supporting and confirming the health promotion messages that are emanating both nationally and locally. Health practitioners both in GP surgeries and in community health need to work effectively to ensure that there is a seamless range of referrals to key programmes and projects operating locally. This needs strong coordination and some of the local partnerships in place need to sustain their efforts to secure the ends of these important interventions.

Developing effective referral systems are also vital to providing an effective care pathway. It is clear that there is a strong commitment to work to support the overall aims of local partnerships, however this work needs to be planned and coordinated to ensure that those in greatest need get access to and benefit from these services. Moreover clients need to be tracked and reviewed to assess their progress and outcomes through the different tiers and

[37] 2009 Population estimates; 2006-based sub national population projections to 2031
[38] NICE benchmark rate per 10,000 Adult population
[39] Referrals received and recorded within SECSCG and Surrey PCT Bariatric datasets, April 2008 to September 2009. Annualised
[40] Referrals received and recorded within SECSCG and Surrey PCT Bariatric datasets, April 2008 to September 2009. Annualised and expressed per 10,000 population

levels of service from community based behavioural change through to medical monitoring and weight management and on if needed to medication and or surgical intervention.

Tackling obesity in both children and adults also need to be addressed separately. The interventions for children are managed through the Childhood Obesity Management Group. It is critical that this group can influence and change patterns of obesity in young people in particular as they move from reception to year six and on into adolescence. There is no such partnership group for Adults in East Sussex and this may be because there are no specific NHS Targets for reducing adult obesity per se but rather partnerships have formed to address increased physical activity and healthy eating which clearly seek to address causes of obesity rather than the condition itself.

Whilst the case for obesity and overweight in children is critically important it is also important to recognise and support the reduction and levels in children who are under weight. The child measurement programme does measure underweight children and it is important that this is supported and developed both through community health and practitioner engagement.

It is clear that the PCT and its partners are providing a wide range of services to support behavioural change, healthy eating, increased physical activity and general weight management. The PCT s currently do not have a dedicated weight management service rather using a wider cocktail of services provided. However the dedication of a service of this sort is essential to build a full care pathway from community interventions on through to more defined medical intervention including prescription and bariatric services.

It is important to ensure that this work also addresses issues of under and overweight in pregnancy and to reduce the likelihood of the complications these conditions present. It is important where possible to follow national guidelines to secure the greatest outcomes for pregnant women who have weight management issues, not simply for their own sakes but also as these are often transferred to their children in later life.

## 8 Stakeholder Engagement

Four specific forms of stakeholder engagement have been completed as part of this needs assessment. These were; an interview programme with key stakeholders and practitioners, a survey of clinicians, a series of three focus groups with practitioners and stakeholders' and interviews with clients who have used the Health Trainer service.

**Interview programme**

Between March and June interviews were completed with a wide range of practitioners and service providers engaged in and delivering services to meet some of the treatment needs of children and adults with obesity in East Sussex. The interviews were confidential and the points raised below have been kept anonymous. Some are quotes which are set out in parenthesis others are simply statements drawn from the notes of these interviews. The interviews raised a series of key issues and priorities which are set out below:

General priorities

- Social marketing approaches were identified as being important to change behaviour and to raise the awareness of the problem of obesity; in particular stakeholders were supportive of national media campaigns which were widely recognised as contributing to raising awareness.
- Primary prevention initiatives addressing the whole population where highlighted as important

Coordination

- Lack of knowledge around availability of services and referral routes
- Strong existing partnership work between practitioners and partners in the community.
- Perceived disparity in ways of addressing weight management in the two PCT areas of East Sussex Downs and Weald and Hastings and Rother.
- Gaps in service provision were widely identified.
- Provider organisation confirmed their own willingness to provide services if commissioned to do so
- There was a general consensus for the need for co-ordinated strategic planning and investment across the county

Impact

- Existing programmes are often time limited and disparate in their capacity to make meaningful interventions and in particular to affect lasting behaviour change
- Programmes delivering opportunities for increased activity, sport and exercise and the healthy schools programmes tend to be aimed at the general population and are not necessarily targeted to those who are either overweight or obese because these are whole population health improvement initiatives.
- Practitioners felt that as East Sussex did not have a formal care pathway for child and adult weight management the measurement of impact was virtually impossible.
- Practitioners identified that there are currently few options to refer children when they come through the national child measurement programme

Concerns

- Limited resources on the ground especially in the case of dieticians and community mental health teams to be able to respond to the needs of obese patients
- Lack of dedicated weight management service for East Sussex was seen by many as a primary concern
- Respondents identified lack of specialist dietetic services for obesity

East Sussex Community Health Services staff perspectives

- NHS East Sussex Community Health Services are interested in providing a weight management service but are not commissioned to do so.
- "There are limited resources for community dietetics, therefore limited capacity for obesity agenda in both adults and children and this is currently delivered by generalist dieticians on the team'. 'This poses particular problems in that dietary support is needed for patients on obesity based medication where dietary management is critical to the success of these drugs. Additionally clients referred for bariatric surgery need to attend at least 12 months specialist weight management. There are simply no resources to make this provision available from a community dietician perspective."
- Patients are being seen by community dieticians both pre surgery and post surgery. In spite of the fact that post surgery dieticians should be provided by the Hospital trust that undertook the operation. It was speculated that as all the hospitals are outside the East Sussex area that community dietician are preferred simply due to locality and ease of access.
- CBT (cognitive behavioural therapy) – "use it for obesity" – "thinking about attitude to food and how it relates to ill-health"

Identifying and working with clients

- Clients in need of support are hard to reach. Targeting provision to areas of deprivation and high health inequalities is critical although correspondingly these communities were seen as 'hard to engage' and their perceived reluctance to take up the positive offers being made were identified as presenting "a real problem"
- Active Hastings was viewed as strong in delivering more focus on those in greatest need and non participants.
- Child Measurement programme and School Nurses indicated that they have encountered many cases of parents who are not aware that their child has a problem, and may be reluctant to affect positive change for their children. Finding the right methods to support families to build children's self confidence is also critical. Working with CAMHS to support families to be more resilient and to tackle the affects of being overweight in particular bullying was seen as important.

Perceptions of current strengths in provision across East Sussex

- Various practitioners on the ground, who engage with local communities, in particular Health Trainers, felt that 'we know our communities well'.
- "We are working in neighbourhoods with the lowest life expectancy" and 'we deliver against health inequalities' (Health Trainers)
- 'We have the skills, qualifications and competencies which enable us to work in schools with young people, exercise delivery' (School Nurses)

- "Got staff trained for Weight Management – re-designed services to deliver the Obesity and Weight Management agenda"
- "Many of our services engage well with the voluntary sector"
- We need a strong forum for sharing information and networking across boundaries
- 'Physical Activity health and food partnerships are strong local partnerships'
- Strong set of experience and skills being developed through Active Hastings especially in working with those who are currently not participating in physical activity.
- 'The work within schools funded by the British Heart Foundation is creating a positive approach to target the delivery of services to young people and their families'

Perceptions of Current Weaknesses in provision across East Sussex

- Clear lack of coordination of resources, which for many has meant that 'we have failed to address the obesity priority in the county'.
- Poor performance management and lack of strategic guidance for the HImP subgroups e.g. food and health
- No formalised care pathway for obesity
- Lack of awareness of health professionals about where to send people onto when they need specialist services
- Lack of resources in particular in specialist services like dietitians and in community Mental Health
- A Diverse market of providers but which has yet to enable commissioned opportunities for the voluntary sector.
- Needs more focused cross county strategy to address obesity, targeting need and coordinating resources through single referral point
- Health Trainers are plugging some of the gaps but with no specialist service to refer on to
- HImP tries to be something to everyone but really needs to be more focused on a couple of issues. Smoking and alcohol should be top priorities. Obesity has negative connotations and action needs to be more connected to wellbeing

**GP / Clinicians Questionnaire**

A questionnaire comprising 5 questions was administered by email to all GPs in East Sussex. A copy of the questionnaire is included in Section 18 of the appendix. Over 300 GPs received this questionnaire and this was sent out to some 70 practices. Responses were received from 37 practices. The points below are set against the 5 questions asked:

- What are the major **challenges** you face with obesity for children and adults?
- What **services** are there **available** for you to refer patients onto?
- What are the **strengths** in existing provision?
- What are the **gaps** in existing provision?
- Do you have any **proposals** for future service provision?

Challenges

- Several GPs felt that there is no easy treatment for obesity, clients are often 'in denial' and 'reticent to tackle their weight problems'

- Many have very sedentary lifestyles and have little history of physical activity, others have strong contradictions being aware of what they should do but failing to take responsibility to change their behaviour
- Many GP's cited concerns about the wide availability of fast/fatty foods, even cheap foods which were high in saturated fats
- Many cited concerns about the relationship between obesity and social deprivation matched with a lack of awareness, motivation, determination resulting in nothing changing
- Several GPs stated the inadequate level of dietitian support and the lack of access/capacity to specialist dietitians
- Several felt the need for a package of exercise and weight monitoring, dietitian led obesity service with psychological input, need to change lifestyles and patient behaviour
- Many GPs expressed their frustration in limited range and level of existing services and the strong need for somewhere to refer patients onto.

Services Available

- Health Trainers were identified as providing an important service
- The 'good work' of practice based nurses who in many cases were cited as the only option for advice, guidance and support locally.
- GP exercise referral programme and subsidised exercise provision was highlighted.
- Advice from a General Practitioner was identified as being important
- Community dietetics service was highlighted as important
- Several GPs recognised the role of pharmaceutical intervention and ultimately Bariatric Surgery

Strengths

- A strong and consistent general response was that there are 'Few' or 'No' strengths as to the way services are currently provided.
- Some GPs felt that there were strengths in the dietitian service although this was tempered with a general perception of the lack of capacity that this service is experiencing.
- A few GP respondents felt that bariatric surgery was an appropriate option and one which they have previously referred patients onto
- Several GPs felt that their practice nurses have a depth of knowledge and experience in working with obese clients and that these nurses are a central addressing obesity

Gaps in Provision

- A clear lack of understanding of the care pathway for obesity locally. Several GPs addressed what they perceived to be the priorities for bridging perceived gaps.
- Many felt the lack of specialist community dietitians was a real concern
- Many were simply unaware of where to refer patients to, other than dietitians and bariatric surgery
- Some felt that there were no short sharp intensive exercise clinics
- A real recognition that what is available is limited and can only target a small proportion of people with high BMIs.

