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THANET HEALTH AND WELLBEING BOARD

19 NOVEMBER 2015

A meeting of the Thanet Health and Wellbeing Board will be held at **10.00 am on Thursday, 19 November 2015** in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Membership:

Dr Tony Martin (Chairman); Hazel Carpenter, Esme Chilton, Councillor L Fairbrass, Councillor Gibbens, Madeline Homer, Mark Lobban, Colin Thompson and Councillor Wells

A G E N D A

Item No

1. **APOLOGIES FOR ABSENCE**

2. **DECLARATION OF INTERESTS**

To receive any declarations of interest. Members are advised to consider the advice contained within the Declaration of Interest form attached at the back of this agenda. If a Member declares an interest, they should complete that form and hand it to the officer clerking the meeting and then take the prescribed course of action.

3. **MINUTES OF THE PREVIOUS MEETING** (Pages 1 - 2)

To approve the minutes of the meeting held on 17 September 2015, copy attached.

4. **THANET CANCER STRATEGY** (Pages 3 - 26)

5. **OBESITY - FOLLOWING A COUNTYWIDE HEALTH NEEDS ASSESSMENT** (Pages 27 - 182)

6. **LEADING INTEGRATED COMMISSIONING - UPDATE** (Pages 183 - 194)

- o Local Partnership Groups – Terms of Reference and update
- o Governance Roadmap

7. **BETTER CARE FUND UPDATE** (Pages 195 - 198)

Declaration of Interests Form

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Public Document Pack Agenda Item 3

THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 17 September 2015 at 10.00 am in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Present: Dr Tony Martin (Chairman); Hazel Carpenter (Thanet Clinical Commissioning Group), Esme Chilton (Future Creative), Councillor L Fairbrass (Thanet District Council), Madeline Homer (Thanet District Council), Emma Hanson (Kent County Council), Colin Thompson (Kent County Council) and Councillor Wells (Thanet District Council)

1. APOLOGIES FOR ABSENCE

Apologies were received from Clive Hart, Cllr Gibbens and Mark Lobban, for whom Emma Hanson was present as substitute.

2. DECLARATION OF INTERESTS

There were no declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 11 July 2015 were agreed.

4. LEADING INTEGRATED HEALTH AND SOCIAL CARE COMMISSIONING IN THANET

Alisa Ogilvie, Chief Operating Officer, Thanet CCG, presented the report which included a proposed roadmap and questions for consideration by the committee.

In response to comments and questions it was noted that:

- Members agreed to the roadmap and timescales contained within it.
- Members would be provided with a link to the KCC Health Wellbeing Board minutes.
- Thanet priorities were reconfirmed to be children, mental health, inequality and frail older people. It was agreed Local Partnership Groups should be established for each to develop the model of care and that there should be an Integrated Commissioning Group that would develop an integrated commissioning plan for Board approval in March 2016. The Thanet Health and Wellbeing Board would be required to agree the terms of reference of any sub-groups, however it was agreed that the Chairman would have delegated power to agree these between Board meetings to enable the groups to be set up.
- It was the Board's intention that terms of reference for its subgroups would be considered at the November THWB meeting.

Jonathan Bates, Chief Finance Officer, Thanet CCG gave a presentation regarding ICO Finance, he highlighted that key to success would be joint working rather than silo working, the development of mutual respect, good management, and good governance.

In response to comments and question it was noted that:

- The pooling of money was not a prerequisite for co-working.
- Good governance should enable rather than block progress.

- Clarity of what was to be delivered was needed to allow providers to meet demand.
- A copy of Mr Bates' slides would be circulated to the Board.
- The direction of travel to align finances, and to form a shadow budget from 2016-2017 was agreed.

5. **THANET CCG LOCALITY PROFILES**

Colin Thompson, Consultant in Public Health, KCC presented the item and noted that there were four different locality clusters each with a different population profile. In summary the committee were presented with key headlines for each of the four areas.

In response to comments and questions it was noted that:

- The data could assist the NHS in aligning its spend to areas of most need.
- Analysis of the data could prove instrumental in identifying areas for potential quick wins, which was one of the Boards objectives.

6. **LOCAL ALCOHOL PROFILES**

Colin Thompson, Consultant in Public Health, KCC presented the item noting that Local Alcohol Profiles had been created for each local authority area in England. He advised that Thanet had scored better than some parts of Northern England, and explained that the Kent Alcohol Strategy had identified a need for greater work to be done within hospitals to target alcoholism. In response the QEQM has had alcohol liaison officers available to provide support to patients. These officers made 186 referrals to Turning Point, an increase from 6 referrals the previous year.

Mr Thompson noted that early intervention was key, and advised that the QEQM had seen a 25% reduction in alcohol specific admissions due to the work of the community detox service, this led to a saving of 83 bed days.

7. **PUBLIC HEALTH TRANSFORMATION WORK**

Karen Sharp, Head of Public Health Commissioning, KCC presented the report noting that the presentation would be made at all of the local Health and Wellbeing Boards in Kent. She explained that a number of key contracts were coming to an end, therefore it was a good time to evaluate and reshape public health provision.

In response to questions and comments it was noted that:

- Kent wide resources could be realigned to areas where health inequality was most prevalent.
- Public Health Transformation wished to move from a Kent wide focus to a local focus, therefore should align its priorities with the priorities of the local Health and Wellbeing Boards.

8. **DEMENTIA UPDATE**

This item would be received by Members at a future meeting of the THWB.

Meeting concluded : 12.20 pm



Thanet Clinical Commissioning Group

**WE ARE
MACMILLAN.
CANCER SUPPORT**



Thanet Cancer Strategy 2015-2020

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Authors

Background

The Department of Health in 'Improving Outcomes: A Strategy for Cancer 2011' made a pledge to set the following challenges;

- Reduce the incidence of cancers which are preventable
- Improve access to screening and introduce new screening programmes
- Achieve earlier diagnosis of cancer
- Ensure all patients have equal access to the best possible treatment

This has been developed further and in 2015 the National Cancer strategy was launched.

There has been considerable progress made on cancer over the past decade. Cancer mortality has fallen nationally, with the introduction of new treatments and drugs survival rates are improving for many cancers and patients' experience of their care has improved. Progress has also been made against smoking, detecting more cancers early through screening and delivering faster diagnosis and treatment. Multi-disciplinary teams now provide more coordinated and higher quality care for patients and there has been considerable financial investment in cancer which has helped to deliver an expanded cancer workforce and more equipment.

The third annual Improving Outcomes published Dec 2013: A Strategy for Cancer report, in partnership with NHS England and Public Health England, reports on:

- significant developments in cancer screening - particularly on the first phase of introducing Bowel Scope Screening (BSS)
- activity to promote earlier diagnosis of symptomatic cancers through the Be Clear on Cancer campaigns and the associated work with primary and secondary care
- progress in ensuring better access for all to the best possible treatment
- significant developments in the collection and reporting of new datasets and the analysis of information to drive improvements and inform patients

We are committed to continuously improving cancer care in Thanet and over the next 5 years we will continue to work with partners, including NHS England, Public Health England and Macmillan cancer support, on priority areas for action.

Introduction

Cancer is a group of conditions where cells in a specific part of the body grow and reproduce uncontrollably. There are over 200 different types of cancer, each with its own methods of diagnosis and treatment, with the four most common types of cancer being breast, lung, prostate and bowel and they account for around 53% of all new cases. The incidence of cancer is increasing, although the potential to save lives through earlier diagnosis is improving.

Cancer is a very common condition and more than one in three people will develop some form of cancer during their lifetime and it accounts for a quarter of all deaths in England. In 2011, almost 331,500 people in the UK were diagnosed with cancer.

In Thanet, the under-75 cancer mortality rate is statistically higher than the England average and the one year survival rate was the fourth lowest (64.1%) out of any CCG area nationally. High death rates due to lung cancer make a large contribution locally to the life expectancy gap with survival being generally lower among patients in more deprived areas.

Appropriate prevention, screening, diagnosis, treatment and rehabilitation and support services will be required to address the changing cancer agenda. This strategy document sets out how we will develop cancer care in Thanet over the next five years to tackle the identified challenges; this includes reducing cancer mortality rates and improving the health of our local population.

Some key actions over the next 5 years will be to ...

Prevention

- Promote health and wellbeing including:
- Campaigns promoting healthy eating and exercise such as Change4Life
- Target preventative messages to at risk communities and groups
- Actively promote the smoking cessation campaigns
- Deliver to recommendations identified within the alcohol strategy

Screening

- Reduce inequalities in uptake by targeting populations where uptake is low, using interventions based on the evidence

Early diagnosis & Referral

- Through our local Communications plan we will provide educational programmes of raising awareness and support early presentation.

Treatment

- We will improve services locally and measure this through compliance against National cancer Access Standards

Patient experience

- We will review and implement the recommendations of the national Cancer voices audit.

Living with and beyond cancer

- To Implement the local recommendations from the survivorship audit (2014)
- Support the implementation of a standardised local approach to Self Care to support independence and well being

End of Life

- To implement the recommendations of the EK End of Life strategy

Governance

- To ensure an effective electronic system is in place for the transfer of communications

The Case for Change

Thanet has the widest gap in life expectancy out of all of the Kent districts. The difference in life expectancy between the most affluent 10% and most deprived 10% is 10.9 years for men and 6.2 years for women. In Thanet, deprivation, crime and unemployment are all statistically higher than the England average. There are a higher proportion of some vulnerable populations in Thanet such as children in care, ex-offenders and people with a mental health condition which bring increasing health and social care problems. Areas where there is higher proportion of vulnerable and deprived communities often have worse data on lifestyles.

Thanet is statistically worse than the England average for a number of cancer indicators. These include under-75 incidence and mortality, prevalence, percentage of urgent GP referrals with cancer, stage at diagnosis and one year survival rate (Appendix 2). The one year survival rate is a particular issue, with Thanet being the fourth worst area in England for this indicator. Although this rate increased between 1997 and 2012, it was at a much lower proportion than in the other CCG areas across Kent.

Locally performances against National Cancer Access Standards have not always been achieved. As part of this Strategy we are determined to improve the pathways to treatment to ensure patients are seen, diagnosed and treated in a timely manner through working in partnership with providers and where necessary holding them to account for their performance of these standards. This will help Thanet CCG to achieve the world class cancer outcomes which are outlined below.



Aim of the Cancer Strategy

The aim of this strategy is to ensure that appropriate prevention, screening, diagnosis, treatment and rehabilitation and support services for cancer are in place to enable Thanet to improve considerably; reducing cancer mortality and improving the health of our local population.

We will raise the profile of cancer across Thanet to broaden the ownership of this critical issue, to ensure that priority is given to reduction of cancer excess mortality. We will work together with stakeholders to ensure the delivery of these outcomes is aligned to achieving World Class Cancer Outcomes.

Prevention

Preventing cancer is a local and national priority and will play a major part in the reduction of cancer deaths and ill health. It involves the promotion of health and wellbeing and the reduction of cancer risk factors. Prevention will have a strong focus on reducing inequalities in cancer mortality in Thanet. Reducing above average rates of smoking, poor diets and alcohol consumption will have significant impacts on our local population. Smoking is by far the most important preventable cause of cancer. It is responsible for one in four UK cancer deaths, and nearly a fifth of all cancer cases (Nice 2015). In Thanet, lung cancer has the highest mortality and years of life lost from any type of cancer and around 90% of lung cancer is attributed to smoking. After smoking, poor diet, obesity and lack of exercise are some of the most important avoidable causes of cancer.

Nationally smoking prevalence is reducing. In 1990 it was 30% and in 2013 it was 19%. The prevalence for Thanet in 2013 was 25%, although there was variation throughout the district. It is generally highest in areas of the highest deprivation (Figure 1). However rates of smoking are higher in men, in young adults, people in routine and manual occupations. Smoking during pregnancy is an issue in Thanet. In 2013/14, the percentage of pregnant women with a smoking status at time of delivery was 17% in Thanet compared to 12% in England as a whole.

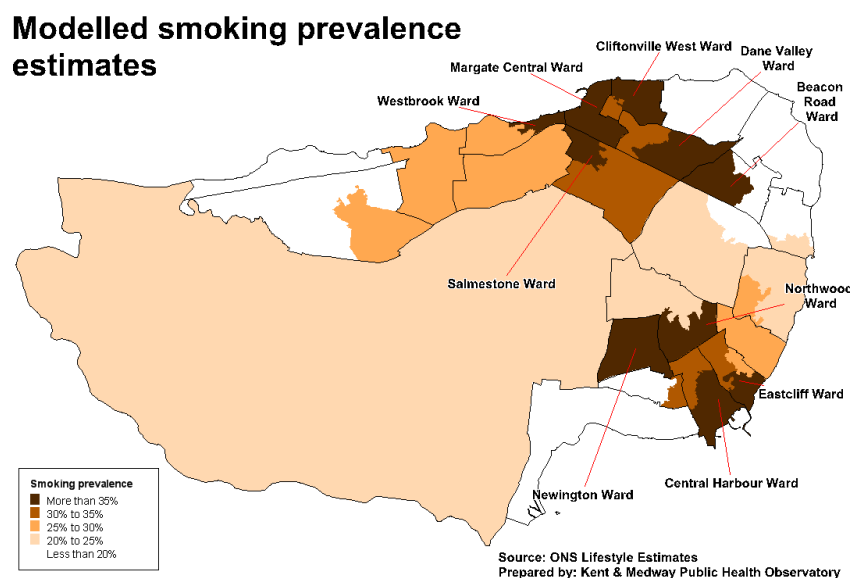


Figure 1: Modelled smoking prevalence estimates across Thanet

Regularly drinking alcohol (up to a pint of premium lager or a large glass of wine a day which contain around three units) can increase the risk of mouth, throat, oesophageal, breast and bowel cancers. A study published in 2011 found that alcohol is responsible for around 4% of UK cancers, about 12,800 cases per year (Parkin et al 2011). The proportion of cases down to alcohol was highest for mouth and throat cancers (around 30%), but bowel cancers accounted for the greatest overall number of cases linked to alcohol (around 4,800 cases a year). Figure 2 shows that alcohol specific hospital admissions increased in most parts of Thanet between 2006 and 2015. There was a slight decrease in Margate, although it was still higher than in other areas of Thanet.

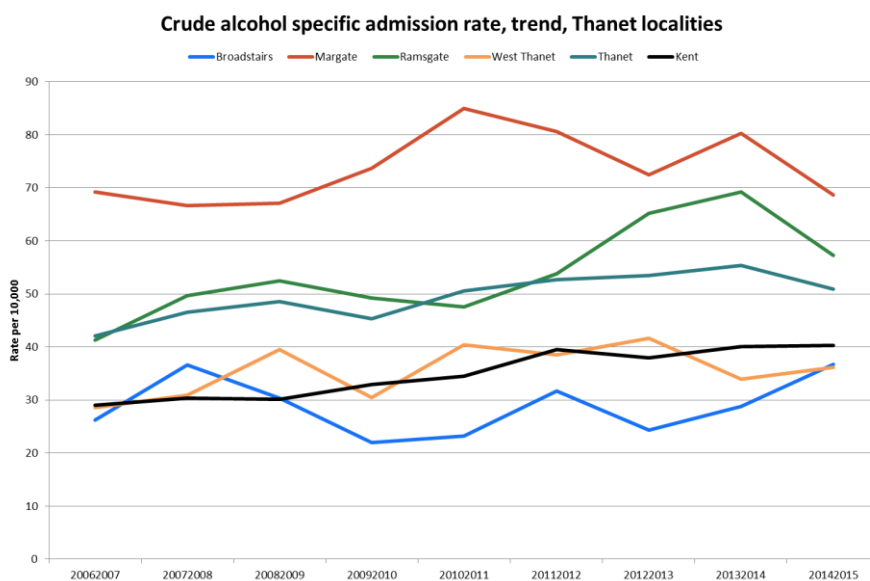
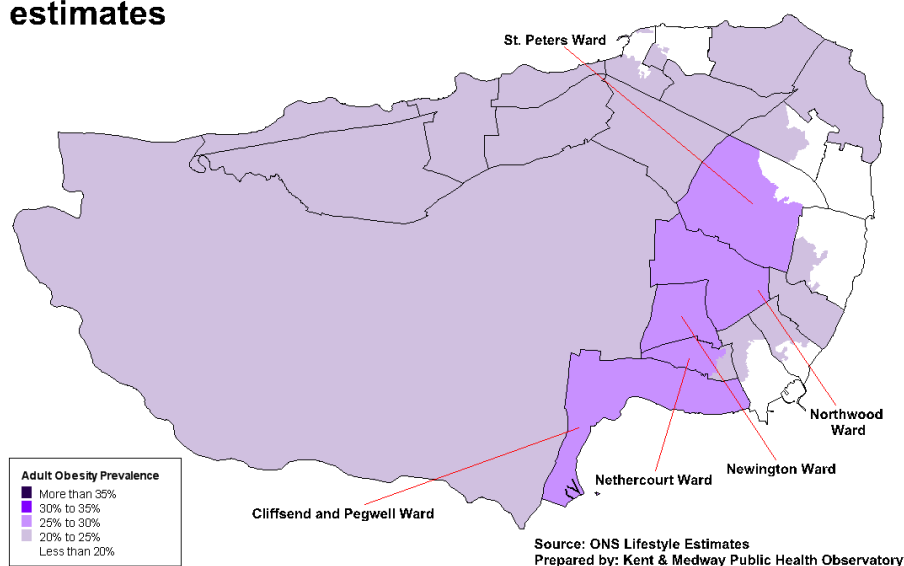


Figure 2: Alcohol specific hospital admission rates

In the UK, 4.4% of all cases of cancer per year in men and 8.2% of all cases of cancer per year in women were estimated to be attributable to obesity. This could increase in the future though because the obesity prevalence trend is increasing. Being overweight or obese is associated with an increased risk of a range of cancers including oesophageal, pancreatic, bowel, breast and rectum. Figure 3 shows the estimated obesity prevalence across Thanet.

Modelled adult obesity prevalence estimates



We Will;

- Ensure that public health services such as the stop smoking service use a more targeted approach to **increasing** access from the most deprived populations in Thanet
- Use social marketing data and methods to tailor preventative messages to at-risk communities and groups
- Build cancer awareness and knowledge of preventative interventions into the 'Make Every Contact Count' programme within health services and partner frontline agencies.
- Promote health and wellbeing through appropriate campaigns such as Change 4Life
- Promote confidence and resilience in children and young people to encourage healthy lifestyle choices and raise their awareness of cancer prevention.

Screening

Screening for cancer aims to find cancers as early as possible. This involves looking for early signs of a particular cancer in healthy people who do not currently have any symptoms. There are three National Screening Programmes established for breast, bowel and cervical cancers.

Screening data for Thanet varies. For breast screening, CCG uptake rates in Kent, Surrey and Sussex range from 58% to 78%. Thanet has an uptake rate of 75% so one of the higher rates for the region. Uptake rates for cervical screening in the region range from 71% to 84%. Thanet has an uptake rate of 76% so close to the average for the region. For bowel screening, regional uptake rates range from 51% to 65%. Thanet's rate is below the regional median— 54%

Generally, populations from more deprived areas are less likely to participate in a screening programme in comparison to those from more affluent areas. The data in appendix 2 shows this to be the case in Thanet with higher screening rates in areas where there is less poverty. This could be due to people with high socioeconomic status being more likely to have more knowledge or sources of care regarding cancer screening services such that they are more motivated to undertake certain types of medical care (Lin 2008)

We Will;

- **Increase awareness and uptake of screening across Thanet**
- **Increase screening rates in low uptake areas by working with specific groups/neighbourhoods/localities**
- **Ensure evidence-based interventions and national guidance is implemented and that new initiatives have audit built in at the planning stage**

Early Diagnosis & Referral

For many cancers, the earlier a cancer is diagnosed and treated, the greater the prospect of survival and improved quality of life. We must continually raise public awareness of cancer symptoms, encouraging people to seek help early and promote early diagnosis in primary care.

We Will;

- **Map differences in cancer presentation, registration and staging ,treatment adherence and survival geography defined by deprivation scores.**
- **Use an established differential needs assessment to target programmes of awareness raising and support early prevention.**
- **Undertake an audit across the whole pathway –focussed on Bowel Cancer initially.**
- **Undertake a reflective audit in practices for patients diagnosed with cancer not on a 2ww pathway.**
- **We will ensure that capacity is available in order to meet the recent changes from the NICE guidance.**

Treatment

Cancer care is complex and relies on highly skilled staff using the most up to date evidence and equipment to provide the best care possible for patients.

Great efforts have been made to ensure timely and high quality care for cancer patients in Thanet. A number of drivers for ensuring better treatment have been introduced nationally, at a regional level and local level.

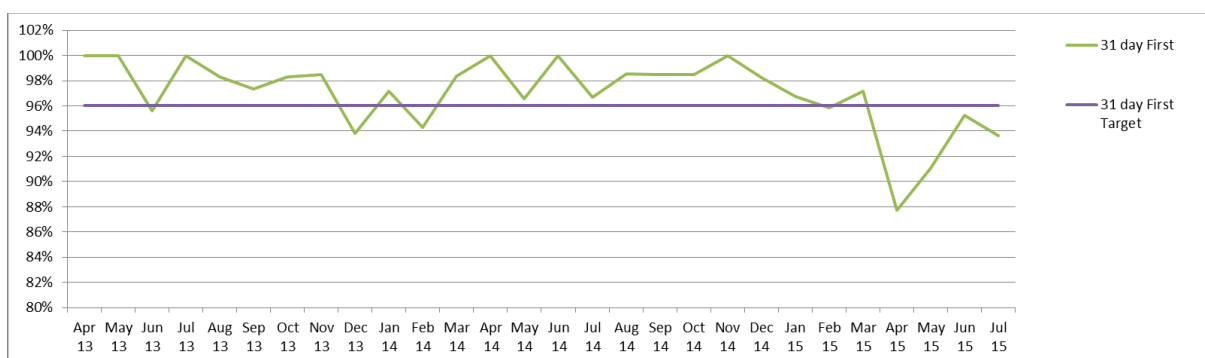
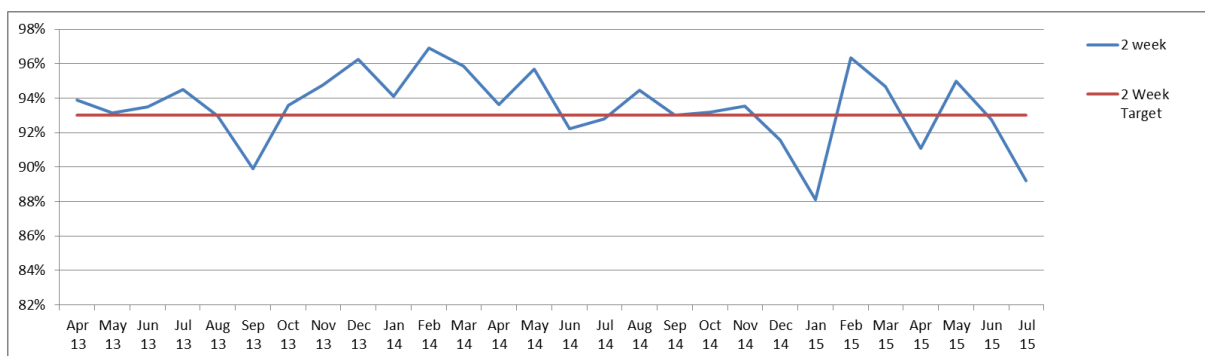
Currently, Thanet patients may access treatment at a number of local hospitals, including the Queen Elizabeth the Queen Mother Hospital, Kent and Canterbury, William Harvey and further afield in Maidstone and specialist hospitals in London.

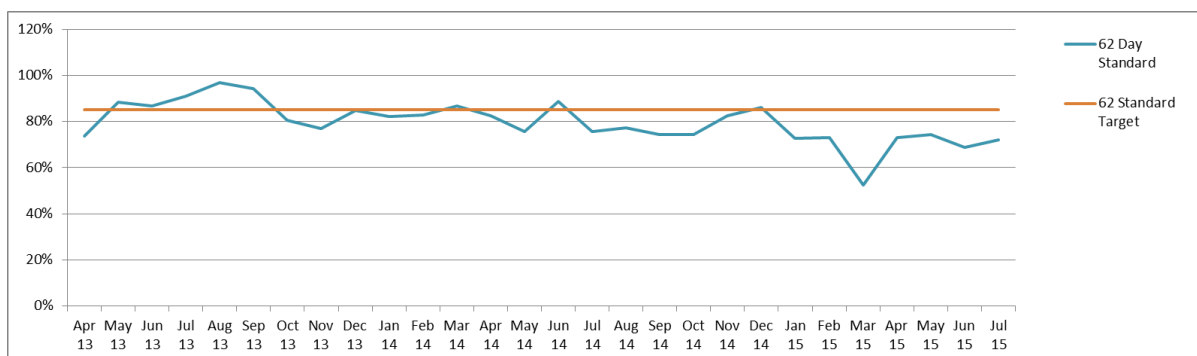
The CCG is committed to ensuring the safe and effective care and treatment is provided ensuring a balance is maintained between centralisation of services and local accessibility.

The current cancer performance has been inconsistent and through this strategy we intend to improve compliance against the national targets

The current Cancer wait targets can be seen in the tables that follow.

**Figure 4 - Cancer Wait Times Performance
Thanet CCG - All Providers**





We Will;

- Focus effort on improving the diagnosis and referral of patients to hospital at Primary Care level through improved awareness amongst GPs.
- Ensure a Cancer Access Standard recovery plan is developed by East Kent Hospitals University Foundation Trust and that this includes Tumour site specific actions that will improve performance.
- We will review the appropriateness of MDT being necessary for all patient reviews for example Prostate cancer.
- We will ensure the patient is central to this process

Patient experience

In October 2011 the NHS National Quality Board (NQB) agreed on a working definition of patient experience to guide the measurement of patient experience across the NHS. This framework outlines those elements which are critical to the patients' experience of NHS Services.

- **Respect for patient-centred values, preferences, and expressed needs**, including: cultural issues; the dignity, privacy and independence of patients and service users; an awareness of quality-of-life issues; and shared decision making;
- **Coordination and integration of care** across the health and social care system;
- **Information, communication, and education** on clinical status, progress, prognosis, and processes of care in order to facilitate autonomy, self-care and health promotion;
- **Physical comfort** including pain management, help with activities of daily living, and clean and comfortable surroundings;
- **Emotional support** and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families and their finances;
- **Welcoming the involvement of family and friends**, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as care-givers;

- **Transition and continuity** as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions;
- **Access to care** with attention for example, to time spent waiting for admission or time between admission and placement in a room in an in-patient setting, and waiting time for an appointment or visit in the out-patient, primary care or social care setting.

Patients express the view that their experience of care is around clinical effectiveness and safety. They want to feel informed, supported and listened to so that they can make meaningful decisions and choices about their care. They want to be treated as a person not a number and they value efficient processes.

Macmillan's 'Nine Outcomes': What matters most to people with cancer

Cancer in the UK 2014 examines the state of cancer in the UK in terms of the nine issues that people affected by cancer have told Macmillan matter most to them. These issues include clinical outcomes as well as the impact of cancer on the whole of a person's life.



Living with and beyond cancer

The cancer story is changing: there are two million people living with or beyond cancer in the UK. This figure is set to rise to four million by 2030.⁹ Cancer incidence is increasing and survival rates are improving. While there is plenty of information and support available to people during their treatment, it can be hard to adjust afterwards and get back to as normal a life as possible. Patients and families may be left with physical, psychological, social and economic effects following diagnosis and treatment. We will support and encourage local people to manage their own conditions and create a pathway of care focused on the needs of patients and families linking with the South Tyneside Pioneer project. Staff across health, social care and the third sector will work collectively on a joined up self-care 'offer' to reduce fragmentation of service delivery and improve the lives of local people. To help support local patients and their families' access is available to emotional and practical support to help people who are trying to return to 'normal life' after the roller coaster experience of cancer. Cancer Connections and Coping with Cancer are both local charities whose work is carried out by volunteers, most of whom have first-hand experience of cancer.

Thanet CCG has contributed to the South East Coast Clinical Networks review of the implementation of the Cancer Recovery Package. A number of recommendations have been made and the CCG is committed to implementing these recommendations locally.

We Will;

- **Ensure that patients, carers and families of those who have had cancer have access to quality information and support services, including access to physical psychological, social and economic support when needed**
- **Support the implementation of a standardised local approach to Self Care to support independence and well being**
- **Raise the awareness to ensure all health professionals are vigilant for signs of recurrence or treatment complications**
- **Contribute to the development of a clear vision and five year strategy for the commissioning and implementation of the Recovery Package.**
- **Work with the Strategic Cancer Network to gather evidence and good practice examples and facilitate the sharing of good practice and knowledge across the CCG.**
- **Implement locally the recommendations of the Cancer Recovery package**

End of Life

A significant proportion of all deaths in Thanet are due to cancer and so ensuring appropriate end of life services and support are available in the right place at the right time is essential. We must ensure that appropriate support is provided that meets the needs of both the person who is dying and the people close to them. There will be a strong focus ensuring that the recommendations of the East Kent Strategy are implemented so that people have the best possible end of life experience and will be;

- treated as an individual, with dignity and respect
- should have access to appropriate medication and support to manage their symptoms
- in familiar surroundings
- in the company of close friends and/or family
- able to be cared for and die in the place of their choice.

Regardless whether the patient is young or old they should receive high quality end of life or palliative care from their GP, nurse, case manager, therapist, hospice, hospital, voluntary organisations and any other professional who is involved in their care. They should be supported physically, psychologically, socially and emotionally and their own personal needs and preferences will be paramount in their care. Carers and families will also receive the help and support they need.

We Will;

- **Implement the recommendations of the East Kent EOL Strategy**
- **Ensure patients preferred place of care is achieved**
- **Review and re design current EOL pathway and services**
- **Ensure and appropriate electronic system is in place for communication of patients wishes at Ends of Life**
- **Ensure EOL training is mandatory for all organisations**

Governance

We are committed to continuously improving cancer care in Thanet and to support us in achieving our goal we have identified a number of cross pathway priorities.

The monitoring and delivery of this strategy will be overseen by the Thanet cancer Steering group which will report to the CLT

We Will;

- **Ensure an effective electronic system to transfer of communications is implemented**
- **Ensure there is effective, safe speedy communication for professionals involved in the care of cancer patients**

How will the Cancer Strategy be implemented?

NHS Thanet Clinical Commissioning Group Cancer Strategy maps out the key priorities and actions for improving the quality of cancer care in Thanet. It is a strategic plan which requires the involvement of key partners and stakeholders.

Clinical Leadership

NHS Thanet CCG has a dedicated Clinical Lead, Public Health Lead, Macmillan GP and Primary Care Nurse for Cancer who have been heavily involved in the development of this strategy and will be tasked with jointly delivering it. The development of this strategy has not been undertaken in isolation and nor will its delivery.

Working with Stakeholders

NHS Thanet CCG will not be able to realise this strategy without working closely with other key stakeholders including local provider organisations (EKHUFT, KCHFT, KCC, Pilgrims hospices), Primary Care, third sector partners and patients, carers and others who are affected by cancer. We will develop models of delivery with our stakeholders to ensure the successful delivery of the actions linked to this strategy. (See Appendix 3)

Communication Plan

To support the delivery of this strategy NHS Thanet CCG will develop a dedicated communication and engagement plan.

To ensure successful implementation we will review the Terms of Reference and membership of the group to ensure there is representation from all relevant groups necessary to oversee the delivery of this strategy. This will ensure that the level of representation is sufficient to provide comprehensive leadership.

Measures of Success

In measuring the success of this strategy Thanet CCG are reliant on data which can be retrospective.

In order to address this we are building in milestones that will demonstrate the effectiveness of the actions contained within the delivery plan.

References

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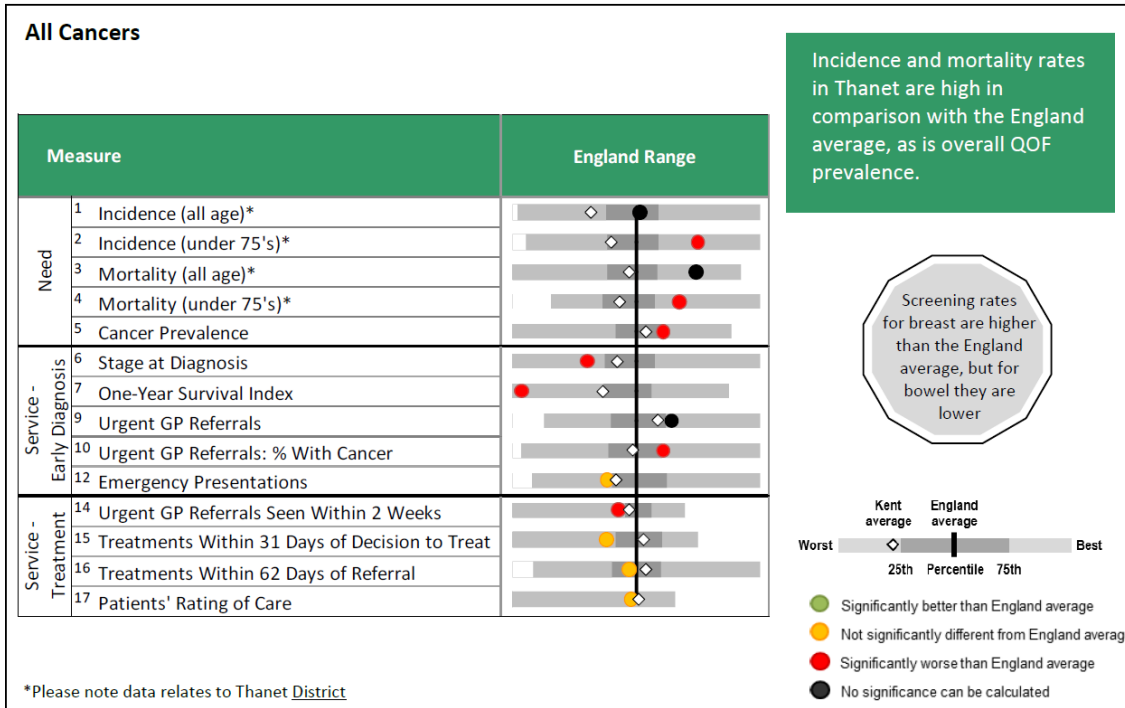
Department of Health, Achieving World -Class Cancer Outcomes a Strategy for England (2015-2020)

Department of Health and the NHS Institute (2010): What Matters To Patients? Developing the Evidence Base for Measuring and Improving Patient Experience

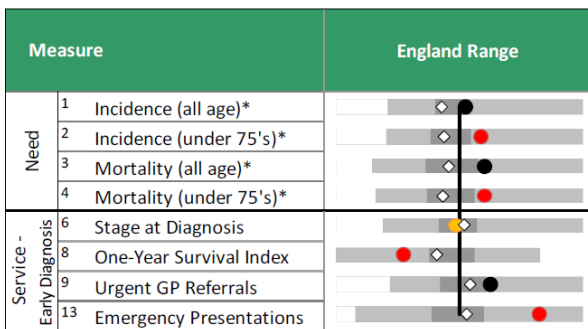
Macmillan cancer support (2014) Macmillan's 'Nine Outcomes': What matters most to people with cancer

South Tyneside Partnership (2014) Cancer Strategy

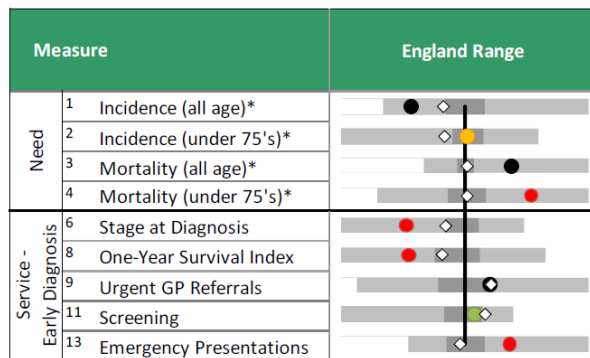
Appendix 1- Thanet cancer profile



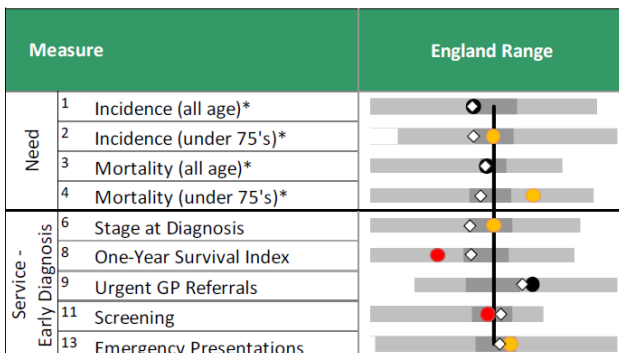
Lung Cancer



Breast Cancer

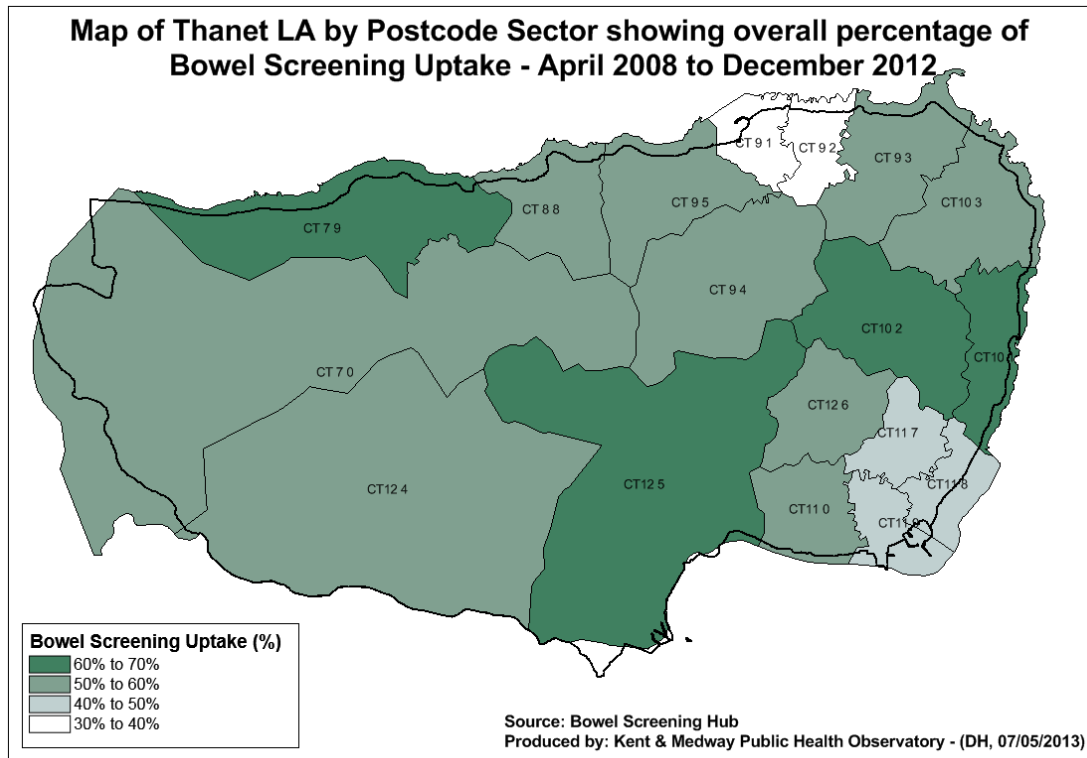


Colorectal Cancer



1/2. Incidence: DSR – HSCIC, 2012. 3/4. Mortality: DSR – HSCIC, 2013. 5. Cancer prevalence (QOF) – HSCIC, 2012/13. 6. Stage at diagnosis: % diagnosed at Stage 1 or 2 – CCT, 2012. 7. One-year survival index – ONS, 2012. 8. One-year survival index: Breast, colorectal & lung cancers combined – ONS, 2012. 9. Urgent GP referrals: Crude rate – CCT, 2013 GP Profile. 10. Urgent GP referrals: Conversion rate (% with cancer) – CCT, 2013 GP Profile. 11. Screening: % of eligible patients screened – CCT, 2013 GP Profile. 12. Emergency presentations (%) – CCT, July-December 2012. 13. Emergency presentations (%) – 'Routes to Diagnosis 2006-2010', NAEDI. 14. Urgent GP referrals seen within 2 weeks (%) – CCT CCG Profile, 2013/14. 15. Treatments within 31 days of decision to treat (%) – CCT CCG Profile, 2013/14. 16. Treatments within 62 days of GP referral (%) – CCT CCG Profile, 2013/14. 17. Patients' rating of care: % cancer patients rating their care as 'excellent' or 'very good' – Cancer Patient Experience Survey 2014.