Proposals

- A large number of GP respondents felt that obesity is a national problem requiring national solutions
- Several felt the need for a strong partnership network work establishing a delivery model with key agencies working effectively together
- Some felt the need for a dedicated local weight management service
- Most suggested the need to review the pricing of healthy and unhealthy foods, to create a disincentive to eat unhealthily.
- Many suggested more health awareness/ education/promotion
- Several proposed obesity clinics for children and adults

The majority of GPs indicated that they would like to be kept informed and engaged in the emerging obesity agenda.

**Focus Group findings**

Three focus groups were held as part of this needs assessment. Two Physical Activity, Health and Food Partnerships were attended and similar questions posed to the practitioners present. A further session was held with school nurses.

Physical Activity Health and Food Partnership -Focus group findings from two workshops/Focus Groups which were held on 14th and 15th July. (A list of focus group attendees is set out in the Appendices: section 19)

**Challenges**

**Children:**

Participants identified that addressing childhood obesity fell into 4 main themes.

**Infancy:** Encouraging the uptake and maintenance of breastfeeding was perceived to be crucial to giving children a good start in life.

**Exercise:** Access to outdoor play facilities were seen to be important

**Knowledge:** Participants felt that parents may have limited knowledge about healthy diets for children and/or limited cooking skills to be able to prepare healthy meals.

**School:** Focus Groups felt that it is incumbent on Healthy Schools to adhere to the guidelines for food in schools which are designed on healthy eating principles. Hailsham Community College was cited as 'a shining example' of how a school can be turned around in terms of food.

**Adults**

Participants felt that adults may experience similar barriers to children, including access to information on healthy eating, the use of convenience food and lack of knowledge and skills for healthy eating. Some participants felt that the use of food as a reward could have

negative health consequences. Isolated older people were also identified as having particular challenges, and may not be motivated to prepare healthy meals.

**What services are available?**
Focus group participants were able to identify a range of primary prevention services. However participants were less aware of any specialist services for obesity.

**Gaps in service provision**
Participants highlighted the gaps in the physical activity provision across the age spectrum. E.g. a county sports development officer was cited as a useful role that could encourage participation in physical activity. Participants also commented on the loss of free swimming at the end of July and this was felt to be likely to impact particularly on confidence and isolation issues for older people. Lack of community weight management services and an undeveloped care pathway for children was also cited.

**Proposals for future service provision**
It was felt there should be emphasis on promoting a generally healthier way of life and not just focusing on individual issues. The geography of the area lends itself to encouraging increased physical activity and this should be exploited to its full advantageous potential. Promoting the health message was seen as vital and awareness of opportunities for exercise in everyday life was seen as important. Participants suggested using alternative methods of communications such as social networking sites to promote messages and access to services

Specific recommendations were:
- Cooking for one to be rolled out across the country
- One to one support is needed for Young People, through the system of peer support and the development of a lifestyle change service e.g. similar to Health Trainer service
- The provision of increased and more affordable access to Leisure Services for Young People.
- A recognition of underweight as a problem, which accesses the same level of interventions as obesity
- The introduction of a buddying provision for Older People to reduce isolation
- The introduction of a designated Physical Activity person to be attached to the School Nurse provision, to provide information, advice and be able to signpost.

**Key issues raised by the School Nurses** (A list of attendees is set out in the Appendix: Section 20):

- Stigma associated with Obesity presented a challenge to engaging with parents, this was said to be easier with Reception Year children than Year 6. School Nurses reported negative responses from some parents and a perception that parents felt 'singled out as poor parents'
- School nurses suggested that some obese children may opt out of the measurement programme and so numbers may be an under representation
- School nurses supported a family based approach to addressing weight issues

- Lack of a paediatric dietitian 'is a concern' and was seen to limit availability of specialist paediatric obesity interventions.
- There was strong support for the work of existing providers of exercise support and parental support, with examples the work of dietitians, Mend programme and Active Hasting where whole family activities are working well
- Some nurses identified a lack of commitment from some schools to working with parents to address obesity problems.

**Proposals**

- Engage existing services in obesity agenda e.g. CAMHS, paediatric dietitian, school sports partnership
- Family based interventions
- Targeted interventions for younger children

**Health Trainer client responses to telephone interviews**

Six clients who indicated that they had seen a Health Trainer for weight related issues were interviewed. A number of these individuals said that they had also experienced other health problems such as mental health issues and physical disability which impacted on their weight.

Clients indicated that they had experienced barriers to achieving a healthy weight such as knowledge of healthy eating, understanding labels, low motivation and lack of skills to deal with temptation.

Clients said that they felt that the 'tailored service' offered by Health Trainers was an important element of the effectiveness of the service, helping people make their own choices and motivating them to continue . In addition other important factors cited by clients were: non judgemental, knowledgeable, approachable and not patronising. In addition Health Trainer clients reported that they used the skills they had developed through seeing a Health Trainer to improve their families diets.

*"Thank you for the service, because without it I definitely wouldn't have been motivated to lose weight"*

**Summary of qualitative assessment**

Interviews with stakeholders identified a number of key themes which are shared across sectors and occupation groups. In particular common themes emerging from the qualitative assessment are:

- Lack of weight management interventions for adults and children
- Lack of knowledge amongst practitioners on how best to support obese clients
- Need for a more co-ordinated approach across the county engaging all relevant agencies and stakeholders
- Different levels of provision across the county
- Issues in community dietetics support for obese patients
- There are some valued services such as Health Trainers

## 9 Mapping services against 'Healthy Weight, Healthy Lives'

In this section we map current provision in East Sussex against the Four Tiers identified in Section 5 and the evidence based approaches set out in the 'Healthy Weight, Healthy Lives'.

The 'Healthy Weight, Healthy Lives' local assessment sets out a series of key actions against the national Healthy Weight, Healthy Lives Strategy. This can be seen in full as Appendix 8 to this needs assessment. The actions identified within the strategy are:

- Understanding the problem in your area and setting local goals
- Local leadership
- Children: healthy growth and healthy weight
- Promoting healthier food choices
- Building physical activity into our lives
- Creating incentives for better health
- Personalised support for overweight and obese individuals
- Monitoring and evaluation
- Building local capabilities

Healthy Weight, Healthy Lives sets out key areas of intervention across the whole care pathway, with a particular focus on whole population prevention interventions. Mapping interventions in place across East Sussex indicates that both PCTs have primary prevention initiatives in place, designed not solely for obesity but to provide a range of benefits associated with improved physical activity and better diet.

To date work to deliver against Healthy Weight, Healthy Lives has focussed on developing whole population prevention activity. Well established partnerships at District and Borough level are in place, which draw down funding from a variety of sources including Sport England and DCMS. The PCTs have commissioned interventions to identify and involve less active groups in physical activity and sport using Life Expectancy data to identify areas of highest need e.g. Active Hastings and Active Rother or BTCV delivered health walks. However these interventions do not specifically target the overweight or obese population

Healthy Weight, Healthy Lives identifies the need for 'personalised support for overweight and obese individuals', which broadly incorporates Tiers 1-4 of the care pathway. Success criteria for this are identified as:

- Everyone able to access appropriate advice and information on healthy weight
- Increasing numbers of overweight and obese individuals able to access appropriate support and services
- Local staff and practitioners understanding their role and empowered to fulfil it

This success criterion addresses three areas.

- Advice and information about healthy weight.
- General primary prevention is described above.
- Increasing numbers of overweight and obese individuals accessing appropriate support and services.

Whilst there are some services at Tier 1 and 2 of the care pathway there is limited availability of services below Tier 4 to support overweight and obese individual to lose weight.

Moreover it is important to enable local staff and practitioners to understand their role and for them to be empowered to fulfil it. However it is not currently clear what specific training and support is available to front line practitioners to support them to advise clients on the importance of a healthy weight.

**Profile of Services against a potential Care Pathway for obesity in East Sussex**

The table below sets out the provision expected within a care pathway and identifies what is available in East Sussex and what is not.

| Tier | Services Available | Gaps |
|---|---|---|
| Foundation Whole Population Activity | • Obesity Strategies<br>• Choosing Health Obesity Action Plans<br>• HIMP Food and Physical Activity Working Groups<br>• NCMP Steering Group<br>• ESCHS/ESCC Food In Schools Programme<br>• Active Hastings/Rother<br>• Community Fruit and vegetable scheme<br>• School Sports Partnerships<br>• Play Partnership<br>• HBC/BHF Hearty Lives Programme<br>• H&R Health Walks<br>• Health Walks schemes in ESDW<br>• ESCHS Physical Activity and Health Programme<br>• Active Hastings Workplace project<br>• ESHT Staff Health and Well-being Group<br>• PCTs Staff Health and Well-being Group | • Evaluation of impact of these actions on whole population targets and outcomes |
| Tier One | • GP and Practice Nurse advice<br>• HBC/BHF Hearty Lives Programme<br>• ESCHS Health Trainers<br>• | • Much in place although little options for forward referral when weight loss is not achieved |
| Tier Two | • H&R GP Exercise Referral Scheme (PCT funding to incentivise GPs)<br>• GP prescribing<br>• Community Dietitians Service<br>• Third sector weight and dieting orgainsations | • Exercise referral not driven by obesity but other co-morbidities<br>• No Tier Two Weight Management Service<br>• No engagement with occupational health |
| Tier Three | • GP Prescribing<br>• support from practice nurses<br>• Support from community dieticians | • No effective Triage for Bariatric Surgery<br>• No Specialist Weight Management Service<br>• No Nurse Specialists, no Specialised Community Dietitians<br>• Little Psychology input including CBT<br>• No funded self help groups |
| Tier Four | • Bariatric Surgery | • Limited capacity for post operative support locally (dietitians, mental health)<br>• No psychological support structures for patients that have completed Bariatric Surgery |

## 10. Options appraisal for commissioning Weight Management Services for adults

The section describes options for commissioning weight management interventions, identifying the strengths and weakness of each option, and provides an estimated cost of implementation. These options were developed in consultation with Stakeholders during Stakeholder workshops. Four options have been identified.