Appendix 2 – Local screening data



Cervical Cytology Screening for Thanet CCG Patients - Jan 2007 to Dec 2012 (pooled data) by age band

Thanet CCG Practices	Practice Name	Percentage screened by age band										All Ages
		25-29	25-64	30-34	35-39	40-44	45-49	50-54	50-64	55-59	60-64	
G82796	THE ALBION ROAD SURGERY	87.10	92.75	97.67	97.78	98.15	93.33	90.16	89.22	92.31	85.19	92.37
G82674	CLIFTONVILLE SURGERY	82.93	89.32	82.50	87.50	91.53	95.92	91.04	90.18	95.45	84.62	89.10
G82219	ST PETER'S SURGERY	81.73	87.36	89.47	90.38	91.60	92.45	90.70	84.00	84.21	76.11	86.80
G82107	MINSTER SURGERY	74.29	85.92	90.10	88.56	87.76	90.27	87.10	83.97	85.91	78.90	85.28
G82810	GARLINGE SURGERY	73.40	85.07	89.77	89.81	86.30	90.08	86.84	82.49	80.23	77.19	84.12
G82210	OSBORNE ROAD SURGERY	71.93	83.91	83.64	79.41	84.52	91.55	91.67	86.10	77.19	86.96	83.69
G82650	MOCKETT'S WOOD SURGERY	71.70	83.02	84.82	81.75	92.19	88.17	86.43	80.87	73.95	81.17	82.41
G82079	WESTGATE SURGERY	76.21	81.45	86.32	86.19	83.14	83.73	83.61	79.01	76.40	76.08	81.21
G82649	UNION ROW SURGERY	71.29	81.72	84.72	80.25	87.91	93.51	90.28	78.23	71.74	58.62	79.83
G82020	THE GRANGE PRACTICE	71.14	79.09	84.18	82.18	80.66	83.24	82.74	76.89	75.10	71.53	78.68
G82126	EAST CLIFF MEDICAL PRACTICE	69.61	78.74	80.53	83.55	86.41	85.92	78.24	73.59	73.65	68.03	77.83
G82812	WICKHAM SURGERY	74.07	78.20	83.33	82.00	89.83	71.43	86.27	74.64	65.12	70.45	77.53
G82150	NEWINGTON ROAD SURGERY	69.75	77.90	79.61	81.73	83.60	83.33	81.77	75.15	68.98	73.50	77.53
G82666	BIRCHINGTON MEDICAL CENTRE	72.54	76.63	80.86	83.89	82.64	79.46	73.33	71.86	70.04	72.27	76.35
G82630	THE BROADWAY PRACTICE	61.18	77.04	75.93	87.73	86.34	82.00	79.38	73.14	71.26	67.68	76.17
G82046	SUMMERHILL SURGERY	65.17	75.84	80.21	79.37	81.95	77.03	79.10	74.14	70.27	71.23	75.43
G82105	BETHESDA MEDICAL CENTRE	66.94	75.39	73.64	78.70	80.00	81.03	76.70	74.63	74.19	72.41	75.36
G82064	DASHWOOD HOUSE	61.98	75.21	79.84	78.11	81.96	82.04	78.19	72.57	72.30	64.57	74.68
G82052	THE LIMES	60.15	73.73	78.19	80.07	78.11	77.38	79.25	72.61	72.22	65.00	73.67
G82066	NORTHDOWN SURGERY	64.56	73.57	77.88	77.21	77.85	77.19	79.18	70.89	67.06	66.06	73.15
G82769	CECIL SQUARE SURGERY	51.25	69.23	66.22	80.60	78.08	76.06	77.08	67.24	58.62	61.54	68.59
Thanet CCG Average		70.42	80.05	82.35	83.66	85.26	84.53	83.29	77.69	75.06	72.81	79.51

Breast Screening Coverage - Thanet CCG Patient - April 2009 to March 2012 (pooled data)

Practice Name	Percentage Screened in 3 year period to March 2012
---------------	--

BIRCHINGTON MEDICAL CENTRE	81.09
MINSTER SURGERY	80.00
ST PETER'S SURGERY	79.76
WESTGATE SURGERY	78.87
THE GRANGE PRACTICE	78.75
SUMMERHILL SURGERY	78.40
OSBORNE ROAD SURGERY	78.23
THE BROADWAY PRACTICE	77.73
CLIFTONVILLE SURGERY	77.18
EAST CLIFF MEDICAL PRACTICE	76.90
MOCKETTS WOOD SURGERY	76.06
NORTHDOWN SURGERY	75.93
THE ALBION ROAD SURGERY	75.71
GARLINGE SURGERY	75.70
DASHWOOD HOUSE	75.15
BETHESDA MEDICAL CENTRE	73.35
NEWINGTON ROAD SURGERY	72.52
THE LIMES	72.33
WICKHAM SURGERY	69.80
UNION ROW SURGERY	67.54
CECIL SQUARE SURGERY	59.86
	77.88

Appendix 3 – NHS Thanet CCG Cancer Work Plan

Cancer framework action plan

Action Number	Improvement Action Plan	Actions required	Leads, Timescales & Comments
1	<i>To develop a cancer strategy for TCCG</i>	<p>To review current data for Thanet and prioritise key recommendations</p> <p>To present this at CLT and hold a PLT session around cancer to launch the document</p> <p>To arrange PLT session FH to speak with HP</p> <p>To learn from other similar areas with regards to strategy development (ie South Tyneside)</p>	<p>CT/FH/GB Oct 2015</p> <p>CT/FH/GB Oct 2015</p> <p>FH Jul 2015</p> <p>FH Jul 2015</p>
2	<i>Improvement in health promotion</i>	<p>To liaise with Comms team around developing a Comms and engagement strategy to raise health literacy within the population. Promoting key messages to general public and professionals.</p> <p>To link with Public Health Stop smoking and health promotion teams and Macmillan to develop some local events in libraries, one stop shops A& E dept etc.</p> <p>FH to liaise with Mark Holmes Macmillan public engagement officer.</p>	<p>FH/CT/GB/SJ Jul 2015</p> <p>FH/CT/GB Sep 2015</p> <p>FH Sep 2015</p>

3	Two week wait referrals Thanet CCG has a higher rate of referrals than the national figure.	Practice profiles will be available July 15 and CT to compile narrative to go along side data With conversion rates	CT Jul 2015
4	Emergency admissions with cancer per 100,000 population Thanet CCG has a higher rate of emergency cancer admissions than the national average	To present audit to practice managers meeting 17/06/15 To commence a Cancer Emergency Presentations Audit with the top 11 Practices	FH Complete Dr C Neden and FH To commence Sep 2015
5	Percentage of diagnostic tests from GP direct access Thanet CCG has a lower rate referred via GP direct access for chest x-rays, brain MRIs and ultrasounds compared to the national average	Consider in line with recently published NICE guidance approach to raise awareness within General Practice.	Dr C Neden/ Dr J Neden Sep 2015
6	Screening uptake breast, For breast screening Thanet has an uptake rate of 75% so one of the higher rates for the region.	Some issues around 6 month review letters being sent to practices. CT to speak with JR re process	CT Sept 2015
7	Screening uptake cervical, Thanet has an uptake rate of 76% so close to the average for the region.	Obtain data from Public Health on a quarterly basis.	CT Oct 2015
8	Screening uptake bowel Thanet's rate is below the regional median– 54%	To review current equity of service- in particular pathway for colonoscopy	GB/FH Aug 2015
9	Routes to diagnosis Thanet CCG is above the national median rate	To commence a Cancer Emergency Presentations Audit with the top 11 Practices	Dr C Neden and FH To commence Sep 2015

	of patients diagnosed via emergency routes for Lung, Breast and Colorectal Cancers		
10	Age standardised under 75 mortality rate: all cancers Thanet CCG is above the national average and has the highest rate in the region.	Implement Thanet Strategy	All Nov 2015
11	1 year survival rate for all cancers The latest figures indicate that Thanet CCG has 1 year survival rates that are below the regional and national averages and one of the lowest in the region.	Implement Thanet Strategy	All Nov 2015
12	Staging for all cancers Thanet CCG had 37.4% of cancers that were diagnosed at stage 1 or 2 which was below the regional average and below the national average.	To review current data for Thanet and prioritise key recommendations To present this at CLT and hold a PLT session around cancer to launch the document To arrange PLT session FH to speak with HP	CT/FH/GB Oct 2015 CT/FH/GB Oct 2015 FH Jul 2015
13	Review Current Performance standards Achievement of the Cancer wait standards has fluctuated from month to month.	Review data monthly and highlight and address underperformance.	GB Ongoing
14	Cancer Recovery Plan EKHUFT have developed a Cancer Recovery Plan for Urology and Lower GI to address performance issues.	Oversee, contribute and monitor delivery of recovery plans.	Dr C Neden/GB Oct 2015

Appendix 4 - Glossary

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OBESITY

HEALTH NEEDS ASSESSMENT

26 October 2015

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Executive Summary

The causes of obesity (commonly defined as a BMI of 30 or more) are complex and although some are genetic, most are modifiable. It will require action from the public, voluntary and commercial organisations as well as individuals, to make an impact on reversing the rise in obesity.

Approximately 10,000 children and 771,476 adults in Kent are overweight or obese. Kent rates do not compare well to other areas in the South East although they are not dissimilar to England and statistical neighbours.

The prevalence of obesity varies across Kent, with the highest prevalence rates of adult obesity to be found in Dartford, Shepway and Swale. The highest rates in four - five year olds are found in Swale, Dartford, Gravesham and Dover. The highest rates in 10 -11 year olds are found in Swale, Swanley, Shepway and Ashford.

People who are obese are at far higher risk than the general population of serious illness including diabetes, heart disease and stroke. Approximately nine years of life is prematurely lost to obesity related conditions. Obesity is forecast to cost the NHS in the region of £50bn by 2050.

Obesity has to be tackled at every stage of the life course. Obesity in pregnancy has serious risks for mother and child. An increasing number of obese children are at risk of a number of serious conditions including type-2 diabetes, cardiovascular disease, certain cancers, lung disease and kidney failure which will follow into adulthood. Adults who are obese have a much higher risk of a number of serious conditions including diabetes, heart disease, stroke and arthritis than the general population and experts are recognising an increasing number of people with severe and complex obesity. There are specific groups who have more of a pre-disposition to obesity than the general population that commissioners of services need to acknowledge.

There is an overarching national 'Call to Action' on obesity with published ambitions for population weight loss and there is evidence that nationally local government organisations are collaborating with clinical groups to improve population health at a local level. The Royal College of Physicians is championing the development of the role of clinicians, particularly in primary care, and have produced a range of teaching packages for prevention and treatment of obesity. In Kent changes in national commissioning arrangements for severe and complex obesity are a catalyst for local co-design of the obesity pathway.

All settings have a role to promote preventive measures; promoting a healthy diet through policy, and designing a less sedentary working environment for example. Weight management programmes should have physical activity, nutrition and behavioural change components to meet National Institute for Health Care and Excellence (NICE) guidance. Interventions should ideally result in at least a five per cent reduction in body weight. Evidence now supports an understanding that a lower level of weight loss maintained over a life time may be a more realistic goal and that weight management interventions should achieve at least an average three per cent reduction in weight that is maintained. NICE calls for the need for further research on methodologies for sustaining weight loss achieved over a lifetime. However, commissioned interventions to identify people who are both at risk and motivated and to follow them into a maintenance phase could be part of a model for Kent, and may contribute to the research base.

Clinical Commissioning Groups (CCGs) have set priorities based on the Five Year Forward Plan, priorities that are drivers for integrated approaches to obesity include tackling health inequalities and preventing and managing long term conditions.

Commissioned services only provide interventions for a fraction of the population at risk; there is a need for front line workers to better understand what they can do and be provided with the tools to do it. Health and social care work in a large number of settings within CCG areas and are well placed to provide these interventions with their clients. To be able to do this effectively a roll-out of training programmes at scale will be required.

Stigma is thought to be a factor that contributes to the low take up of some services, including family weight management programmes; an identified gap in provision of suitable interventions for teenagers and males has been found. Another identified gap is that not all eligible women see a dietician during pregnancy. Further work needs to be undertaken to ensure there is a complete healthy weight pathway across all areas of Kent for both adults, and children and young people.

There are robust published pathways and recommendations for the approach to prevention, identification and management of obesity and well regarded models of good practice available elsewhere that Kent could learn from. A clear strategic direction is needed to integrate all the action that is necessary and to facilitate co-commissioning where this adds value. Kent would benefit from having an integrated model for obesity that includes other related health improvement strands such as emotional health and wellbeing, smoking and alcohol.

There will be increased demand, which we are seeing already with more people with severe and complex obesity seeking help and more limited funding in the future. A commissioning model that adds value by better integrating services and budgets across organisations should be considered. Value will also be added by all commissioning organisations including in their contracts and agreements measures that result in healthy eating, increased physical activity and wellbeing. Top down and bottom up approaches need to be taken, to also include work at a community level in areas of highest need.

Better data sharing across the system will enable more robust measurement of outcomes and inform commissioning of effective interventions.

The challenge is to work at scale to mobilise existing resources and assets to tackle obesity through the organised efforts of society.

1. Introduction

- 1.1 Obesity is a common risk factor for diabetes, other metabolic diseases, heart disease, stroke, liver disease, many cancers, arthritis and depression, causing death and injury and posing a high burden to health and social care.
- 1.2 The rising trend of overweight and obesity has been acknowledged as one of the most serious public health problems in the UK and by 2050 obesity is predicted to affect 50% of adult women, 60% of adult men and 25% of children.
- 1.3 The purpose of this document is to describe the current prevalence of obesity in Kent and to identify the needs and gaps across Kent and in Clinical Commissioning Group areas. It is intended that the needs assessment will inform commissioning intentions in a climate where there are high demands on clinical services and reducing budgets.

2. Background

2.1 Definitions

In adults, obesity is commonly defined as a body mass index (BMI) of 30 or more. For children in the UK, the British 1990 growth reference charts are used to define weight status.

- 2.2 In children the UK90 clinical cut points are as follows:

- Clinically very underweight: ≤ 0.4 th centile
- Clinically low weight: ≤ 2 nd centile
- Clinically healthy weight: > 2 nd - < 91 st centile
- Clinically overweight: ≥ 91 st centile
- Clinically obese ≥ 98 th centile
- Clinically extremely obese: ≥ 99.6 th centile

- 2.3 In adults, degrees of overweight and obesity are classified according to body mass index (BMI), calculated by dividing a person's weight in kilograms by the square of their height in metres:

- Healthy weight — BMI of 18.5–24.9 kg/m²
- Overweight — BMI of 25–29.9 kg/m²
- Obesity I — BMI of 30–34.9 kg/m²
- Obesity II — BMI of 35–39.9 kg/m²
- Obesity III — BMI of greater than or equal to 40 kg/m²

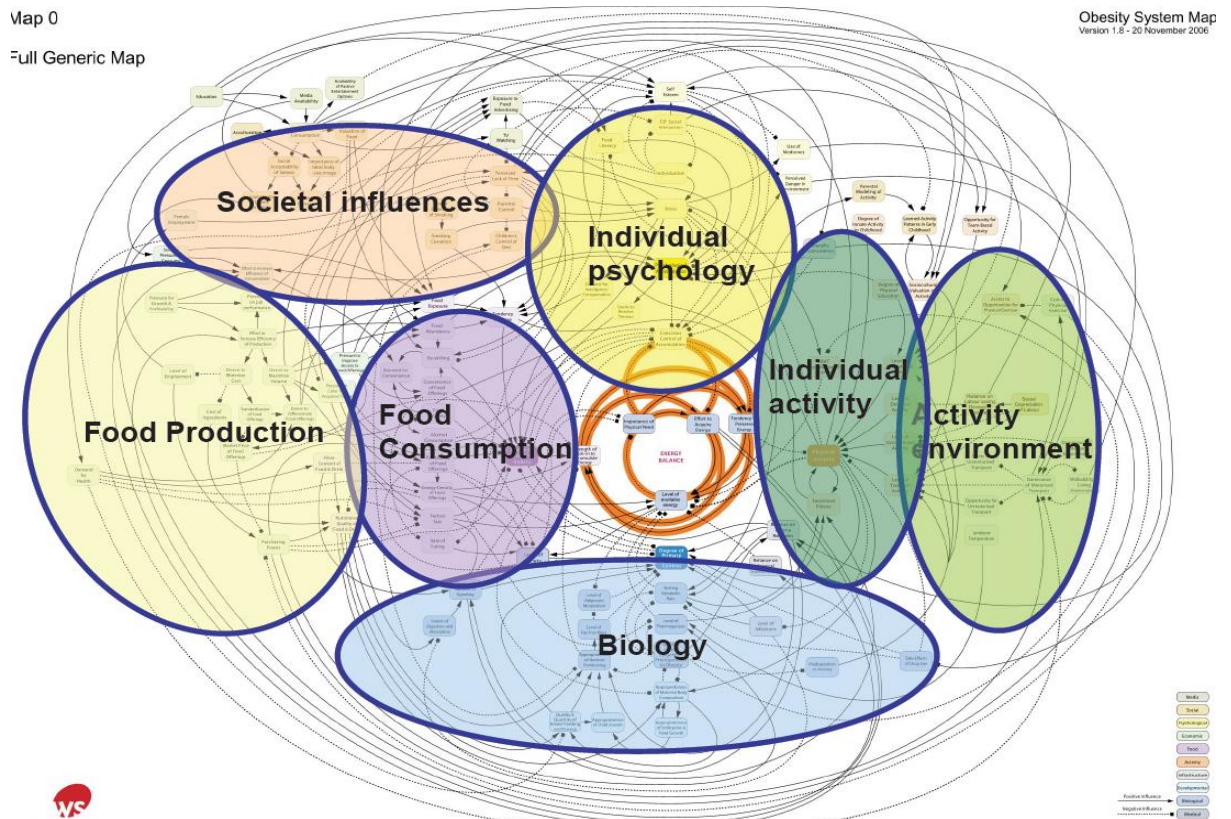
2.4 Measurement

The use of lower thresholds (23kg/m² to indicate increased risk and 27.5 kg/m² to indicate high risk) to trigger action to reduce the risk of conditions such as type 2 diabetes, has been recommended for Black African, African-Caribbean and Asian (South Asian and Chinese) groups

- 2.5 BMI is not used to definitively diagnose obesity – as people who are very muscular sometimes have a high BMI, without excess fat – but for most people, it can be a useful indication of whether they may be overweight.

- 2.6 A better measure of excess fat is waist circumference, and can be used as an additional measure in adults who are overweight (with a BMI of 25 to 29.9) or moderately obese (with a BMI of 30 to 34.9).
- 2.7 Generally, men with a waist circumference of 94cm or more and women with a waist circumference of 80cm or more are more likely to develop obesity-related health problems.
- 2.8 **Causes of obesity**
Obesity occurs when energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity over a prolonged period. There are many complex behavioural and societal factors that combine to contribute to the causes of obesity. Over 100 variables directly or indirectly influence obesity, with energy balance at its centre ⁽¹⁾.
- 2.9 A plentiful supply of energy dense, flavour enhanced food and the day to day use of labour-saving devices means that it has become 'normal' to gain excess weight. Environmental factors affecting weight loss or maintenance include the design of local housing estates that encourage and enable people to walk and cycle, the accessibility of shops and public services and the availability of good quality sport and leisure opportunities, including parks and open spaces.

2.10 **Figure 1: The Foresight Systems Map**



Source: *Butland B, Jebb S, Kopelman P, McPherson K, Thomas S, et al (2007)*

- 2.11 Physiological, psychological, social and environmental factors all contribute to overweight and obesity in individuals, communities and wider society. Most people's bodies are good at storing excess energy from our diets as fat. Our bodies regulate appetite and storage of fat through complex mechanisms. Other physiological factors that influence our weight include early development before and after birth, the amount of physical activity we do and the types of food we eat. Weight is affected by our habits and beliefs. These in turn affect behaviour around healthy eating and physical activity. Low mood has also been linked to obesity.
- 2.12 There are also links between social inclusion, wellbeing and physical activity and people not feeling fully in control of the food they eat. Social issues are important determinants of obesity in children and adults. Economic factors can also influence an individual's ability to choose a diet that is lower in fats and sugars and access opportunities to be physically active. Addressing health inequalities through broad action across Kent will improve health, including healthy weight. Concerns about safety, anti-social behaviour and crime may also deter people from being physically active in their local area.

2.13

Summary

- **The causes of obesity are complex and although some are genetic, most are modifiable.**
- **It will require action from public, voluntary and commercial organisations as well as individuals to have an impact on slowing or reversing the rise in obesity.**

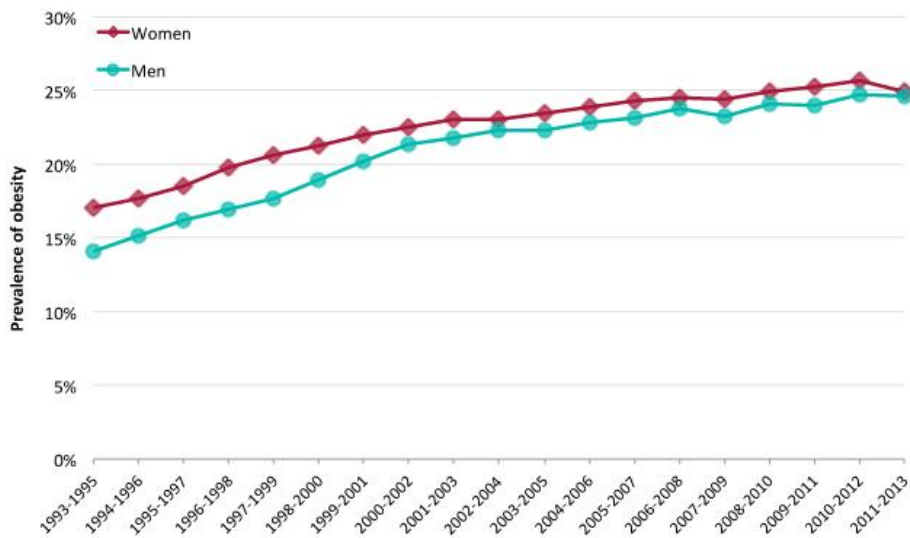
3. Epidemiology of the Disease

3.1 Prevalence of overweight and obesity in adults

In England, the prevalence of obesity among adults rose from 14.9% to 24.9% between 1993 and 2013. The rate of increase has slowed down since 2001, although the trend is still rising.

Figure 2: Prevalence of obesity among adults aged 16+ years

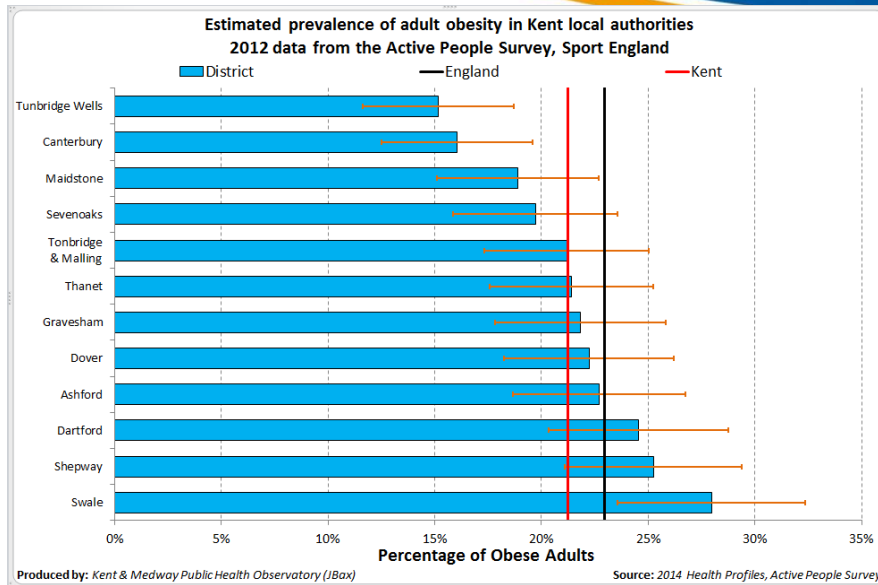
Health Survey for England 1993-2013 (3-year average)



There are an estimated 2.1 million adults in the UK with a body mass index (BMI) of 40 or over, which is approximately 5.4% of the adult population. This translates into 64,000 adults in Kent.

3.2 Dartford Shepway and Swale localities have estimated rates of obesity above the England average, Tunbridge Wells, Canterbury and Maidstone have rates below the England average.

Figure 3: Adult obesity by Kent local authorities



3.3 The percentage of adults in England who have excess weight (overweight and obesity combined) is 63.8%. 68% of men and 58% of women are overweight or obese (BMI 25 kg/m² or more). In Kent the excess weight rate is 64.6%. This translates into 771,476 people across Kent aged 16 and above.

Table 1: Overweight and obese adults (excess weight) in Kent compared with England and the South East (% 2012)

Kent	64.6
South East	63.1
England	63.8

Source: Public Health Outcomes Framework

Table 2: Estimated number of people with excess weight by local authority, 2012

Ashford	64,241	Canterbury	69,319
Dartford	53,543	Dover	57,992
Gravesham	53,836	Maidstone	84,109
Sevenoaks	61,133	Shepway	59,145
Swale	75,641	Thanet	75,065
Tonbridge and Malling	63,111	Tunbridge Wells	54,669

Source: Obese prevalence, APHO 2014; overweight prevalence, NHS Information Centre, Health Survey for England, 2012; Population, ONS mid year estimates, 2012

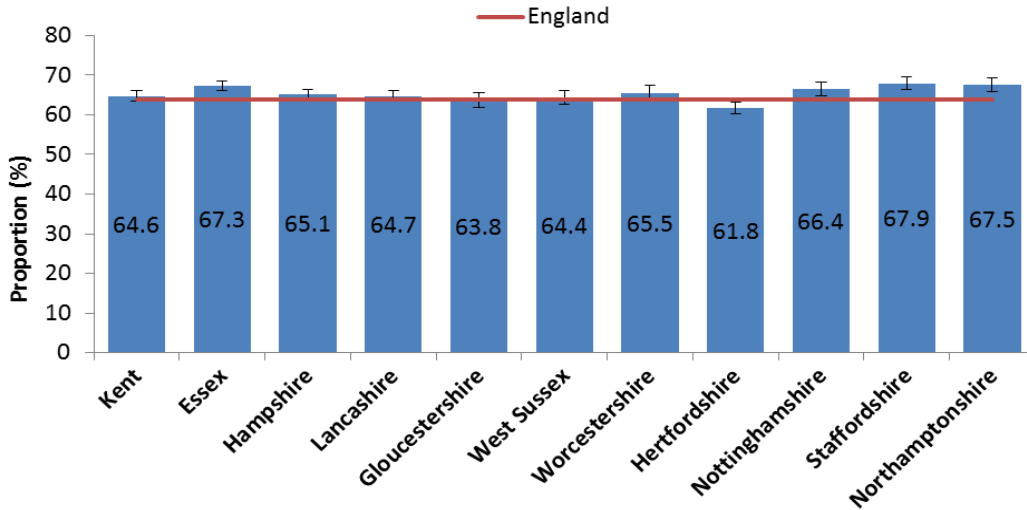
Note: overweight prevalence not available at LA level, and the England prevalence was applied to LA population

Canterbury is the only authority with prevalence of excess weight better than the England average (54.2%). Both Thanet (68.4%) and Swale (68.8%) are worse than the England average. All the nine other authorities have rates similar to England.

3.4 When Kent rates of excess weight are compared to its CIPFA (Chartered Institute of Public Finance and Accountancy) statistical neighbours Kent is in the middle of the

range.

Figure 4: Proportion (%) of estimated excess weight in adults, CIPFA Statistical Neighbours 2012



3.5 The prevalence of overweight and obesity in children

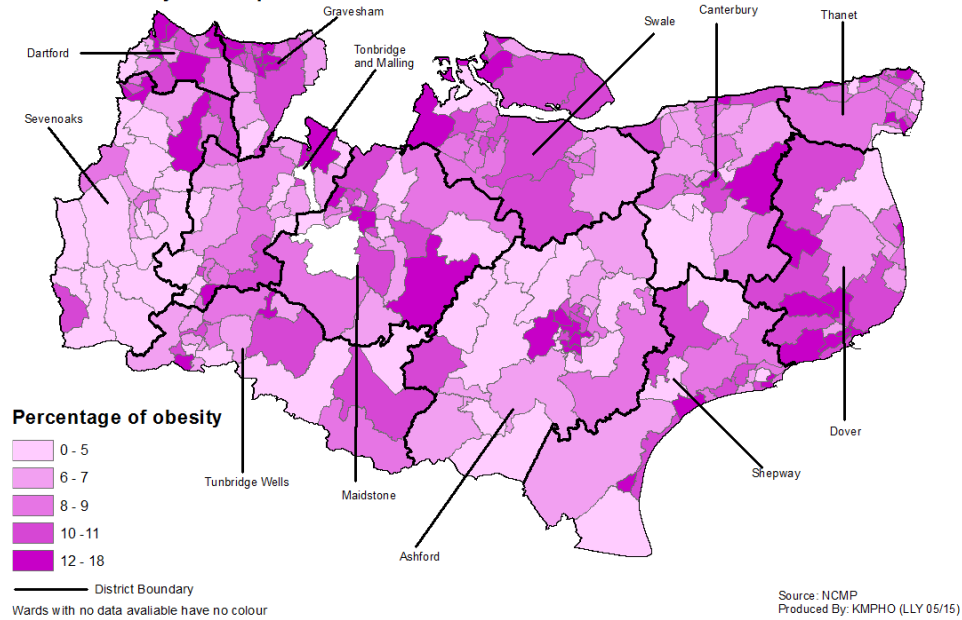
The National Children Measurement Programme records the weight and height of reception year and year 6 pupils for the whole of Kent. This data is then used to calculate a score for childhood weight and determines the weight category for each child. This is the most reliable source of information we have. Year 6 has a lower percentage of children with a healthy weight compared to reception year. During 2013-14 children with a healthy weight increased for both cohorts however reception year remains higher at 78.5% compared to 66.2% for year 6. The percentage of children who are overweight has remained stable from 2011 to 2014. In 2013-14 both reception and year 6 figures decreased to 12.5% for reception year and 14.1% for year 6.

3.6 Obesity rates for year 6 pupils are more than double reception year rates. Rates have remained stable, but show a slight increase in 2013-14 for year 6 pupils to 18.5% but a decrease of 0.8% for reception year from 2012-13 to 2013-14.

3.7 Obesity in reception year is higher in most major town(s) of each district. Sevenoaks and Ashford districts show a larger number of wards that have a low level of obesity (between 0-5%). A higher level of obesity is found in Swale, Dartford, Gravesham and Dover. This reflects national findings that rates are higher in urban areas.

Figure 5: Level of obesity in reception year across Kent for 2011/12 to 2013/14

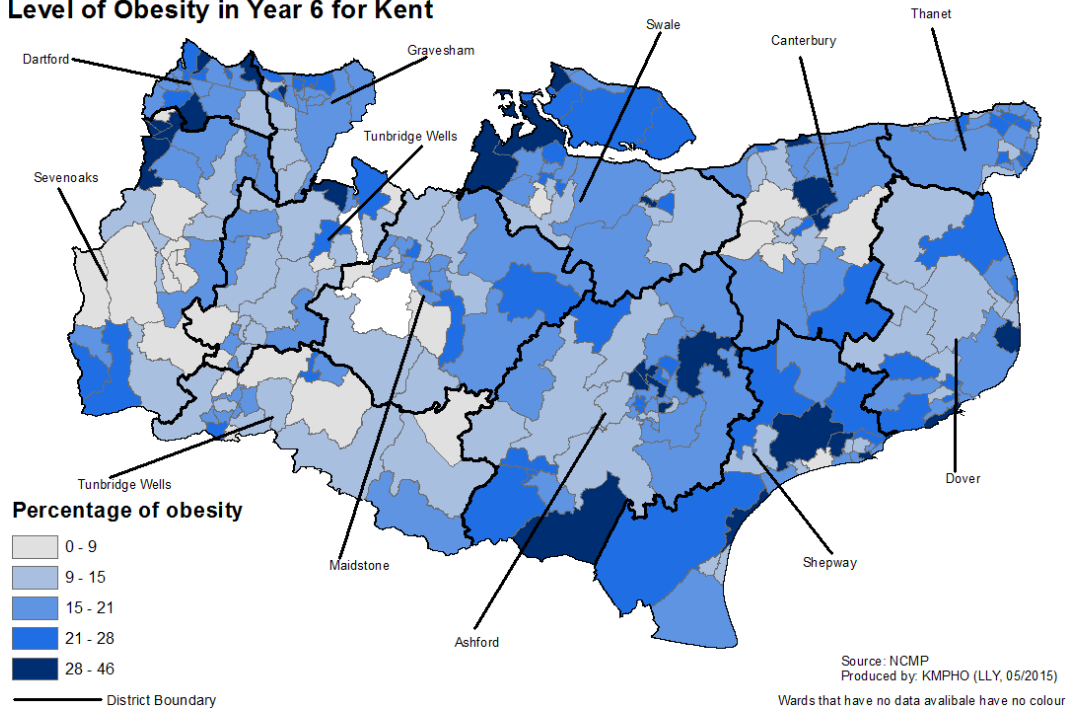
**National Child Measurement Programme, 2011/12 - 2013/14
Level of Obesity in Reception Year for Kent**



- 3.8 Obesity has increased from reception year to year 6 from 2011/12 to 2013/14 . Maidstone has a lower level of obesity for year 6 pupils compared to other districts from 2011/12 to 2013/14. Swale, Swanley, Shepway and Ashford all show the highest level of obesity for year 6 pupils (28-46%) across a number of wards for 2011/12 to 2013/14.

Figure 6: Level of obesity in year 6 across Kent for 2011/12 to 2013/14

**National Child Measurement Programme, 2011/2012 - 2013/14
Level of Obesity in Year 6 for Kent**



3.9 Across Kent approximately 10,000 children who were weighed and measured in 2013/14 are classified as being overweight or obese. The rates per locality and the numbers of children are shown below:

Table 3: Percentage and approximate number of children classified as overweight and obese by district, 2013/14

District	Percentage				Number				Number of children measured	
	Overweight		Obese		Overweight		Obese		Reception	Year 6
	Reception	Year six	Reception	Year six	Reception	Year six	Reception	Year six		
Ashford	12.5%	13.8%	8.7%	21.1%	190	188	132	287	1517	1362
Canterbury	12.4%	14.9%	7.9%	17.6%	169	199	108	235	1359	1335
Dartford	12.8%	14.4%	9.1%	22.4%	165	162	118	252	1290	1125
Dover	12.0%	14.0%	9.0%	18.1%	140	139	105	179	1167	990
Gravesham	15.0%	16.1%	9.8%	19.9%	184	176	120	217	1226	1091
Maidstone	10.6%	14.2%	6.0%	17.2%	177	220	99	266	1662	1546
Sevenoaks	11.2%	11.3%	6.9%	16.1%	133	119	82	169	1185	1050
Shepway	13.5%	13.5%	8.9%	20.5%	153	132	101	201	1135	980
Swale	13.5%	14.1%	10.4%	21.0%	227	209	175	312	1687	1483
Thanet	12.4%	15.3%	9.6%	19.2%	194	201	151	252	1570	1313
Tonbridge and Malling	12.5%	14.4%	6.2%	14.8%	178	179	88	185	1420	1247
Tunbridge Wells	13.0%	13.5%	5.7%	13.8%	153	135	67	138	1177	1002
Medway	13.1%	15.4%	9.0%	17.2%	408	425	280	476	3113	2765

Source: NCMP

Note - % of children and number of children measured were provided by PHE, number of overweight and obese were estimated from these

3.10 Mortality & morbidity

It has been predicted that in 20 years' time obesity unchecked will result in an

additional 544,000-668,000 cases of diabetes, 331,000-461,000 cases of coronary heart disease and between 87,000-130,000 additional cases of cancer ⁽²⁾. Women in general have a higher risk of developing co-morbidities.

Table 4: Relative risk* of disease relative to the non-obese population

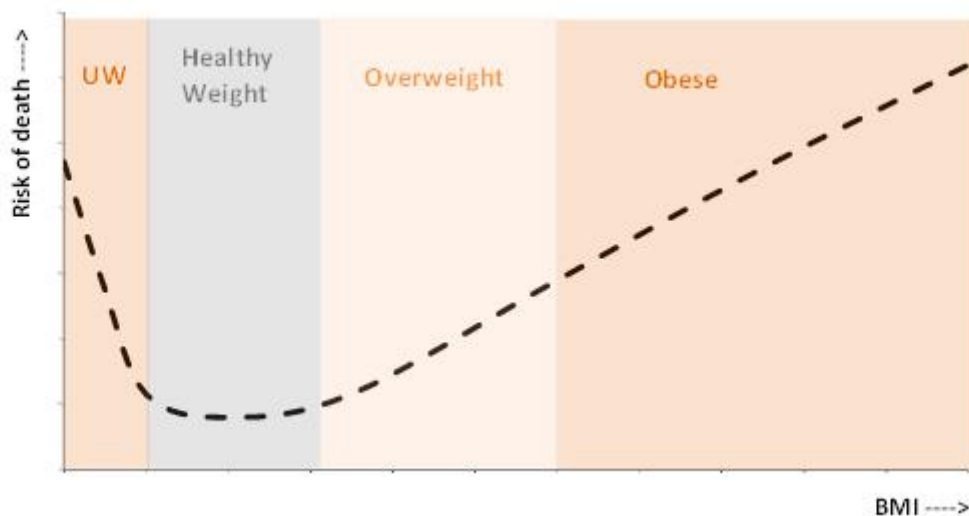
	men	women
Type 2 diabetes	5.2	12.7
Hypertension	2.6	4.2
Myocardial infarction	1.5	3.2
Cancer of the colon	3.0	2.7
Angina	1.8	1.8
Gall bladder diseases	1.8	1.8
Ovarian cancer	-	1.8
Osteo-arthritis	1.9	1.4
Stroke	1.3	1.3

National Audit Office 2001

*Relative risk is a measure of the **risk** of a certain event happening in one group compared to the **risk** of the same event happening in another group.

- 3.11 Women who are obese are estimated to be around 13 times more likely to develop type 2 diabetes and four times more likely to develop hypertension than women who are not obese. Men who are obese are estimated to be around five times more likely to develop type 2 diabetes and 2.5 times more likely to develop hypertension than men who are not obese ⁽³⁾. People who are obese may also experience mental health problems as a result of stigma and bullying or discrimination in the workplace ⁽⁴⁾.
- 3.12 A number of large scale prospective studies have demonstrated an association between BMI and risk of death (below), with higher risks of death observed in the lower and upper BMI categories than in the middle categories ^(5,6). However, the precise increase in mortality reported for a given level of obesity varies.

Figure 5: Schematic illustration of the association between mortality and BMI for adults BMI



Obesity was only mentioned on 0.23% of all death certificates issued in England during 2006, although this proportion has been increasing over time ⁽⁷⁾. In 2001, the National

Audit Office (NAO) ⁽³⁾ estimated that approximately 6% of all deaths in England in 1998 were caused by obesity – a total of 30,000 excess deaths in that year. Many of these deaths were premature, it is estimated that life was reduced by nine years. The Foresight Report estimates that obese individuals are expected to die approximately 11 years earlier than non-obese individuals ⁽¹⁾.

3.13 **Mortality and morbidity-maternal, children and young people**

Obesity increases the risk of a woman having a late miscarriage, a stillbirth or neonatal death ⁽⁸⁾. It also increases the health risks to the mother during the antenatal, intrapartum, and postnatal periods. These include death, pre-eclampsia, infection, cardiac disease, haemorrhage and miscarriage ⁽⁹⁾.

Obese children and adolescents are at an increased risk of developing a chronic disease such as type-2 diabetes, cardiovascular disease, certain cancers, lung disease and kidney failure which will follow into adulthood. Type 2 diabetes is usually found in adults, but increasingly more children are being diagnosed. A surveillance programme of children under 17 in the UK found that 95% of those diagnosed with type 2 diabetes were overweight and 83% obese. Type 2 diabetes was found to be increasing, with children from minority ethnic groups at higher risk than white children ⁽¹⁰⁾. Overweight and obese children are 40-50% more likely to suffer from asthma than normal weight children. Sleep apnoea is common in obese children and adolescents and could be as high as 60% ⁽¹¹⁾. The World Health Organization (WHO) regards childhood obesity as one of the most serious global public health challenges for the 21st century.

3.14 In the Bogalusa Heart Study in the US ⁽¹²⁾, 70% of obese five-17 year olds were found to have at least one risk factor for cardiovascular disease (CVD) for example high cholesterol levels, high blood pressure and abnormal glucose tolerance. Recent analysis of the National Longitudinal Study of Adolescent Health found that diabetes risk was particularly high in adults who were obese as adolescents compared to those with adult-onset obesity.

3.15 Recent findings from the Millennium Cohort Study ⁽¹³⁾, suggest that childhood obesity may be associated with emotional and behavioural problems from a very young age, with obese boys at particular risk.

3.16 **Economic burden**

The Foresight Report (2007) estimated that by 2050 the cost of treating its co-morbidities in the UK will reach £49.9billion. More recent projections predict that health costs associated with obesity are projected to rise nationally by £2bn between 2010 and 2030 ⁽¹⁴⁾. The impact of this on the Kent health economy is estimated to be over £55m. (This is using the number of Kent residents as a proportion of the whole of England 2013 population, KMPHO)

Table 5: Estimated additional costs to England and Kent associated with obesity

	2013	Projected cost increase 2013
ENGLAND	53,865,817	£2,000,000,000
KENT	1,493,512	

Kent % of whole England	2.77%		£55,453,053
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This is contributed to by 44% of the incidence of diabetes, 23% of heart disease and between 7%-41% of certain cancers. This will also have an increased impact on social care costs. An estimated 16 million days of sickness absence a year are attributable to obesity, in addition obese people are less likely to be in employment than people of a healthy weight and the associated welfare costs are estimated to be between £1 billion and £6 billion. The NHS and local authority are major employers so this will impact on their available workforce.

3.17

Summary

- **Approximately 10,000 children and 771,476 adults in Kent are overweight or obese.**
- **There is some evidence that both child and adult prevalence rates are levelling off.**
- **Kent rates do not compare well to other areas in the South East although they are not dissimilar to England and statistical neighbours.**
- **Adults who are obese are at far higher risk than the general population of serious illness including diabetes, heart disease and stroke.**
- **Obese children and adolescents are at an increased risk of developing chronic disease such as asthma, type-2 diabetes, cardiovascular disease, certain cancers, lung disease and kidney failure.**
- **Approximately nine years of life is prematurely lost to obesity related conditions.**
- **It is estimated that by 2050 the cost of treating the co-morbidities of obesity in the UK will reach £49.9billion.**

4. Risk Factors

- 4.1 Although there are people in all population groups who are overweight or obese, obesity is related to social disadvantage ⁽¹⁵⁾.
- 4.2 In women, obesity prevalence increases with greater levels of deprivation, regardless of the measure used. For men, only occupation-based and qualification-based measures show differences in obesity rates by levels of deprivation ⁽¹⁶⁾.
- 4.3 For both men and women, obesity prevalence decreases with increasing levels of educational attainment. Around 30% of men and 33% of women with no qualifications are obese compared to 21% of men and 17% of women with a degree or equivalent ⁽¹⁷⁾.
- 4.4 Data on obesity and disability is not robust. However, analysis shows that children who have a limiting illness are more likely to be obese or overweight, particularly if they also have a learning disability ⁽¹⁸⁾. Those children who have a limiting illness and a learning disability are one and a half times as likely to be obese as children with neither, whilst a child who also has a learning disability is twice as likely to be obese ⁽¹⁹⁾.
- 4.5 People from the following ethnic groups are at an equivalent risk of diabetes, other health conditions or mortality at a lower BMI than the white European population as follows: ⁽²⁰⁾
- South Asian people who are immigrants and descendants from Bangladesh, Bhutan, India, Indian-Caribbean (immigrants of South Asian family origin), Maldives, Nepal, Pakistan and Sri Lanka
 - African-Caribbean/Black Caribbean people who are immigrants and descendants from the Caribbean islands (people of black Caribbean family origin may also be described as African-American)
 - Black African people who are immigrants and descendants from African nations. In some cases, they may also be described as sub-Saharan African or African-American
 - 'Other minority ethnic groups' include people of Chinese, Middle-Eastern and mixed family origin, as follows:
 - Chinese people who are immigrants and descendants from China, Taiwan, Singapore and Hong Kong
 - Middle-Eastern people who are immigrants and descendants from Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syria, the United Arab Emirates and Yemen
 - People of mixed family origin have parents of two or more different ethnic groups.
- 4.6 Reasonable adjustments should be made for these specific groups, for example people with mental health conditions and disabilities, including learning disabilities. For some, more tailored interventions will be needed. People from Black and Asian origin are more at risk of ill health because of obesity than the general population and should be recruited into interventions at a lower BMI than the general population.
- 4.7 It is well recognised that children who are obese are likely to have obese parents ^(21, 22).

Life course research suggests that adult health and inequalities can be influenced by the intra-uterine environment ⁽²³⁾. A systematic review of the childhood predictors of adult obesity showed that maternal obesity and weight gain during pregnancy are related to higher BMI in childhood and subsequent obesity in adulthood ⁽²¹⁾.

4.8 An obese child at any age increases the risk of obesity in adulthood anywhere between 15-99% ⁽²⁴⁾. The older a child is at onset, the more likely adult obesity becomes. According to one study, the age at which a child become obese has a direct influence on later obesity risk, with five - seven years being a critical age to increase the risks of adult obesity ⁽²⁵⁾. Prevention at an early age could reduce the number of obese adults.

4.9

Summary

- **People from black and Asian ethnic origins have a greater pre-disposition to obesity than the general population that services need to acknowledge.**
- **Adults and children with disabilities are more likely to be obese.**
- **Obesity is associated with lower educational attainment.**
- **Obese parents are likely to have obese children.**
- **An obese child is likely to become an obese adult.**

5. National Policy and Drivers

- 5.1 Tackling obesity continues to be a national government priority; the most recent policy document has been *Healthy Lives, Healthy People: A Call to Action on Obesity* ⁽²⁶⁾, which was published in 2011. A Call to Action gave a new direction to tackling obesity; recommending empowering people and communities to take action and building local capability. It gave direction for both local and national working together, national leadership and clarified the role of the government in helping people to make healthy food and drink choices and to become more physically active.

The policy sets out two national ambitions for obesity:

- A sustained downward trend in the level of excess weight in children by 2020
- A downward trend in the level of excess weight averaged across all adults by 2020.

- 5.2 National policy on diet and obesity has been summarised by the Department of Health, this includes guidelines on physical activity ⁽²⁷⁾.

- 5.3 The key national drivers are within the Public Health Outcomes Framework. The Public Health Outcomes Framework sets out the broad range of measures, relating to improving and protecting health across the life course and to reduce inequalities. The key outcomes relevant to impact on obesity are:

- breastfeeding initiation
- breastfeeding prevalence at six - eight weeks
- excess weight in four - five and 10-11 year olds
- excess weight in adults
- percentage of physically active and inactive adults - active adults
- percentage of active and inactive adults - inactive adults

- 5.4 NICE guidelines ⁽²⁸⁾ state "It is unlikely that the problem of obesity can be addressed through primary care management alone. More than half the adult population are overweight or obese and a large proportion will need help with weight management. Although there is no simple solution, the most effective strategies for prevention and management share similar approaches. The clinical management of obesity cannot be viewed in isolation from the environment in which people live."

- 5.5 NICE recommends that local authorities should work with local partners, such as industry and voluntary organisations, to create and manage more safe spaces for incidental and planned physical activity, addressing as a priority any concerns about safety, crime and inclusion. They should provide facilities and schemes such as cycling and walking routes, cycle parking, area maps and safe play areas making streets cleaner and safer, through measures such as traffic calming, congestion charging, pedestrian crossings, cycle routes, lighting and walking schemes; ensuring buildings and spaces are designed to encourage people to be more physically active.

- 5.6 NHS England Five Year Forward Plan for the NHS puts prevention high on the agenda. It requires providers and commissioners to work together to dissolve the artificial barriers between prevention and treatment, physical health and mental health, and calls for integrated working across primary, community, social care and acute care

(29)

- 5.7 The Royal College of Physicians ⁽³⁰⁾ reviewed the cost effectiveness of a range of interventions and concluded that prevention of overweight and obesity can be cost effective, but interventions that modified a target population's environment, i.e. fiscal and regulatory measures, reported the most favourable cost effectiveness ^(31,32).
- 5.8 The District Council Network have proposed a District Offer to embed health interventions more strongly into the work of councils ⁽³³⁾ and the Local Government Association ⁽³⁴⁾ have allied themselves to Clinical Commissioning Groups calling for health in every policy approach. The implications for work on obesity include more collaborative work on:
- Travel and transport (e.g. active travel plans)
 - Food procurement (e.g. school meals and catering in residential settings)
 - Planning and licensing (e.g. influencing design of new builds to include green spaces, planning permission for food outlets)
 - Trading Standards (e.g. regulation of food establishments and opportunities for awards for healthier options)
 - Environmental health (e.g. public food safety, air quality)
 - Opportunities for physical activity (e.g. leisure centres, local authority health programmes, adult education)
 - Sustainability (e.g. reducing vehicle emissions, recycling)
 - Food security (e.g. supporting Kent producers, food banks, cookery classes)
 - Education (e.g. integrating the Child Measurement Programme more strategically).
- 5.9 The Royal College of Physicians ⁽³⁰⁾ has championed need for increased knowledge and skills of physicians across the whole care pathway and produced a range of training resources. Recent national consultation ⁽³⁵⁾ on commissioning arrangements for Tier 4 obesity treatment services is an opportunity to engage with local CCGs about how obesity services can be better integrated into a more robust pathway between prevention and treatment.
- 5.10

Summary

- **There is an overarching national 'Call to Action' on obesity with published ambitions for population weight loss.**
- **There is evidence that nationally local government organisations are collaborating with clinical groups to improve population health at a local level.**
- **The Royal College of Physicians is championing the development of the role of clinicians for prevention and treatment of obesity.**
- **Changes in national commissioning arrangements for severe and complex obesity are a catalyst for local co-design of the obesity pathway.**

6. Treatment: Evidence Base

- 6.1 The Royal College of Physicians (RCP) has raised concerns about the increasing number of people with extreme levels of obesity⁽³⁰⁾. They state that this level of obesity is more likely to be associated with multiple medical, psychological, and social problems and markedly reduced life expectancy. They highlight the impact of psychological problems, depression and poor quality of life; these problems also impact on the efficacy of any interventions. This has certainly been the experience of specialist obesity providers in Kent.
- 6.2 The RCP describes the role of an MDT (multidisciplinary team) as including helping the patient in making cognitive and behavioural changes, providing dietary evaluation, interpretation and advice on change, physical activity assessment and advice, possibly prescription, and signposting, psychological treatment and bariatric surgery.
- 6.3 NICE⁽³⁶⁾ has concluded that the strongest evidence base for any interventions is for bariatric surgery because the effect is immediate. However, the RCP review raises concerns about the degree to which guidelines are followed and stresses the need for lifelong follow up to ensure success with weight loss after bariatric surgery, weight loss maintenance, improvement in comorbidities, and reduction and management of potential complications of surgery. The British Obesity and Metabolic Surgery Society recommend that after the hospital two year follow-up period that the patient is referred back to the Tier 3 specialist service⁽³⁷⁾, this is not commissioned in Kent.
- 6.4 **The importance of prevention**
Clearly there is a need for services to support, manage and treat the increasing number of patients with severe and complex obesity but it is important that such conditions are as far as possible prevented. A population approach to increasing physical activity, ensuring that people can access a healthy diet and also addressing some of the underlying causes, through motivational interviewing or talking therapies is needed. Interventions should be provided for families as well as individuals⁽³⁸⁾.
- 6.5 Everyone should take part in universally available activities that reduce energy consumption and increase energy expenditure. The 2011 report from the Chief Medical Officers for England, Wales, Scotland and Northern Ireland sets out physical activity recommendations for different groups⁽³⁹⁾. For adults: 'over a week, activity should add up to at least 150 minutes (2 ½ hours) of moderate-intensity activity, in bouts of 10 minutes or more'. One way to approach this is to do 30 minutes on at least five days a week. Children and young people should take part in moderate- to vigorous-intensity physical activity for at least 60 minutes. Children under five should be active for three hours every day.
- 6.6 Everyone should follow a dietary pattern that is mainly based on vegetables, fruits, beans and pulses, whole grains and fish. NICE⁽⁴⁰⁾ recommends that this is done by reducing how often energy dense foods and drinks (such as fried foods, biscuits, savoury snacks, confectionery and drinks made with full fat milk or cream) are eaten substituting energy dense items with foods and drinks with a lower energy density (such as fruit and vegetables or water instead of fizzy drinks and juice), using food and drink labels to choose options lower in fat and sugar and choosing smaller portions or avoiding additional servings of energy dense foods. The Eatwell Plate⁽⁴¹⁾ is still recommended as the best balance for a healthy diet, although this is under review.

The impact on weight of alcohol should also be addressed.

- 6.7 The Scientific Advisory Committee on Nutrition (SACN) is the source for advice to national bodies and government departments and has recently published a report with revised recommendations for the consumption of carbohydrates⁽⁴²⁾. SACN recommends that:
- The average population intake of free sugars should account for no more than 5% of daily dietary energy intake, half of the current recommendation of 10%.
 - The current recommendation that carbohydrates, should form approximately 50% of daily calorie intake is maintained.
 - Those aged 16 and over increase their intake of fibre to 30g a day, 25g for 11- to 15 -year-olds, 20g for 5- to 11-year-olds and 15g for 2- to 5-year olds.
 - Sugar sweetened beverages should be minimized for children and adults.
- 6.8 Interventions should be tailored to the user(s) and provide on-going support, including where possible a motivational interviewing approach. The physical activity component of interventions should focus on activities that fit easily into people's everyday lives and should aim to improve people's belief in their ability to change.
- 6.9 The dietary approach to weight loss is that total energy intake should be less than energy expenditure. Diets that have a 600 kcal/day deficit or a low-fat diet are recommended⁽⁴³⁾. Low-calorie diets (1000–1600 kcal/day) may also be considered, but are less likely to be nutritionally complete. Low glycaemic index or load diets can be effective. Both behaviour therapy and cognitive behaviour therapy have been found to be effective.
- 6.10 **Weight Management Programmes**
Commercial and community-based weight management programmes should only be commissioned if they follow best practice issued by NICE⁽⁴⁴⁾. All programmes should have on-going monitoring of patients and provision of support and care. To do this Kent providers should work closely with Clinical Commissioning Groups and medical practices.
- 6.11 Weight loss targets should be based on the individual's comorbidities and risks, rather than their weight alone. Previous guidance has stated that in patients with BMI 25-35 kg/m² a 5-10% weight loss (approximately 5-10 kgs) is required for cardiovascular disease and metabolic risk reduction. In patients with BMI >35 kg/m² obesity-related comorbidities are likely to be present therefore weight loss interventions should be targeted to improving these comorbidities; in many individuals a greater than 15-20% weight loss (will always be over 10 kg) will be required to obtain a sustained improvement in comorbidity health⁽⁴⁵⁾.
- 6.12 Recent NICE guidance⁽⁴³⁾ stresses that even a small amount of weight loss may be beneficial if it is maintained over a lifetime. Support for people to maintain weight loss needs to be considered as part of the pathway. Using existing community assets needs to be considered but within a longer term supportive framework.
- 6.13 **Special groups**
NICE guidance⁽⁴⁶⁾ tells us that well designed and evidence-based interventions are likely to be applicable to most population groups. However, some population groups may require specific tailored interventions, examples include: during and after

pregnancy; menopause; while stopping smoking; 'pre-diabetes'; black and minority ethnic groups⁽⁵²⁾; low income groups; disabled people.

- 6.14 Women who are planning to become pregnant should be advised of the benefits of losing weight prior to pregnancy⁽⁴⁷⁾. They should not be advised to lose weight during pregnancy. Women who have a BMI >30 should be informed about the increased risks to herself and her baby and advised that losing weight after pregnancy will have no adverse effects. Pregnant women should be given advice about healthy eating and undertaking moderate intensity physical activity of 30 minutes duration. NICE guidance recommends that all women with a BMI >30 are referred to a dietician.
- 6.15 **Integrated approaches**
NICE guideline (CG43) states "It is unlikely that the problem of obesity can be addressed through primary care management alone. More than half the adult population are overweight or obese and a large proportion will need help with weight management. Although there is no simple solution, the most effective strategies for prevention and management share similar approaches. The clinical management of obesity cannot be viewed in isolation from the environment in which people live"⁽⁴⁸⁾.
- 6.16 It recommends that local authorities should work with local partners, such as industry and voluntary organisations, to create and manage more safe spaces for incidental and planned physical activity, addressing as a priority any concerns about safety, crime and inclusion. They should provide facilities and schemes such as cycling and walking routes, cycle parking, area maps and safe play areas, making streets cleaner and safer, through measures such as traffic calming, congestion charging, pedestrian crossings, cycle routes, lighting and walking schemes; ensuring buildings and spaces are designed to encourage people to be more physically active.
- 6.17 Nurseries and other childcare facilities should: minimise sedentary activities during play time, and provide regular opportunities for enjoyable active play and structured physical activity sessions.
- 6.18 Head teachers and chairs of governors, in collaboration with parents and pupils, should assess the whole school environment and ensure that the ethos of all school policies help children and young people to maintain a healthy weight, eat a healthy diet and be physically active. This includes policies relating to building layout and recreational spaces, catering (including vending machines) and the food and drink children bring into school, the taught curriculum (including PE), guidance on food procurement and healthy catering. Consideration should also be given to reducing the time children spend sitting in lessons, (some encouraging work is currently being done in Norway).
- 6.19 Workplaces should provide opportunities for staff to eat a healthy diet and be physically active. This includes active and continuous promotion of healthy choices in restaurants, hospitality, vending machines and shops for staff and clients. This should be in line with existing guidance on working practices and policies - such as active travel policies for staff and visitors, a supportive physical environment such as improvements to stairwells, and providing showers and secure cycle parking. Recreational opportunities such as supporting out-of-hours social activities, lunchtime walks and use of local leisure facilities should be provided.
- 6.20 Policy makers, commissioners, managers, practitioners and other professionals working in local authorities, the NHS and the wider public, private, voluntary and

community sectors should be supporting local communities on developing preventive approaches to tackle obesity ⁽⁴⁹⁾.

6.21

Summary

- Clinicians are seeing more people with more complex needs for which specialist services which include an MDT are necessary.
- Interventions should have physical activity, nutrition and behaviour change components.
- Interventions for some specific groups will be needed, for example: during and after pregnancy; during menopause; while stopping smoking; 'pre-diabetes'; black and minority ethnic groups; low income groups; disabled people. Programmes that specifically target those with a learning disability will need Easy-read publicity as a matter of course. Services need to be equipped to seek out these population groups and to design interventions that specifically meet their needs and are delivered in venues that are likely to be attended by the target groups, for example faith centres.
- Community based weight management interventions should ideally achieve a 5-10% reduction in body weight but should achieve at least an average 3% reduction in weight, with an understanding that a lower level of weight loss maintained over a life time may be a more realistic goal.
- All settings have a role to promote preventive measures.
- Further research is needed on methodologies for sustaining weight loss achieved over a lifetime.

7. Dartford Gravesham and Swanley

7.1 Background

NHS Dartford Gravesham and Swanley Clinical Commissioning Group (CCG) serves a population of approximately 250,000. The CCG projects that by 2013 there will be a population increase of 11%, not including the 15,000 new homes expected in the new development at Ebbsfleet Garden City. There will be a 49% increase in the 85+ population and the CCG predicts that 60% of its hospital funding will be spent on treating older people with complex needs and multiple health conditions. It has therefore put prevention, tackling childhood obesity and tackling health inequalities at the heart of its Five Year Plan ⁽⁵⁰⁾.

7.2 The majority of patients will access acute hospital provision at Darent Valley Hospital provided by the Dartford and Gravesham NHS Trust. Community services are provided at the Livingstone Hospital in Dartford and the Gravesham Community Hospital in Gravesend. There are 34 GP practices in Dartford Gravesham and Swanley, including the White Horse Walk-in Centre in Northfleet. There are 52 pharmacies, 32 dental practices, 15 children's centres and 45 schools ⁽⁵¹⁾. These are all potential settings for interventions, but will require investment in training and education programmes to enable this to happen.

7.3 Adult obesity in Dartford Gravesham and Swanley CCG

Dartford Gravesham and Swanley has a higher than the England average prevalence of adult obesity (52)

Table 1: Adult obesity rates in Dartford Gravesham and Swanley

Adult obesity 2014	%
Dartford Gravesham and Swanley CCG	28.1
England	24.1
England worst	30.9

Public Health England CCG Neighbourhood Profiles

It also has lower than the national average numbers of people with a healthy diet

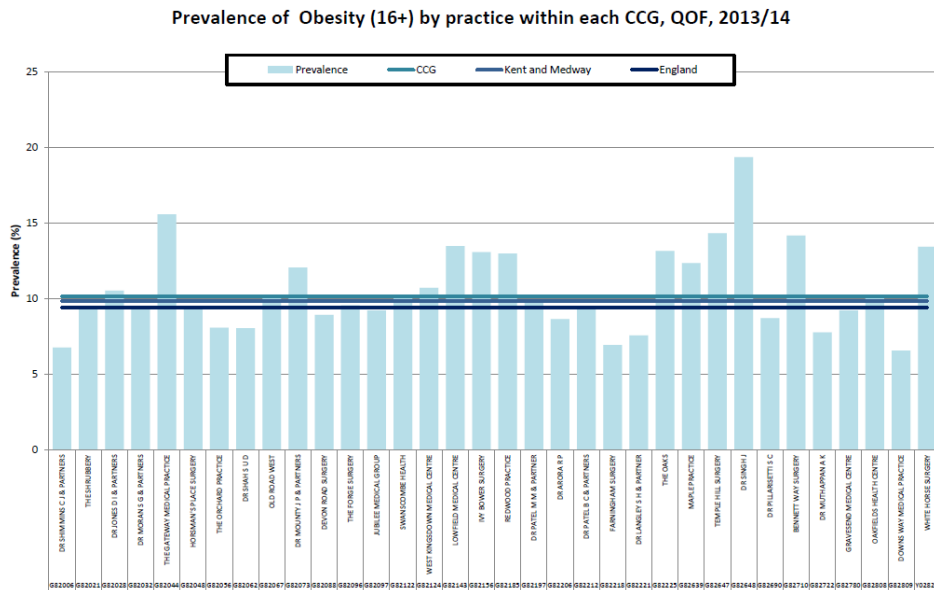
Table 2: Adult healthy eating rates in Dartford Gravesham and Swanley

Adult healthy eating 2014	%
Dartford Gravesham and Swanley CCG	25.7
England	28.7
England worst	19.4

Public Health England Neighbourhood Health Profiles

7.4 The recorded QoF data shows prevalence of obesity by practice. Obesity is not generally well recorded in primary care.

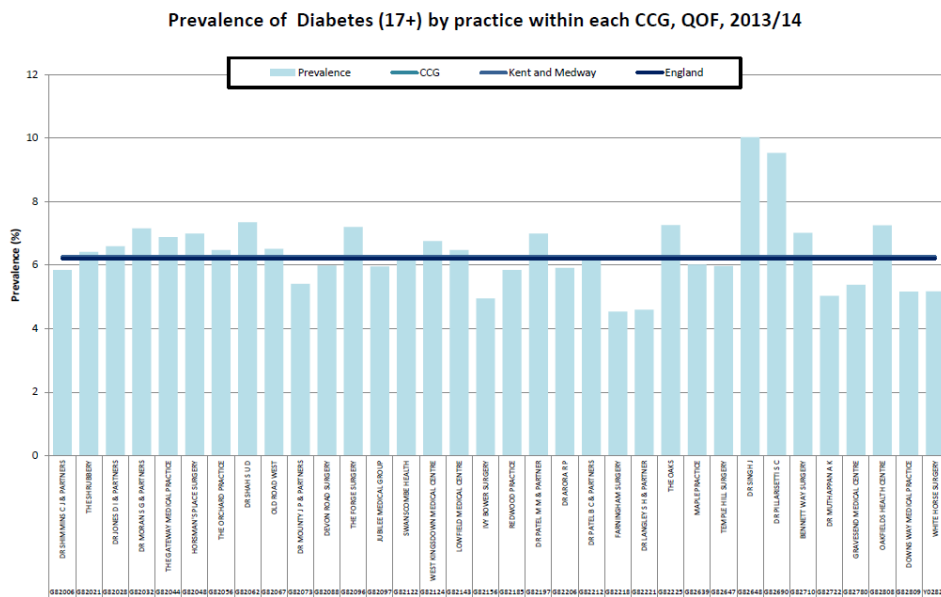
Figure 1: Prevalence of obesity in Dartford Gravesham and Swanley practices



Kent and Medway Public Health Observatory Health and Social Care Maps

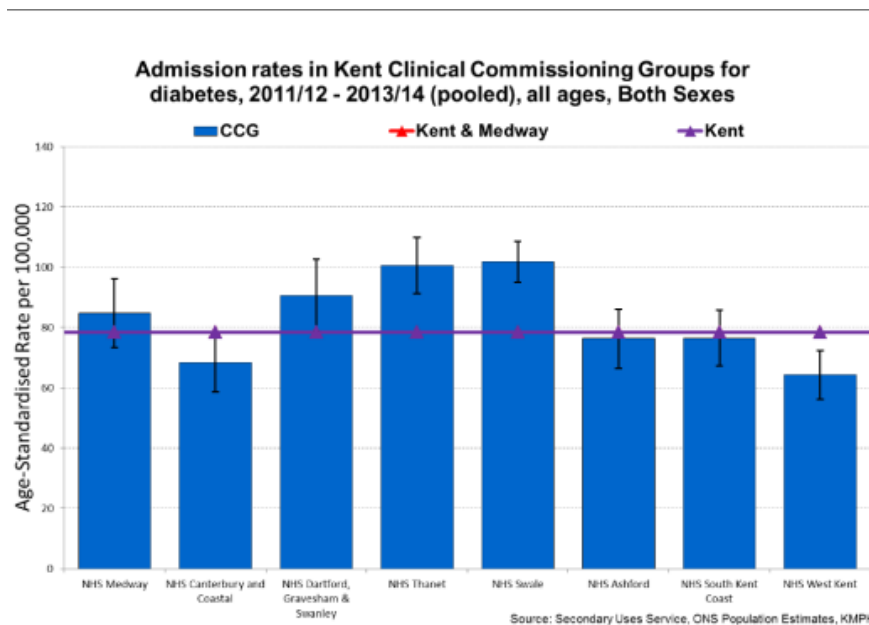
7.5 As already described, obesity contributes to a number of serious and preventable conditions including Type 2 diabetes, Obesity accounts for 44% of people with diabetes. The following chart shows the prevalence of diabetes by practice within Dartford Gravesham and Swanley CCG.

Figure 2: Prevalence of Diabetes in Dartford Gravesham and Swanley practices



7.6 Figure 3 shows the rates of diabetes admission by Clinical Commissioning Groups across Kent and Medway. Dartford Gravesham and Swanley CCG has the third highest rate across Kent and Medway.

Figure 3: Admission rates for diabetes in CCGs in Kent and Medway 2011/12-2013/14

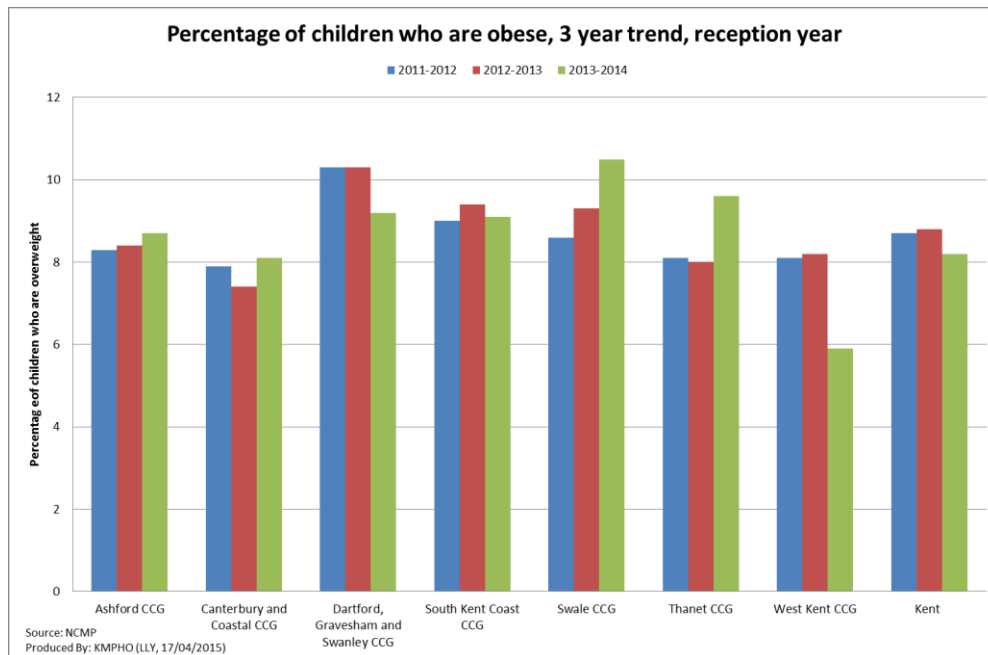


7.7 **Childhood obesity in Dartford Gravesham and Swanley**
The data that is available for childhood obesity is taken from the National Child Measurement Programme. In Kent the school nursing teams measure children at 4-5 years (reception) and at 10-11 years (year 6). In 2013/14 94.9% of eligible children

were measured.

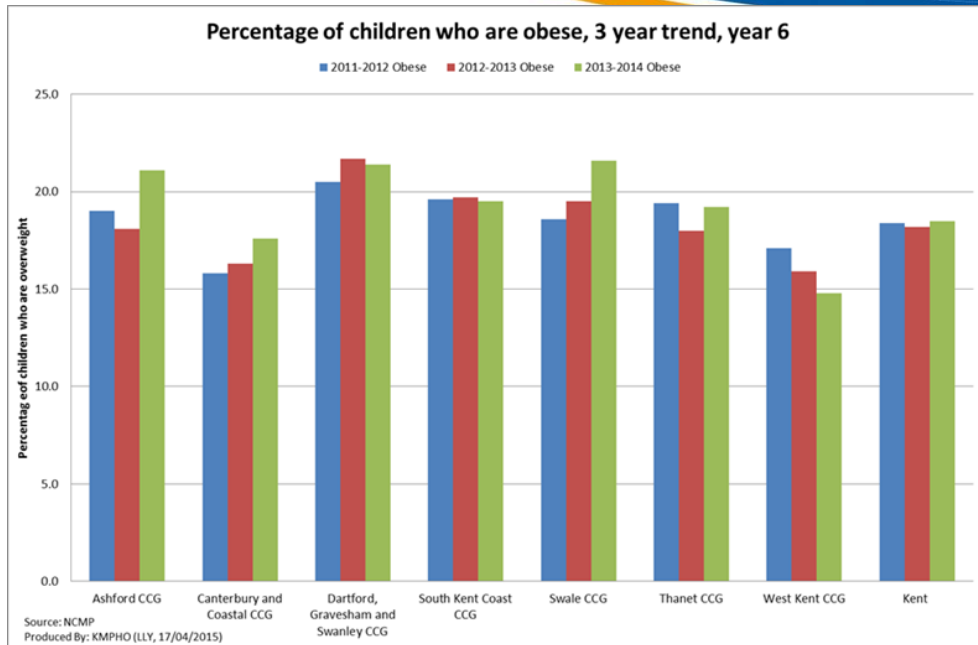
- 7.8 In 2012/13, within Kent the proportion of obese reception year children was highest in Dartford Gravesham and Swanley. This reduced in 2013/14 but is still higher than the Kent average.

Figure 4: Childhood obesity by CCG in reception year 2011/2012-2013/2014



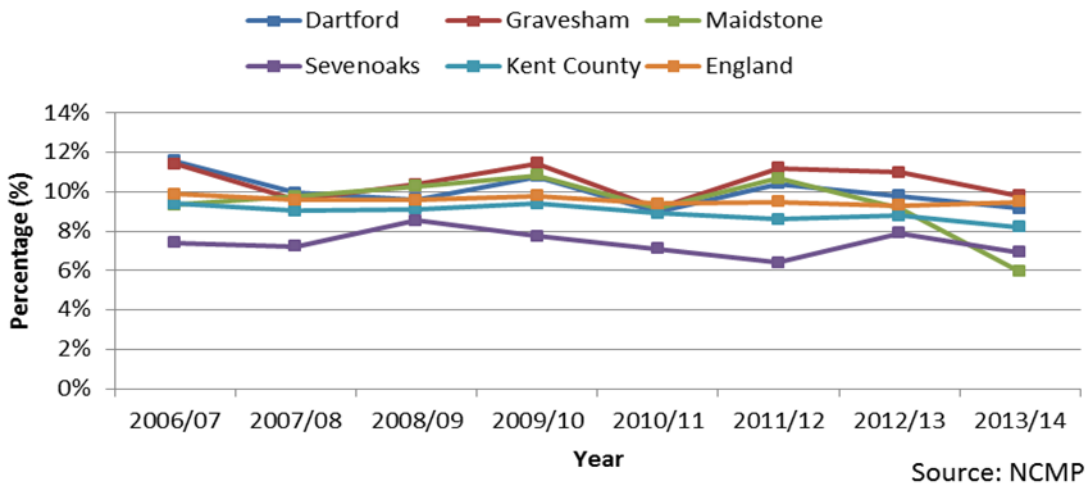
- 7.9 Across Kent trends are showing some signs of plateauing in year 6 from 2011-2014 whilst Dartford, Gravesham and Swanley CCG shows an increase from 2011-12 to 2012-13 and a small decrease to 2013/14, but overall an increase over the three years. Dartford Gravesham and Swanley and Swale have the highest rates in Kent.