1. Do nothing and maintain the status quo
2. Develop a single referral point for obesity services enabling patients to access existing services more effectively
3. Development of a virtual Weight Management Service
4. Development of a dedicated Weight Management Service at Tiers 2 and 3 of service provision

### Option 1 Do nothing new (maintain existing activities)

This option describes the current status quo of service provision. East Sussex has strong Tier 1 primary care provision for obesity with GP and Nurse based life style advice and wellbeing provision, Health Trainers (in Hastings and |Rother in particular), school nurses, and some basic information and signposting for weight reduction, physical activity and health eating, although this is not wholly formalised across both PCT localities.

Services at Tiers 2 and 3 of a care pathway for obesity are however currently not present. GPs have stated their concerns about not having anywhere to refer patients onto for more specialist weight management provision and indicate that they often either send patients leisure providers, exercise referral (if another co-morbidity is present) or provide information about weight management support in the or independent sector.

Strengths:

- No additional cost
- Pockets of good practice but this is not universal to the whole area

Weaknesses

- Lack of capacity in existing generic services e.g. dietetics
- Lack of cohesive cross county approach to obesity with defined criteria for progression through services at Tiers 2 and 3
- Management of Tier 4 provision , few patients able to address the 6 month dedicated weight reduction requirement set by the NICE guidelines
- No effective referral points and hence a disparate set of providers being approached in an ad hoc basis by GPs and their practice nurses.

Cost: Potential increased preventable cost in Tier 4 interventions and in treating diseases associated with obesity.

**Option 2 Development of a single point of referral**

Make better use of existing resources by co-ordinating access through a single referral point to manage access to e.g. exercise referral, dietetic support and community interventions.

Strengths

- Maximisation of existing provision
- Agreed protocols for criteria for weight management access
- Dedicated single referral point
- Consistency of advice and process throughout East Sussex
- Strong support for whole population weight reduction, exercise and healthy eating

Weaknesses

- No provision in parts of the county where services are currently unavailable
- Capacity issues in existing services which may prevent effective access to services
- Services are not commissioned but referred on and hence in some cases capacity and waiting times will be stretched.

Cost

The only direct cost of this option is the referral team itself (indirect costs as in Option 1). The estimate is based on 3 staff assessing provision, managing referrals and providing support materials and literature. Estimated cost circa. £150,000.

**Option 3 Virtual Weight Management Service**

Commission a referral management service and community weight management service for East Sussex. Triage patients into the appropriate Tier of service to meet their need from a menu of service which would be likely to include specialist weight management, exercise referral, 1:1 behaviour change etc.

Strengths

- An effective service managed through the referral point
- Services are accessed and funded centrally with capacity to review impact and scope of service provision effectively

Weaknesses

- Lack of dedicated staff team to design bespoke options for the specific service needs of clients and to review treatment and service impact
- Lack of practitioner and clinician input to service
- Coordination of resources still ad hoc across the county, subject to the availability of providers on the ground

Cost

Option 2, plus costs of providing weight management interventions estimated at 500 patients @ £1000 making a total of £650,000.

**Option 4 Dedicated Weight Management Service**

A fully operational dedicated Weight Management Service Team including a referral unit, plus 2 dedicated consultant dietitians, pharmacologist, exercise and physical activity manager, mental health nurse, child obesity specialist, plus a dedicated patient budget as described in option 3 above.

Hence the services commissioned would be include those set out in options two and three.

Strengths

- Comprehensive weight management team, with commissioning budget for specialist services to be accessed from the provider arm and private and third sector providers.
- Services would align themselves to the NICE guidelines for Bariatric Surgery and meet targeted thresholds for obesity rates in East Sussex
- Capacity to dedicate cross partnership interventions in a coordinated cross county manner

Weaknesses

- High cost model
- Operationally a dedicated weight management service may in the first instance unearth a higher level of prevalence and needs which may place pressure on services through the sheer volume of new patients

Cost

The cost base for this option would include the cost of a referral unit £150,000, the cost of a dedicated weight management team of specialist of 6 staff members each costing circa £50,000 including on costs i.e. £300,000 and a commissioning budget of £500,000. Thus totalling £950,000

**Option appraisal**

In simple terms the core options recommended from a pure service provision perspective is Option 4. However with the high likelihood of financial constraint and with this approach requiring a growth in budget, the likely options for realistic development would be option 2 followed by 3 progressing onto 4 when funding is available.

Option 2 is a baseline requirement for more effective coordination and delivery of existing service providers. Option 3 in effect provides a dedicated commissioning budget for services and Options 4 takes this one stage further with the addition of a dedicated multi disciplinary weight management staff team

It would be prudent to start slowly and build services against the increasing trend in prevalence.

## 10 Recommendations

The analysis of East Sussex interventions against a 4 Tier model and 'Healthy Weight, Healthy Lives' identifies that there are gaps in provision of services at Tiers 2 and 3 particularly in relation to providing specific services that support and enable obese and overweight people to lose weight with NHS support. Although services are in place at Tier 1 there may be local variation in availability based on differences in Life Expectancy, or GP practice approach. This assessment is supported in the views expressed by Stakeholders in primary and community care services, and wider partners with an interest in the obesity agenda. Based on this gap analysis the main recommendations to address obesity in East Sussex are set out below.

Overarching

- Develop a commissioning framework for delivering the Healthy Weight agenda
- Develop a comprehensive strategy to address overweight and obesity across East Sussex
- Consider establishing a multi agency cross county strategic group to co-ordinate the Healthy weight, physical activity and healthy eating agenda's
- Ensure evaluation is built into all interventions to assess their effectiveness at a local level
- Ensure that front line practitioners have access to training and support appropriate to their role, to enable them to discuss issues relating to healthy weight with clients

Whole population

- Consider the effectiveness of the role of the HImP working groups in addressing healthy weight and related agenda's
- Ensure that social marketing activities to support the healthy weight, physical activity and healthy eating agenda's are joined up and co-ordinated across East Sussex
- Ensure that the healthy weight agenda is joined up with other related work streams e.g. Active Travel, mental health , sustainability
- Make best use of local free resources in intervention design e.g. by utilising green spaces

Tier 1

- Review exercise referral across East Sussex to consider how this meets the needs of local people and is accessible to vulnerable groups e.g. those on low income

Tier 2

- Commission family based weight management interventions for young people, in line with NICE guidance
- Consider commissioning specific weight management interventions to meet the needs of overweight and obese adults in East Sussex (an options appraisal to inform this is set out below)

Tier 3

- Commission family based weight management interventions for young people, in line with NICE guidance
- Consider commissioning specific weight management interventions to meet the needs of overweight and obese adults in East Sussex (an options appraisal to inform this is set out below)

Tier 4

- Specialist commissioning should maintain services and support design and delivery of the proposes Overweight and Obesity Strategy for East Sussex

## Appendices

### 1 Obesity Needs Assessment: Aims, objectives and methodology

The brief for this commission set an objective to complete a needs assessment for the treatment and prevention of obesity amongst the East Sussex population by:

- Providing a statement of the problem in East Sussex
- Identifying general population and sub categories with incidence and prevalence of obesity
- Summarise incidence and prevalence across the East Sussex area
- Review and assess the current services available, their referral points, the service outcomes from these providers and the handling of clients with this condition
- Assess the effectiveness and cost effectiveness of obesity services
- Compare services in East Sussex with available benchmarks elsewhere
- Collect the views of service users, practitioners and stakeholders
- Undertake a quantified assessment of models of care with the use of treatment outcome mapping and service impact models
- Assess collected outcome measures
- Summarise the needs assessment and provide recommendations for service commissioning and development/improvement

Key focus of the Needs assessment will be to:

- Inform future commissioning
- Identify gaps in services to prevent and treat obesity in East Sussex
- Assess the PCTs against 'Healthy Weight, Healthy Lives' to inform the PCT of it position in relation to the forthcoming Care Quality Commission inspection
- Also East Sussex Community Health Service the provider arm of the PCTs is currently redesigning / reconfiguring its services and this Needs Assessment will inform this process as well

Methodology

The methodology for this needs assessment has been based on a series of phases research elements. They include:

- Base line literature review
- Review of Existing commissioned services
- Data collection and analysis of Prevalence and incidence
- Interview programme with key practitioners
- 6 focus groups (Clients, Practitioners and Stakeholder groups)
- Research Analysis
- Stakeholder Workshops
- Final report (including executive summary)

## 2 Policy context in summary

The table below sets out the key policy documents reviewed as part of this needs assessment. The table seeks to contextualise the key policy priorities emerging nationally and regionally.

| DOCUMENT | OVERALL SUMMARY IN RELATION TO OBESITY AND OVERWEIGHT |
|---|---|
| **Saving Lives (1999)** [41] | Aim to reduce deaths in under 75 year olds from cancer, coronary heart disease and stroke by 2010, identifying overweight and obesity as important risk factors for these conditions. |
| **The NHS: a Plan for Investment (2000)** [42] | Improvements in diet and nutrition recognised as central to preventing deaths from heart disease and cancers.<br>This plan embraced health inequalities, setting a target to improve childhood nutrition amongst others.<br>The five-a-day initiative and National Fruit Scheme were introduced. |
| **Coronary Heart Disease National Service Framework (2000)**[43] | A requirement for all NHS bodies to work with local authorities in delivering effective programmes to promote health and reduce overweight and obesity. |
| **The NHS Cancer Plan (2000)** [44] | Reinforced the role of diet and nutrition in the development, prevention and management of disease with specific local level recommendations for action to tackle obesity. |
| **Diabetes National Service Framework (2001)** [45] | Interventions for prevention and reduction in the prevalence of overweight and obesity, targeting work on individuals with an increased risk of developing type 2 diabetes and encouraging the adoption of a balanced diet and increased activity. |
| **A Strategy for Sustainable Farming and Food (2002)** [46] | Local Strategic Partnerships should use their influence to improve local nutrition and reduce food inequalities. |
| **Tackling Health Inequalities: A Programme for Action (2003)**[47] | Recognised poor diet as a key contributor to health inequalities and focuses on improving the diet of women, infants and the over fifties. |
| **Children, young people and maternity services National Service Framework (2003)** [48] | Introduced a multi-agency Child Health Promotion Programme. All PCTs to implement community based programmes to address local and national public health priorities including nutrition and physical activity. |
| **Securing Good health** | Substantial change is needed to produce the reductions in preventable |