Figure 5: Childhood obesity by CCG in reception year 2011/2012-2013/14



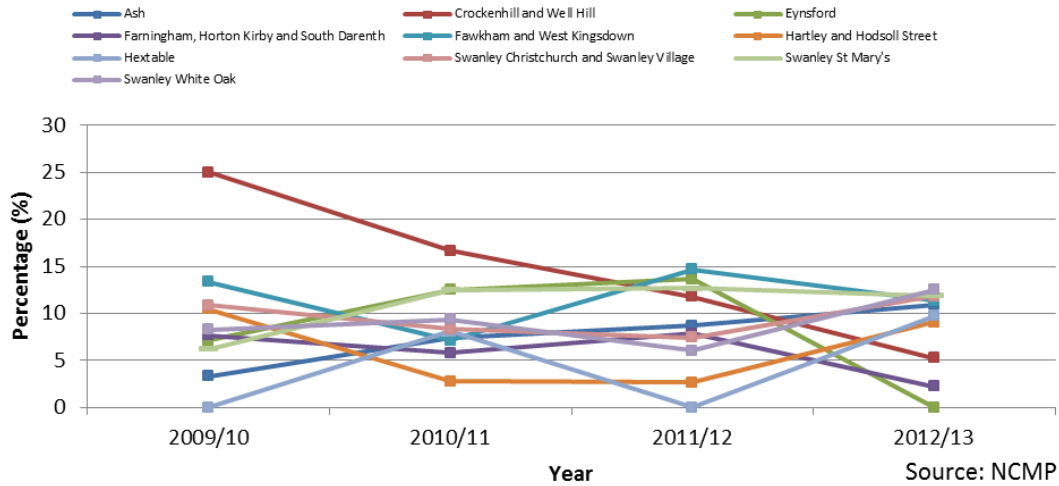
7.10 Figure 6 below shows the trends between the local authorities within Dartford, Gravesham and Swanley and Maidstone compared with Kent and England for reception year. Rates in all areas are showing signs of reducing but not to the extent of Maidstone.

Figure 6: Prevalence of obesity in reception year children, ages 4-5, persons, 2006/07 to 2012/13 by local authority



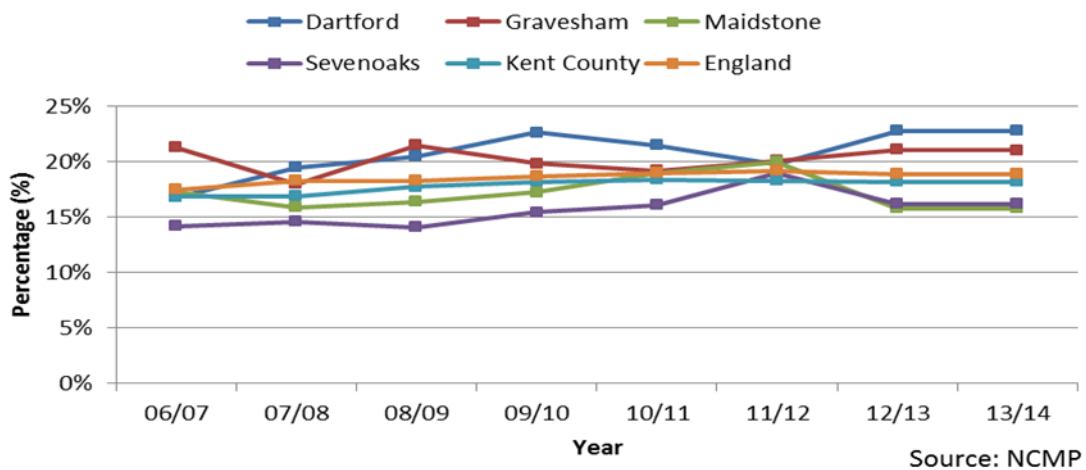
7.11 Reporting by districts often masks the differences between areas and these can be seen in the Health and Social Care maps in Appendix 1. Figure 12 below shows the differences in trends between the wards of Sevenoaks that are part of Sevenoaks district. Swanley in particular has a very different demography compared to the district as a whole and the differences are reflected in the obesity data. Crockenhill and Well Hill show rates that are reducing considerably year on year from 2009/10, generally the more rural area rates are reducing and the urban areas are increasing.

Figure 7: Prevalence of obesity in reception year children, ages 4-5, persons, 2009/10 to 2012/13, Swanley and Northern Parishes, Sevenoaks District.



7.12 Figure 8 below shows the trend in year 6 obesity rates in local authority areas which provide evidence of plateauing over the last year.

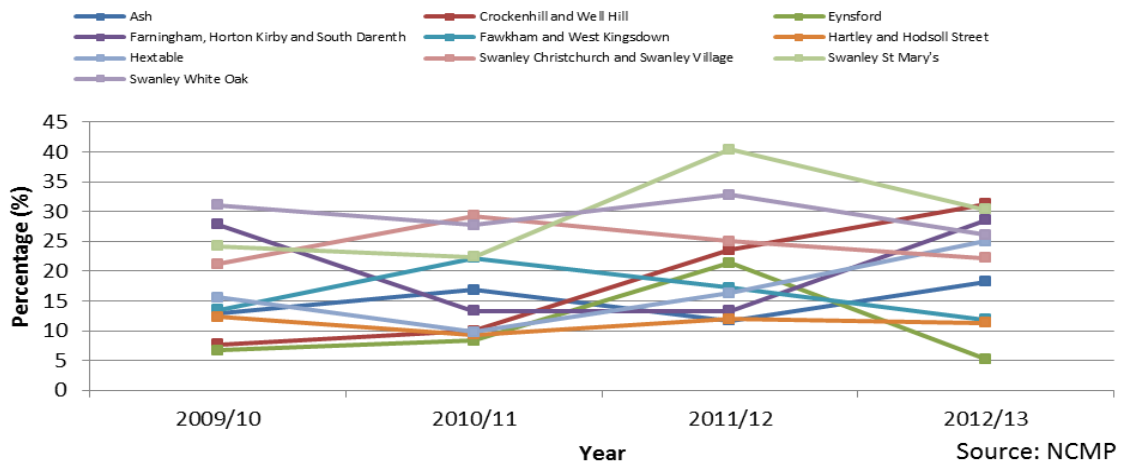
Figure 8: Prevalence of obesity in year six children, ages 10-11, persons, 2006/07 to 2013/14 by local authority.



7.13 Figure 9 below shows the trend for the Dartford Gravesham and Swanley wards at year 6. This shows a different pattern to reception year data with Crockenhill and Well Hill and other rural area rates increasing and the more urban areas decreasing 2012/13 to 2013/14.

Figure 9: Prevalence of obesity in year six children, ages 10-11, persons, 2009/10

to 2012/13, Swanley and Northern Parishes, Sevenoaks District.



7.14 **Services available to tackle obesity in Dartford Gravesham and Swanley for children and families**

Intervention during the early years of life is described in the Healthy Child programme. Health visitors promote infant led weaning as part of their universal offer and provide public health advice and interventions that encourage healthy eating and physical activity to parents and carers and their young families. Across Kent, the 'Born to Move' initiative is a Health Visitor led project to raise awareness of the importance of human interaction between parent /carer and infant or child to enable optimal development, physically and emotionally which may have some impact on childhood obesity. Children Centre staff have a responsibility for creating an environment that promotes healthy eating and physical activity and this is part of an agreement between Public Health and the Children's Centre which is subject to monitoring and audit.

7.15 At Tier 1 there are a number of initiatives commissioned by Public Health in Kent County Council that are delivered in Children's Centres. These include the Community Chef provided by Healthy Living Centres in Dartford and Gravesham.

7.16 The school nursing team operates an open referral process - they receive referrals from other professionals e.g. GPs, schools and health visitors, in addition to parents/carers and young people self-referring. Following referral they undertake a package of care i.e. four contacts with a child/young person, in addition they can refer to dieticians, paediatricians, Kent Community Health Foundation Trust and borough council community healthy living/exercise programmes which vary across Kent.

7.17 The School Nurse Team undertakes the National Child Measurement Programme in years 6 and reception and offer support to parents following receipt of the result letters. They work closely with the local Health and Wellbeing Teams supporting schools and parents both pre- and post- the measurements. Local National Child Measurement Programme Groups work in partnership to support the measurement programme to maximise the impact of nutrition, physical activity and self-esteem enhancing interventions and to promote joint working and on-ward referrals.

- 7.18 The Healthy Schools team in Kent Community Health Foundation Trust is currently working intensively with targeted schools across Kent. In addition all schools have access to schools premium funding to optimise physical activity and access to school sports interventions. For families who struggle with their weight there are fun oriented programmes aimed at families with children of junior school age in all district localities in Kent. This is an example of what is offered:
- Year 6 Healthy Lifestyle support lessons
 - Year R Healthy Lifestyle support lessons
 - Weighing and measuring (School nurses) Yr. 6 Yr. R
 - Assemblies for promoting targeted lifestyle programme
 - Parent engagement event
 - Follow up support offer from Don't Sit, Get Fit following NCMP result letter
 - Targeted lifestyles programme rolled out
 - Sports days event(s)
 - Healthy School Enhancement Model achievement.
- 7.19 As well as providing Don't Sit, Get Fit interventions in schools and the community supported by the nutritionist, Dartford Borough Council provides the Dynamo Club for families with children above the 91st centile. In 2013/14 12 children and their families were engaged in this programme.
- 7.20 The Gr@nd Healthy Living Centre in Gravesham provides the 12 week Family Healthy Weight programme which engaged 60 participants from 35 families in 2013/14. It also provides less intensive interventions through the Don't Sit, Get Fit programme. A nutritionist from Dartford and Gravesham NHS Trust works across Dartford and Gravesham to provide nutritionist support to these programmes.
- 7.21 Sevenoaks District Council runs a Fun Fit and Active programme which is delivered in five schools. In 2013/14 it ran three programmes for 23 families. In addition to the 12 week programme the team undertook whole school workshops within schools on healthy eating and physical activities which engaged 1,300 children.
- 7.22 Acute and community Paediatric Dietetic services are provided in the Dartford Gravesham and Swanley CCG area by the Nutrition and Dietetic Department within the Dartford and Gravesham NHS Trust. The acute service is provided at Darent Valley Hospital and the Community base is at Archery House, also in Dartford. Their draft weight management referral pathway for children describes interventions at 75th -91st centile, above the 91st centile and above the 98th centile.
- 7.23 At lower BMIs the service recommends a discussion about readiness to change and brief advice which may result in a referral to the Don't Sit Get Fit Family Weight Management Programme (DSGF) or to a hospital based clinic if necessary. Children with a BMI above the 91st centile should be assessed for any co-morbidities or underlying conditions and then either referred to a dietician at Darent Valley Hospital or to DSGF. If referred, the dieticians will undertake an initial home visit with all the family and provide access to their support programme. Above the 98th centile a referral should be made to a registered dietician for weight management advice and also referred to Don't Sit Get Fit. Communication between the DSGF team and the dietetic team is good as they provide the nutritionist for the DSGF weight management programme.

7.24 **Services available to tackle obesity in Dartford Gravesham and Swanley for adults**

There are a range of services and opportunities for adults for physical activity, including commercial and local authority sport and leisure services, outdoor and natural environment organisations and workplace initiatives. Kent Sport provides an extensive number of cycling and walking programmes as well as supporting sports clubs. They also manage coaching and volunteering programmes. Kent County Council Public Health commissions and delivers Sky Ride in partnership with KCC Highways and Transportation and Kent Sport. Other Kent County Council departments offering opportunities for physical activity include Country Parks and Explore Kent. There is a Cyclo Park in Gravesham, close to the A2 and Kent County Council is currently evaluating outdoor gyms.

7.25 Healthy Living Centres in Dartford, Gravesham and a virtual centre in Sevenoaks provide:

- opportunities for drop-in sessions on healthy eating, bring and share and recipe swaps, fruit and veg bags, home growing of produce and where kitchen space is adequate, cooking skills sessions for young parents/cook and eat sessions;
- opportunities for indoor and outdoor physical activity through support and signposting to group activities such as swimming, health walks, line dancing/other types of dancing and various sporting activities either directly or through partners. This will include a new cycling fitness project;
- a base from which health trainers can promote increased participation in community based projects in support of health and wellbeing.

7.26 More intensive programmes for adults are provided by the Why Weight adult weight management programme which is run primarily in Dartford town centre at Peppercorns, a local community hall with a fitness studio. Since January 2013, courses have been delivered in outer parishes of the borough.

7.27 The Gr@nd healthy living centre in Gravesham provides a 12 week programme which is tailored to the needs of specific target groups including Black, Minority and Ethnic (BME) communities, rural groups, deprived areas and men. At the end of the intervention participants are offered a free one week pass at Cascades, Cygnets or Swanscombe Leisure Centres and a free swimming session at Cascades or Cygnets. Participants are invited back to exercise sessions and signposted to free exercise or relevant events, and are offered reduced gym membership for 12 months. This programme attracts participants of a slightly lower age than the 50 year Kent average.

7.28 The Sevenoaks District run Why Weight 12 week programme which is based on the Counterweight model and delivered in locations based on need and deprivation in the district. The adult weight management programme is run in both towns and villages, primarily in the leisure centre in Swanley with additional classes being run in New Ash Green and West Kingsdown. In addition the Get Sorted service is based at the local leisure centres in the district, offering 1:1 sessions to completed Why Weight participants. Each participant is offered 6 x 1:1 sessions throughout the year to achieve their long term and short term goals.

7.29 In Dartford Gravesham and Swanley, specialist community weight management services are currently provided by The Bariatric Consultancy called 4 healthy weight. These patients have severe and complex obesity and may experience delay in

accessing other services as a result. Analysis shows that those accessing 4 healthy weight services have a range of over 60 conditions; many have a number of co-morbidities. The most commonly appearing conditions are diabetes, hypertension, musculo-skeletal conditions, depression, polycystic ovary syndrome and respiratory problems. In addition, over 45% of 4 healthy weight patients have two or more diagnosed mental health conditions. Tier 3 services are well used by patients in the CCG. The majority of patients lose more than 5% of their body weight from this programme.

- 7.30 There is no Tier 4 service provided in Kent and patients need to go outside of the district to access this service provided by hospitals approved by NHS England. A total of 168 bariatric operations were carried out on Kent patients in 2013/14; 99 of them referred by the Bariatric Consultancy. All surgery is undertaken in approved hospitals out of area.

Table 3: Bariatric Admissions by Clinical Commissioning Groups 2006/07-2013/14

Number of annual admissions for bariatric surgery* by Clinical Commissioning Group - 2006/07 to 2013/14								
CCG	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
NHS Ashford CCG		4	5	12	16	16	14	9
NHS Canterbury & Coastal CCG	<i>supressed</i>		10	11	19	38	18	24
NHS Dartford, Gravesham & Swanley CCG	5	16	13	27	34	46	46	40
NHS South Kent Coast CCG	<i>supressed</i>	6	6	34	30	34	27	18
NHS Swale CCG	<i>supressed</i>	6	8	11	23	23	21	19
NHS Thanet CCG		9	10	18	22	26	24	11
NHS West Kent	4	13	21	38	48	56	70	47

Where the primary diagnosis was obesity (ICD-10 E66) the following codes were used for the main or secondary procedure within the relevant time periods:
 2006/07 to 2008/09 inclusive G28*, G27.2-G27.9, G30.1-G30.4, G30.8- G30.9, G31*, G32*, G33.0-G33.3, G33.5-G33.9, G38.7, G38.8, G48.1, G48.2, G71.6.
 2009/10 to 2013/14 inclusive G27.1-G27.9, G28*, G31*, G32*, G33*, G30.1, G30.3, G30.4, G30.5, G30.9, G38.7, G48.1, G48.2, G48.5, G48.6, G71.6, G71.7.

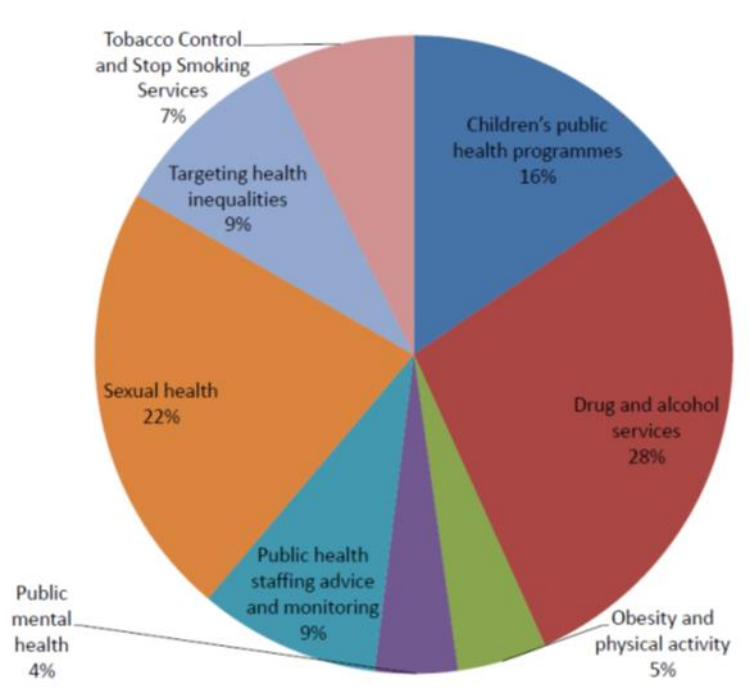
Source: Secondary Uses Service

- 7.31 There are some proposed national changes to commissioning that will impact on the future provision of Tier 3 and 4 services ⁽³¹⁾.
- 7.32 Local data indicates that currently 21% of pregnant women have a BMI >30 and the rate is increasing. Information on the risks of having a BMI >30 are provided in the Antenatal Care Pathway notes and women with a BMI >35 are referred to Pregnancy Plus education and monitoring programme run by community midwives with dietetic support. Women with a BMI >35 are also referred to a dietician as well as Consultant Led Antenatal Care and are offered screening for diabetes. A diabetes specialist midwife provides advice on the care of those screened at high risk of developing gestational diabetes. All staff are given training and education on obesity in pregnancy via mandatory training programmes. However, no maternity services meet NICE guidance ⁽⁴⁷⁾ which states that all women with a BMI of 30 and above should be referred to a dietician.
- 7.33 **Financial considerations**
 Between 2010 and 2030 health costs associated with obesity are projected to rise nationally by £2bn ⁽¹⁴⁾. The burden of costs to Kent have been very crudely calculated as over £55m using the number of Kent residents as a proportion of the whole of England 2013 population. (KMPHO) This is contributed to by 44% of the incidence of diabetes, 23% of heart disease and between 7%-41% of certain cancers. A clinical working group (Royal College of Physicians, 2013) found that obese individuals had

medical costs 30% higher than those with normal weight: it is estimated that 23% of spending on all drugs is attributable to overweight and obesity⁽¹⁴⁾.

- 7.34 Obesity will also have an increased impact on social care costs and an estimated 16 million days of sickness absence a year are attributable to obesity. Obese people are less likely to be in employment than people of a healthy weight. The associated welfare costs are estimated to be between £1 billion and £6 billion⁽⁵⁹⁾. The NHS and local authority are major employers so this will impact on their available workforce.
- 7.35 The working group determined that treatment is cost effective and in some cases it costs less to provide it than not. Targeting treatment at those most likely to benefit will further enhance cost efficacy. The time period for assessing cost efficacy may be extended compared to some other areas of health intervention and this requires commissioning authorities to have an appropriate long-term view on the value of obesity treatment.
- 7.36 Kent County Council Public Health invests approximately £3m in obesity and physical activity, which is approximately 5% of the budget across Kent. It is difficult to quantify the impact of reductions to the public health grant 2015/16.

7.37 **Figure 11: Spending by KCC Public Health 2015/16**



- 7.38 **Public consultations**
 In 2014 a consultation questionnaire was designed to ask the adult public about their own circumstances and their views on what interventions should be provided to help people stay a healthy weight. It was posted on the Kent County Council website in standard and easy read formats. An e-mail was sent to a broad range of partners for promotion. Six hundred and two responses were received, over the sample size required. A copy of the questionnaire is in Appendix 3

Table 4: Interventions that Kent adults agree would help with weight loss

Agree or strongly agree what would help?	
Having advice on healthy eating	96%
Available and affordable fresh fruit and vegetables	95%
Access to local leisure facilities	91%
Weight loss classes	90%
Local walks led mostly by volunteers	87%
Helping people with healthy eating	81%
Health Trainers	80%
Exercise classes that your GP tells you to go to	79%
Having one to one meetings with an adviser	79%
Taking part in sport?	77%
Attending a weight loss class	76%
Classes that help pregnant women to be a healthy weight	75%
Being able to walk and cycle near to where you live	47%

7.39 A short questionnaire was also designed and tested with a group of young people. It was completed by 120 children aged 11-12 in a school and 12 young people aged 13-24 in a youth setting. It was also posted on SurveyMonkey. In total there were 178 responses. The respondents thought that the best way to deliver health messages would be through TV adverts. To enable families to be more active free gym passes and family activities should be provided so that they get more exercise. They also thought healthy food should be more accessible and there was a need to promote messages such as the five a day campaign. In order to deliver these messages young people think that getting a professional athlete or celebrity on board to promote the messages would encourage families to act. Young people think that it is important to be educated and given information about being overweight, or how to avoid putting on weight. The channels for this should be social media such as Facebook. Access to free gyms or exercise groups was also a highly suggested recommendation.

7.40 Stakeholder Views - the Big Weight Debate summary

Stakeholders attending the Big Weight Debate workshop on 8 December 2014 told us they wanted:

- locally tailored services
- enhanced community capacity
- additional resources for targeting services in areas of greatest inequality.

Key themes that emerged were:

- **Strategic Direction** joint priority setting, agreement on strategy, common goals and outcomes
- **Commissioning** needs to reflect differential levels of obesity, put measures into specifications
- **Service Users** acceptability, accessibility, building trust, holistic offer, social and fun
- **Workforce** huge potential untapped front line work force with training needs

- **Communication** simple clear consistent messages, knowing what interventions are in place
- **Pathways** life course approach, knowing referral process and motivation key
- **Into practice** signage, walking routes and using stairs; workplace interventions.

The full report is provided in Appendix 6.

7.41 **Views from general practice**

Three GPs in Dartford Gravesham and Swanley and two GPs in West Kent responded to a short questionnaire about their views about tackling obesity. The GPs pointed to issues of embarrassment and denial when discussing weight with parents and one GP said that in the discussion there was often a lack of understanding of causes and solutions. Concern was expressed about stigma and a reluctance to disrupt the professional relationship by causing offence. One GP stated that because patients are not coming to primary care because of weight issues, there is not time within the consultation to discuss obesity. The respondents were unaware of some of the service provision that is in place, particularly for families but also that there was longer term, non-surgical psychological based support for people with a lot of weight to lose. Other professional support that was mentioned included dietetics, school nursing, health visitors and surgery.

- 7.42 One respondent was concerned that this was a societal issue and not a medical one and cited the Finnish heart disease programme in the 1970s which worked when the total country took responsibility for the issue. A key issue raised was motivation that people often felt that they had tried and failed in the past, people needed to want to take action. An advantage of provision that they knew about was that it was free. Ideas that were given for what else could be done included pathways, practice based programmes, starting early i.e. antenatally, providing fun accessible programmes for children and young people and taking a family approach, more referrals to exercise programmes and looking at what works. One GP was unsure about where responsibility lies for tackling childhood obesity, whether it was school nurses, public health, GPs or schools and called for a more integrated approach across local authority, social care and NHS and that cultural change was more important than pathways.

7.43

Summary

- Dartford Gravesham and Swanley have high levels of adult and childhood obesity compared to England.
- NHS Dartford Gravesham and Swanley CCG are committed to prevention and have prioritised childhood obesity and tackling health inequalities.
- The needs of Swanley and the northern parishes need to be seen independently of the Sevenoaks profile.
- Two community hospitals, 34 GP practices, 32 dental practices, 52 pharmacies, 15 children's centres and 45 schools as well as NHS and local authority workplaces are key settings for prevention.
- Family weight management services are provided but are under-used and there is little provision for teenagers.
- Maternity services do not meet NICE guidance as not all eligible women see a dietician during pregnancy.
- Further work needs to be undertaken to ensure there is a complete healthy weight pathway in place for both adults and children and young people.

8. West Kent

8.1 Background

NHS West Kent Clinical Commissioning Group (CCG) provides services for Maidstone, Tunbridge Wells, Tonbridge and part of Sevenoaks District. The population of West Kent CCG is 464,000 and although generally affluent, there are hidden pockets of deprivation within the West Kent health economy. The CCG are working together with partners to improve the experience of end of life care; improve health in the most disadvantaged communities; support people with mental ill health to live well; and give children the best start in life. Integrated prevention services accessed through a single point of contact to support people live healthy lives are planned for 2016. The West Kent Health and Wellbeing Board have prioritised adult and child obesity in 2015 ⁽⁵³⁾.

8.2 The majority of West Kent patients access Maidstone and Tunbridge Wells NHS Trust services in the Maidstone and Tunbridge Wells hospitals. Community services are provided at Benenden, Hawkhurst, Sevenoaks and Edenbridge War Memorial Hospital. There are 62 GP practices in West Kent and 70 pharmacies and 68 dental practices. There are 22 Children's Centres and 195 schools, including Pupil Referral Units ⁽⁵⁴⁾. These are all potential settings for interventions, but will require investment in training and education programmes to enable this to happen.

8.3 West Kent has similar rates of adult obesity to the England average (55).

Table 1: Adult obesity rates in West Kent

Adult obesity 2014	%
West Kent CCG	24.7
England	24.1
England worst	30.9

Public Health England CCG Neighbourhood Profiles

It is also similar to the England adult healthy eating prevalence.

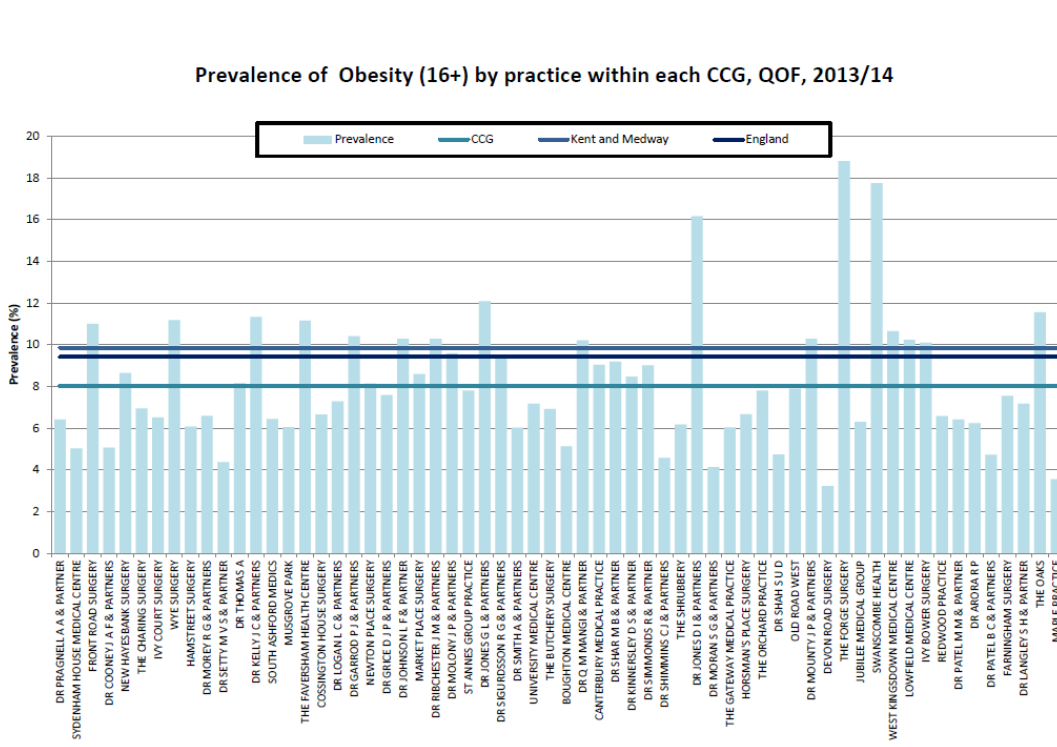
Table 2: Adult healthy eating rates in West Kent

Adult healthy eating 2014	%
West Kent CCG	30.3
England	28.7
England worst	19.4

Public Health England CCG Neighbourhood Profiles

8.4 The recorded QoF data shows prevalence of obesity by GP practice. Obesity is not generally well recorded in primary care.

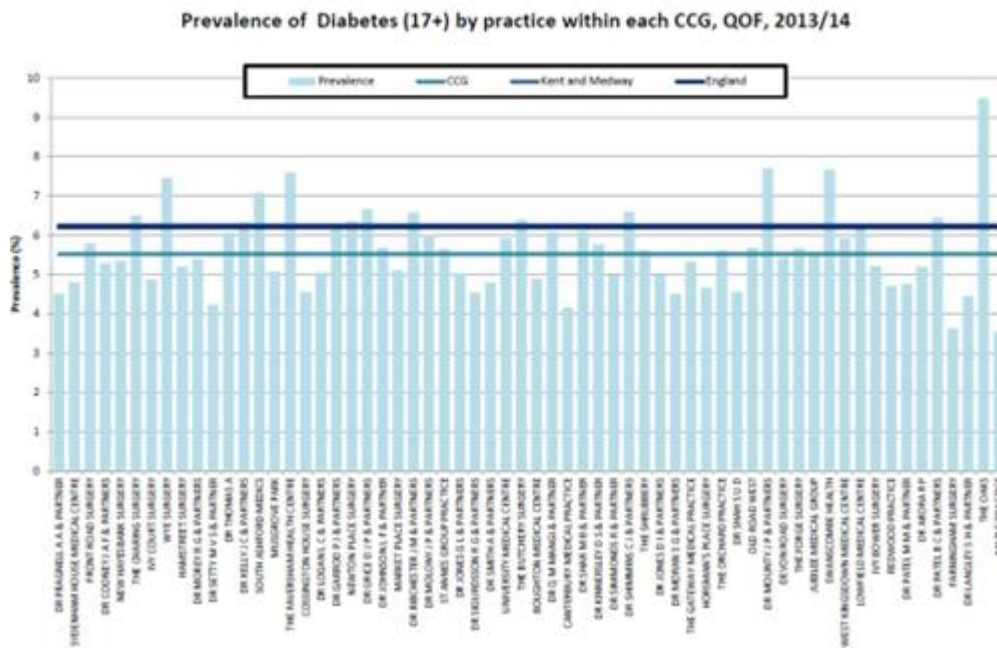
Figure 1: Prevalence of obesity in Dartford Gravesham and Swanley practices



Kent and Medway Public Health Observatory Health and Social Care Maps

8.5 As already described, obesity contributes to a number of serious and preventable conditions including Type 2 diabetes. Obesity accounts for 44% of people with diabetes. The following chart shows the prevalence of diabetes by practice within West Kent CCG.

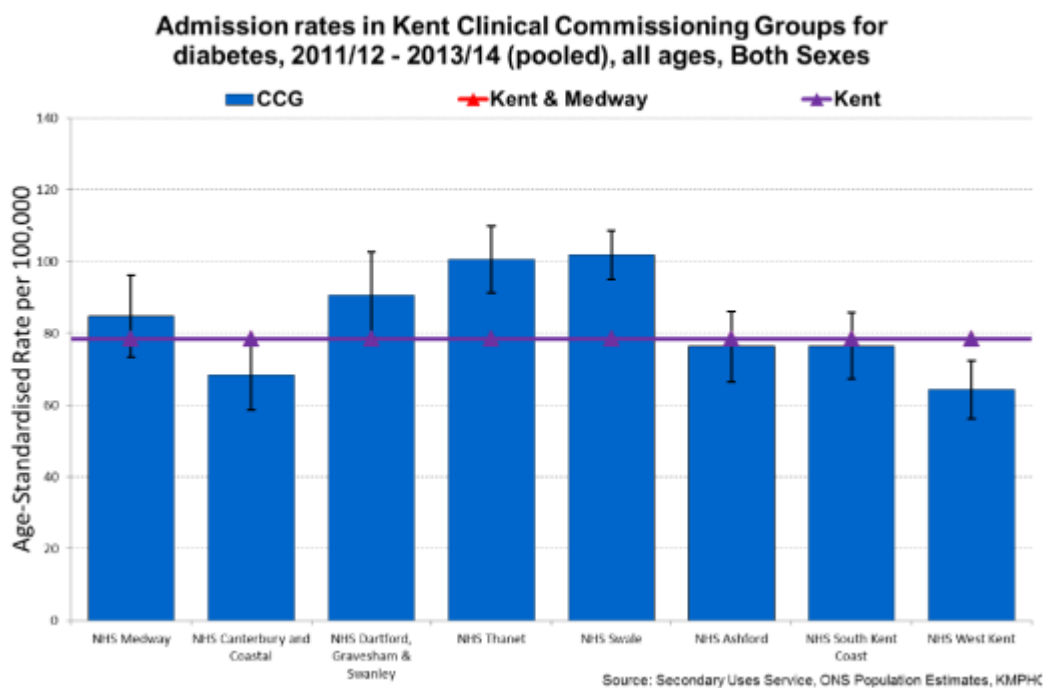
Figure 2: Prevalence of obesity in Dartford Gravesham and Swanley practices



Kent and Medway Public Health Observatory Health and Social Care Maps

8.6 Figure 3 shows the rates of diabetes admission by Clinical Commissioning Groups across Kent and Medway. West Kent CCG has the lowest rate in Kent and Medway.

Figure 3: Admission rates for diabetes in CCGs in Kent and Medway

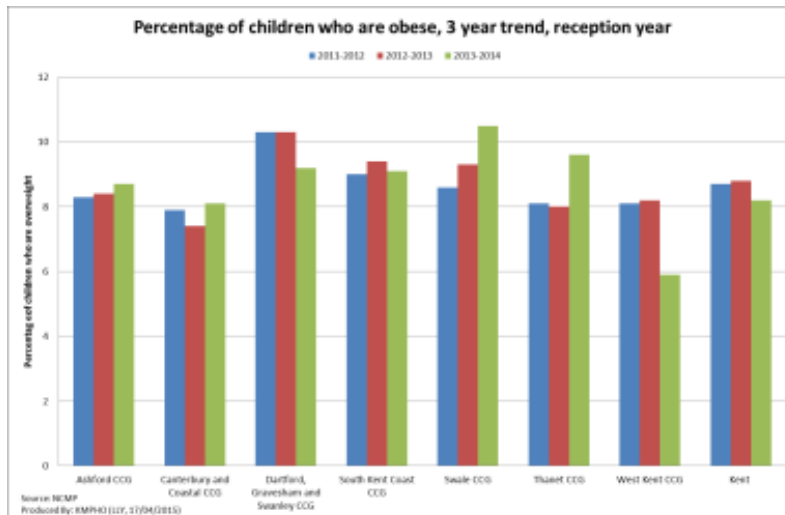


8.7 The data that is available for child obesity is taken from the National Child Measurement

Programme. In Kent the school nursing teams measure children at 4-5 years (reception) and at 10-11 years (year 6). In 2013/14 94.9% of eligible children were measured.

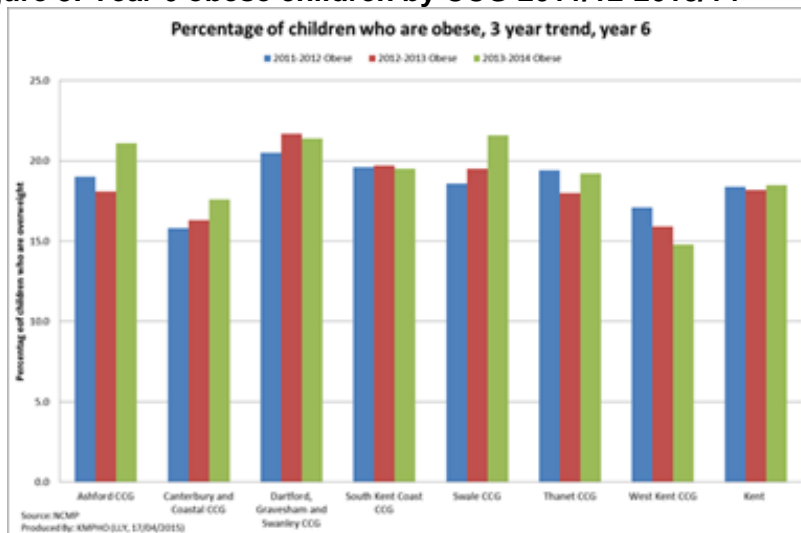
- 8.8 In 2012/13, the proportion of obese reception year children in West Kent reduced in 2013/14 and has the lowest prevalence of any Kent CCG in Kent 2012/14.

Figure 4: Year R obese children by CCG 2011/12-2013/14



- 8.9 The Kent trend is showing some signs of plateauing from 2011-2014. West Kent year 6 prevalence is decreasing year or year and is better than the England average.

Figure 5: Year 6 obese children by CCG 2011/12-2013/14



Reporting by CCGs or by districts often masks the differences between areas and these can be seen in the Health and Social Care maps in Appendix 1.

- 8.10 **Services available to tackle obesity in West Kent for children and families**
Evidence based intervention during the early years of life is described in the Healthy Child programme. Health visitors promote infant led weaning as part of their universal

offer and provide public health advice and interventions that encourage healthy eating and physical activity to parents and carers and their young families. Across Kent, the 'Born to Move' initiative is a health visitor led project to raise awareness of the importance of human interaction between parent /carer and infant or child to enable optimal development, physically and emotionally which may have some impact on childhood obesity. Children Centre staff have a responsibility for creating an environment that promotes healthy eating and physical activity and this is part of an agreement between Public Health and the Children's Centre which is subject to monitoring and audit. Other providers deliver interventions in Children's Centres for example the Community Chef programme in Tunbridge Wells.