[41] Saving lives Our Healthier Nation: executive summary, Department of Health 1st June 1999
[42] The NHS: a Plan for Investment (2000)
[43] Coronary Heart Disease, National Service Framework (2000)
[44] The NHS Cancer Plan (2000)
[45] Diabetes, National Service Framework (2001)
[46] A Strategy for Sustainable Farming and Food (2002)
[47] Tackling Health Inequalities: A Programme for Action (2003)
[48] Children, young people and maternity services, National Service Framework (2003)

| DOCUMENT | OVERALL SUMMARY IN RELATION TO OBESITY AND OVERWEIGHT |
|---|---|
| **for the Whole Population (2004)** [49] | diseases such as obesity that will lead to the greatest reductions in future health costs.<br>NHS providers need to be more effective and there should be an enhanced role for schools, local authorities and other public sector agencies, employers, and private and voluntary sector providers in developing opportunities for people to secure better health. |
| **Choosing Health: Making Health Choices Easier (2004)** [50]<br>www.dh.gov.uk | Significant Government Public Health paper to reduce overweight and obesity in England advocating the significance of national and local cross-agency action to address public health priorities.<br>Focus to be on training, management, provision of evidence based obesity prevention and treatment across NHS organisations.<br>Other initiatives include implementing care pathways, developing patient activity questionnaires and national campaigns to raise awareness to the risks of obesity.<br>Contains targets directly related to physical activity, diet and nutrition that will contribute to the reduction in overweight and obesity. |
| **Delivering Choosing health: Making healthier choices easier (2005)**[51] | Delivering Choosing health sets out the key steps that need to be taken over the three years 2005-2008 to deliver the white paper commitments. Tackling obesity is one of the key priorities. |
| **Our health, our care, our say: A new direction for community services (2006)**[52] | Our health, our care, our say is a national strategy for improving the whole health and social care system in England. There are four main goals: to provide better prevention services with earlier intervention, to improve access to social and primary care, to tackle inequalities and improve access to community services, and to provide better support for people with long term needs. |
| | |
| **Our health, our care, our say: a new direction for community services (2006)** [53] | Introduces 'life checks' for individuals to assess their lifestyle risks and take the right steps to make healthier choices including diet, nutrition and physical activity. |
| **National Institute for Health and Clinical Excellence (NICE): Guidance on the prevention, identification, assessment and** | Evidence based guidance and recommendations for public health and clinical opportunities to prevent and reduce overweight and obesity.<br>Recognises how important that staff who advise on diet, weight and activity need appropriate training, experience and enthusiasm to motivate change. |

[49] Securing Good health for the Whole Population (2004)

[50] Choosing Health: Making Health Choices Easier (2004)

51 Delivering Choosing health: Making healthier choices easier (2005)51

[52] Our health, our care, our say: a new direction for community services (2006)

[53] Our health, our care, our say: a new direction for community services (2006)

| DOCUMENT | OVERALL SUMMARY IN RELATION TO OBESITY AND OVERWEIGHT |
|---|---|
| **management of overweight and obesity in adults and children (2006)** [54] | |
| **Lightening the load: tackling overweight and obesity (2007)** [55] | Toolkit to provide a starting point for developing a local strategy to tackle overweight and obesity. |
| **Healthy Weight, Healthy Lives: a Cross Government Strategy (2009)** [56] | To focus on action in five main policy areas<br>1. Promote children's health – aim to reduce proportion of overweight and obese children to 2000 levels by 2020<br>2. Promote healthy food<br>3. Build physical activity into our lives<br>4. Support health at work and provide incentives more widely to promote health – make NHS an exemplar organisation<br>5. Provide effective treatment and support when people become overweight or obese |
| **Healthy Weight, Healthy Lives: Guidance for local areas (2008)** [57] | Sets out a framework, along with indicators of success that local areas might use to deliver their child obesity goals as part of the NHS operating framework, Vital Signs and Local Area Agreement. |
| **Our NHS, Our Future; Darzi review (2008)** [58] | Aims to improve the overall quality and effectiveness of patient care with a range of tools by which NHS organisations are measured:<br>• World Class Commissioning (2007)<br>• Annual Health Check: Care Quality Commission (2009) |
| **High Quality Care for All: NHS Next Stage Review Final Report (2008)** [59] | Every PCT will commission comprehensive wellbeing and preventive personalised services in partnership with local authorities to be focused on six key goals, one of which is tackling obesity<br>A coalition for better health, with a set of new voluntary agreements focused initially on combating obesity<br>Raised awareness of vascular risk assessment – helping people to stay healthy and know when they need to get help<br>Support for people to stay healthy at work |

[54] National Institute for Health and Clinical Excellence (NICE): Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (2006)
[55] Lightening the load: tackling overweight and obesity (2007)

[56] Healthy Weight, Healthy Lives: a Cross Government Strategy (2009)
[57] Healthy Weight, Healthy Lives: Guidance for local areas (2008)
[58] Our NHS, Our Future; Darzi review (2008)
[59] High Quality Care for All: NHS Next Stage Review Final Report (2008)

| DOCUMENT | OVERALL SUMMARY IN RELATION TO OBESITY AND OVERWEIGHT |
|---|---|
| | |
| **Healthier People, excellent care: A vision for the South East Coast (2008)** [60] | Based on Darzi review<br>Focus on reducing health inequalities, promote sustainability to maximise positive impact on health, improve workplace health, promote physical and mental well-being in children, improve healthy life expectancy of older people<br>Improving health is a priority over treating illness and requires long term investment |
| **Healthier People, excellent care: A vision for the South East Coast A year of progress (2009)** [61] | Following extensive consultation with public, staff and clinicians from previous document, the NHS South East Coast vision for improving health and care for the residents of Kent, Surrey and Sussex over the coming decade.<br>Clinical ownership and leadership to be the heart of the quality agenda and through the engagement of clinicians real change will happen. |
| **RCOG 2010** [62] | Recommend highlighting the inherent risks of obesity in pregnancy at a primary care level to all women of childbearing age with a BMI of 30 and above and providing support to lose weight before conception.<br><br>The recommendations include specific guidance on the management of pregnancy in women with a pre-pregnancy BMI of 30 and above. These relate to higher intake of supplementary medicines such as folic acid and vitamin D and senior, ideally consultant lead care throughout. |
| **Map Of Medicine** [63] | Map of Medicine defines clear pathways for individuals depending on exactly which degree of obesity or overweight they demonstrate (explained in detail below). |
| **The Marmot Review** [64] | One of the key messages of the review was one of reducing health inequalities and ensuring a healthy standard of living for all, which includes a focus on the population's weight. |

[60] Healthier People, excellent care: A vision for the South East Coast (2008)

[61] Healthier People, excellent care: A vision for the South East Coast A year of progress (2009)

62 Management of Women with Obesity in Pregnancy, Royal College of Obstetricians and Gynaecologists: J Modder MRCOG, CMACE and KJ Fitzsimons Ph.D, CMACERCOG, March 2010

63 Map Of Medicine, Institute for Innovation and Improvement NHS Evidence; Last updated 29th January 2010

64 The Marmot Review: Strategic Review Of Health Inequalities In England Post 2010; February 2010 isbn 978-0-9564870-0-1

# 3 Health Survey for England 2008

The primary focus of the Health Survey for England in 2008 was physical activity and fitness. Adults and children were asked to recall their physical activity over recent weeks, and objective measures of physical activity and fitness were also obtained.

Physical activity has become an increasingly important public health issue as governments attempt to curb the levels of child and adult obesity. The health benefits of a physically active lifestyle have been well documented, and participation in regular physical activity can increase the quality of life and independence in older age. Physical inactivity is associated with all-cause mortality and many chronic diseases, including ischaemic heart disease, diabetes, certain cancers and obesity.

In England, physical inactivity was estimated in 2002 to cost £8.2 billion a year. Sedentary time is at least as important as moderate-intensity physical activity as a disease risk factor. Sedentary behaviours are also associated with increased risk of obesity and cardiovascular disease independently of moderate to vigorous activity levels.

In 2008, based on self-reported physical activity, 39%of men and 29%of women aged 16 and over met the Chief Medical Officer's minimum recommendations for physical activity in adults (using information from the enhanced 2008 questionnaire). The proportion of both men and women who met the recommendations generally decreased with age.

There was a clear association between meeting the physical activity recommendations and body mass index (BMI) category. 46%of men and 36%of women who were neither overweight nor obese met the recommendations, followed by 41%of men and 31%of women who were overweight and only 32%of men and 19%of women who were obese.

The HSE 2008 included a general population sample of adults representative of the whole population at both national and regional level. A sub-sample was identified in which the main survey was supplemented with objective measures of physical activity(records of activity using and accelerometer) and of fitness (a step test). For the general population sample, 16,056 addresses were randomly selected in 1,176 postcode sectors, issued over twelve months from January to December 2008. The sub-sample was taken in 384 sampling points. Up to two individuals in the sub-sample households were selected to wear an accelerometer to measure physical activity; in households where interviews were conducted, eligible adults aged 16-74 were offered a step test during a nurse visit, to measure fitness.

A total of 15,102 adults were interviewed in 2008. A household response rate of 64% was achieved for the core sample. Among the general population sample, 10,740 adults had a nurse visit.

**Key findings in 2008 based on self-*reported physical activity*:**

- 39% of men and 29% of women aged 16 and over met the Chief Medical Officer's minimum recommendations for physical activity in adults (i.e. at least 30 minutes of moderate or vigorous activity on at least five days in the week).

- The proportion of both men and women who met the recommendations generally decreased with age.

- There was a clear association between meeting the physical activity recommendations and body mass index (BMI) category. 46% of men and 36% of women who were neither overweight nor obese met the recommendations, followed by 41% of men and 31% of women who were overweight and only 32% of men and 19% of women who were obese.

- Men averaged more days than women in walking, sports and exercise. On average, men participated in non-occupational physical activity on 13.9 days in the past four weeks, compared with 12.2 days for women. 18% of men and 21% of women spent no time in non-occupational physical activity in the four weeks.