- 8.11 The school nursing team operates an open referral process - they receive referrals from other professionals e.g. GPs, schools and health visitors, in addition to parents/carers and young people self -referring. Following referral they would provide a package of care i.e. four contacts with a child/young person. In addition they can refer to dietitians, paediatricians, borough and district community healthy living/exercise programmes. The school nurse team undertakes the National Child Measurement Programme in reception and year 6 and offer support to parents following receipt of the result letters. They work closely with the local Health and Wellbeing Teams supporting schools and parents both before and after the measurements. Four locality National Child Measurement Programme Groups work in partnership in West Kent to support the measurement programme to maximise the impacts of nutrition, physical activity and self-esteem enhancing interventions and to promote joint working and onward referrals.
- 8.12 The Healthy Schools team in Kent Community Health Foundation Trust is currently working intensively with targeted schools in West Kent. In addition all schools have access to schools premium funding to optimise physical activity and access to school sports interventions. For families who struggle with their weight there are fun oriented programmes aimed at families with children of junior school age in all district localities in Kent. This is an example of what is offered:
- Year 6 Healthy Lifestyle support lessons
 - Year R Healthy Lifestyle support lessons
 - Weighing and measuring (School nurses) Yr. 6 Yr. R
 - Assemblies for promoting targeted lifestyle programme
 - Parent engagement event
 - Follow up support offer from Don't Sit Get Fit following NCMP result letter
 - Targeted lifestyles programme rolled out
 - Sports days event(s)
 - Healthy School Enhancement Model achievement.
- 8.13 Tunbridge Wells Borough Council provides a 10 week programme called Learn Eat and Play (LEAP) which includes physical activity, healthy eating and behaviour change and as part of this has a practical cookery session every other week. It replaced Mind, Exercise, Nutrition Do it! (MEND) as very few families attended. The partnership works across Tunbridge Wells and Tonbridge and Malling and consists of a community chef, four nutritionists and three exercise/ dance specialists. In the weeks before LEAP is planned to start, a separate four week cookery course called Cook and Eat is offered, this is done in much the same way as other programmes as a more acceptable intervention that could be a gateway to the LEAP programme. Twenty-nine families took part in Cook and Eat between July 2013 and 31st March 2014 across six schools. Cook and Eat enrolled 27 boys and 17 girls during this time, giving them the opportunity

to try new foods, learn some basic food preparation and cooking skills and enable them to meet new people.

- 8.14 Tonbridge and Malling Borough Council also provide the LEAP programme. From 18 families, a total of 34 children were recruited to LEAP in 2013/14. Tonbridge and Malling also has the Go for It! programme which worked with 18 children of whom eight had a learning disability.
- 8.15 Sevenoaks District Council runs a Fun Fit and Active programme which is delivered in five schools. In 2013/14 it ran three programmes for 23 families. In addition to the 12 week programme the team undertook whole school workshops within schools on healthy eating and physical activities which engaged 1,300 children.
- 8.16 Maidstone Borough Council uses a programme Go For It! provided by Zeroth which is a 12 week course run in term time using a different model to most of the other programmes. The children and young people are invited to attend 20 activity sessions. These include a mix of activities to improve strength, cardiovascular fitness, flexibility and motor skills through studio based activities, team games and working out in the Zeroth gym, if old enough. For every child registered, at least one parent/guardian had to commit to attending the adult workshops. Topics for the adults include: healthy eating; food labelling; activity levels; behaviour and health. Parents were encouraged to be a positive role model, and not to be afraid of change. In 2013/14 31 children aged four-11 and 22 children aged 12+ attended the programme.
- 8.17 There are no dedicated weight management programmes designed for older children. It is likely that the needs of older children will become more complex and therefore would benefit from a more specialised service.
- 8.18 There are no dedicated Tier 3 services for children in Kent; therefore access to a specialist dietician is important. This access is variable across Kent. Maidstone and Tunbridge Wells NHS Trust provides consultant only referrals for children who have diabetes. Children with obesity (only) will be seen by the paediatric dieticians employed by Kent Community Healthcare Foundation Trust (KCHFT). The KCHFT paediatric team has a 0.2 w.t.e.team leader with two paediatric dieticians and one assistant working across Kent. The team provides the totality of dietetic services for children in the whole of West Kent and East Kent (not Dartford Gravesham and Swanley). In West Kent there are two weekly clinics run in the hospital for consultant only referrals and one clinic for GP referrals from the Tonbridge and Tunbridge Wells area only.
- 8.19 **Services available to tackle obesity in West Kent for adults**
There are a range of services and opportunities for adults for physical activity, including commercial and local authority sport and leisure services, outdoor and natural environment organisations and workplace initiatives. Kent Sport provides an extensive number of cycling and walking programmes as well as supporting sports clubs. They also manage coaching and volunteering programmes. Kent County Council Public Health commissions and delivers Sky Ride in partnership with KCC Highways and Transportation and Kent Sport. Other Kent County Council departments offering opportunities for physical activity include Country Parks and Explore Kent. Kent County Council is currently evaluating the effectiveness of outdoor gyms.
- 8.20 Healthy Living Centres provide the following for adults:

- opportunities for drop-in sessions on healthy eating, bring and share and recipe swaps, fruit and veg bags, home growing of produce and where kitchen space is adequate, cooking skills sessions for young parents/cook and eat sessions;
- opportunities for indoor and outdoor physical activity through support and signposting to group activities such as swimming, health walks, line dancing/other sorts of dancing and various sporting activities either directly or through partners. This will include a new cycling fitness project;
- a base from which health trainers can promote increased participation in community based projects in support of health and wellbeing.

- 8.21 More intensive programmes for adults are provided by the districts and borough councils. The Sevenoaks Why Weight 12 week programme is based on the Counterweight model and delivered in locations based on need and deprivation in the district. The adult weight management programme is run in both towns and villages, primarily in leisure centres in Sevenoaks and Edenbridge.
- 8.22 The Sevenoaks Get Sorted service is based at the local leisure centres in the district, offering 1:1 sessions to completed Why Weight participants. Each participant is offered 6 x 1:1 sessions throughout the year to achieve their long term and short term goals. Why Weight adult weight management programme which is run primarily in Dartford town centre at Peppercorns, a local community hall with a fitness studio. Since January 2013, courses have been delivered in outer parishes of the borough.
- 8.23 Maidstone Borough Council and Tonbridge and Malling offers the Counterweight programme aimed at giving people the skills to manage their weight for life and a 10 week adult weight management programme run by Maidstone Leisure Centre. Maidstone Leisure Centre provides a programme that includes weekly seminars, weigh-ins, exercise classes, gym sessions and a supermarket trip identifying what foods to buy to manage weight.
- 8.24 The Sevenoaks District run Why Weight 12 week programme is based on the Counterweight model and delivered in locations based on need and deprivation in the district. The adult weight management programme is run in both towns and villages, primarily in the leisure centre in Swanley with additional classes being run in New Ash Green and West Kingsdown. In addition the Get Sorted service is based at the local leisure centres in the district, offering 1:1 sessions to completed Why Weight participants. Each participant is offered 6 x 1:1 sessions throughout the year to achieve their long term and short term goals.
- 8.25 Tunbridge Wells Borough Council provide a 10 week programme at venues across the borough called Weight for It.
- 8.26 For people with severe and complex obesity, specialist community weight management services are currently provided by the Bariatric Consultancy known as 4 healthy weight. Many of these patients have complex needs and may experience delay in accessing other services as a result. Analysis shows that those accessing 4 healthy weight services have a range of over 60 conditions; many have a number of co-morbidities. The most commonly appearing conditions are diabetes, hypertension, musculo-skeletal conditions, depression, polycystic ovary syndrome and respiratory problems. In addition, over 45% of 4 healthy weight patients have two or more diagnosed mental health conditions. Tier 3 services are well used by patients in the CCG. The majority of patients lose more than 5% of their body weight whilst on this programme.

- 8.27 There is no Tier 4 service provided in Kent and patients need to go outside of the district to access this service. A total of 168 bariatric operations were carried out on Kent patients in 2013/14; 99 of them referred by the Bariatric Consultancy. All surgery is undertaken in approved hospitals out of area.

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NHS Dartford, Gravesham & Swanley CCG	5	16	13	27	34	46	46	40
NHS South Kent Coast CCG	supressed	6	6	34	30	34	27	18
NHS Swale CCG	supressed	6	8	11	23	23	21	19
NHS Thanet CCG		9	10	18	22	26	24	11
NHS West Kent	4	13	21	38	48	56	70	47

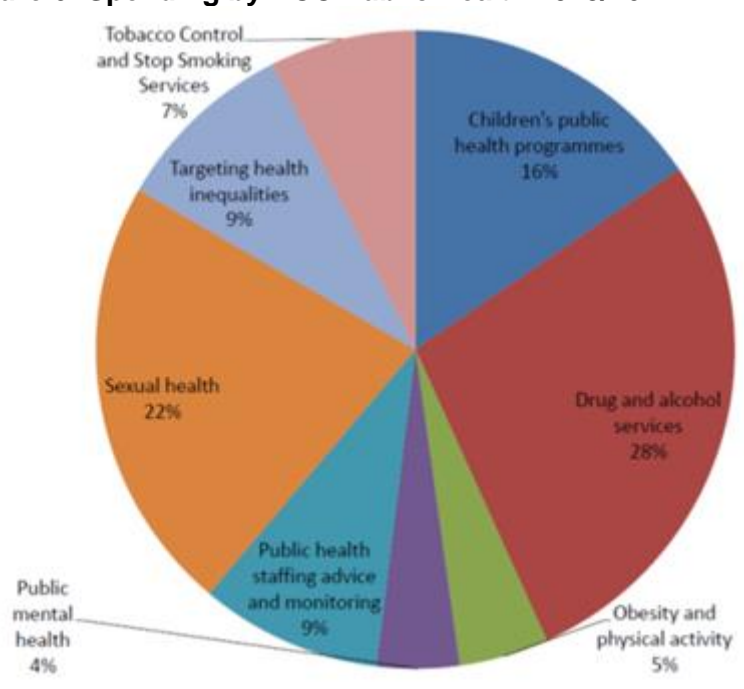
Where the primary diagnosis was obesity (ICD-10 E66) the following codes were used for the main or secondary procedure within the relevant time periods:
 2006/07 to 2008/09 inclusive G28*, G27.2-G27.9, G30.1-G30.4, G30.8- G30.9, G31*, G32*, G33.0-G33.3, G33.5-G33.9, G38.7, G38.8, G48.1, G48.2, G71.6.
 2009/10 to 2013/14 inclusive G27.1-G27.9, G28*, G31*, G32*, G33*, G30.1, G30.3, G30.4, G30.5, G30.9, G38.7, G48.1, G48.2, G48.5, G48.6, G71.6, G71.7.

Source: Secondary Uses Service

- 8.28 There are some proposed national changes to commissioning that will impact on the future provision of Tier 3 and 4 services ⁽³¹⁾.
- 8.29 Provision of support for managing weight in pregnancy is variable across Kent. It is of concern that no Kent Trusts meet NICE guidance ⁽⁴⁷⁾ for referring all women with a BMI of 30 or more to a specialist dietician. In West Kent maternity services are provided by Maidstone and Tunbridge Wells NHS Trust.
- 8.30 Women can expect to have their height, weight and BMI recorded at booking. Within the notes there is a separate section to record the care plan for women with a BMI >30. There are two midwives with a special interest in healthy weight each of who have a total of six hrs protected time per week to fulfil this role (taken from existing midwifery establishment). These midwives run Healthy Weight Clinics for all women with a BMI >35. Women with a BMI >40 are referred to an obstetrician, anaesthetist and dietician. There are also two specialist diabetes midwives who have a total of 11.25 hrs per week of protected time to provide support to women with or at risk of developing diabetes. No specific information or advice on diet and exercise is included in the notes but the Start4Life leaflet, a copy of the NHS Direct page on Health in Pregnancy (includes information on diet & exercise) & the A-Z of Pregnancy & Nutrition are included in antenatal packs.
- 8.31 **Financial considerations**
 Between 2010 and 2030 health costs associated with obesity are projected to rise nationally by £2bn ⁽¹⁴⁾. The burden of costs to Kent have been very crudely calculated as over £55m using the number of Kent residents as a proportion of the whole of England 2013 population. (KMPHO) This is contributed to by 44% of the incidence of diabetes, 23% of heart disease and between 7% and 41% of certain cancers. A clinical working party (Royal College of Physicians) found that obese individuals had medical costs 30% higher than those with normal weight: it is estimated that 23% of spending on all drugs is attributable to overweight and obesity ⁽³⁰⁾.

- 8.32 Obesity will also have an increased impact on social care costs and an estimated 16 million days of sickness absence a year are attributable to obesity. Obese people are less likely to be in employment than people of a healthy weight. The associated welfare costs are estimated to be between £1 billion and £6 billion⁽¹⁴⁾. The NHS and local authority are major employers so this will impact on their available workforce.
- 8.33 The working group determined that treatment is cost effective and in some cases it costs less to provide it than not. Targeting treatment at those most likely to benefit will further enhance cost efficacy. The time period for assessing cost efficacy may be extended compared to some other areas of health intervention and this requires commissioning authorities to have an appropriate long-term view on the value of obesity treatment.
- 8.34 Kent County Council Public Health invests approximately £3m in obesity and physical activity, which is approximately 5% of the budget. It is within a block contract which means funding by area and by intervention is difficult to disaggregate.

8.35 **Figure 6: Spending by KCC Public Health 2015/16**



8.36 **Public consultations**

In 2014 a consultation questionnaire was designed to ask the adult public about their own circumstances and their views on what interventions should be provided to help people stay a healthy weight. It was posted on the Kent County Council website in standard and easy read formats. An e-mail was sent to a broad range of partners for promotion. Six hundred and two responses were received, over the sample size required.

Table 4: Interventions that Kent adults agree would help with weight loss

Agree or strongly agree what would help?	
Having advice on healthy eating	96%
Available and affordable fresh fruit and vegetables	95%
Access to local leisure facilities	91%
Weight loss classes	90%
Local walks led mostly by volunteers	87%
Helping people with healthy eating	81%
Health Trainers	80%
Exercise classes that your GP tells you to go to	79%
Having one to one meetings with an adviser	79%
Taking part in sport?	77%
Attending a weight loss class	76%
Classes that help pregnant women to be a healthy weight	75%
Being able to walk and cycle near to where you live	47%

8.37 A short questionnaire was also designed and tested with a group of young people. It was completed by 120 children aged 11-12 in a school and 12 young people aged 13-24 in a youth setting. It was also posted on SurveyMonkey. In total there were 178 responses. The respondents thought that the best way to deliver health messages would be through TV adverts. To enable families to be more active free gym passes and family activities should be provided so that they get more exercise.

They also thought healthy food should be more accessible and there was a need to promote messages such as the five a day campaign. In order to deliver these messages young people think that getting a professional athlete or celebrity on board to promote the messages would encourage families to act. Young people think that it is important to be educated and given information about being overweight, or how to avoid putting on weight. The channels for this should be social media such as Facebook. Access to free gyms or exercise groups was also a highly suggested recommendation.

8.38 Stakeholder Views-The Big Weight Debate Summary

Stakeholders attending the Big Weight Debate workshop on 8 December 2014 told us they wanted:

- locally tailored services
- enhanced community capacity
- additional resources for targeting services in areas of greatest inequality.

Key themes that emerged were:

- **Strategic Direction** joint priority setting, agreement on strategy, common goals and outcomes
- **Commissioning** needs to reflect differential levels of obesity, put measures into specifications
- **Service Users** acceptability, accessibility, building trust, holistic offer, social and fun

- **Workforce** huge potential untapped front line work force with training needs
- **Communication** simple clear consistent messages, knowing what interventions are in place
- **Pathways** life course approach, knowing referral process and motivation key
- **Into practice** signage, walking routes and using stairs; workplace interventions.

8.39 Three GPs in Dartford Gravesham and Swanley and two GPs in West Kent responded to a short questionnaire about their views about tackling obesity. The GPs pointed to issues of embarrassment and denial when discussing weight with parents and one GP said that in the discussion there was often a lack of understanding of causes and solutions. Concern was expressed about stigma and a reluctance to disrupt the professional relationship by causing offence. One GP stated that because patients are not coming to primary care because of weight issues, there is not time within the consultation to discuss obesity. The respondents were unaware of some of the service provision that is in place, particularly for families but also that there was longer term, non-surgical psychological based support for people with a lot of weight to lose. Other professional support that was mentioned included dietetics, school nursing, health visitors and surgery.

8.40 One respondent was concerned that this was a societal issue and not a medical one and cited the Finnish heart disease programme in the 1970s which worked when the total country took responsibility for the issue. A key issue raised was motivation that people often felt that they had tried and failed in the past, people needed to want to take action. An advantage of provision that they knew about was that it was free. Ideas that were given for what else could be done included pathways, practice based programmes, starting early i.e. antenatally, providing fun accessible programmes for children and young people and taking a family approach, more referrals to exercise programmes and looking at what works. One GP was unsure about where responsibility lies for tackling childhood obesity, whether it was school nurses, public health, GPs or schools and called for a more integrated approach across local authority, social care and NHS and that cultural change was more important than pathways.

8.41

Summary

- **NHS West Kent CCG has comparable or better levels of adult and child obesity compared to England.**
- **NHS West Kent CCG are committed to prevention and have prioritised childhood obesity and tackling health inequalities.**
- **Five hospitals, 62 GP practices, 70 pharmacies and 68 dental practices, 22 Children's Centres and 195 schools as well as NHS and local authority workplaces are key settings for prevention.**
- **Family weight management services are under-used and there are few opportunities for teenagers.**
- **Maternity services do not meet NICE guidance and not all eligible women see a dietician during pregnancy.**
- **Further work needs to be undertaken to ensure there is a complete healthy weight pathway in place for both adults and children and young people.**

9. Ashford

9.1 Background

NHS Ashford Clinical Commissioning Group (CCG) provides services for a population of 122,000 people. The CCG are working together with partners on a five year plan to achieve NHS England ambitions which include improving the quality of life of people with long term conditions, preventing hospital admissions and increasing life expectancy. One of four CCG priorities is reducing health inequalities. The Ashford Health and Wellbeing Board have taken a keen interest in adult and child obesity in 2015 ⁽⁵⁶⁾.

9.2 The majority of Ashford patients access hospital services from the William Harvey Hospital which is part of the East Kent Hospitals University Foundation NHS Trust. There are no community hospitals in Ashford. There are 15 GP practices in Ashford, 19 pharmacies and 14 dental practices. There are six Children's Centres and 51 schools, including Pupil Referral Units. (57)

9.3 Ashford has worse rates of adult obesity compared to the England average. Rates are highest in Beaver, Stanhope, Norman and Aylesford Green wards.

Table: 1 Adult obesity in Ashford CCG

Adult obesity 2014	%
Ashford CCG	27
England	24.1
England worst	30.9

Public Health England CCG Neighbourhood Profiles

Ashford has similar rates to the England for adult healthy eating prevalence. (58)

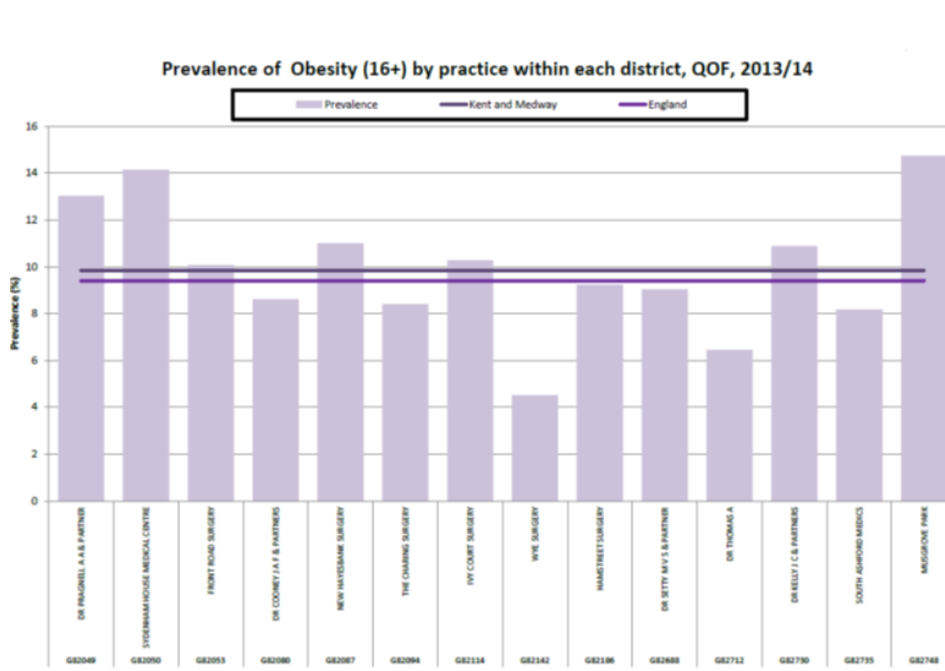
Table 2: Adult healthy eating in Ashford CCG

Adult healthy eating 2014	%
Ashford CCG	27.4
England	28.7
England worst	19.4

Public Health England Neighbourhood Profiles

9.4 The recorded QoF data shows prevalence of obesity by GP practice. Obesity is not generally well recorded in primary care.

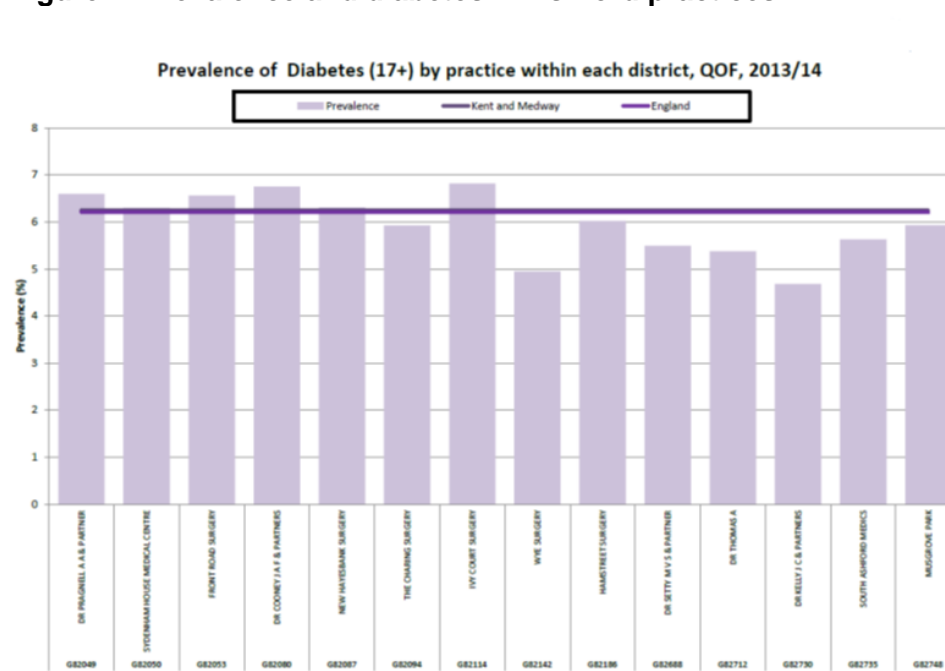
Figure 1: Prevalence of obesity in Ashford practices



Kent and Medway Public Health Observatory Health and Social Care Maps

9.5 As already described, obesity contributes to a number of serious and preventable conditions including Type 2 diabetes, Obesity accounts for 44% of people with diabetes nationally. The following chart shows the prevalence of diabetes by practice within Ashford CCG.

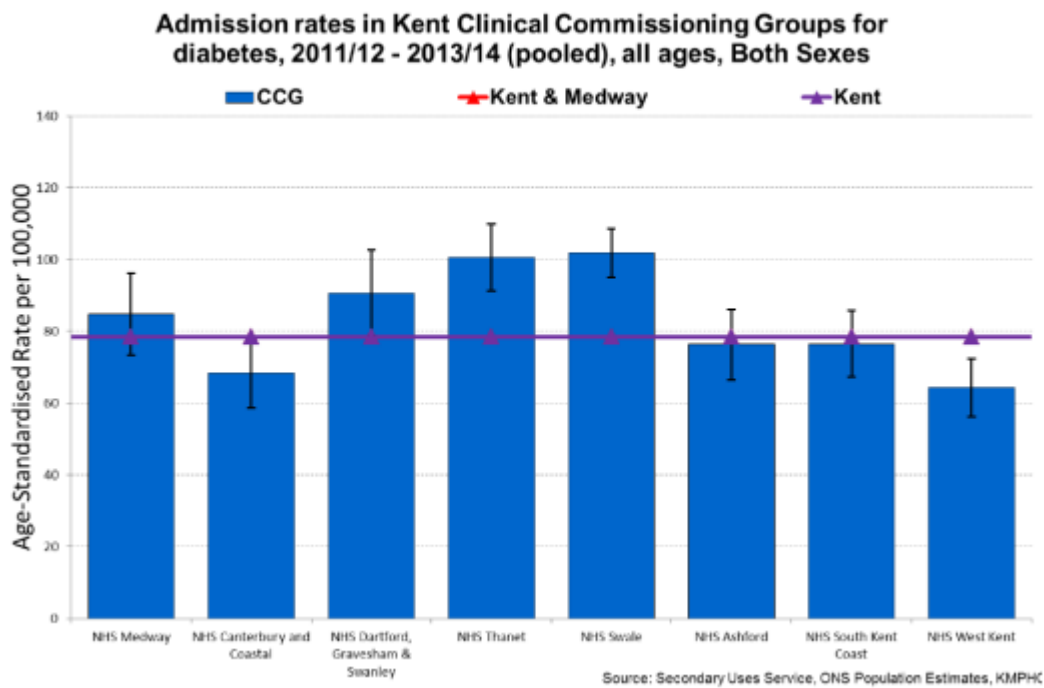
Figure 2: Prevalence and diabetes in Ashford practices



Kent and Medway Public Health Observatory Health and Social Care Maps

- 9.6 Figure 3 shows the rates of diabetes admission by Clinical Commissioning Groups across Kent and Medway. Ashford CCG has average rates of diabetes compared to Kent and Medway.

Figure 3: Admission rates for diabetes in CCGs in Kent and Medway 2011/12-2013/14

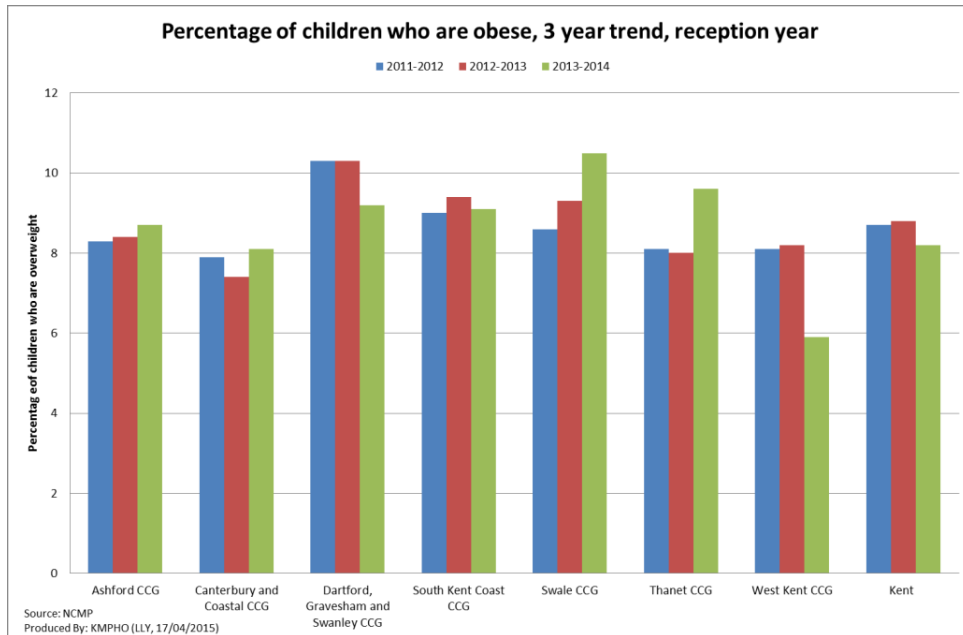


9.7 Childhood obesity in Ashford

The data that is available for child obesity is taken from the National Child Measurement Programme. In Kent the school nursing teams measure children at 4-5 years (reception) and at 10-11 years (year 6). In 2013/14 94.9% of eligible children were measured.

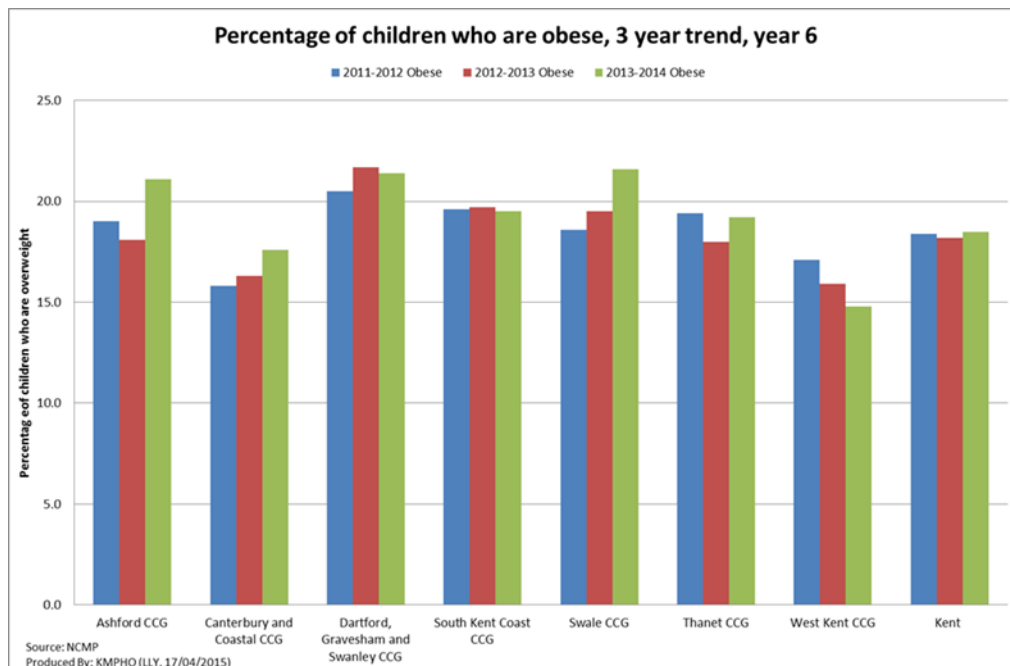
- 9.8 In 2012/13, the proportion of obese reception year children in Ashford has grown year on year from 2011/2012- 2013/2014.

Figure 4: Childhood obesity by CCG in reception year 2011/2012-2013/2014



9.9 The Kent trend is showing some signs of plateauing from 2011-14. Ashford CCG year 6 obesity prevalence was decreasing from 2011/12-2012/13 but increased in 2013/14. Ashford prevalence is higher than the Kent average.

Figure 5: Childhood obesity by CCG in reception year 2011/2012-2013-2014



Reporting by CCGs or by districts often masks the differences between areas and these can be seen in the Health and Social Care maps in Appendix 1.

- 9.10 **Services available in Ashford to tackle obesity for children and families**
Evidence based intervention during the early years of life is described in the Healthy Child programme. Health visitors promote infant led weaning as part of their universal offer and provide public health advice and interventions that encourage healthy eating and physical activity to parents and carers and their young families. Across Kent, the 'Born to Move' initiative is a health visitor led project originally piloted in Ashford which aims to raise awareness of the importance of human interaction between parent /carer and infant or child to enable optimal development, physically and emotionally which may have some impact on childhood obesity. Children Centre staff have a responsibility for creating an environment that promotes healthy eating and physical activity and this is part of an agreement between Public Health and the Children's Centres which is subject to monitoring and audit.
- 9.11 At Tier 1 there are a number of initiatives commissioned by Public Health in Kent County Council that are delivered by Kent Community Health Foundation Trust (KCHFT) which include Food Champions. KCHFT have previously delivered training on consistent messages for both physical activity and healthy eating including the Acorns to Oaks training which was to support Children's Centre staff to raise the issue of weight and be able to support families locally.
- 9.12 The school nursing team operates an open referral process - they receive referrals from various other professionals e.g. GPs, schools and health visitors, in addition to parents/carers and young people self -referring. Following referral they would provide a package of care i.e. four contacts with a child/young person. In addition they can refer to dieticians, paediatricians, healthy living/exercise programmes. The School Nurse Team undertakes the National Child Measurement Programme in reception and year 6 and offer support to parents following receipt of the result letters. A locality National Child Measurement Programme Group strives to work in partnership across Ashford to support the measurement programme to maximise the impacts of nutrition, physical activity and self-esteem enhancing interventions and to promote joint working and on-ward referrals.
- 9.13 The Healthy Schools team in Kent Community Health Foundation Trust is currently working intensively with targeted schools in Ashford. In addition all schools have access to schools premium funding to optimise physical activity and access to school sports interventions. For families who struggle with their weight there are fun oriented programmes aimed at families with primary school aged children. This is an example of what is offered:
- Year 6 Healthy Lifestyle support lessons
 - Year R Healthy Lifestyle support lessons
 - Weighing and measuring (School nurses) Yr. 6 Yr. R
 - Assemblies for promoting targeted lifestyle programme
 - Parent engagement event
 - Follow up support following NCMP result letter
 - Targeted lifestyles programme rolled out
 - Sports days event(s)
 - Healthy School Enhancement Model achievement.
- 9.14 Family weight management programmes are provided by the Healthy Weight team within Kent Community Healthcare Trust. Ready Steady Go is a 12 week programme

for families with children between seven and 11 whose weight is equal to or above the 91st centile. In 2013/14 across the former Eastern Coastal Kent PCT geography there were 82 referrals, 48 participants engaged with the service and 23 participants completed the course.

- 9.15 Recruitment into these programmes is a challenge which is thought to be partly due to the stigma associated with having excess weight and also the low number of referrals from health professionals and other front line staff. To help with recruitment and to provide an intervention that is more acceptable Change 4 Life Clubs have also been started for families with children seven-11. These are five week interventions. In 2013/14 there were 126 families referred, 91 families attended and 68 families completed.
- 9.16 There are no dedicated weight management programmes designed for older children. It is likely that the needs of older children will become more complex and therefore would benefit from a more specialised service.
- 9.17 There are no dedicated Tier 3 services for children in Kent; therefore access to a specialist dietician is important. This access is variable across Kent. Each clinic has the capacity to see six patients. In East Kent both consultants and GPs can refer into the service but there is higher demand than in the former West Kent PCT area. Across Kent KCHFT report waiting times of six months and this has been added to the Trust risk register. The Dietetic Team has begun to work with the Healthy Weight Team to look at how a pathway could be designed so that children who do not need to be referred to a specialist service can be referred to the Tier 2 Ready Steady Go programmes and Change 4 Life Clubs. Currently this would just be for children ages seven-11 in Ashford.
- 9.18 **Services in Ashford that are available to tackle adult obesity**
There are a range of services and opportunities for adults for physical activity, including commercial and local authority sport and leisure services, outdoor and natural environment organisations and workplace initiatives. Kent Sport provides an extensive number of cycling and walking programmes as well as supporting sports clubs. They also manage coaching and volunteering programmes. Kent County Council Public Health commissions and delivers Sky Ride in partnership with KCC Highways and Transportation and Kent Sport. Other Kent County Council departments offering opportunities for physical activity include Country Parks and Explore Kent. Kent County Council is currently evaluating the effectiveness of outdoor gyms.
- 9.19 Public Health commissions Healthy Walks from Kent Community Health Foundation Trust and they also provide an opportunity for 30 people in East Kent to be trained as food champions.
- 9.20 For people who need more intensive support Fresh Start is a 12 week community weight management scheme offering a structured integrated service to support overweight and obese individuals. The aim of the scheme is to support individuals to achieve an average weight loss of 1-2lbs per week, with an overall loss of 5% body weight. The key objectives of the scheme are: to provide support and advice on behaviour change; provide nutritional advice needed to alter diet; provide appropriate physical activity advice to increase activity levels.
- 9.21 The Fresh Start Scheme is provided in Ashford and predominantly delivered in

pharmacy settings. Approximately 40 community pharmacies, eight health trainers and one GP surgery deliver the scheme across East Kent.

- 9.22 All pharmacy advisers are registered to make referrals to the local Exercise Referral Scheme which offers a range of local leisure centre memberships. Clients are encouraged to increase their activity levels during and after attending the Fresh Start Scheme. Clients are also encouraged to take up the six weeks 'Pedometer Challenge' and are guided on how to start and achieve this whilst attending the Fresh Start Scheme. Clients are also signposted to the free East Kent Health Walks Scheme to further increase their activity levels.
- 9.23 For people with severe and complex obesity, specialist community weight management services are currently provided by the Bariatric Consultancy known as 4 healthy weight. Many of these patients have complex needs and may experience delay in accessing other services as a result of their weight. Analysis shows that those accessing 4 healthy weight services have a range of over 60 conditions; many have a number of co-morbidities. The most commonly appearing conditions are diabetes, hypertension, musculo-skeletal conditions, depression, polycystic ovary syndrome and respiratory problems. In addition, over 45% of 4 healthy weight patients have two or more diagnosed mental health conditions. Tier 3 services are well used by patients in the CCG. The majority of patients lose more than 5% of their body weight whilst on this programme.
- 9.24 There is no Tier 4 service provided in Kent and patients need to go outside of the district to access this service. A total of 168 bariatric operations were carried out on Kent patients in 2013/14; 99 of them referred by the Bariatric Consultancy. All surgery is undertaken in approved hospitals out of area.

Table 3: Bariatric Admissions by Clinical Commissioning Groups 2006/07-2013/14

Number of annual admissions for bariatric surgery* by Clinical Commissioning Group - 2006/07 to 2013/14								
CCG	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
NHS Ashford CCG		4	5	12	16	16	14	9
NHS Canterbury & Coastal CCG	supressed		10	11	19	38	18	24
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Where the primary diagnosis was obesity (ICD-10 E66) the following codes were used for the main or secondary procedure within the relevant time periods:
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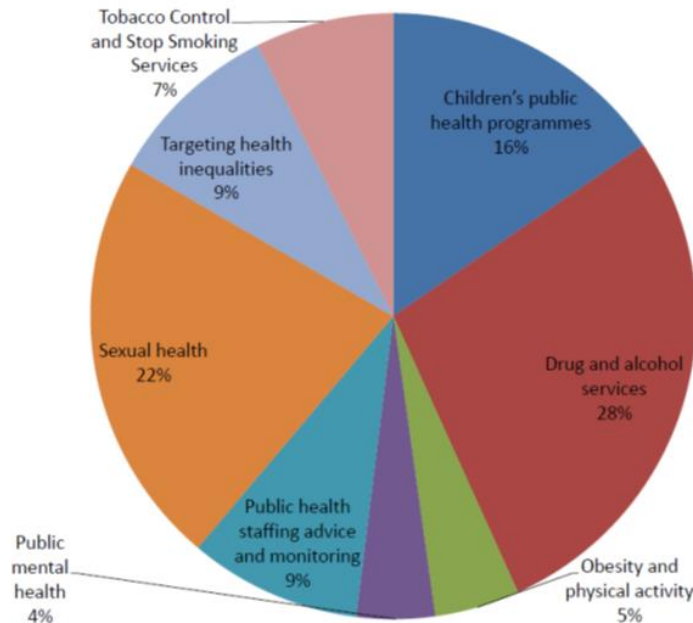
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- 9.25 There are some proposed national changes to commissioning that will impact on the future provision of Tier 3 and Tier 4 weight management services ⁽³¹⁾.
- 9.26 Provision of specialist support for managing weight in pregnancy is variable across Kent. It is of concern that no Kent Trusts meet NICE guidance ⁽⁴⁷⁾ for referring all women with a BMI of 30 or more to a specialist dietician.
- 9.27 Ashford women receive midwifery services from East Kent Hospitals University NHS Foundation Trust. A referral pathway has been established with the community dietician but there is a lack of consistency in acceptance of referrals. Although BMI is

recorded in the pregnancy notes there is no space to record referral to specialist services. Those women with a BMI >35 will be referred to an obstetrician and anaesthetist but there isn't sufficient capacity in their clinics to see every woman. The Trust has reviewed its clinical equipment to ensure it is appropriate for heavier weight women. The service has no midwife with a specialist interest in healthy weight/obesity.

- 9.28 East Kent Hospitals University Foundation NHS Trust have previously been involved in the HELP cluster randomised control trial with Slimming World where 598 pregnant women in total were recruited across maternity sites in England and Wales: of these 598 women, 464 were followed up 12 months after their babies were born (the study's primary endpoint). Women being seen by the Trust can expect to have their height, weight and BMI recorded at booking. Within the notes there is a separate section to record the care plan for women with a BMI >30. There are two midwives with a special interest in healthy weight each of who have a total of six hrs protected time per week to fulfil this role (taken from existing midwifery establishment). These midwives run Healthy Weight Clinics for all women with a BMI >35. Women with a BMI >40 are referred to an obstetrician, anaesthetist and dietician. There are also two specialist diabetes midwives who have a total of 11.25 hrs per week of protected time to provide support to women with or at risk of developing diabetes. No specific information or advice on diet and exercise is included in the notes but the Start4Life leaflet, a copy of the NHS Direct page on Health in Pregnancy (includes information on diet & exercise) & the A-Z of Pregnancy & Nutrition are included in ante-natal packs.
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9.36 **Stakeholder Views - the Big Weight Debate summary**

Stakeholders attending the Big Weight Debate workshop on 8 December 2014 told us they wanted:

- locally tailored services
- enhanced community capacity
- additional resources for targeting services in areas of greatest inequality.

Key themes that emerged were:

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- **Communication** simple clear consistent messages, knowing what interventions are in place
- **Pathways** life course approach, knowing referral process and motivation key
- **Into practice** signage, walking routes and using stairs; workplace interventions.

9.37 **Views from general practice**

Three GPs in Dartford Gravesham and Swanley and two GPs in West Kent responded to a short questionnaire about their views about tackling obesity. The GPs pointed to issues of embarrassment and denial when discussing weight with parents and one GP said that in the discussion there was often a lack of understanding of causes and solutions. Concern was expressed about stigma and a reluctance to disrupt the professional relationship by causing offence. One GP stated that because patients are not coming to primary care because of weight issues, there is not time within the consultation to discuss obesity. The respondents were unaware of some of the service provision that is in place, particularly for families but also that there was longer term non-surgical psychological based support for people with a lot of weight to lose. Other professional support that was mentioned included dietetics, school nursing, health visitors and surgery.

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9.39

Summary

- **NHS Ashford CCG has comparable or better levels of child obesity compared to England but worse adult obesity rates.**
- **NHS Ashford CCG are committed to providing better care for people with long term conditions, increasing life expectancy and tackling health inequalities.**
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- **Family weight management services are under-used and there are very limited services available for teenagers.**
- **Maternity services do not meet NICE guidance as not all eligible women see a dietician during pregnancy.**
- **Further work needs to be undertaken to ensure there is a complete healthy weight pathway in place for both adults and children and young people.**

10. Canterbury and Coastal CCG

10.1 Background

NHS Canterbury and Coastal CCG covers the City of Canterbury, the towns of Faversham, Whitstable, Herne Bay, Sandwich & Ash as well as surrounding rural areas (a population of 211,651.) There are 22 practices in Canterbury and Coastal, 15 of which are located in Canterbury City Council area. Four practices are located in Faversham within Swale Borough Council area and the other three practices are located in the Dover District Council area. There is also a branch practice located in Chilham which is in the Ashford Borough Council area. CCG priorities (59) are long term conditions (particularly people who have a number of conditions), urgent care, mental health, children and young people and maternity; obesity impacts on all these strands.

10.2 The majority of Canterbury and Coastal CCG patients access hospital services from the Kent and Sussex Hospital in Canterbury and four community hospitals and one community mental health hospital. There are 21 GP practices in Canterbury and Coastal, 40 pharmacies and 37 dental practices. There are 10 Children's Centres and 71 schools, including Pupil Referral Units ⁽⁶⁰⁾.

10.3 Adult obesity in Canterbury and Coastal Kent CCG

Canterbury and Coastal CCG has similar rates of adult obesity compared to the England average.

Table 1: Adult obesity in Canterbury and Coastal Kent CCG

Adult obesity 2014	%
Canterbury and Coastal CCG	24.1
England	24.1
England worst	30.9

Public Health England CCG Neighbourhood Profiles

Canterbury and Coastal CCG has similar rates to the England for adult healthy eating prevalence. (61)

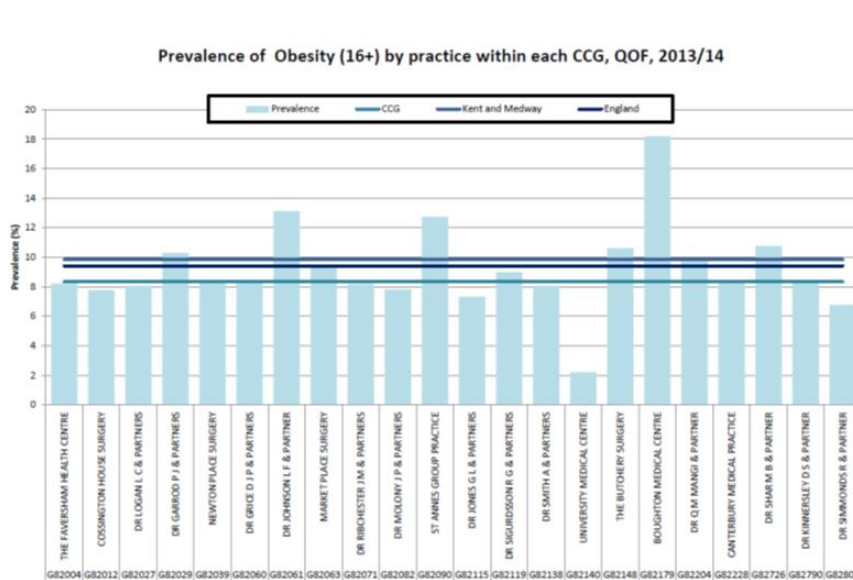
Table 2: Adult Healthy eating rates in Canterbury and Coastal Kent CCG

Adult healthy eating 2014	%
Canterbury and Coastal CCG	28.0
England	28.7
England worst	19.4

Public Health England CCG Neighbourhood Profiles

10.4 The recorded QoF data shows prevalence of obesity by GP practice. Obesity is not generally well recorded in primary care.

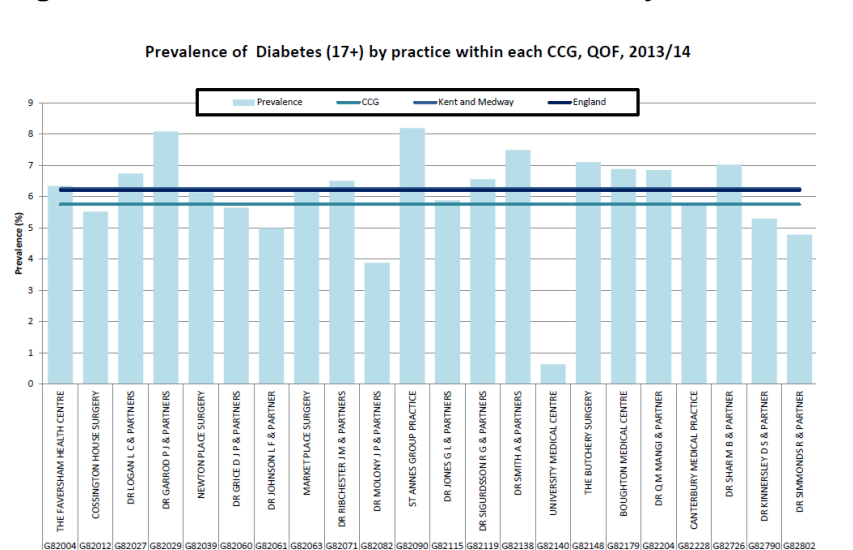
Figure 1: Prevalence of obesity in Canterbury and Coastal CCG



Kent and Medway Public Health Observatory Health and Social Care Maps

10.5 As already described, obesity contributes to a number of serious and preventable conditions including Type 2 diabetes. Obesity accounts for 44% of people with diabetes nationally. The following chart shows the prevalence of diabetes by practice within Canterbury and Coastal CCG.

Figure 2: Prevalence of Diabetes in Canterbury and Coastal CCG

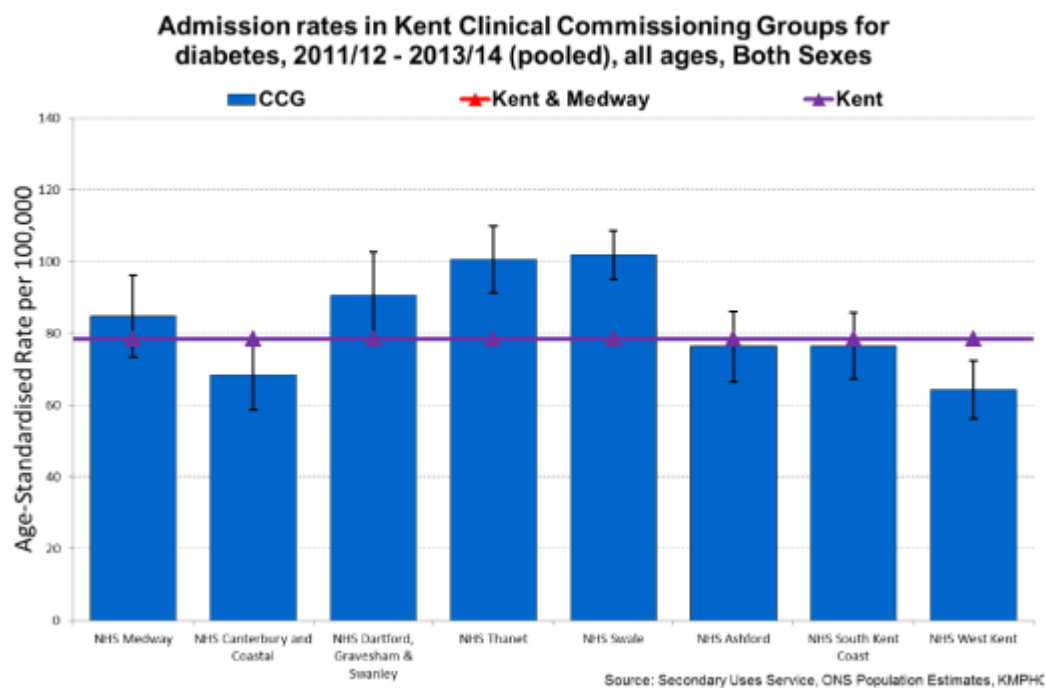


Kent and Medway Public Health Observatory Health and Social Care Maps

10.6 Figure 3 shows the rates of diabetes admission by Clinical Commissioning Groups across Kent and Medway. Canterbury and Coastal CCG has the second lowest

prevalence of diabetes compared to Kent and Medway.

Figure 3: Admission rates for diabetes in CCGs in Kent and Medway 2011/2012-2013/2014

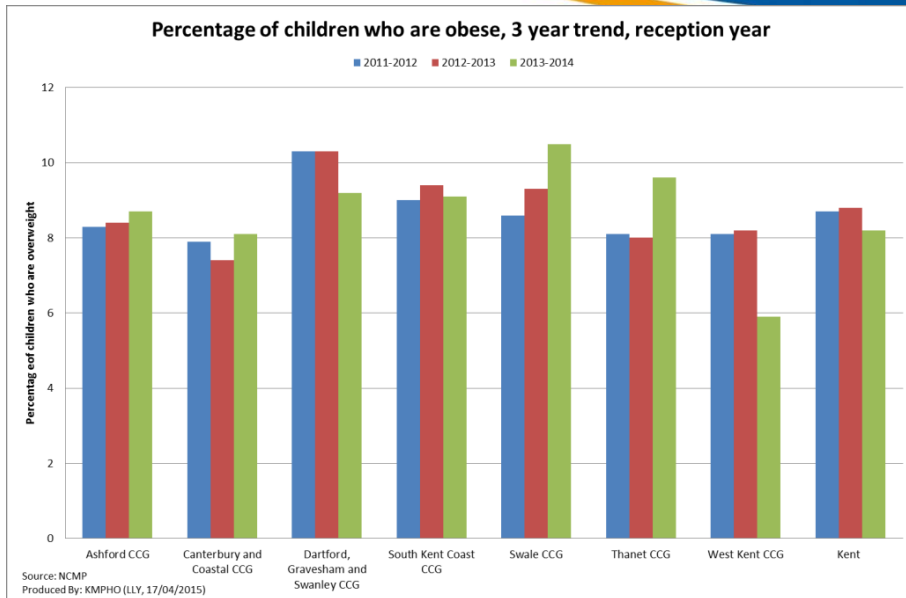


10.7 Childhood obesity in Canterbury and Coastal CCG

The data that is available for child obesity is taken from the National Child Measurement Programme. In Kent the school nursing teams measure children at 4-5 years (reception) and at 10-11 years (year 6). In 2013/14 94.9% of eligible children were measured.

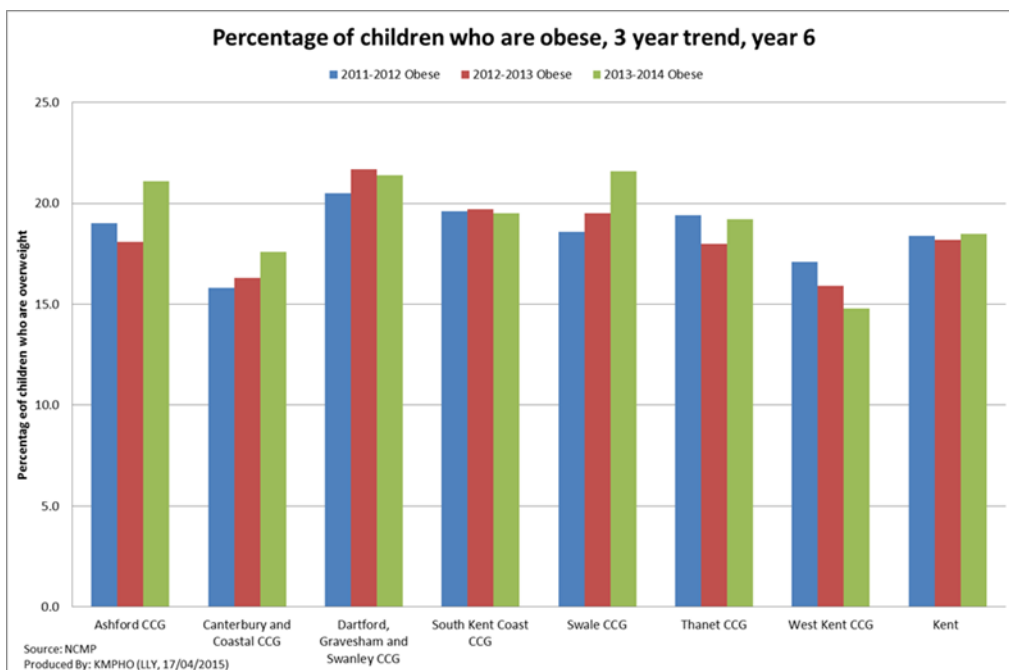
10.8 The proportion of obese reception year children in Canterbury and Coastal CCG has fluctuated between 2011/12 and 2013/14.

Figure 4: Childhood obesity by CCG in reception year 2011/2012-2013/2014



10.9 The Kent trend is showing some signs of plateauing from 2011-14. Canterbury and Coastal CCG year 6 prevalence has increased year on year since 2011/12, although it is similar to the Kent average.

Figure 5: Childhood obesity by CCG in reception year 2011/2012-2013/2014



Reporting by CCGs or by districts often masks the differences between areas and these can be seen in the Health and Social Care maps in Appendix 1.

10.10 **Services for children and families available in Canterbury and Coastal CCG**
 Evidence based intervention during the early years of life is described in the Healthy Child programme. Health visitors promote infant led weaning as part of their universal offer and provide public health advice and interventions that encourage healthy eating

and physical activity to parents and carers and their young families. Across Kent, the 'Born to Move' initiative is a health visitor led project which aims to raise awareness of the importance of human interaction between parent /carer and infant or child to enable optimal development, physically and emotionally which may have some impact on childhood obesity. Children Centre staff have a responsibility for creating an environment that promotes healthy eating and physical activity and this is part of an agreement between Public Health and the Children's Centres which is subject to monitoring and audit.

- 10.11 At Tier 1 there are a number of initiatives commissioned by Public Health in Kent County Council that are delivered by Kent Community Health Foundation Trust (KCHFT) which include food champions. KCHFT have previously delivered training on consistent messages for both physical activity and healthy eating along with the Acorns to Oaks training which was to support Children's Centre staff to raise the issue of weight and be able to support families locally.
- 10.12 The school nursing team operates an open referral process - they receive referrals from various other professionals e.g. GPs, schools and health visitors, in addition to parents/carers and young people self -referring. Following referral they would provide a package of care i.e. four contacts with a child/young person. In addition they can refer to dietitians, paediatricians, healthy living/exercise programmes. The School Nurse Team undertakes the National Child Measurement Programme in reception and year 6 and offers support to parents following receipt of the result letters. A locality National Child Measurement Programme Group works in partnership across Canterbury and Coastal district to support the measurement programme to maximise the impacts of nutrition, physical activity and self-esteem enhancing interventions and to promote joint working and onward referrals.
- 10.13 The Healthy Schools team in Kent Community Health Foundation Trust is currently working intensively with targeted schools in Canterbury and Ashford. In addition all schools have access to schools premium funding to optimise physical activity and access to school sports interventions. For families who struggle with their weight there are fun oriented programmes aimed at families with primary school aged children. This is an example of what is offered:
- Year 6 Healthy Lifestyle support lessons
 - Year R Healthy Lifestyle support lessons
 - Weighing and measuring (School nurses) Yr. 6 Yr. R
 - Assemblies for promoting targeted lifestyle programme
 - Parent engagement event
 - Follow up support following NCMP result letter
 - Targeted lifestyles programme rolled out
 - Sports days event(s)
 - Healthy School Enhancement Model achievement.
- 10.14 In the former Eastern Coastal Kent PCT area these services are provided by the Healthy Weight team within Kent Community Healthcare Foundation Trust. Ready Steady Go is a 12 week programme for families with children between seven and 11 whose weight is equal to or above the 91st centile. In 2013/14 across the former Eastern Coastal Kent PCT geography there were 82 referrals, 48 participants engaged with the service and 23 participants completed the course.

- 10.15 Recruitment into these programmes is a challenge which is thought to be partly due to the stigma associated with having excess weight and also the low number of referrals from health professionals and other front line staff. It has been widely reported that front line staff do not feel confident to raise the issue of weight; this is a training need across the whole of Kent. To help with recruitment and to provide an intervention that is more acceptable Change 4 Life Clubs have also been started for families with children seven-11. These are five week interventions. There were 126 families referred, 91 families attended and 68 families completed.
- 10.16 There are no dedicated weight management programmes designed for older children. It is likely that the needs of older children will become more complex and therefore would benefit from a more specialised service.
- 10.17 There are no dedicated Tier 3 services for children in Kent; therefore access to a specialist dietician is important. This access is variable across Kent. Each clinic has the capacity to see six patients. In East Kent both consultants and GPs can refer into the service but there is higher demand than in the former West Kent PCT area. Across Kent KCHFT report waiting times of six months and this has been added to the Trust risk register. The Dietetic Team has begun to work with the Healthy Weight Team to look at how a pathway could be designed so that children who do not need to be referred to a specialist service can be referred to the Tier 2 Ready Steady Go programmes and Change 4 Life Clubs. Currently this would just be for children ages seven-11 in East Kent.
- 10.18 **Services for adults available in Canterbury and Coastal CCG**
There are a range of services and opportunities for adults for physical activity, including commercial and local authority sport and leisure services, outdoor and natural environment organisations and workplace initiatives. Kent Sport provides an extensive number of cycling and walking programmes as well as supporting sports clubs. They also manage coaching and volunteering programmes. Kent County Council Public Health commissions and delivers Sky Ride in partnership with KCC Highways and Transportation and Kent Sport. Other Kent County Council departments offering opportunities for physical activity include Country Parks and Explore Kent. Kent County Council is currently evaluating the effectiveness of outdoor gyms.
- 10.19 Public Health commissions Healthy Walks from Kent Community Health Foundation Trust and they also provide an opportunity for 30 people in East Kent to be trained as food champions.
- 10.20 For people who need more intensive support Fresh Start is a 12 week community weight management scheme offering a structured integrated service to support overweight and obese individuals. The aim of the scheme is to support individuals to achieve an average weight loss of 1-2lbs per week, with an overall loss of 5% body weight. The key objectives of the scheme are: to provide support and advice on behaviour change; provide nutritional advice needed to alter diet; provide appropriate physical activity advice to increase activity levels.
- 10.21 The Fresh Start Scheme is provided in Canterbury and Coastal CCG and predominantly delivered in pharmacy settings. Approximately 40 community pharmacies, eight health trainers and one GP surgery deliver the scheme across East Kent.
- 10.22 All pharmacy advisers are registered to make referrals to the local Exercise Referral

Scheme which offers a range of local leisure centre memberships. Clients are encouraged to increase their activity levels during and after attending the Fresh Start Scheme. Clients are also encouraged to take up the six weeks 'Pedometer Challenge' and are guided on how to start and achieve this whilst attending the Fresh Start Scheme. Clients are also signposted to the free East Kent Health Walks Scheme to further increase their activity levels.

- 10.23 For people with severe and complex obesity, specialist community weight management services are currently provided by the Bariatric Consultancy known as 4 healthy weight. Many of these patients have complex needs and may experience delay in accessing other services as a result of their weight. Analysis shows that those accessing 4 healthy weight services have a range of over 60 conditions; many have a number of co-morbidities. The most commonly appearing conditions are diabetes, hypertension, musculo-skeletal conditions, depression, polycystic ovary syndrome and respiratory problems. In addition, over 45% of 4 healthy weight patients have two or more diagnosed mental health conditions. Tier 3 services are well used by patients in the CCG. The majority of patients lose more than 5% of their body weight whilst on this programme.
- 10.24 There is no Tier 4 service provided in Kent and patients need to go outside of the district to access this service. A total of 168 bariatric operations were carried out on Kent patients in 2013/14; 99 of them referred by the Bariatric Consultancy. All surgery is undertaken in approved hospitals out of area.

Table 3: Bariatric Admissions by Clinical Commissioning Groups 2006/07-2013/14

Number of annual admissions for bariatric surgery* by Clinical Commissioning Group - 2006/07 to 2013/14								
CCG	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
NHS Ashford CCG		4	5	12	16	16	14	9
NHS Canterbury & Coastal CCG	<i>supressed</i>		10	11	19	38	18	24
NHS Dartford, Gravesham & Swanley CCG	5	16	13	27	34	46	46	40
NHS South Kent Coast CCG	<i>supressed</i>	6	6	34	30	34	27	18
NHS Swale CCG	<i>supressed</i>	6	8	11	23	23	21	19
NHS Thanet CCG		9	10	18	22	26	24	11
NHS West Kent	4	13	21	38	48	56	70	47

Where the primary diagnosis was obesity (ICD-10 E66) the following codes were used for the main or secondary procedure within the relevant time periods:
 2006/07 to 2008/09 inclusive G28*, G27.2-G27.9, G30.1-G30.4, G30.8- G30.9, G31*, G32*, G33.0-G33.3, G33.5-G33.9, G38.7, G38.8, G48.1, G48.2, G71.6.
 2009/10 to 2013/14 inclusive G27.1-G27.9, G28*, G31*, G32*, G33*, G30.1, G30.3, G30.4, G30.5, G30.9, G38.7, G48.1, G48.2, G48.5, G48.6, G71.6, G71.7.

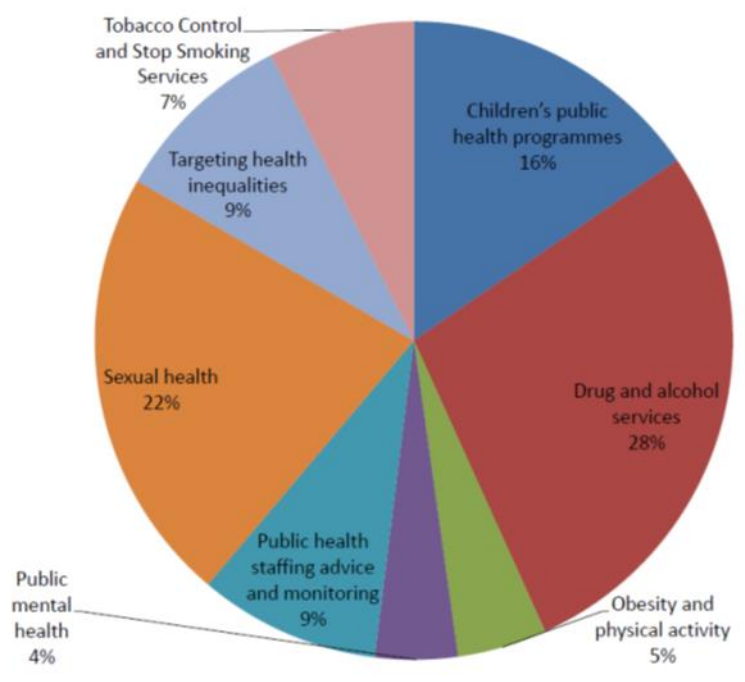
Source: Secondary Uses Service

- 10.25 There are some proposed national changes to commissioning that will impact on the future provision of Tier 3 and 4 services ⁽³¹⁾.
- 10.26 Provision of specialist support for managing weight in pregnancy is variable across Kent. It is of concern that no Kent Trusts meet NICE guidance ⁽⁴⁷⁾ for referring all women with a BMI of 30 or more to a specialist dietician.
- 10.27 Women resident in Canterbury and Coastal CCG receive midwifery services from East Kent Hospitals University Foundation NHS Trust. A referral pathway has been established with the community dietician but there is a lack of consistency in acceptance of referrals. Although BMI is recorded in the pregnancy notes there is no space to record referral to specialist services. Those women with a BMI >35 will be referred to an obstetrician and anaesthetist but there isn't sufficient capacity in their

clinics to see every woman. The Trust has reviewed its clinical equipment to ensure it is appropriate for heavier weight women. The service has no midwife with a specialist interest in healthy weight/obesity.

- 10.28 East Kent Hospitals University Foundation NHS Trust have previously been involved in the HELP cluster randomised control trial with Slimming World where 598 pregnant women in total were recruited across maternity sites in England and Wales: of these 598 women, 464 were followed up 12 months after their babies were born (the study's primary endpoint). Data collection was completed in February 2014 and results are awaited. Women can expect to have their height, weight and BMI recorded at booking. Within the notes there is a separate section to record the care plan for women with a BMI >30. There are two midwives with a special interest in healthy weight each of who have a total of six hrs protected time per week to fulfil this role (taken from existing midwifery establishment). These midwives run Healthy Weight Clinics for all women with a BMI >35. Women with a BMI >40 are referred to an obstetrician, anaesthetist and dietician. There are also two specialist diabetes midwives who have a total of 11.25 hrs per week of protected time to provide support to women with or at risk of developing diabetes. No specific information or advice on diet and exercise is included in the notes but the Start4Life leaflet, a copy of the NHS Direct page on Health in Pregnancy (includes information on diet & exercise) and the A-Z of Pregnancy & Nutrition are included in antenatal packs.
- 10.29 **Financial information**
Between 2010 and 2030 health costs associated with obesity are projected to rise nationally by £2bn⁽¹⁴⁾. The burden of costs to Kent have been very crudely calculated as over £55m using the number of Kent residents as a proportion of the whole of England 2013 population. (KMPHO) This is contributed to by 44% of the incidence of diabetes, 23% of heart disease and between 7%-41% of certain cancers. A clinical working group (Royal College of Physicians, 2013) found that obese individuals had medical costs 30% higher than those with normal weight: it is estimated that 23% of spending on all drugs is attributable to overweight and obesity⁽³⁰⁾.
- 10.30 Obesity will also have an increased impact on social care costs and an estimated 16 million days of sickness absence a year are attributable to obesity. Obese people are less likely to be in employment than people of a healthy weight. The associated welfare costs are estimated to be between £1 billion and £6 billion⁽¹⁴⁾. The NHS and local authority are major employers so this will impact on their available workforce.
- 10.31 The working group determined that treatment is cost effective and in some cases it costs less to provide it than not. Targeting treatment at those most likely to benefit will further enhance cost efficacy. The time period for assessing cost efficacy may be extended compared to some other areas of health intervention and this requires commissioning authorities to have an appropriate long-term view on the value of obesity treatment.
- 10.32 Kent County Council Public Health invests approximately £3m in obesity and physical activity, which is approximately 5% of the budget. It is within a black contract which means funding by area and by intervention is difficult to disaggregate.

Figure 6: Spending by KCC Public Health 2015/2016



10.33 **Public consultations**

In 2014 a consultation questionnaire was designed to ask the adult public about their own circumstances and their views on what interventions should be provided to help people stay a healthy weight. It was posted on the Kent County Council website in standard and easy read formats. An e-mail was sent to a broad range of partners for promotion. Six hundred and two responses were received, over the sample size required.

Table 4: Interventions that Kent adults agree would help with weight loss

Agree or strongly agree what would help?	
Having advice on healthy eating	96%
Available and affordable fresh fruit and vegetables	95%
Access to local leisure facilities	91%
Weight loss classes	90%
Local walks led mostly by volunteers	87%
Helping people with healthy eating	81%
Health Trainers	80%
Exercise classes that your GP tells you to go to	79%
Having one to one meetings with an adviser	79%
Taking part in sport?	77%
Attending a weight loss class	76%
Classes that help pregnant women to be a healthy weight	75%
Being able to walk and cycle near to where you live	47%

10.34 A short questionnaire was also designed and tested with a group of young people. It was completed by 120 children aged 11-12 in a school and 12 young people aged 13-24 in a youth setting. It was also posted on SurveyMonkey. In total there were 178

responses. The respondents thought that the best way to deliver health messages would be through TV advertisements. To enable families to be more active free gym passes and family activities should be provided so that they get more exercise.

10.35 The young people also thought healthy food should be more accessible and there was a need to promote messages such as the five a day campaign. In order to deliver these messages young people think that getting a professional athlete or celebrity on board to promote the messages would encourage families to act. Young people think that it is important to be educated and given information about being overweight, or how to avoid putting on weight. The channels for this should be social media such as Facebook. Access to free gyms or exercise groups was also a highly suggested recommendation.

10.36 **Stakeholder Views-The Big Weight Debate Summary**

Stakeholders attending the Big Weight Debate workshop on 8 December 2014 told us they wanted:

- locally tailored services
- enhanced community capacity
- additional resources for targeting services in areas of greatest inequality.

Key themes that emerged were:

- **Strategic Direction** joint priority setting, agreement on strategy, common goals and outcomes
- **Commissioning** needs to reflect differential levels of obesity, put measures into specifications
- **Service Users** acceptability, accessibility, building trust, holistic offer, social and fun
- **Workforce** huge potential untapped front line work force with training needs
- **Communication** simple clear consistent messages, knowing what interventions are in place
- **Pathways** life course approach, knowing referral process and motivation key
- **Into practice** signage, walking routes and using stairs; workplace interventions.

10.37 **Views from general practice**

Three GPs in Dartford Gravesham and Swanley and two GPs in West Kent responded to a short questionnaire about their views about tackling obesity. The GPs pointed to issues of embarrassment and denial when discussing weight with parents and one GP said that in the discussion there was often a lack of understanding of causes and solutions. Concern was expressed about stigma and a reluctance to disrupt the professional relationship by causing offence. One GP stated that because patients are not coming to primary care because of weight issues, there is not time within the consultation to discuss obesity. The respondents were unaware of some of the service provision that is in place, particularly for families but also that there was longer term non-surgical psychological based support for people with a lot of weight to lose. Other professional support that was mentioned included dietetics, school nursing, health visitors and surgery.

10.38 One respondent was concerned that this was a societal issue and not a medical one and cited the Finnish heart disease programme in the 1970s which worked when the total country took responsibility for the issue. A key issue raised was motivation that people often felt that they had tried and failed in the past, people needed to want to take action. An advantage of provision that they knew about was that it was free. Ideas that were given for what else could be done included pathways, practice based programmes, starting early i.e. antenatally, providing fun accessible programmes for children and young people and taking a family approach, more referrals to exercise programmes and looking at what works. One GP was unsure about where responsibility lies for tackling childhood obesity, whether it was school nurses, public health, GPs or schools and called for a more integrated approach across local authority, social care and NHS and that cultural change was more important than pathways.

10.39

Summary

- **NHS Canterbury and Coastal CCG has better levels of child obesity compared to England and comparable adult obesity rates.**
- **NHS Canterbury and Coastal CCG are committed to providing better care for people with long term conditions, urgent care, mental health, children and young people and maternity.**
- **Five community hospitals, 22 GP practices, 40 pharmacies, 37 dental practices, 10 children's centres and 71 schools as well as NHS and local authority workplaces are key settings for prevention, achieving this will require training.**
- **Family weight management services are under-used and there are very few services for teenagers.**
- **Maternity services do not meet NICE guidance as not all eligible women see a dietician during pregnancy.**
- **Further work needs to be undertaken to ensure there is a complete healthy weight pathway in NHS Canterbury and Coastal CCG.**

11. South Kent Coast CCG

11.1 Background

NHS South Kent Coast has a population of 199,000. It covers the district of Shepway and the towns of Deal and Dover. More people in the area have long-term health conditions, such as heart disease, stroke, diabetes, cancer, high blood pressure, epilepsy and learning disabilities, than the average for England. The CCG priorities ⁽⁶²⁾ are for fewer people under 75 dying from respiratory disease, fewer unplanned hospital admissions for adults with long term health conditions and more people feeling supported to manage their condition, obesity impacts particularly on hospital admissions and losing weight as part of a patient self-management model for long term conditions.

11.2 The majority of South Kent Coast CCG patients access hospital services outside the CCG boundaries. Queen Elizabeth The Queen Mother Hospital and the Kent and Sussex hospitals are nearest. There are three community hospitals in the CCG area, The Queen Victoria, Buckland and Royal Victoria hospitals. There are 32 GP practices in South Kent Coast, 42 pharmacies and 27 dental practices. There are 15 children's centres and 86 schools, including Pupil Referral Units ⁽⁶³⁾.

11.3 South Kent Coast CCG has worse rates of adult obesity compared to the England average.

Table 1: Adult obesity in South Kent Coast CCG

Adult obesity 2014	%
South Kent Coast CCG	26.5
England	24.1
England worst	30.9

Public Health England

South Kent Coast CCG has similar rates to the England for adult healthy eating prevalence ⁽⁶⁴⁾.