- For both men and women, participation in walking and in sports and exercise generally fell with age.

**Key findings in 2008 based on *objective measures of physical activity* (i.e. using accelerometry[65] records):**

- Based on accelerometry, only 6% of men and 4% of women met the government's current recommendations for physical activity, by achieving at least 30 minutes of moderate or vigorous activity on at least five days in the week of accelerometer wear, accumulated in bouts of at least 10 minutes. Men were less likely than women to be in the low activity category (50% and 58% respectively), defined as doing less than 30 minutes of moderate or vigorous activity (accumulated in 10 minute bouts) on all days in the week of accelerometer wear.

- Men and women aged 16-34 were most likely to have met the recommendations (11% and 8% respectively), and the proportion of both men and women meeting the recommendations fell in the older age groups. Similarly, the proportion in the low activity category increased with age for both sexes.

- Among those whose self-reported activity level corresponded with meeting the recommendations, only 10% of men and 8% of women also met the recommendations based on accelerometry. Just under half were in the intermediate category (49% of men, 48% of women), and 41% of men and 44% of women were actually in the low activity category.

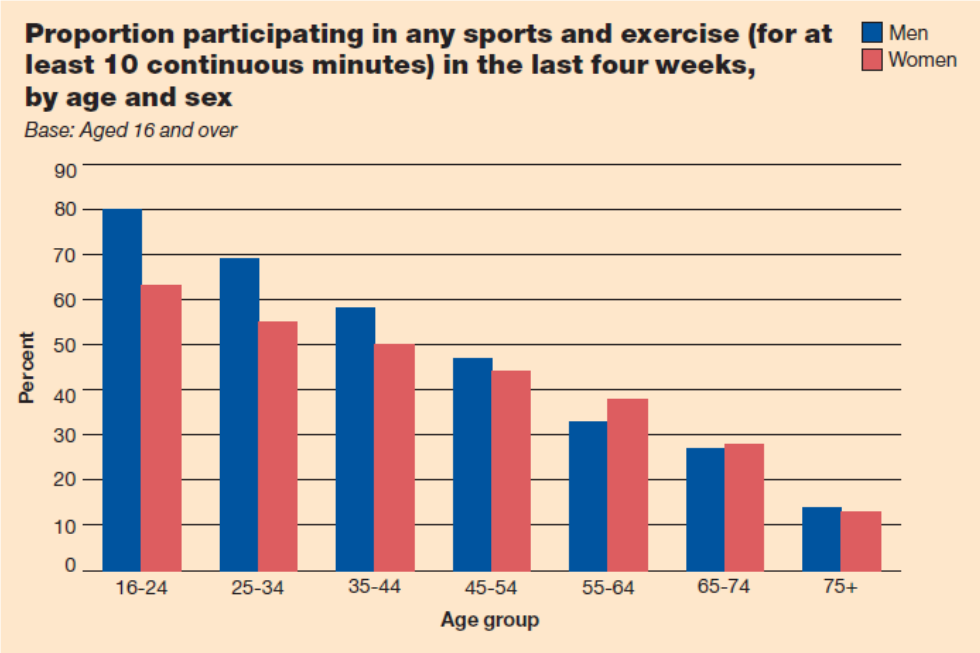
[65] Up to two individuals in the sub-sample households were selected to wear an accelerometer – an electronic sensor designed to record physical activity.

**Key findings in 2008 based on *objective measures of fitness* (i.e. using a step test):**

- Men were significantly fitter than women: the average level of maximal oxygen uptake (VO2max) was 36.3 ml O2/min/kg for men and 32.0 ml O2/min/kg for women. In both sexes, the mean VO2max decreased with age.

- Virtually all participants were deemed able to walk at 3mph on the flat. 84% of men and 97% of women would require moderate exertion for this activity. 32% of men and 60% of women were not fit enough to sustain walking at 3mph up a 5% incline (i.e. they would require severe or maximal exertion, and were classified as 'unfit'). Lack of fitness increased significantly with age; only 32% of men and 12% of women aged 55-74 would find that this exercise required only moderate exertion.

**Figure 1 Proportion participating in any sport and exercise (for at least 10 continuous minutes) in the last four weeks by age and sex (Health Survey for England 2008).**




Obesity is a major public health problem due to its association with serious chronic diseases such as type 2 diabetes, hypertension and hyperlipidaemia (high levels of fats in the blood that can lead to narrowing and blockages of blood vessels), all of which are major risk factors for cardiovascular disease and cardiovascular related mortality. Obesity is also associated with cancer, disability and reduced quality of life, and can lead to premature death. The

annual cost of treating co-morbidities related to overweight and obesity is estimated to be £4.2 billion and is forecast to more than double by 2050.

The prevalence of overweight and obesity is indicated by body mass index (BMI) as a measure of general obesity, and/or waist circumference as a measure of abdominal obesity. BMI, defined as weight in kilograms divided by the square of the height in metres (kg/m2) was calculated in order to group people into the following categories:

**Figure 2 Prevalence of overweight and obesity by age group (Health Survey for England 2008)**


BMI (kg/m2) Description

- Less than 18.5 Underweight
- 18.5 to less than 25 Normal
- 25 to less than 30 Overweight
- 30 or more Obese

Mean BMI was higher in men than women, 27.2kg/m2 compared with 26.9kg/m2. Mean BMI increased with age in both sexes up to the age group 65-74.

66%of men and 57%of women were overweight or obese, and almost a quarter of adults (24%of men and 25%of women) were obese. Prevalence of overweight and obesity was lowest in the 16-24 age group, and generally higher in the older age groups among both men and women.

Using the NICE categories, most men and women who were overweight or obese tended also to have a high or very high waist circumference, and were therefore at increased health risk. Using combined categories of BMI and waist circumference to assess risk, 20% of men were estimated to be at increased risk, 14% at high risk and 21% at very high risk. The equivalent proportions for women were 15% at increased risk, 17%at high risk and 24% at very high risk.

## 4 Prevalence Data Tables (Children)

The tables set out below relate to the National Child Measurement Programme data collected by school nurses with Reception Year children and Year 6 children in 2007/08 and 2008/09. The information has been broken down into Local Authorities within East Sussex and Practice Based Commissioning (PBC) clusters within the two PCT areas.

Local Authority level data

**Table 21: Percentage of reception year children classified as overweight (of those measured), 2007-08 to 2008-09 academic years by Local Authority area.**

| Percentage of reception year children classified as overweight (of those measured), 2007/08 and 2008-09 academic years | | | | | |
|---|---|---|---|---|---|
| | 2007/08 | | 2008/09 | | Change |
| East Sussex | 506 | 12.1 | 605 | 12.7 | 0.6 |
| Hastings | 92 | 10.6 | 132 | 11.4 | 0.8 |
| Eastbourne | 97 | 14.7 | 123 | 14.6 | -0.1 |
| Rother | 61 | 9.4 | 92 | 10.0 | 0.6 |
| Lewes | 117 | 14.7 | 88 | 13.7 | -1.0 |
| Wealden | 139 | 11.5 | 170 | 12.8 | 1.3 |

**Table 22: Percentage of reception year children classified as obese (of those measured), 2007/08 and 2008/09 academic years by Local Authority area.**

| Percentage of reception year children classified as obese (of those measured), 2007/08 and 2008/09 academic years | | | | | |
|---|---|---|---|---|---|
| | 2007/08 | | 2008/09 | | Change |
| East Sussex | 325 | 7.8 | 357 | 8.2 | 0.4 |
| Hastings | 75 | 8.6 | 71 | 8.5 | -0.1 |
| Eastbourne | 55 | 8.4 | 95 | 10.6 | 2.2 |
| Rother | 43 | 6.6 | 52 | 8.4 | 1.8 |
| Lewes | 75 | 9.4 | 71 | 8.1 | -1.3 |
| Wealden | 77 | 6.4 | 68 | 6.0 | -0.4 |

**Table 23: Percentage of reception year children classified as overweight or obese (of those measured), 2007/08 and 2008/09 academic years by Local Authority area.**

| Percentage of reception year children classified as overweight or obese (of those measured), 2007/08 and 2008/09 academic years | | | | | |
|---|---|---|---|---|---|
| | 2007/08 | | 2008/09 | | Change |
| East Sussex | 831 | 19.8 | 881 | 20.9 | 1.1 |
| Hastings | 167 | 19.2 | 167 | 19.9 | 0.7 |
| Eastbourne | 152 | 23.1 | 225 | 25.2 | 2.1 |
| Rother | 104 | 16.0 | 114 | 18.4 | 2.4 |
| Lewes | 192 | 24.1 | 161 | 21.8 | -2.3 |
| Wealden | 216 | 17.9 | 214 | 18.8 | 0.9 |

**Table 24: Percentage of year 6 children classified as overweight (of those measured), 2007/08 and 2008/09 academic years by Local Authority area.**

| Percentage of year 6 children classified as overweight (of those measured), 2007/08 and 2008/09 academic years | | | | | |
|---|---|---|---|---|---|
| | 2007/08 | | 2008/09 | | Change |
| East Sussex | 576 | 13.1 | 605 | 13.6 | 0.5 |
| Hastings | 101 | 12.7 | 132 | 15.1 | 2.4 |
| Eastbourne | 102 | 11.8 | 123 | 13.9 | 2.1 |
| Rother | 122 | 16.5 | 92 | 13.2 | -3.3 |
| Lewes | 105 | 13.8 | 88 | 12.5 | -1.3 |
| Wealden | 146 | 11.9 | 170 | 13.2 | 1.3 |

**Table 25: Percentage of year 6 children classified as obese (of those measured), 2007/08 and 2008/09 academic years by Local Authority area.**

| Percentage of year 6 children classified as obese (of those measured), 2007/08 and 2008/09 academic years | | | | | |
|---|---|---|---|---|---|
| | 2007/08 | | 2008/09 | | Change |
| East Sussex | 674 | 15.3 | 644 | 13.6 | -1.7 |
| Hastings | 124 | 15.6 | 122 | 14.0 | -1.6 |
| Eastbourne | 132 | 15.2 | 133 | 15.1 | -0.1 |
| Rother | 121 | 16.4 | 106 | 15.3 | -1.1 |
| Lewes | 123 | 16.1 | 99 | 14.1 | -2.0 |
| Wealden | 174 | 14.1 | 184 | 14.4 | 0.3 |