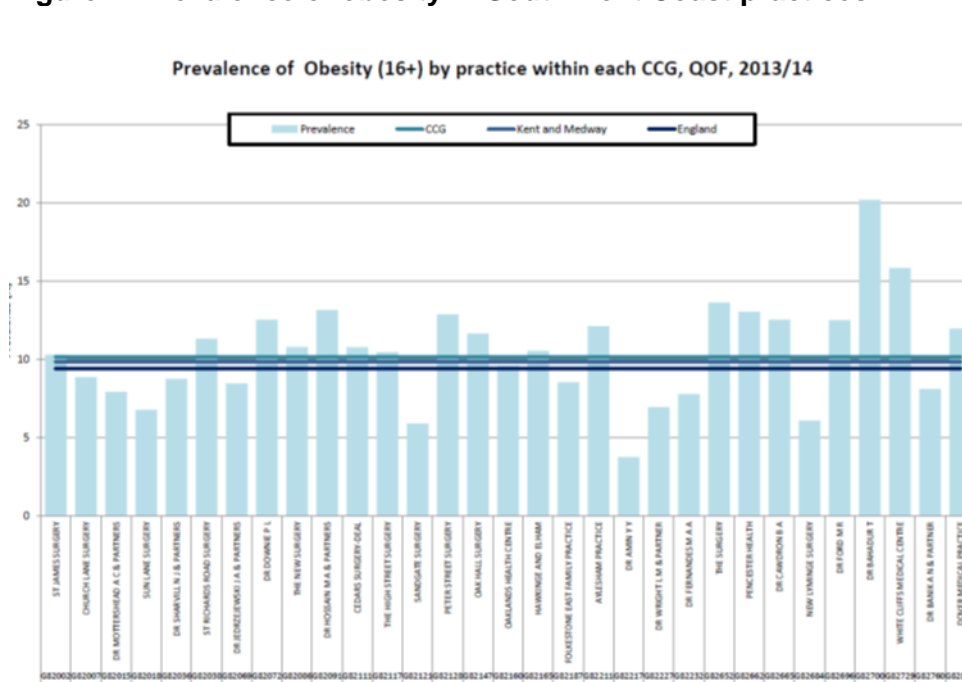
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South Kent Coast CCG	26.0
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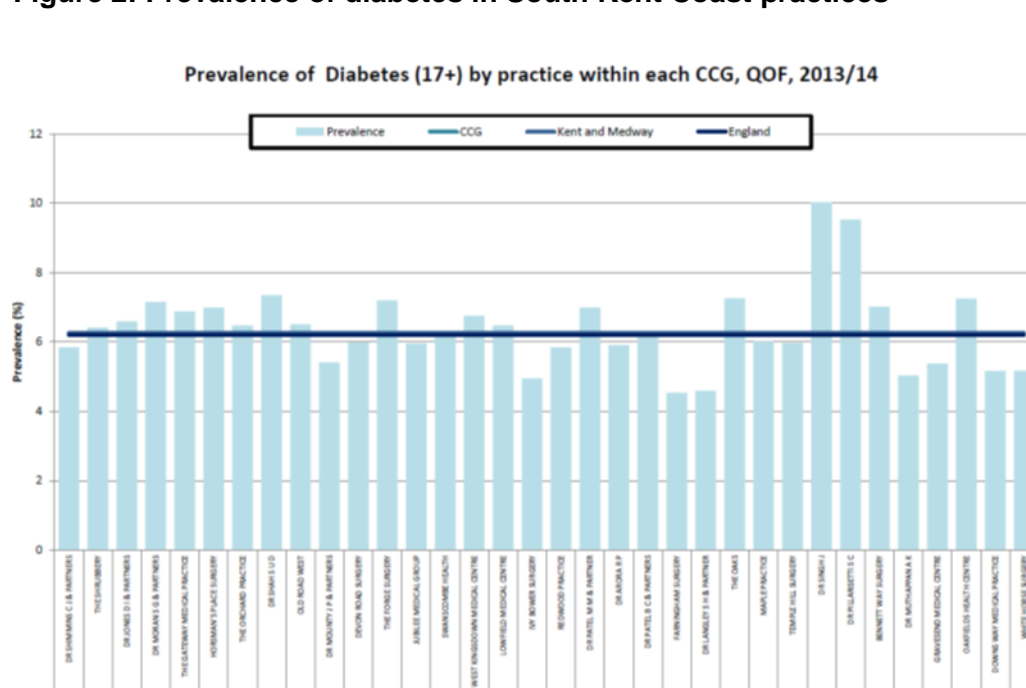
Figure 1: Prevalence of obesity in South Kent Coast practices



Kent and Medway Public Health Observatory Health and Social Care Maps

11.5 As already described, obesity contributes to a number of serious and preventable conditions including Type 2 diabetes, Obesity accounts for 44% of people with diabetes nationally. The following chart shows the prevalence of diabetes by practice within South Kent Coast CCG.

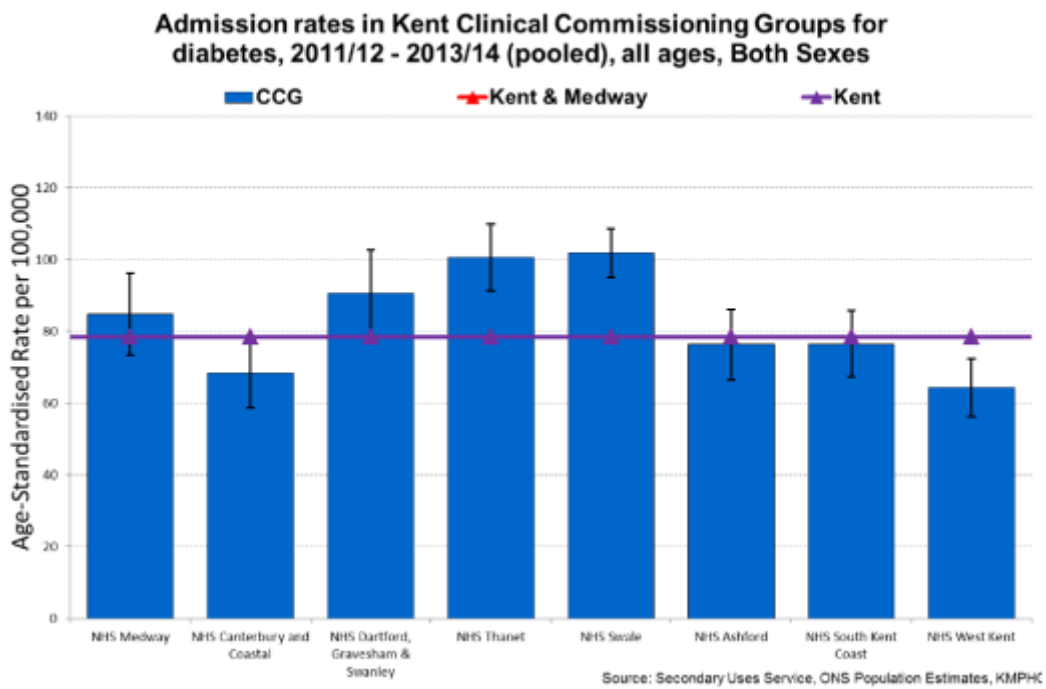
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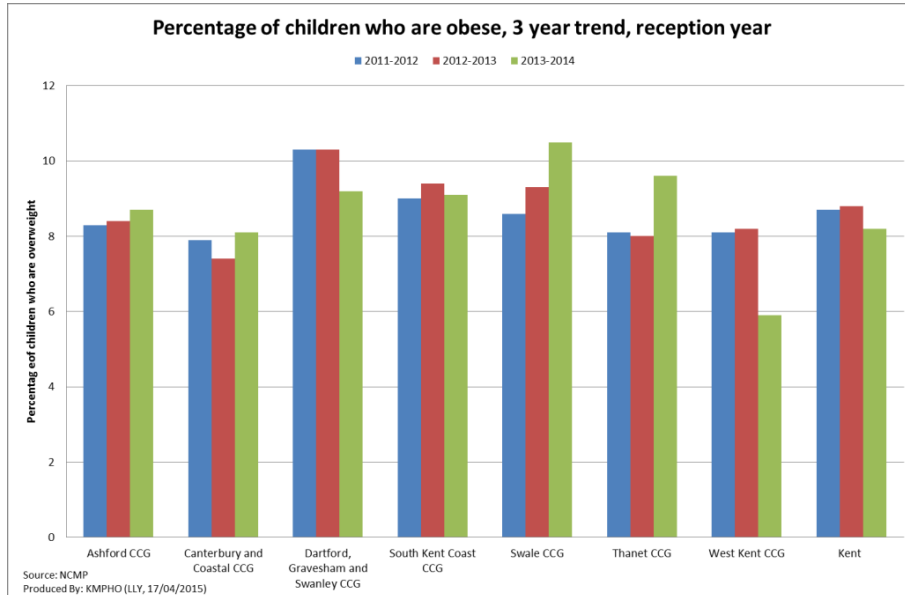
- 11.6 Figure 3 shows the rates of diabetes admission by Clinical Commissioning Groups across Kent and Medway. South Kent Coast CCG a prevalence of diabetes similar to the Kent and Medway average.

Figure 3: Admission rates for diabetes in CCGs in Kent and Medway 2011/2012-2013/2014



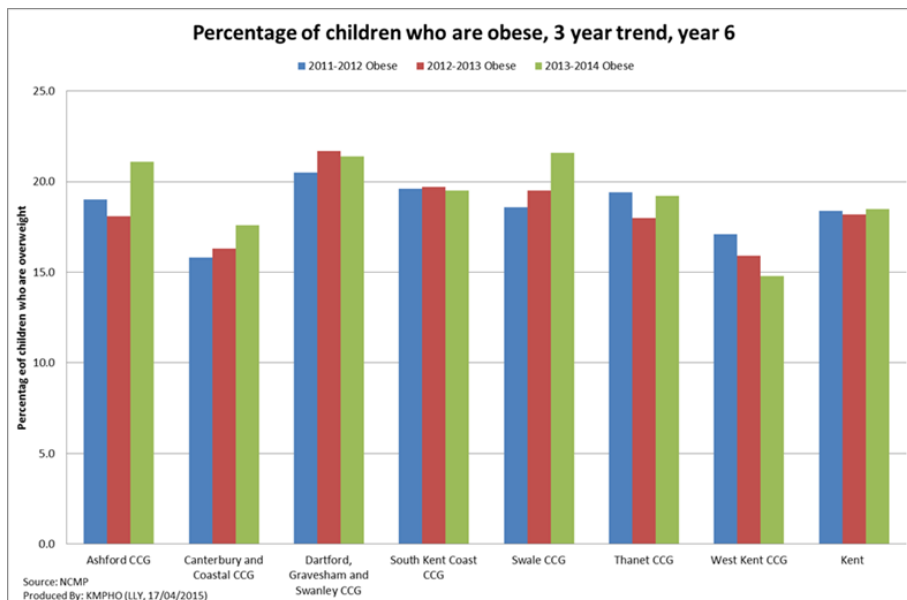
- 11.7 **Childhood obesity in South Kent Coast**
 The data that is available for child obesity is taken from the National Child Measurement Programme. In Kent the school nursing teams measure children at 4-5 years (reception) and at 10-11 years (year 6). In 2013/14 94.9% of eligible children were measured.
- 11.8 The proportion of obese reception year children in South Kent Coast CCG has fluctuated between 2011/12- 2013/14.

Figure 4: Childhood obesity by CCG in reception year 2011/2012-2013/2014



11.9 South Kent Coast CCG year 6 prevalence has levelled off over the three years from 2011/12-2013/14. The Kent trend is also showing some signs of plateauing over this time period.

Figure 4: Childhood obesity by CCG in year 6 2011/2012-2013/14



Reporting by CCGs or by districts often masks the differences between areas and these can be seen in the Health and Social Care maps in Appendix 1

11.10 **Services available to tackle childhood obesity in South Kent Coast**
Evidence based intervention during the early years of life is described in the Healthy

Child programme. Health visitors promote infant led weaning as part of their universal offer and provide public health advice and interventions that encourage healthy eating and physical activity to parents and carers and their young families. Across Kent, the 'Born to Move' initiative is a health visitor led project which aims to raise awareness of the importance of human interaction between parent /carer and infant or child to enable optimal development, physically and emotionally which may have some impact on childhood obesity. Children Centre staff have a responsibility for creating an environment that promotes healthy eating and physical activity and this is part of an agreement between Public Health and the Children's Centre which is subject to monitoring and audit.

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- 11.18 **Services available to tackle adult obesity in South Kent Coast**
There are a range of services and opportunities for adults for physical activity, including commercial and local authority sport and leisure services, outdoor and natural environment organisations and workplace initiatives. Kent Sport provides an extensive number of cycling and walking programmes as well as supporting sports clubs. They also manage coaching and volunteering programmes. Kent County Council Public Health commissions and delivers Sky Ride in partnership with KCC Highways and Transportation and Kent Sport. Other Kent County Council departments offering opportunities for physical activity include Country Parks and Explore Kent. Kent County Council is currently evaluating the effectiveness of outdoor gyms.
- 11.19 Public Health commissions Healthy Walks from Kent Community Health Foundation Trust and they also provide an opportunity for 30 people in East Kent to be trained as food champions.
- 11.20 For people who need more intensive support Fresh Start is a 12 week community weight management scheme offering a structured integrated service to support overweight and obese individuals. The aim of the scheme is to support individuals to achieve an average weight loss of 1-2lbs per week, with an overall loss of 5% body weight. The key objectives of the scheme are: to provide support and advice on behaviour change; provide nutritional advice needed to alter diet; provide appropriate physical activity advice to increase activity levels.
- 11.21 The Fresh Start Scheme is provided in South Kent Coast CCG and predominantly delivered in pharmacy settings. Approximately 40 community pharmacies, eight health trainers and one GP Surgery deliver the scheme across in East Kent.

- 11.22 All pharmacy advisers are registered to make referrals to the local Exercise Referral Scheme which offers a range of local leisure centre memberships. Clients are encouraged to increase their activity levels during and after attending the Fresh Start Scheme. Clients are also encouraged to uptake the six weeks 'Pedometer Challenge' and are guided on how to start and achieve this whilst attending the Fresh Start Scheme. Clients are also signposted to the free East Kent Health Walks Scheme to further increase their activity levels.
- 11.23 In addition the Balmoral practice has been offering an in-house Tier 2 weight management programme for its own and neighbouring patients in Deal since 2008. The programme is open ended and some patients have been attending the programme from the beginning. It is run by a dietician and a health care assistant with support from other members of the primary care team. There had formerly been an exercise component but the provider left and the practice is seeking to re-instate this. The programme runs one half day a week.
- 11.24 For people with severe and complex obesity specialist community weight management services are currently provided by the Bariatric Consultancy known as 4 healthy weight. Many of these patients have complex needs and may experience delay in accessing other services as a result of their weight. Analysis shows that those accessing 4 healthy weight services have a range of over 60 conditions; many have a number of co-morbidities. The most commonly appearing conditions are diabetes, hypertension, musculo-skeletal conditions, depression, polycystic ovary syndrome and respiratory problems. In addition, over 45% of 4 healthy weight patients have two or more diagnosed mental health conditions. Tier 3 services are well used by patients in the CCG. The majority of patients lose more than 5% of their body weight whilst on this programme.
- 11.25 There is no Tier 4 service provided in Kent and patients need to go outside of the district to access this service. A total of 168 bariatric operations were carried out on Kent patients in 2013/14; 99 of them referred by the Bariatric Consultancy. All surgery is undertaken in approved hospitals out of area.

Table 3: Bariatric admissions by Clinical Commissioning Groups in Kent and Medway 2006/2007-2013/2014

Number of annual admissions for bariatric surgery* by Clinical Commissioning Group - 2006/07 to 2013/14								
CCG	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
NHS Ashford CCG		4	5	12	16	16	14	9
NHS Canterbury & Coastal CCG	<i>supressed</i>		10	11	19	38	18	24
NHS Dartford, Gravesham & Swanley CCG	5	16	13	27	34	46	46	40
NHS South Kent Coast CCG	<i>supressed</i>	6	6	34	30	34	27	18
NHS Swale CCG	<i>supressed</i>	6	8	11	23	23	21	19
NHS Thanet CCG		9	10	18	22	26	24	11
NHS West Kent	4	13	21	38	48	56	70	47

Where the primary diagnosis was obesity (ICD-10 E66) the following codes were used for the main or secondary procedure within the relevant time periods:
 2006/07 to 2008/09 inclusive G28*, G27.2-G27.9, G30.1-G30.4, G30.8- G30.9, G31*, G32*, G33.0-G33.3, G33.5-G33.9, G38.7, G38.8, G48.1, G48.2, G71.6.
 2009/10 to 2013/14 inclusive G27.1-G27.9, G28*, G31*, G32*, G33*, G30.1, G30.3, G30.4, G30.5, G30.9, G38.7, G48.1, G48.2, G48.5, G48.6, G71.6, G71.7.

Source: Secondary Uses Service

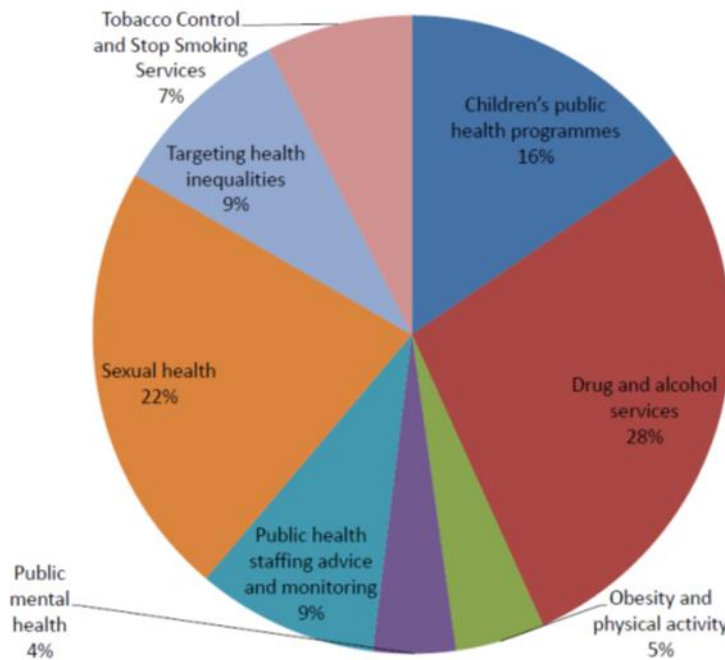
- 11.26 There are some proposed national changes to commissioning that will impact on the future provision of Tier 3 and Tier 4 services. (31)

- 11.27 Provision of specialist support for managing weight in pregnancy is variable across Kent. It is of concern that no Kent Trusts meet NICE guidance (47) for referring all women with a BMI of 30 or more to a specialist dietician.
- 11.28 South Kent Coast CCG midwifery services are provided by East Kent Hospitals University Foundation NHS Trust. A referral pathway has been established with the community dietician but there is a lack of consistency in acceptance of referrals. Although BMI is recorded in the pregnancy notes there is no space to record referral to specialist services. Those women with a BMI >35 will be referred to an obstetrician and anaesthetist but there isn't sufficient capacity in their clinics to see every woman. The Trust has reviewed its clinical equipment to ensure it is appropriate for heavier weight women. The service has no midwife with a specialist interest in healthy weight/obesity.
- 11.29 East Kent Hospitals University Foundation NHS Trust have previously been involved in the HELP cluster randomised control trial with Slimming World where 598 pregnant women in total were recruited across maternity sites in England and Wales: of these 598 women, 464 were followed up 12 months after their babies were born (the study's primary endpoint). Data collection was completed in February 2014 and results are awaited. Women can expect to have their height, weight and BMI recorded at booking. Within the notes there is a separate section to record the care plan for women with a BMI >30. There are two midwives with a special interest in healthy weight each of who have a total of six hrs protected time per week to fulfil this role (taken from existing midwifery establishment). These midwives run Healthy Weight Clinics for all women with a BMI >35. Women with a BMI >40 are referred to an obstetrician, anaesthetist and dietician. There are also two specialist diabetes midwives who have a total of 11.25 hrs per week of protected time to provide support to women with or at risk of developing diabetes. No specific information or advice on diet and exercise is included in the notes but the Start4Life leaflet, a copy of the NHS Direct page on Health in Pregnancy (includes information on diet & exercise) & the A-Z of Pregnancy & Nutrition are included in ante-natal packs.
- 11.30 **Financial implications**
Between 2010 and 2030 health costs associated with obesity are projected to rise nationally by £2bn⁽⁵⁹⁾. The burden of costs to Kent have been very crudely calculated as over £55m using the number of Kent residents as a proportion of the whole of England 2013 population. (KMPHO) This is contributed to by 44% of the incidence of diabetes, 23% of heart disease and between 7%-41% of certain cancers. A clinical working group (Royal College of Physicians, 2013) found that obese individuals had medical costs 30% higher than those with normal weight: it is estimated that 23% of spending on all drugs is attributable to overweight and obesity⁽³⁰⁾.
- 11.31 Obesity will also have an increased impact on social care costs and an estimated 16 million days of sickness absence a year are attributable to obesity. Obese people are less likely to be in employment than people of a healthy weight. The associated welfare costs are estimated to be between £1 billion and £6 billion⁽¹⁴⁾. The NHS and local authority are major employers so this will impact on their available workforce.
- 11.32 The working group determined that treatment is cost effective and in some cases it costs less to provide it than not. Targeting treatment at those most likely to benefit will further enhance cost efficacy. The time period for assessing cost efficacy may be extended compared to some other areas of health intervention and this requires commissioning authorities to have an appropriate long-term view on the value of obesity

treatment.

- 11.33 Kent County Council Public Health invests approximately £3m in obesity and physical activity, which is approximately 5% of the budget. It is within a black contract which means funding by area and by intervention is difficult to disaggregate.

Figure 5: Spending by KCC Public Health 2015/2016



- 11.34 In 2014 a consultation questionnaire was designed to ask the adult public about their own circumstances and their views on what interventions should be provided to help people stay a healthy weight. It was posted on the Kent County Council website in standard and easy read formats. An e-mail was sent to a broad range of partners for promotion. Six hundred and two responses were received, over the sample size required.

Table 4: Interventions that Kent adults agree would help with weight loss

Agree or strongly agree what would help?	
Having advice on healthy eating	96%
Available and affordable fresh fruit and vegetables	95%
Access to local leisure facilities	91%
Weight loss classes	90%
Local walks led mostly by volunteers	87%
Helping people with healthy eating	81%
Health Trainers	80%
Exercise classes that your GP tells you to go to	79%
Having one to one meetings with an adviser	79%
Taking part in sport?	77%
Attending a weight loss class	76%
Classes that help pregnant women to be a healthy weight	75%
Being able to walk and cycle near to where you live	47%

- 11.35 A short questionnaire was also designed and tested with a group of young people. It was completed by 120 children aged 11-12 in a school and 12 young people aged 13-24 in a youth setting. It was also posted on SurveyMonkey. In total there were 178 responses. The respondents thought that the best way to deliver health messages would be through TV adverts. To enable families to be more active free gym passes and family activities should be provided so that they get more exercise.
- 11.36 The young people also thought healthy food should be more accessible and there was a need to promote messages such as the five a day campaign. In order to deliver these messages young people think that getting a professional athlete or celebrity on board to promote the messages would encourage families to act. Young people think that it is important to be educated and given information about being overweight, or how to avoid putting on weight. The channels for this should be social media such as Facebook. Access to free gyms or exercise groups was also a highly suggested recommendation.
- 11.37 **Stakeholder Views-The Big Weight Debate Summary**
Stakeholders attending the Big Weight Debate workshop on 8 December 2014 told us they wanted:

- locally tailored services
- enhanced community capacity
- additional resources for targeting services in areas of greatest inequality.

Key themes that emerged were:

- **Strategic Direction** joint priority setting, agreement on strategy, common goals and outcomes
- **Commissioning** needs to reflect differential levels of obesity, put measures into specifications
- **Service Users** acceptability, accessibility, building trust, holistic offer, social and fun
- **Workforce** huge potential untapped front line work force with training needs
- **Communication** simple clear consistent messages, knowing what interventions are in place
- **Pathways** life course approach, knowing referral process and motivation key
- **Into practice** signage, walking routes and using stairs; workplace interventions.

- 11.38 **Views from general practice**
Three GPs in Dartford Gravesham and Swanley and two GPs in West Kent responded to a short questionnaire about their views about tackling obesity. The GPs pointed to issues of embarrassment and denial when discussing weight with parents and one GP said that in the discussion there was often a lack of understanding of causes and solutions. Concern was expressed about stigma and a reluctance to disrupt the professional relationship by causing offence. One GP stated that because patients are not coming to primary care because of weight issues, there is not time within the consultation to discuss obesity. The respondents were unaware of some of the service

provision that is in place, particularly for families but also that there was longer term non-surgical psychological based support for people with a lot of weight to lose. Other professional support that was mentioned included dietetics, school nursing, health visitors and surgery.

- 11.39 One respondent was concerned that this was a societal issue and not a medical one and cited the Finnish heart disease programme in the 1970s which worked when the total country took responsibility for the issue. A key issue raised was motivation that people often felt that they had tried and failed in the past, people needed to want to take action. An advantage of provision that they knew about was that it was free. Ideas that were given for what else could be done included pathways, practice based programmes, starting early i.e. ante natally, providing fun accessible programmes for children and young people and taking a family approach, more referrals to exercise programmes and looking at what works. One GP was unsure about where responsibility lies for tackling childhood obesity, whether it was school nurses, public health, GPs or schools and called for a more integrated approach across local authority, social care and NHS and that cultural change was more important than pathways.

11.40

Summary

- **NHS South Kent Coast CCG has worse levels of child obesity in year 6 compared to England and worse adult obesity rates.**
- **NHS South Kent Coast CCG priorities are fewer people under 75 dying from respiratory disease, fewer unplanned hospital admissions for adults with long term health conditions and more people feeling supported to manage their condition.**
- **Three community hospitals, 32 GP practices in South Kent Coast, 42 pharmacies, 27 dental practices, 15 children's centres and 86 schools as well as NHS and local authority workplaces are key settings for prevention, achieving this will require training.**
- **Balmoral Practice is the only GP practice in Kent providing dedicated weight management programmes for patients.**
- **Family weight management services are under-used and there is very little provision for teenagers.**
- **Maternity services do not meet NICE guidance as not all eligible women see a dietician during pregnancy.**
- **Further work needs to be undertaken to ensure there is a complete healthy weight pathway in NHS South Kent Coast CCG for both adults and children and young people.**

12. Swale

- 12.1 NHS Swale Clinical Commissioning Group has a population of 106,570. It covers Sheppey, Sittingbourne, Teynham and the surrounding rural communities. The CCGs priorities that are relevant to obesity include reducing health inequality, improving the quality of life for patients with complex and long-term conditions, improving care by integrating services and promoting wellbeing and mental health ⁽⁶⁵⁾.
- 12.2 The majority of Swale CCG patients access acute hospital services outside of the CCG boundaries, Medway is nearest for most. There are two community hospitals in the CCG area, Sittingbourne Memorial and Sheppey Community hospitals. There are 20 GP practices in Swale, 25 pharmacies and 15 dental practices. There are eight Children's Centres and 45 schools, including Pupil Referral Units ⁽⁶⁶⁾.
- 12.3 Swale CCG has the worse rate of adult obesity in England.

Table 1: Adult obesity rates in Swale

Adult obesity 2014	%
Swale CCG	30.9
England	24.1
England worst	30.9

Public Health England CCG Neighbourhood Profiles

Swale CCG has worse rates than England for adult healthy eating prevalence ⁽⁶⁷⁾.

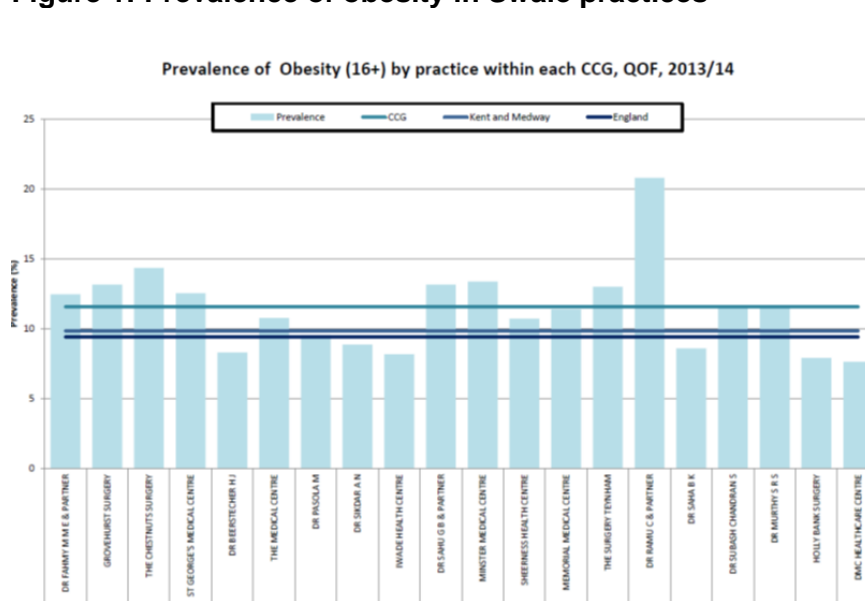
Table 2: Adult healthy eating rates in Swale

Adult healthy eating 2014	%
Swale CCG	22.3
England	28.7
England worst	19.4

Public Health England CCG Neighbourhood Profiles

- 12.4 The recorded QoF data shows prevalence of obesity by GP practice. Obesity is not generally well recorded in primary care.

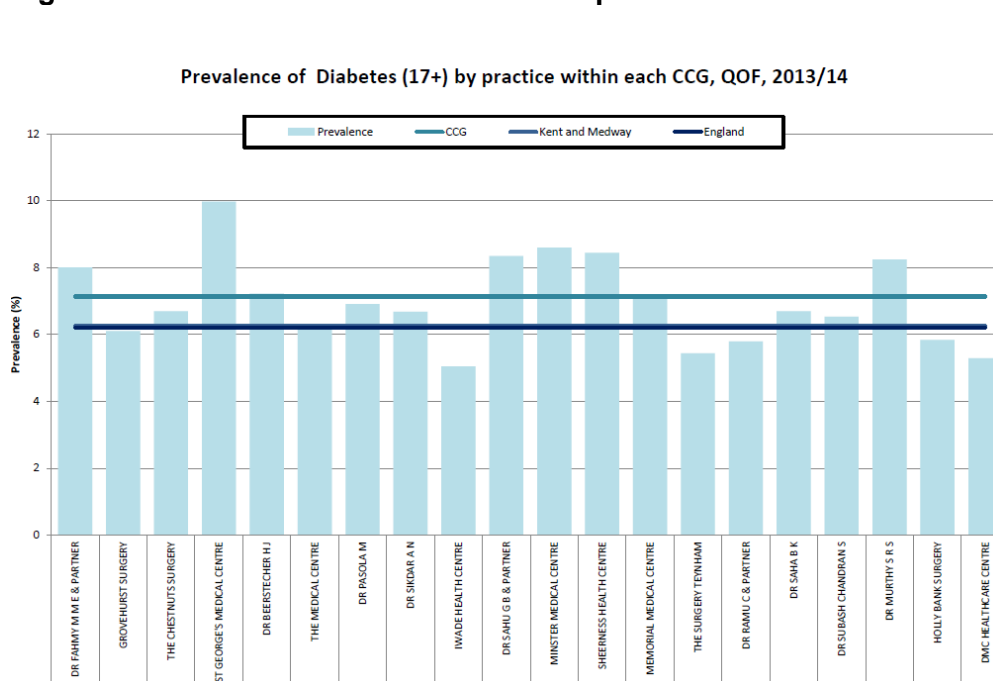
Figure 1: Prevalence of obesity in Swale practices



Kent and Medway Public Health Observatory Health and Social Care Maps

- 12.5 As already described, obesity contributes to a number of serious and preventable conditions including Type 2 diabetes, Obesity accounts for 44% of people with diabetes nationally. The following chart shows the prevalence of diabetes by practice within Swale CCG.

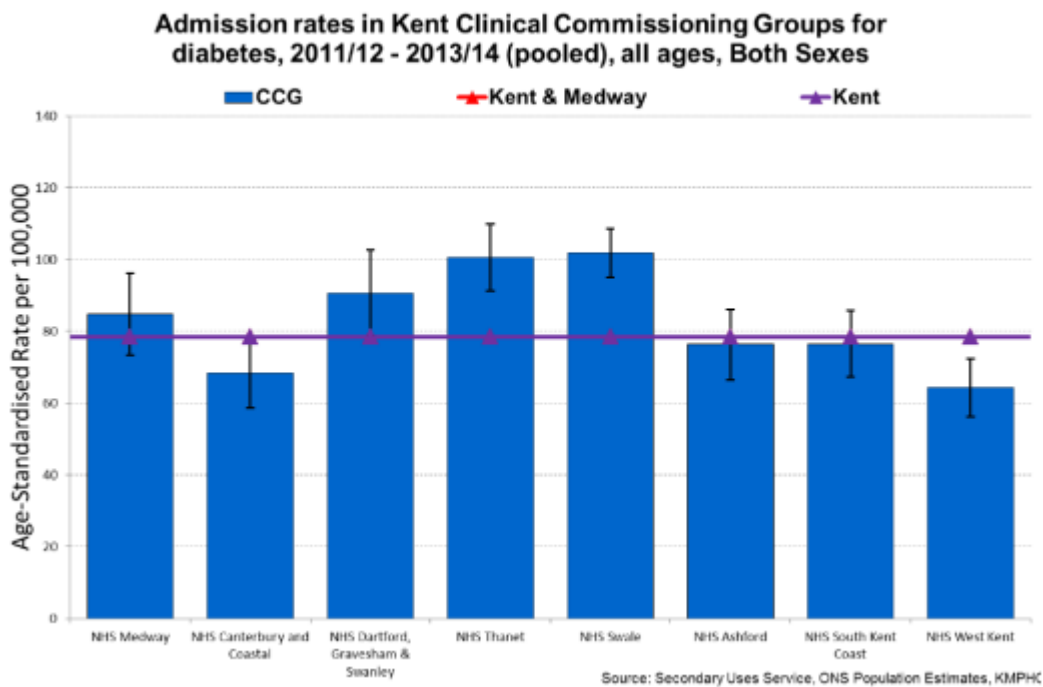
Figure 2: Prevalence of diabetes in Swale practices



Kent and Medway Public Health Observatory Health and Social Care Maps

- 12.6 Figure 3 shows the rates of diabetes admission by Clinical Commissioning Groups across Kent and Medway. Swale and Thanet CCGs have the highest admission rates for diabetes.

Figure 3: Admission rates for diabetes in CCGs in Kent and Medway 2011/2012-2013/2014

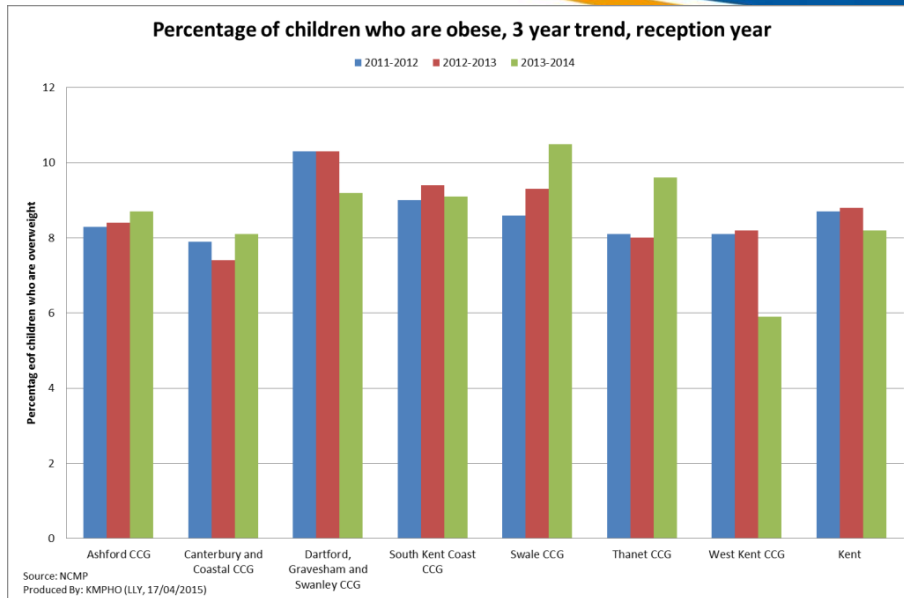


12.7 Childhood obesity in Swale

The data that is available for child obesity is taken from the National Child Measurement Programme. In Kent the school nursing teams measure children at 4-5 years (reception) and at 10-11 years (year 6). In 2013/14 94.9% of eligible children were measured.

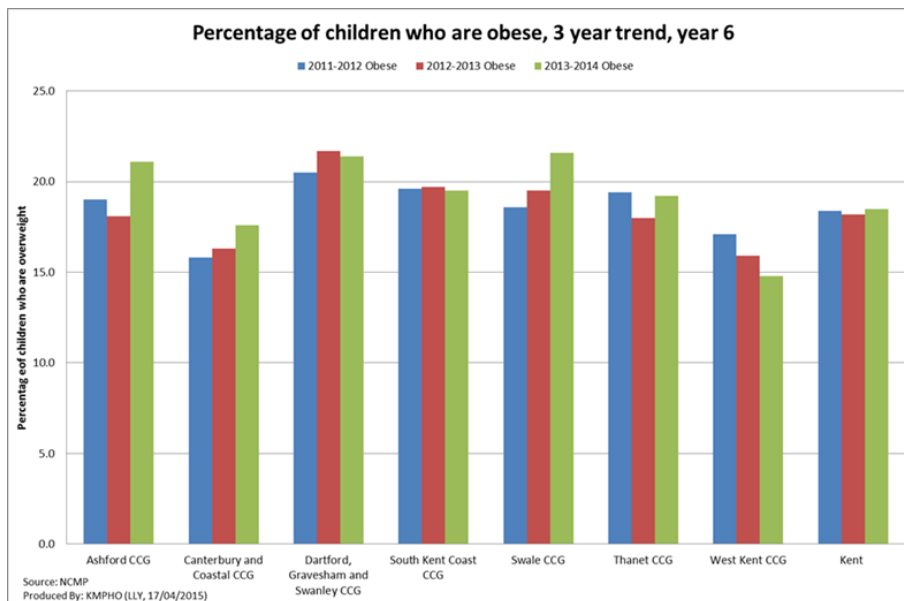
- 12.8 The proportion of obese reception year children in Swale CCG has increased year on year between 2011/12 and 2013/14. Swale has the worst rates in Kent.

Figure 4: Childhood obesity by CCG in reception year 2011/2012-2013/2014



12.9 Swale CCG year 6 prevalence has increased year on year over the three years from 2011/12-2013/14. The Kent trend is also showing some signs of plateauing over this time period.

Figure 5: Childhood obesity by CCG in reception year 2011/2012-2013/2014



Reporting by CCGs or by districts often masks the differences between areas and these can be seen in the Health and Social Care maps in Appendix 1.