**Table 26: Percentage of Year 6 children classified as overweight or obese (of those measured), 2007/08 and 2008/09 academic years by Local Authority area.**

| Percentage of year 6 children classified as overweight or obese (of those measured), 2007/08 and 2008/09 academic years | | | | | |
|---|---|---|---|---|---|
| | 2007/08 | | 2008/09 | | Change |
| East Sussex | 1250 | 28.5 | 1249 | 28.1 | -0.4 |
| Hastings | 225 | 28.4 | 254 | 29.1 | 0.7 |
| Eastbourne | 234 | 27.0 | 256 | 29.0 | 2.0 |
| Rother | 243 | 32.9 | 198 | 28.5 | -4.4 |
| Lewes | 228 | 29.9 | 187 | 26.6 | -3.3 |
| Wealden | 320 | 26.0 | 354 | 27.7 | 1.7 |

**Table 27: Percentage of reception year children classified as overweight (of those measured), 2007-08 to 2008-09 academic years by PBC area.**

| Percentage of reception year children classified as overweight (of those measured), 2007/08 academic year (Modelled) | | | | | |
|---|---|---|---|---|---|
| | 2007-08 | | 2008-09 | | Change |
| Hastings & Rother | 150 | 10.0 | | 11.0 | 1.0 |
| West Hastings | 17 | 8.6 | | | |
| St Leonards | 54 | 11.9 | | | |
| East Hastings | 23 | 9.5 | | | |
| Bexhill Centre | 30 | 8.8 | | | |
| Rural Rother | 25 | 9.5 | | | |
| East Sussex Downs & Weald | 343 | 13.2 | | 13.6 | 0.4 |
| Eastbourne Central | 36 | 14.3 | | | |
| Eastbourne East | 17 | 16.1 | | | |
| Eastbourne CG | 75 | 15.2 | | | |
| Havens | 41 | 15.4 | | | |
| Hailsham | 27 | 10.8 | | | |
| Seaford | 31 | 16.9 | | | |
| Lewes | 39 | 12.1 | | | |
| High Weald | 77 | 10.7 | | | |
| East Sussex | 493 | 12.1 | | 12.7 | 0.6 |

**Table 28: Percentage of reception year children classified as obese (of those measured), 2007/08 and 2008/09 academic years by PBC area.**

| Percentage of reception year children classified as obese (of those measured), 2007/08 academic year (Modelled) | | | | | |
|---|---|---|---|---|---|
| | 2007-08 | | 2008-09 | | Change |
| Hastings & Rother | 116 | 7.7 | | 8.4 | 0.7 |
| West Hastings | 17 | 8.5 | | | |
| St Leonards | 38 | 8.4 | | | |
| East Hastings | 24 | 9.6 | | | |
| Bexhill Centre | 22 | 6.4 | | | |
| Rural Rother | 15 | 5.8 | | | |
| East Sussex Downs & Weald | 204 | 7.9 | | 8.1 | 0.2 |
| Eastbourne Central | 21 | 8.3 | | | |
| Eastbourne East | 11 | 10.7 | | | |
| Eastbourne CG | 35 | 7.2 | | | |
| Havens | 35 | 13.0 | | | |
| Hailsham | 17 | 6.8 | | | |
| Seaford | 19 | 10.4 | | | |
| Lewes | 21 | 6.4 | | | |
| High Weald | 44 | 6.2 | | | |
| East Sussex | 319 | 7.8 | | 8.2 | 0.4 |

**Table 29: Percentage of reception year children classified as overweight or obese (of those measured), 2007/08 and 2008/09 academic years by PBC area.**

| Percentage of reception year children classified as overweight or obese (of those measured), 2007/08 academic year (Modelled) | | | | | |
|---|---|---|---|---|---|
| | 2007-08 | | 2008-09 | | Change |
| Hastings & Rother | 266 | 17.6 | | 19.4 | 1.8 |
| West Hastings | 33 | 17.1 | | | |
| St Leonards | 92 | 20.3 | | | |
| East Hastings | 47 | 19.2 | | | |
| Bexhill Centre | 52 | 15.2 | | | |
| Rural Rother | 41 | 15.3 | | | |
| | | | | | |
| East Sussex Downs & Weald | 547 | 21.1 | | 21.7 | 0.6 |
| Eastbourne Central | 57 | 22.6 | | | |
| Eastbourne East | 28 | 26.8 | | | |
| Eastbourne CG | 111 | 22.4 | | | |
| Havens | 77 | 28.4 | | | |
| Hailsham | 44 | 17.6 | | | |
| Seaford | 50 | 27.3 | | | |
| Lewes | 59 | 18.5 | | | |
| High Weald | 121 | 16.9 | | | |
| | | | | | |
| East Sussex | 812 | 19.8 | | 20.9 | 1.1 |

**Table 30: Percentage of year 6 children classified as overweight (of those measured), 2007/08 and 2008/09 academic years by PBC area.**

| Percentage of year 6 children classified as overweight (of those measured), 2007/08 academic year (Modelled) | | | | | |
|---|---|---|---|---|---|
| | 2007-08 | | 2008-09 | | Change |
| Hastings & Rother | 215 | 14.2 | | 14.4 | 0.2 |
| West Hastings | 20 | 11.9 | | | |
| St Leonards | 51 | 12.6 | | | |
| East Hastings | 34 | 13.2 | | | |
| Bexhill Centre | 53 | 15.3 | | | |
| Rural Rother | 57 | 16.9 | | | |
| | | | | | |
| East Sussex Downs & Weald | 347 | 12.4 | | 13.2 | 0.8 |
| Eastbourne Central | 38 | 11.4 | | | |
| Eastbourne East | 16 | 11.6 | | | |
| Eastbourne CG | 71 | 12.1 | | | |
| Havens | 37 | 13.9 | | | |
| Hailsham | 23 | 9.0 | | | |
| Seaford | 25 | 13.2 | | | |
| Lewes | 39 | 13.2 | | | |
| High Weald | 98 | 13.4 | | | |
| | | | | | |
| East Sussex | 562 | 13.1 | | 13.6 | 0.5 |

**Table 31: Percentage of year 6 children classified as obese (of those measured), 2007/08 and 2008/09 academic years by PBC area[66].**

| Percentage of year 6 children classified as obese (of those measured), 2007/08 academic year (Modelled) | | | | | |
|---|---|---|---|---|---|
| | 2007-08 | | 2008-09 | | Change |
| Hastings & Rother | 246 | 16.2 | | 14.6 | -1.6 |
| West Hastings | 26 | 15.0 | | | |
| St Leonards | 68 | 17.0 | | | |
| East Hastings | 40 | 15.7 | | | |
| Bexhill Centre | 49 | 14.1 | | | |
| Rural Rother | 62 | 18.5 | | | |
| | | | | | |
| East Sussex Downs & Weald | 417 | 14.9 | | 14.4 | -0.5 |
| Eastbourne Central | 50 | 15.0 | | | |
| Eastbourne East | 23 | 16.3 | | | |
| Eastbourne CG | 98 | 16.6 | | | |
| Havens | 52 | 19.5 | | | |
| Hailsham | 34 | 13.4 | | | |
| Seaford | 31 | 16.1 | | | |
| Lewes | 36 | 12.3 | | | |
| High Weald | 94 | 12.8 | | | |
| | | | | | |
| East Sussex | 662 | 15.3 | | 14.5 | -0.8 |

[66] JSNA Scorecard 107 2007-08 data 2008-09 compared. NB full data for the whole are will not be available till October 2010

**Table 32: Percentage of year 6 children classified as overweight or obese (of those measured), 2007/08 and 2008/09 academic years by PBC area[67].**

| Percentage of year 6 children classified as overweight or obese (of those measured), 2007/08 academic year (Modelled) | | | | | |
|---|---|---|---|---|---|
| | 2007-08 | | 2008-09 | | Change |
| Hastings & Rother | 460 | 30.4 | | 29.0 | -1.4 |
| West Hastings | 46 | 26.9 | | | |
| St Leonards | 119 | 29.6 | | | |
| East Hastings | 74 | 28.8 | | | |
| Bexhill Centre | 102 | 29.4 | | | |
| Rural Rother | 119 | 35.5 | | | |
| | | | | | |
| East Sussex Downs & Weald | 764 | 27.3 | | 27.6 | 0.3 |
| Eastbourne Central | 88 | 26.4 | | | |
| Eastbourne East | 40 | 28.0 | | | |
| Eastbourne CG | 169 | 28.7 | | | |
| Havens | 88 | 33.4 | | | |
| Hailsham | 56 | 22.4 | | | |
| Seaford | 56 | 29.3 | | | |
| Lewes | 75 | 25.5 | | | |
| High Weald | 192 | 26.2 | | | |
| | | | | | |
| East Sussex | 1224 | 28.5 | | 29.5 | 1.0 |

[67] JSNA Scorecard 108 2007-08 data 2008-09 compared. NB full data for the whole are will not be available till October 2010

# 5 Prevalence Data Tables (Adults)

Local Authority Data

**Table 33: Estimated prevalence of obesity, persons aged 16 years and over by Local Authority area**[68]

| Estimated prevalence of obesity, persons aged 16 years and over, 2003 to 2005 (Modelled) | | |
|---|---|---|
| East Sussex | 98932 | 22.2 |
| Hastings | 18083 | 24.2 |
| Eastbourne | 18405 | 21.6 |
| Rother | 16608 | 21.4 |
| Lewes | 17983 | 21.9 |
| Wealden | 26265 | 20.9 |

**Table 34: Estimated prevalence of participation in sport and active recreation, persons aged 16 years and over, 2005, 2007 & 2009 over by Local Authority area**[69]

| Estimated prevalence of participation in sport and active recreation, persons aged 16 years and over, 2005, 2007 & 2009 (Modelled) | | | | | | |
|---|---|---|---|---|---|---|
| | 2005 | | 2007 | | 2009 | |
| East Sussex | | | 90908 | 20.4 | | |
| Hastings | | | 13766 | 18.4 | | |
| Eastbourne | | | 16535 | 19.4 | | |
| Rother | | | 15301 | 19.7 | | |
| Lewes | | | 17258 | 21.0 | | |
| Wealden | | | 28049 | 22.3 | | |

**Table 35: Estimated prevalence fruit and veg consumption (5 or more portions a day), persons aged 16 years and over by Local Authority area**[70]

| Estimated prevalence fruit and veg consumption (5 or more portions a day), persons aged 16 years and over, 2003 to 2005 (Modelled) | | |
|---|---|---|
| East Sussex | 150651 | 33.8 |
| Hastings | 19876 | 26.6 |
| Eastbourne | 29226 | 34.3 |
| Rother | 26309 | 33.9 |
| Lewes | 27179 | 33.1 |
| Wealden | 41722 | 33.2 |

[68] JSNA Scorecard 109, 2008-09
[69] JSNA Scorecard 110, 2008-09
[70] JSNA Scorecard 111, 2008-09

## 5.1 PCT Data

**Table 36: Estimated prevalence of obesity, persons aged 16 years and over by PCT/PBC area**[71]

| Estimated prevalence of obesity, persons aged 16 years and over, 2003 to 2005 (Modelled) | | |
|---|---|---|
| Hastings & Rother | 34013 | 22.7 |
| West Hastings | 3759 | 22.4 |
| St Leonards | 9015 | 22.9 |
| East Hastings | 5453 | 23.5 |
| Bexhill Centre | 8892 | 22.6 |
| Rural Rother | 6895 | 22.1 |
| | | |
| East Sussex Downs & Weald | 63301 | 22.0 |
| Eastbourne Central | 7269 | 21.9 |
| Eastbourne East | 2886 | 24.6 |
| Eastbourne CG | 13945 | 22.3 |
| Havens | 7152 | 25.9 |
| Hailsham | 5102 | 23.8 |
| Seaford | 5181 | 22.4 |
| Lewes | 5645 | 19.1 |
| High Weald | 16122 | 20.7 |
| | | |
| East Sussex | 97314 | 22.2 |

[71] JSNA Scorecard 109, 2008-09

**Table 37: Estimated prevalence of participation in sport and active recreation, persons aged 16 years and over, 2005, 2007 & 2009 over by PCT/PBC area**[72]

| Estimated prevalence of participation in sport and active recreation, persons aged 16 years and over, 2007 (Modelled) | | | | | | |
|---|---|---|---|---|---|---|
| | 2005 | | 2007 | | 2009 | |
| Hastings & Rother | | | 28413 | 19.0 | | |
| West Hastings | | | 3112 | 18.5 | | |
| St Leonards | | | 7301 | 18.5 | | |
| East Hastings | | | 4253 | 18.5 | | |
| Bexhill Centre | | | 7349 | 18.7 | | |
| Rural Rother | | | 6399 | 20.7 | | |
| | | | | | | |
| East Sussex Downs & Weald | | | 59870 | 21.0 | | |
| Eastbourne Central | | | 6537 | 19.5 | | |
| Eastbourne East | | | 2187 | 18.6 | | |
| Eastbourne CG | | | 12245 | 19.7 | | |
| Havens | | | 5152 | 18.9 | | |
| Hailsham | | | 4675 | 20.2 | | |
| Seaford | | | 4688 | 20.2 | | |
| Lewes | | | 6909 | 23.3 | | |
| High Weald | | | 17477 | 23.6 | | |
| | | | | | | |
| East Sussex | | | 88283 | 20.4 | | |

[72] JSNA Scorecard 110 2007-08 data 2008-09 not available at District level

**Table 38: Estimated prevalence fruit and vegetable consumption (5 or more portions a day), persons aged 16 years and over by PCT/PBC area**[73]

| Estimated prevalence fruit and veg consumption (5 or more portions a day), persons aged 16 years and over, 2003 to 2005 (Modelled) | | |
|---|---|---|
| | 2008-09 | |
| Hastings & Rother | 48665 | 32.5 |
| West Hastings | 4506 | 26.9 |
| St Leonards | 10878 | 27.6 |
| East Hastings | 6613 | 28.5 |
| Bexhill Centre | 14371 | 36.6 |
| Rural Rother | 12299 | 39.5 |
| | | |
| East Sussex Downs & Weald | 98382 | 34.3 |
| Eastbourne Central | 11508 | 34.7 |
| Eastbourne East | 3767 | 32.1 |
| Eastbourne CG | 21141 | 33.9 |
| Havens | 7987 | 29.0 |
| Hailsham | 6663 | 31.1 |
| Seaford | 7881 | 34.0 |
| Lewes | 10908 | 36.9 |
| High Weald | 28526 | 36.6 |
| | | |
| East Sussex | 147047 | 33.8 |

Quality Outcome Framework data

**Table 39: Quality Outcome Framework Obesity Register PCT based 2008-09**

| Quality Outcome Framework Obesity Register Summary 2008-2009 | Obesity Register | Obesity Prevalence using 16+ population |
|---|---|---|
| East Sussex Down and Weald | 24032 | 8.8% |
| Hastings and Rother | 16473 | 12.1% |
| | | |
| East Sussex | 40505 | 10.5% |

[73] JSNA Scorecard 111 2008-09 based on Health Survey for England and local population estimates

## 6 Questionnaire used in this research

### GP Questionnaire

| Question | Response |
|---|---|
| 1. What are the major challenges you face with obesity for children and adults? | |
| 2. What services are there available for you to refer patients onto? | |
| 3. What are the strengths in existing provision? | |
| 4. What are the gaps in existing provision? | |
| 5. Do you have any proposals for future service provision? | |

### Health Trainer Client Questions

Six clients were interviewed – five women and one man, with a variety of ages and health states but all had seen a HT as a result of issues with their weight. Some of the clients had young children.

In all cases it was essentially a weight issue that led them to seek assistance from a HT but the clients also suffered variously from mental health issues (stress and anxiety), disability preventing robust exercise (asbestosis in both lungs, arthritis), ill health (stroke), severe lack of confidence, a recognition of low fitness levels and unhealthy eating patterns, which compounded their weight problems.

In most cases the clients had accessed a HT through self-referral – advertisement; HT stand at Parents Conference; fliers at Children's Centres. All found the HT service easy to access.

When asked about their experience with a HT the clients were unanimous in their praise of the service and the individual HTs. All HTs had provided advice regarding healthy eating; examining individual clients' eating patterns and suggesting healthy alternatives, to enable the clients to make informed choices. Clients stated that their HTs had provided advice on portion sizes, how to interpret the 5 a day policy, how to read and interpret food labels when shopping and diarised eating patterns to illustrate where the client could make healthier choices, motivating clients to pursue their goals.

One client commented that she thought she had a good knowledge about healthy eating but had her 'eyes opened' about the choices available. This client has had a lifelong weight issue and the knowledge imparted by the HT has assisted her in losing 3 ½ stone. Another client, with a craving for sweets, told how her HT had discussed how she could substitute raisins and cereal bars and, following this advice, had weaned herself off sweets and was eating more healthily. A client who historically had a fried breakfast each morning had benefited from advice on reducing this by having a variety of healthier alternatives. He now only has one fried breakfast per week and has succeeded in losing a stone.

The key seemed to be providing tailored individual healthy alternatives that suited each client's palate, achieving this through consultation and input from the client, motivating them to continue after the sessions with the HT had ended.

The success of the clients' experiences with the HT service was underpinned by:

- The HTs clear knowledge, understanding and ability to provide pertinent information regarding weight loss
- The HTs were very personable and easy to talk to – "I told her things I haven't even told my friends or family"
- All the clients stated that they felt they had someone to talk to who understood their issues and who didn't judge them
- The HTs were really positive and encouraging and never patronising – the HTs "advised not nagged"
- HTs built the clients confidence and self-belief, motivating them to continue to lose weight even after the sessions had finished. One client who had been unable to attend gym sessions due to a crippling lack of confidence felt able to make solo visits after being chaperoned by her HT for several weeks

Not only did this experience benefit the clients but positively impacted on their families. Those with children acted on the information they had been provided with by the HT and involved them in making healthy choices, trying new foods and understanding the food choices they made by looking at labels when selecting purchases.

In addition to assisting clients to lose weight through the healthy eating route, the HTs provided advice and information on physical activity to promote weight loss and make healthier lifestyle choices. This was manifested in:

- Attending regular swimming sessions
- Attending 'Curves' slimming club
- Attending a local gym
- Attending trampolining sessions with her daughter
- Getting active with her children
- Getting involved and accessing services through Active Hastings
- Engaging with Change 4 Life – using recipes to get children involved with cooking
- Taking chair-based exercise for those with disabilities

Furthermore, the confidence the HT promoted in their clients encouraged one to get out of the house and undertake a computer course at Horizons. An increased awareness of health and healthy choices prompted one client to access the Smoking Cessation service.

Each of the clients stated explicitly that they would not have lost weight without HT intervention and have already recommended the service to friends and family.

*"Thank you for the service, because without it I definitely wouldn't have been motivated to lose weight"*

**Practitioner Interview Programme Discussion Points/Questions**

| Discussion Point | Comments/Feedback | Actions |
|---|---|---|
| 1. What are the major challenges you face with obesity for children and adults? | | |
| 2. What are the key priorities for you? | | |
| 3. Have you attempted to improve this priority issue previously? | | |
| 4. What are/have been your desired outcomes? | | |
| 5. What has been currently/previously commissioned for?<br>Children<br>Adults | | |
| 6. What are the gaps in service provision? | | |
| 7. What are your direct and indirect spend/duration of contract?<br>Evaluation methods | | |
| 8. What are the strengths and gaps – local capacity? | | |
| 9. What support do you think you need – specialist support | | |
| 10. Are there any discontinued contracts – reason | | |
| 11. Descriptions of commissioning process | | |
| 12. LA/PCT involvement in local commissioning | | |
| 13. Involving service users in the focus groups – Who and How? | | |
| 14. Any other information | | |

**Focus Group/Workshop Lines of Inquiry**

Physical Activity, Health and Food Partnerships

- 14th July: Eastbourne Avenue House BN21 3XY (2.00pm)
- 15th July: Hastings Renaissance House TB37 6AN(10.00am), London Road

School Nurses

- 19th July 9.00am Apex Way Hailsham BN27 3WA

| Question | Response |
|---|---|
| 1. What are the major challenges you face with obesity for children and adults? | |
| 2. What services are there available for you to refer patients onto? | |
| 3. What are the strengths in existing provision? | |
| 4. What are the gaps in existing provision? | |
| 5. Do you have any proposals for future service provision? | |

## 7 Attendees at Workshops and interview programme

Physical Activity, Health and Food Partnerships

14th July: Eastbourne Avenue House BN21 3XY (2.00pm)
Attendees:

East Sussex PCT's
East Bourne Borough Council
Community Dietician
Children's Services
Downs Community Schools Partnership

15th July: Hastings Renaissance House TB37 6AN (10.00am), London Road
Attendees:
East Sussex PCT's
Age Concern
Active Hastings
Hastings and Rother Social Care Forum
Sussex Schools Partnership

School Nurses

19th July 9.00am Apex Way Hailsham BN27 3WA
Attendees:

SNIPE
Health Visitor Team Leader
School Nurse
Locality Manager
School Nurse
School Nurse
HV/Team Leader
SCNN
School Nurse
Team Leader
School Nurse

## 8 Assessment of Health Weight Healthy Lives Strategy

This table assesses current activity in place to deliver against the Healthy Weight/Healthy Live Strategy.

| Action | Key Success Areas | East Sussex Activity | Gaps | Identified by Stakeholders? | Recommendation |
|---|---|---|---|---|---|
| Understanding the problem in your area and setting local goals | • A clear understanding of the prevalence of obese and overweight individuals and behaviours that contribute to this across the local area | • JSNA Scorecard<br>• NCMP data 08/09<br>• NCMP Steering Group<br>• Investing In Life | | Data on prevalence is not widely distributed amongst practitioners/ stakeholders | • Agree care pathways for adults and children |
| | • PCTs have well-developed local plans in place to tackle child obesity in conjunction with LAs, through the LAA process where appropriate | • Obesity Strategies<br>• Choosing Health Obesity Action Plans<br>• HIMP Food and Physical Activity Working Groups | Ensure all obesity interventions systematically evaluated | Child obesity plans are whole population focused and less is being targeted to those in greatest need | • Build into all contracts and provide technical support for evaluation through specialised health improvement staff commissioned from ESCHS |
| Local leadership | • Clearly identified responsibility for actions, with overall leadership and governance agreed by all partners | • HIMP Food and Physical Activity Working Groups | Countywide action plans and strategies co-ordinated across agencies | | • Consider developing countywide strategic group to co-ordinate actions across sectors |
| Choosing interventions - Children: healthy growth and healthy weight | • As many mothers breastfeeding up to 6 months as possible, with families knowledgeable about healthy weaning and feeding of their young children | • Breastfeeding Strategy<br>• Breastfeeding Action Plan<br>• Breastfeeding Group | Lack of available data on prevalence of breastfeeding across the county | | |
| | • All children growing up | • ESCHS/ESCC Food In | Limited activity in | | • Review commissioning |

| Action | Key Success Areas | East Sussex Activity | Gaps | Identified by Stakeholders? | Recommendation |
|---|---|---|---|---|---|
| | with a healthy weight by eating well, for example by eating at least 5 portions of fruit and vegetables a day | Schools Programme<br>• Active Hastings/Rother<br>• Community Fruit and vegetable scheme | ESDW<br><br>Little evidence of impact across the population | | for healthy weight in ESDW |
| | • All children growing up with a healthy weight by enjoying being active, for example by doing at least one hour of moderately intensive physical activity each day | • School Sports Partnerships<br>• Play Partnership | Impact is limited and targeted young people in greatest need often opt out on these opportunities | | • Development of targeted physical activity provision for children who are overweight and or obese |
| | • Parents have the knowledge and confidence to ensure that their children eat healthily and are active and fit | • ESCHS/ESCC Food In Schools Programme<br>• School Sports Partnerships<br>• Play Partnership<br>• Active Hasting BHF funded programme | Lack of targeted provision to parents with the greatest need | | • Prioritisation of those parents who have the greatest need through a formalised care pathway. |
| | • All schools are Healthy Schools, and parents who need extra help are supported through children's centres, health services and their local community | • ESCC Healthy Schools Programme | Evaluation | General sense that much is being done but less being targeted to those schools with the greatest needs | • Schools need to take responsibility and address their Child Measurement Programme data. |
| Choosing interventions - Promoting healthier food choices | • More eligible families signing up to the Healthy Start scheme | Children's centres promote uptake | | | Evaluate up take of healthy start scheme |
| | • Less consumption of high fat, sugar, salt (HFSS) foods, especially by children | • ESCHS/ESCC Food In Schools Programme<br>• ESCHS Food and Health Programme | No evidence of the impact of this whole population priority | | |

| Action | Key Success Areas | East Sussex Activity | Gaps | Identified by Stakeholders? | Recommendation |
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| | | • ESCHS Health Trainers<br>• HIMP Food and Physical Activity Working Groups<br>• HBC/BHF Hearty Lives Programme | | | |
| | • More consumption of fruit and vegetables – more people eating 5 A DAY, especially children | • ESCHS/ESCC Food In Schools Programme<br>• Community Fruit and Veg Project in H&R<br>• ESCHS Food and Health Programme<br>• ESCHS Health Trainers<br>• HIMP Food and Physical Activity Working Groups<br>• HBC/BHF Hearty Lives Programme | No evidence of the impact of this whole population priority | | |
| | • More healthy options in convenience stores, school canteens, vending machines, at supermarket tills and at non-food retailers | • ESCHS/ESCC Food In Schools Programme | Interventions for adults in wider settings e.g. workplaces | | • Consider developing workplace health promotion interventions which include strong focus on healthy options |
| Choosing interventions - Building physical activity into our lives | • More people, more active, more often, particularly those individuals and families who are currently the most inactive | • Active Hastings<br>• Active Rother C<br>• H&R Health Walks<br>• Health Walks schemes in ESDW<br>• ESCHS Physical Activity and Health Programme<br>• ESCHS Health Trainers<br>• HIMP Food and Physical Activity Working Groups<br>• H&R GP Exercise Referral | Fewer services in ESDW<br><br>Integration into other agenda's e.g. access to green space<br><br>Little evidence available as to the impact with those | More target exercise provision for those who are overweight or obese | • Review primary prevention commissioning in ESDW<br><br>• Develop comprehensive commissioning plan for healthy weight and incorporate delivery in all settings in particular |

| Action | Key Success Areas | East Sussex Activity | Gaps | Identified by Stakeholders? | Recommendation |
|---|---|---|---|---|---|
| | | Scheme (PCT funding to incentivise GPs)<br>• Exercise Referral Schemes in WDC and LDC areas (not PCT funded)<br>• HBC/BHF Hearty Lives Programme<br>• Fit As A Fiddle project<br>• Access To Nature project | who are most inactive | | utilising rural nature of East Sussex<br>• Review exercise referral schemes in ESDW and H&R in light of NICE guidance and regional work |
| | • Reduced car use, especially for trips under a mile in distance | • ESCC School Travel Plan Project<br>• PCT sustainable Development Management Plan<br>• LA's sustainability / carbon reduction plans | Ensure active travel agenda fully integrated into other work streams | | Map active travel work developing as part of sustainability agenda across East Sussex |
| | • More outdoor play by children | • East Sussex Play Strategy<br>• Play Pathfinder Projects | Integrate spatial planning into healthy weight agenda. | | Consider developing countywide healthy weight group to take forward this agenda and incorporate all relevant partners |
| Choosing interventions - Creating incentives for better health | • More workplaces that promote healthy eating and activity, with the public sector acting as an exemplar, both through the location and design of the buildings on the government estate and through staff engagement programmes | • Active Hastings Workplace project<br>• ESHT Staff Health and Well-being Group<br>• PCTs Staff Health and Well-being Group | Co-ordinated county wide workplace health initiative | | Consider developing workplace health programme |

| Action | Key Success Areas | East Sussex Activity | Gaps | Identified by Stakeholders? | Recommendation |
|---|---|---|---|---|---|
| Choosing interventions - Personalised support for overweight and obese individuals | • Everyone able to access appropriate advice and information on healthy weight | • ESCHS Health Trainers<br>• ESCHS Health Promotion Resources Centre<br>• Change 4 Life initiatives | Weight management services for adults and children | Advice is available via GPs and Practice nurses. Beyond this initial; advice there is little available to take people further | • Commission weight management services for adults and children at Tiers 2 and 3 |
| | • Increasing numbers of overweight and obese individuals able to access appropriate support and services | No Weight Management Services commissioned by NHS in East Sussex | Commissioning of Weight Management Services in line with the available evidence base | Critical area that most stakeholders have stated needs to be addressed | • Commission weight management services for adults and children at Tiers 2 and 3 |
| | • Local staff and practitioners understanding their role and empowered to fulfil it | Designated action plans where some staff are aware of their roles but without a care pathway this is relatively fragmented | Effective care pathway<br>Need for brief intervention training for overweight/obesity | Role within healthy weight healthy lives understood however within the treatment of obesity this is less defined | • Establish care pathway for obesity<br>• Commission brief intervention training for all practitioners<br>• Commission training on healthy weight for all practitioners |
| Monitoring and evaluation | • Clear indicators of success for all programmes | • ESCHS Healthy Weight Team<br>• Contracts with non NHS partners | | | Ensure all contracts have clear performance criteria, based on outcomes, and are robustly managed |
| | • Robust monitoring of performance, to update and improve programmes | | Performance indicators for all services | | |

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| | • Evaluation built into all programmes so that activities are contributing to the evidence base | • ESCHS Healthy Weight Team<br>• Contracts with non NHS partners | Evaluation report<br><br>09/10 reports to contain evidence of evaluation | | Ensure specialist health improvement services support others to evaluate health promotion work |
| Building local capabilities | • Everyone working at a local level is clear about their role in promoting the benefits of a healthy weight | | Brief intervention training for overweight/ obesity | | Commission brief intervention training for all practitioners<br><br>Commission training on healthy weight for all practitioners |
| | • Appropriate training is available so that both health and non-health professionals feel confident in sensitively raising the issue of weight with those who are overweight or obese | | Brief intervention training for overweight/obesity | | Commission brief intervention training for all practitioners<br><br>Commission training on healthy weight for all practitioners |