12.10 **Services available for children and families to tackle obesity in Swale**
Evidence based intervention during the early years of life is described in the Healthy Child programme. Health visitors promote infant led weaning as part of their universal offer and provide public health advice and interventions that encourage healthy eating and physical activity to parents and carers and their young families. Across Kent, the 'Born to Move' initiative is a health visitor led project which aims to raise awareness of the importance of

human interaction between parent /carer and infant or child to enable optimal development, physically and emotionally which may have some impact on childhood obesity. Children Centre staff have a responsibility for creating an environment that promotes healthy eating and physical activity and this is part of an agreement between Public Health and the Children's Centre which is subject to monitoring and audit.

- 12.11 At Tier 1 there are a number of initiatives commissioned by Public Health in Kent County Council that are delivered by Kent Community Health Foundation Trust (KCHFT) which include food champions. KCHFT have previously delivered training on consistent messages for both physical activity and healthy eating e.g. the Acorns to Oaks training which was to support Children's Centre staff to raise the issue of weight and be able to support families locally.
- 12.12 The school nursing team from Medway Foundation Trust provide services for Swale, including the National Child Measurement Programme where they measure the children and offer support to parents after the results letters are sent out. The Swale team pro-actively calls parents and carers on the day the child is measured offering support, advice and onward referrals to family weight management services where required. There is a dedicated team for Swale and the school nursing service provides health education which includes healthy eating. They undertake hearing tests, growth monitoring and give advice on health related issues. They will also support pupils with chronic health issues. A locality National Child Measurement Programme Group strives to work in partnership across Swale to support the measurement programme to maximise the impacts of nutrition, physical activity and self-esteem enhancing interventions and to promote joint working and onward referrals.
- 12.13 The Healthy Schools team in Kent Community Health Foundation Trust is currently working intensively with targeted schools in Swale. In addition all schools have access to schools premium funding to optimise physical activity and access to school sports interventions. For families who struggle with their weight there are fun oriented programmes aimed at families with primary school aged children. This is an example of what is offered:
- Year 6 Healthy Lifestyle support lessons
 - Year R Healthy Lifestyle support lessons
 - Weighing and measuring (School nurses) Yr. 6 Yr. R
 - Assemblies for promoting targeted lifestyle programme
 - Parent engagement event
 - Follow up support following NCMP result letter
 - Targeted lifestyles programme rolled out
 - Sports days event(s)
 - Healthy School Enhancement Model achievement.
- 12.14 Swale family weight management services are provided by the Healthy Weight team within Kent Community Healthcare Trust. Ready Steady Go is a 12 week programme for families with children between seven and 11 whose weight is equal to or above the 91st centile. In 2013/14 across the former Eastern Coastal Kent PCT geography there were 82 referrals, 48 participants engaged with the service and 23 participants completed the course. These courses are rotated across localities over the course of a year.
- 12.15 Recruitment into these programmes is a challenge which is thought to be partly due to the stigma associated with having excess weight and also the low number of referrals from

health professionals and other front line staff. It has been widely reported that front line staff do not feel confident to raise the issue of weight; this is a training need across the whole of Kent. To help with recruitment and to provide an intervention that is more acceptable Change 4 Life Clubs have also been started for families with children seven-11. These are five week interventions. There were 126 families referred, 91 families attended and 68 families completed.

- 12.16 There are no dedicated weight management programmes designed for older children. It is likely that the needs of older children will become more complex and therefore would benefit from a more specialised service.
- 12.17 There are no dedicated Tier 3 services for children in Kent; therefore access to a specialist dietician is important. This access is variable across Kent. Each clinic has the capacity to see six patients. In East Kent both consultants and GPs can refer into the service but there is higher demand than in the former West Kent PCT area. Across Kent KCHFT report waiting times of six months and this has been added to the Trust risk register. The Dietetic Team has begun to work with the Healthy Weight Team to look at how a pathway could be designed so that children who do not need to be referred to a specialist service can be referred to the Tier 2 Ready Steady Go programmes and Change 4 Life Clubs. Currently this would just be for children ages seven-11 in East Kent.
- 12.18 **Services available in Swale to tackle adult obesity**
There are a range of services and opportunities for adults for physical activity, including commercial and local authority sport and leisure services, outdoor and natural environment organisations and workplace initiatives. Kent Sport provides an extensive number of cycling and walking programmes as well as supporting sports clubs. They also manage coaching and volunteering programmes. Kent County Council Public Health commissions and delivers Sky Ride in partnership with KCC Highways and Transportation and Kent Sport. Other Kent County Council departments offering opportunities for physical activity include Country Parks and Explore Kent. Kent County Council is currently evaluating the effectiveness of outdoor gyms.
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- 12.21 The Fresh Start Scheme is provided in Swale CCG and predominantly delivered in pharmacy settings. Approximately 40 community pharmacies, eight health trainers and one GP surgery deliver the scheme across East Kent.
- 12.22 All pharmacy advisers are registered to make referrals to the local Exercise Referral Scheme which offers a range of local leisure centre memberships. Clients are encouraged to increase their activity levels during and after attending the Fresh Start Scheme. Clients are also encouraged to take up the six weeks 'Pedometer Challenge'

and are guided on how to start and achieve this whilst attending the Fresh Start Scheme. Clients are also signposted to the free East Kent Health Walks Scheme to further increase their activity levels.

- 12.23 Specialist weight management services are recommended for people with severe and complex obesity, they are typically 12-24 month duration and a standard outcome is a weight loss of 5-10%. The Swale Weight Management Service (SWMS) provides this service for people in Swale. It is part of the KCHFT block contract for health improvement services. Once referred by a GP all clients are initially assessed by the multi-disciplinary team. The MDT does not currently have a bariatric physician and cannot therefore refer onto the surgical pathway, which is a major weakness. In 2013/14 the service saw 209 patients. 28.9% of SWMS patients completed 12 months. The service achieved a weight loss of 5-10% in 5.4% of all patients and a weight loss in excess of 10% in 3.7% of the total cohort.
- 12.24 There is no Tier 4 service provided in Kent and patients need to go outside of the district to access this service. A total of 168 bariatric operations were carried out on Kent patients in 2013/14. All surgery is undertaken in approved hospitals out of area.

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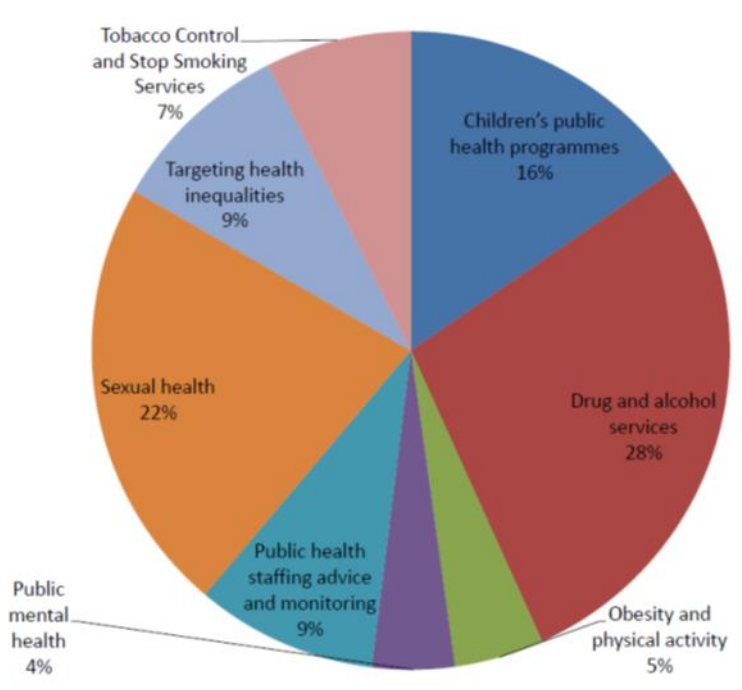
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- 12.27 Medway Foundation Trust provides maternity services for Swale. The Trust follows a pathway for maternal obesity. Women with a BMI >35-40 are seen by the lead midwife for diabetes and obesity, which is a job share 18 hours per week. In addition there is an evening four week programme for women and their partners which includes healthy eating in pregnancy, exercise and pregnancy and psychological aspects. One session is left open to cover a subject of interest to the group. Women with a BMI>40 and above are referred to a consultant. Twenty-one women are participating in a Metformin study.
- 12.28 **Financial considerations**
 Between 2010 and 2030 health costs associated with obesity are projected to rise nationally by £2bn ⁽¹⁴⁾. The burden of cost to Kent has been very crudely calculated as

over £55m using the number of Kent residents as a proportion of the whole of England 2013 population. (KMPHO) This is contributed to by 44% of the incidence of diabetes, 23% of heart disease and between 7%-41% of certain cancers. A clinical working group (Royal College of Physicians, 2013) found that obese individuals had medical costs 30% higher than those with normal weight: it is estimated that 23% of spending on all drugs is attributable to overweight and obesity ⁽³⁰⁾.

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Figure 6: Spending by KCC Public Health 2015/16



- 12.32 **Public consultations**
In 2014 a consultation questionnaire was designed to ask the adult public about their own circumstances and their views on what interventions should be provided to help people stay a healthy weight. It was posted on the Kent County Council website in standard and

easy read formats. An e-mail was sent to a broad range of partners for promotion. Six hundred and two responses were received, over the sample size required.

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- 12.33 A short questionnaire was also designed and tested with a group of young people. It was completed by 120 children aged 11-12 in a school and 12 young people aged 13-24 in a youth setting. It was also posted on SurveyMonkey. In total there were 178 responses. The respondents thought that the best way to deliver health messages would be through TV adverts. To enable families to be more active free gym passes and family activities should be provided so that they get more exercise.
- 12.34 The young people also thought healthy food should be more accessible and there was a need to promote messages such as the five a day campaign. In order to deliver these messages young people think that getting a professional athlete or celebrity on board to promote the messages would encourage families to act. Young people think that it is important to be educated and given information about being overweight, or how to avoid putting on weight. The channels for this should be social media such as Facebook. Access to free gyms or exercise groups was also a highly suggested recommendation.
- 12.35 **Stakeholder Views-The Big Weight Debate Summary**
Stakeholders attending the Big Weight Debate workshop on 8 December 2014 told us they wanted:
- locally tailored services
 - enhanced community capacity
 - additional resources for targeting services in areas of greatest inequality.

Key themes that emerged were:

- **Strategic Direction** joint priority setting, agreement on strategy, common goals and outcomes
- **Commissioning** needs to reflect differential levels of obesity, put measures into specifications
- **Service Users** acceptability, accessibility, building trust, holistic offer, social and fun

- **Workforce** huge potential untapped front line work force with training needs
- **Communication** simple clear consistent messages, knowing what interventions are in place
- **Pathways** life course approach, knowing referral process and motivation key
- **Into practice** signage, walking routes and using stairs; workplace interventions.

12.36 **Views from general practice**

Three GPs in Dartford Gravesham and Swanley and two GPs in West Kent responded to a short questionnaire about their views about tackling obesity. The GPs pointed to issues of embarrassment and denial when discussing weight with parents and one GP said that in the discussion there was often a lack of understanding of causes and solutions. Concern was expressed about stigma and a reluctance to disrupt the professional relationship by causing offence. One GP stated that because patients are not coming to primary care because of weight issues, there is not time within the consultation to discuss obesity. The respondents were unaware of some of the service provision that is in place, particularly for families but also that there was longer term non-surgical psychological based support for people with a lot of weight to lose. Other professional support that was mentioned included dietetics, school nursing, health visitors and surgery.

- 12.37 One respondent was concerned that this was a societal issue and not a medical one and cited the Finnish heart disease programme in the 1970s which worked when the total country took responsibility for the issue. A key issue raised was motivation that people often felt that they had tried and failed in the past, people needed to want to take action. An advantage of provision that they knew about was that it was free. Ideas that were given for what else could be done included pathways, practice based programmes, starting early i.e. ante natally, providing fun accessible programmes for children and young people and taking a family approach, more referrals to exercise programmes and looking at what works. One GP was unsure about where responsibility lies for tackling childhood obesity, whether it was school nurses, public health, GPs or schools and called for a more integrated approach across local authority, social care and NHS and that cultural change was more important than pathways.

12.38

Summary

- **NHS Swale CCG has the worst levels of adult obesity in the country but levels of child obesity are comparable to the England average.**
- **NHS Swale CCG priorities that are relevant to obesity include reducing health inequality, improving the quality of life for patients with complex and long-term conditions, improving care by integrating services and promoting wellbeing and mental health.**
- **Three community hospitals, 20 GP practices in Swale, 25 pharmacies, 15 dental practices, 8 children's centres and 45 schools as well as NHS and local authority workplaces are key settings for prevention; achieving this will require training at scale.**
- **Family weight management services are under-used and there are no programmes for teenagers.**
- **There are no specialist weight management services for children and specialist services for adults have no bariatric physician.**
- **Maternity services do not meet NICE guidance as not all eligible women see a dietician during pregnancy.**
- **Further work needs to be undertaken to ensure there is a complete healthy weight pathway in NHS Swale CCG for adults, children and young people.**

13. Thanet

- 13.1 Thanet CCG serves the geographical area covered by Thanet District Council. This comprises 140,157 registered patients living in an area extending from the rural communities in the west of the district such as Sarre, Monkton and St Nicholas-at-Wade to the three main coastal towns of Margate, Ramsgate and Broadstairs.
- 13.2 The majority of NHS Thanet CCG patients access hospital services out of the CCG boundaries. Queen Elizabeth The Queen Mother Hospital and the Kent and Sussex hospitals are nearest. There are three community hospitals in the CCG area, The Queen Victoria, Buckland and Royal Victoria hospitals. There are 32 GP practices in Thanet, 42 pharmacies and 27 dental practices. There are 15 children's centres and 86 schools, including Pupil Referral Units ⁽⁶⁹⁾.
- 13.3 Thanet CCG has worse rates of adult obesity compared to the England average.

Table 1: Adult obesity in Thanet

Adult obesity 2014	%
Thanet CCG	27.7
England	24.1
England worst	30.9

Public Health England

Thanet CCG has worse rates compared to the England average for adult healthy eating prevalence.

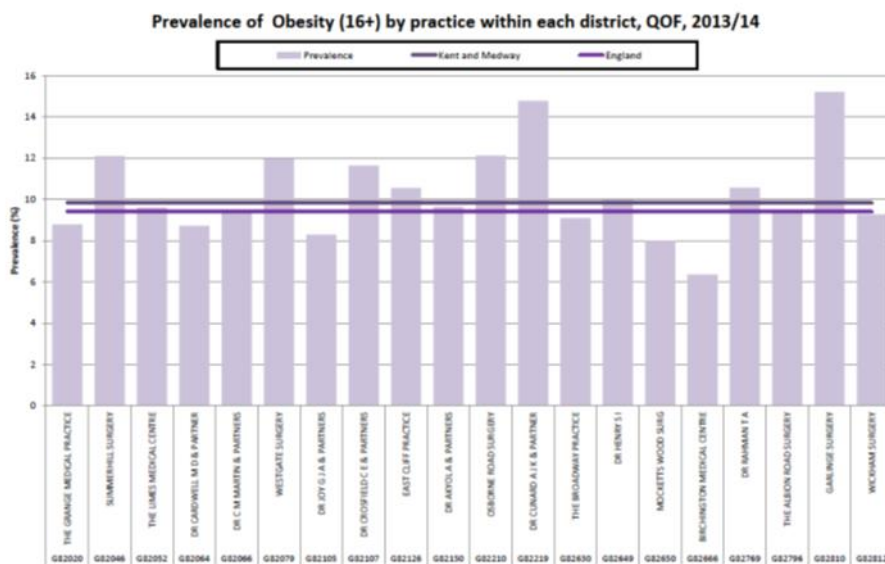
Table 2: Adult healthy eating rates in Thanet

Adult healthy eating 2014	%
Thanet CCG	24.7
England	28.7
England worst	19.4

Public Health England

- 13.4 The recorded QoF data shows prevalence of obesity by GP practice. Obesity is not generally well recorded in primary care.

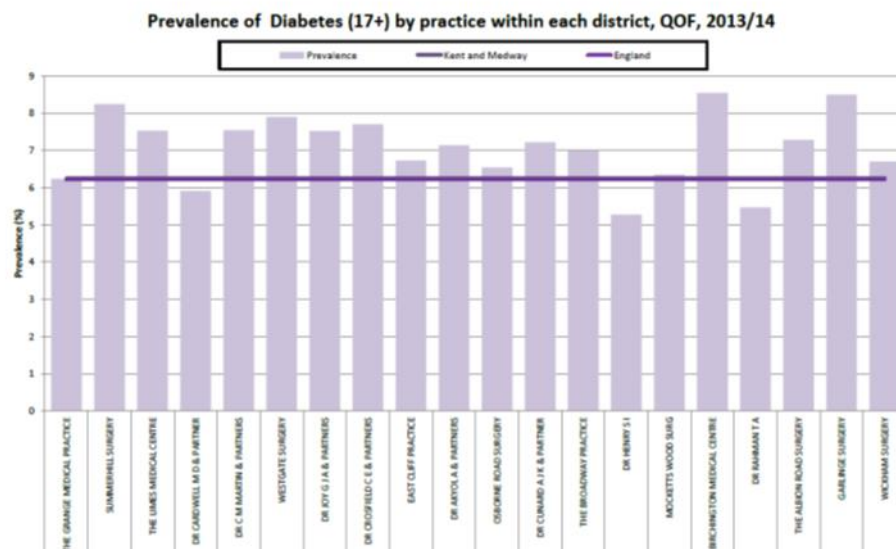
Figure 1: Prevalence of obesity in Thanet practices



Kent and Medway Public Health Observatory Health and Social Care Maps

13.5 As already described, obesity contributes to a number of serious and preventable conditions including Type 2 diabetes, Obesity accounts for 44% of people with diabetes nationally. The following chart shows the prevalence of diabetes by practice within Thanet CCG.

Figure 2: Prevalence of diabetes in Thanet practices

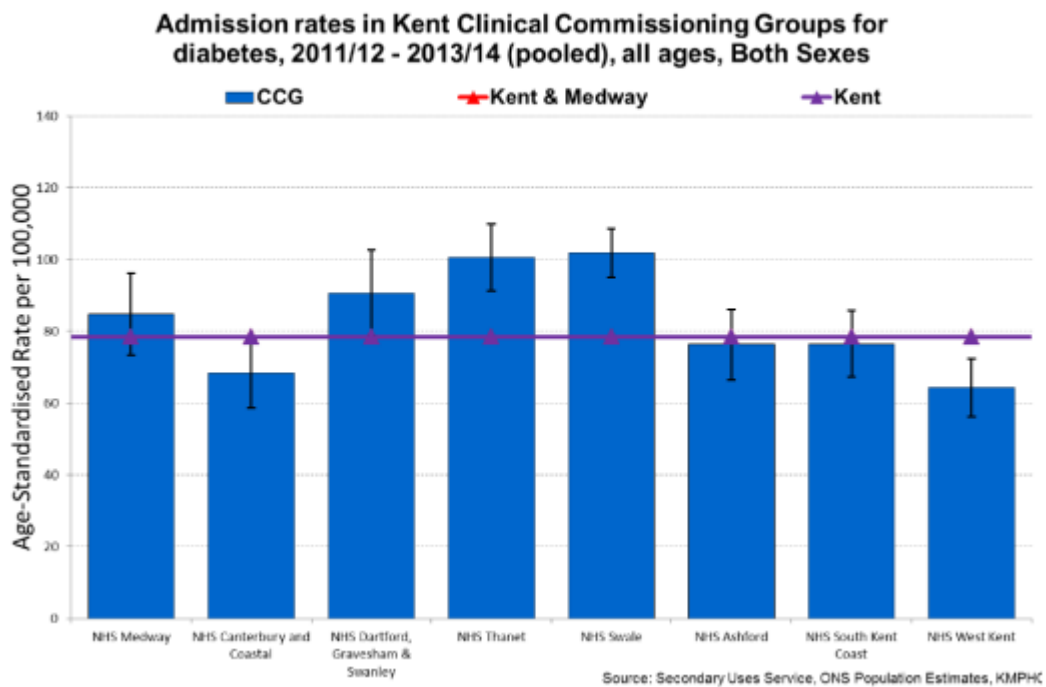


Kent and Medway Public Health Observatory Health and Social Care Maps

13.6 Figure 3 shows the rates of diabetes hospital admissions by Clinical Commissioning

Groups across Kent and Medway. Thanet and Swale CCGs have the highest rates of hospital admission for diabetes in Kent and Medway.

Figure 3: Admission rates for diabetes in CCGs in Kent and Medway 2011/2012-2013/2014

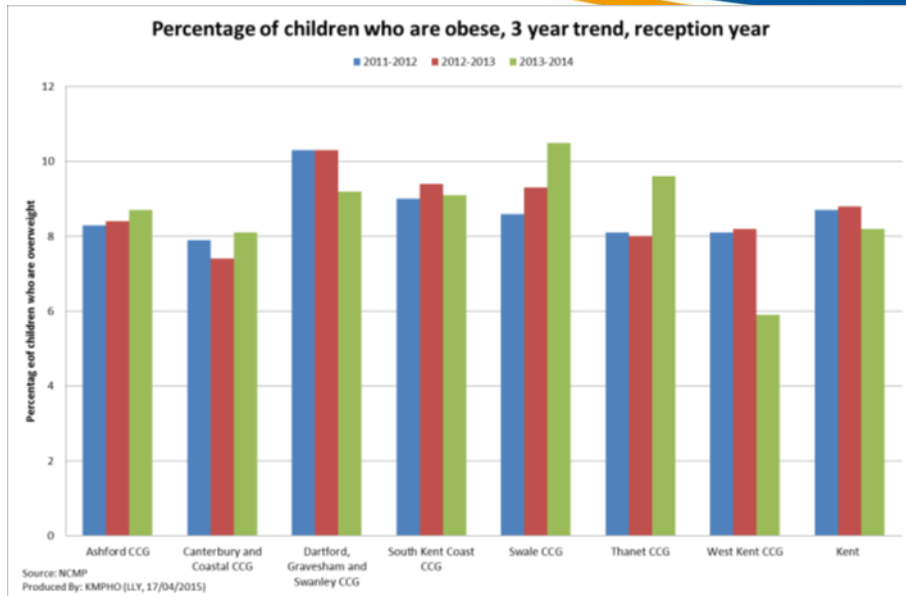


13.7 Childhood obesity in Thanet

The data that is available for child obesity is taken from the National Child Measurement Programme. In Kent the school nursing teams measure children at 4-5 years (reception) and at 10-11 years (year 6). In 2013/14 94.9% of eligible children were measured.

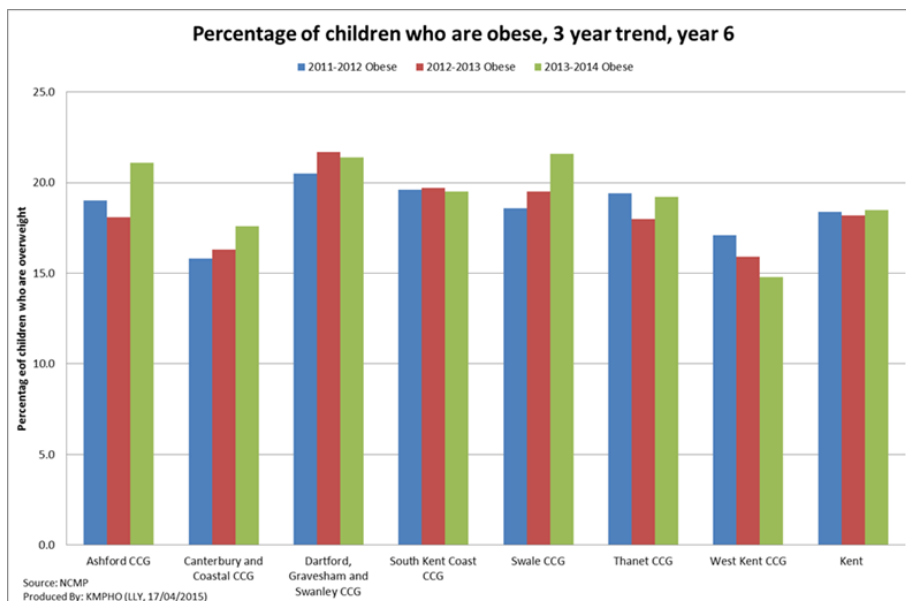
13.8 The proportion of obese reception year children in Thanet CCG has fluctuated between 2011/12- 2013/14.

Figure 4: Childhood obesity by CCG in reception year 2011/2012-2013/2014



13.9 Thanet CCG Year 6 prevalence has fluctuated over the three years from 2011/12-2013/14. The Kent trend is also showing some signs of plateauing over this time period.

Figure 4: Childhood obesity by CCG in reception year 2011/2012-2013/2014



Reporting by CCGs or by districts often masks the differences between areas and these can be seen in the Health and Social Care maps in Appendix 1.

13.10 **Services available in Thanet to tackle obesity for children and families**
Evidence based intervention during the early years of life is described in the Healthy Child programme. Health visitors promote infant led weaning as part of their universal offer and provide public health advice and interventions that encourage healthy eating and physical activity to parents and carers and their young families. Across Kent, the 'Born to Move' initiative is a Health Visitor led project which aims to raise awareness of

the importance of human interaction between parent /carer and infant or child to enable optimal development, physically and emotionally which may have some impact on childhood obesity. Children Centre staff have a responsibility for creating an environment that promotes healthy eating and physical activity.

- 13.11 At Tier 1 there are a number of initiatives commissioned by Public Health in Kent County Council that are delivered by Kent Community Health Foundation Trust (KCHFT) which include Food Champions. KCHFT have previously delivered training on consistent messaging for both physical activity and healthy eating. They have provided a number of programmes such as the Acorns to Oaks training which was to support Children's Centre staff to raise the issue of weight and be able to support families locally.
- 13.12 The school nursing team operates an open referral process - they receive referrals from various other professionals e.g. GPs, schools and health visitors, in addition to parents/carers and young people self-referring. Following referral they would provide a package of care i.e. four contacts with a child/young person. In addition they can refer to dieticians, paediatricians, healthy living/exercise programmes. The School Nurse Team undertakes the National Child Measurement Programme in reception and year 6 and offer support to parents following receipt of the result letters. A locality National Child Measurement Programme Group works in partnership across Thanet to support the measurement programme to maximise the impacts of nutrition, physical activity and self-esteem enhancing interventions and to promote joint working and on-ward referrals.
- 13.13 The Healthy Schools team in Kent Community Health Trust is currently working intensively with targeted schools in Thanet. In addition all schools have access to schools premium funding to optimise physical activity and access to school sports interventions. For families who struggle with their weight there are fun oriented programmes aimed at families with primary school aged children. This is an example of what is offered:
- Year 6 Healthy Lifestyle support lessons
 - Year R Healthy Lifestyle support lessons
 - Weighing and measuring (School nurses) Yr. 6 Yr. R
 - Assemblies for promoting targeted lifestyle programme
 - Parent engagement event
 - Follow up support following NCMP result letter
 - Targeted lifestyles programme rolled out
 - Sports days event(s)
 - Healthy School Enhancement Model achievement.
- 13.14 In the former Eastern Coastal Kent PCT area family weight management programmes are provided by the Healthy Weight team within Kent Community Healthcare Trust. Ready Steady Go is a 12 week programme for families with children between seven and 11 whose weight is equal to or above the 91st centile. In 2013/14 across the former Eastern Coastal Kent PCT geography there were 82 referrals, 48 participants engaged with the service and 23 participants completed the course.
- 13.15 Recruitment into these programmes is a challenge which is thought to be partly due to the stigma associated with having excess weight and also the low number of referrals from health professionals and other front line staff. It has been widely reported that

front line staff do not feel confident to raise the issue of weight; this is a training need across the whole of Kent. To help with recruitment and to provide an intervention that is more acceptable Change 4 Life Clubs have also been started for families with children seven-11. These are five week interventions. There were 126 families referred, 91 families attended and 68 families completed.

- 13.16 There are no dedicated weight management programmes designed for older children. It is likely that the needs of older children will become more complex and therefore would benefit from a more specialised service.
- 13.17 There are no dedicated Tier 3 services for children in Kent; therefore access to a specialist dietician is important. This access is variable across Kent. Each clinic has the capacity to see six patients. In East Kent both consultants and GPs can refer into the service but there is higher demand than in the former West Kent PCT area. Across Kent KCHFT report waiting times of six months and this has been added to the Trust risk register. The Dietetic Team has begun to work with the Healthy Weight Team to look at how a pathway could be designed so that children who do not need to be referred to a specialist service can be referred to the Tier 2 Ready Steady Go programmes and Change 4 Life Clubs. Currently this would just be for children ages seven-11 in East Kent.
- 13.18 **Services available in Thanet to tackle obesity in adults**
There are a range of services and opportunities for adults for physical activity, including commercial and local authority sport and leisure services, outdoor and natural environment organisations and workplace initiatives. Kent Sport provides an extensive number of cycling and walking programmes as well as supporting sports clubs. They also manage coaching and volunteering programmes. Kent County Council Public Health commissions and delivers Sky Ride in partnership with KCC Highways and Transportation and Kent Sport. Other Kent County Council departments offering opportunities for physical activity include Country Parks and Explore Kent. Kent County Council is currently evaluating the effectiveness of outdoor gyms.
- 13.19 Public Health commissions Healthy Walks from Kent Community Health Foundation Trust and they also provide an opportunity for 30 people in East Kent to be trained as food champions every year.
- 13.20 For people who need more intensive support Fresh Start is a 12 week community weight management scheme offering a structured integrated service to support overweight and obese individuals. The aim of the scheme is to support individuals to achieve an average weight loss of 1-2lbs per week, with an overall loss of 5% body weight. The key objectives of the scheme are: to provide support and advice on behaviour change; provide nutritional advice needed to alter diet; provide appropriate physical activity advice to increase activity levels.
- 13.21 The Fresh Start Scheme is provided in Thanet CCG and predominantly delivered in pharmacy settings. Approximately 40 community pharmacies, eight health trainers and one GP Surgery deliver the scheme across in East Kent.
- 13.22 All pharmacy advisers are registered to make referrals to the local Exercise Referral Scheme which offers a range of local leisure centre memberships. Clients are encouraged to increase their activity levels during and after attending the Fresh Start Scheme. Clients are also encouraged to uptake the six weeks 'Pedometer Challenge'

and are guided on how to start and achieve this whilst attending the Fresh Start Scheme. Clients are also signposted to the free East Kent Health Walks Scheme to further increase their activity levels.

- 13.23 For people with severe and complex obesity specialist community weight management services are currently provided by The Bariatric Consultancy known as 4Healthy Weight. Many of these patients have complex needs and may experience delay in accessing other services as a result of their weight. Analysis shows that those accessing 4 healthy weight services have a range of over 60 conditions; many have a number of co-morbidities. The most commonly appearing conditions are diabetes, hypertension, musculo-skeletal conditions, depression, polycystic ovary syndrome and respiratory problems. In addition, over 45% of 4 healthy weight patients have two or more diagnosed mental health conditions. Tier 3 services are well used by patients in the CCG. The majority of patients lose more than 5% of their body weight whilst on this programme.
- 13.24 There is no Tier 4 service provided in Kent and patients need to go outside of the district to access this service. A total of 168 bariatric operations were carried out on Kent patients in 2013/14; 99 of them referred by The Bariatric Consultancy. All surgery is undertaken in approved hospitals out of area.

Table 3: Bariatric Admissions by Clinical Commissioning Groups 2006/07-2013/14

Number of annual admissions for bariatric surgery* by Clinical Commissioning Group - 2006/07 to 2013/14								
CCG	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
NHS Ashford CCG		4	5	12	16	16	14	9
NHS Canterbury & Coastal CCG	<i>supressed</i>		10	11	19	38	18	24
NHS Dartford, Gravesham & Swanley CCG	5	16	13	27	34	46	46	40
NHS South Kent Coast CCG	<i>supressed</i>	6	6	34	30	34	27	18
NHS Swale CCG	<i>supressed</i>	6	8	11	23	23	21	19
NHS Thanet CCG		9	10	18	22	26	24	11
NHS West Kent	4	13	21	38	48	56	70	47

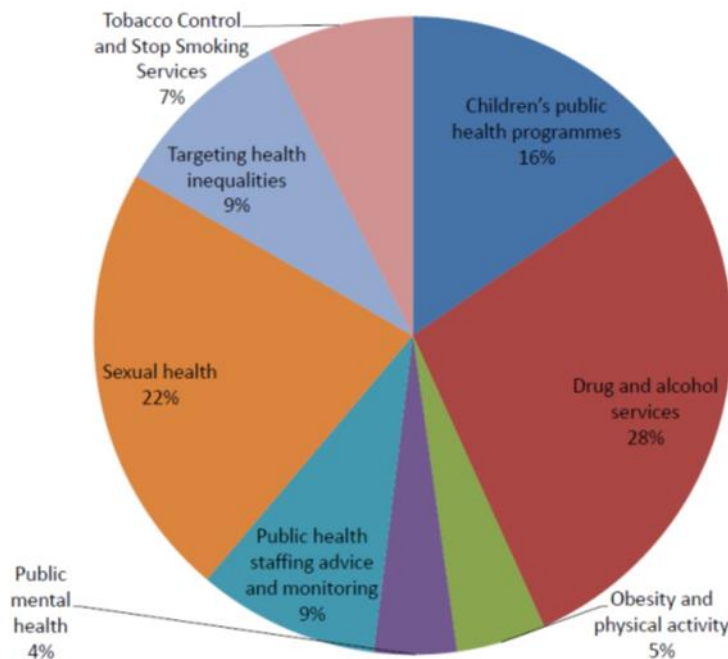
Where the primary diagnosis was obesity (ICD-10 E66) the following codes were used for the main or secondary procedure within the relevant time periods:
 2006/07 to 2008/09 inclusive G28*, G27.2-G27.9, G30.1-G30.4, G30.8- G30.9, G31*, G32*, G33.0-G33.3, G33.5-G33.9, G38.7, G38.8, G48.1, G48.2, G71.6.
 2009/10 to 2013/14 inclusive G27.1-G27.9, G28*, G31*, G32*, G33*, G30.1, G30.3, G30.4, G30.5, G30.9, G38.7, G48.1, G48.2, G48.5, G48.6, G71.6, G71.7.

Source: Secondary Uses Service

- 13.25 There are some proposed national changes to commissioning that will impact on the future provision of Tier 3 and 4 services ⁽³¹⁾.
- 13.26 Provision of specialist support for managing weight in pregnancy is variable across Kent. It is of concern that no Kent Trusts meet NICE guidance ⁽⁴⁷⁾ for referring all women with a BMI of 30 or more to a specialist dietician.
- 13.27 South Kent Coast CCG midwifery services are provided by East Kent Hospitals University Foundation NHS Trust. A referral pathway has been established with the community dietician but there is a lack of consistency in acceptance of referrals. Although BMI is recorded in the pregnancy notes there is no space to record referral to specialist services. Those women with a BMI >35 will be referred to an obstetrician and anaesthetist but there isn't sufficient capacity in their clinics to see every woman. The Trust has reviewed its clinical equipment to ensure it is appropriate for heavier weight women. The service has no midwife with a specialist interest in healthy weight/obesity.

- 13.28 East Kent Hospitals University Foundation NHS Trust have previously been involved in the HELP cluster randomised control trial with Slimming World where 598 pregnant women in total were recruited across maternity sites in England and Wales: of these 598 women, 464 were followed up 12 months after their babies were born (the study's primary endpoint). Data collection was completed in February 2014 and results are awaited. Women can expect to have their height, weight and BMI recorded at booking. Within the notes there is a separate section to record the care plan for women with a BMI >30. There are two midwives with a special interest in healthy weight each of who have a total of six hrs protected time per week to fulfil this role (taken from existing midwifery establishment). These midwives run Healthy Weight Clinics for all women with a BMI >35. Women with a BMI >40 are referred to an obstetrician, anaesthetist and dietician. There are also two specialist diabetes midwives who have a total of 11.25 hrs per week of protected time to provide support to women with or at risk of developing diabetes. No specific information or advice on diet and exercise is included in the notes but the Start4Life leaflet, a copy of the NHS Direct page on Health in Pregnancy (includes information on diet & exercise) & the A-Z of Pregnancy & Nutrition are included in ante-natal packs.
- 13.29 **Financial considerations**
Between 2010-2030 health costs associated with obesity are projected to rise nationally by £2bn.⁽¹⁴⁾ The burden of costs to Kent have been very crudely calculated as over £55m using the number of Kent residents as a proportion of the whole of England 2013 population. (KMPHO) This is contributed to by 44% of the incidence of diabetes, 23% of heart disease and between 7%-41% of certain cancers. A clinical working group (Royal College of Physicians, 2013) found that obese individuals had medical costs 30% higher than those with normal weight: it is estimated that 23% of spending on all drugs is attributable to overweight and obesity⁽³⁰⁾.
- 13.30 Obesity will also have an increased impact on social care costs and an estimated 16 million days of sickness absence a year are attributable to obesity. Obese people are less likely to be in employment than people of a healthy weight. The associated welfare costs are estimated to be between £1 billion and £6 billion⁽¹⁴⁾. The NHS and local authority are major employers so this will impact on their available workforce.
- 13.31 The working group determined that treatment is cost effective and in some cases it costs less to provide it than not. Targeting treatment at those most likely to benefit will further enhance cost efficacy. The time period for assessing cost efficacy may be extended compared to some other areas of health intervention and this requires commissioning authorities to have an appropriate long-term view on the value of obesity treatment.
- 13.32 Kent County Council Public Health invests approximately £3m in obesity and physical activity, which is approximately 5% of the budget. It is within a block contract which means funding by area and by intervention is difficult to disaggregate.

Figure 5: Spending by KCC Public Health 2015/16



13.33 Public consultations

In 2014 a consultation questionnaire was designed to ask the adult public about their own circumstances and their views on what interventions should be provided to help people stay a healthy weight. It was posted on the Kent County Council website in standard and easy read formats. An e-mail was sent to a broad range of partners for promotion. Six hundred and two responses were received, over the sample size required.

Table 4: Interventions that Kent adults agree would help with weight loss

Agree or strongly agree what would help?	
Having advice on healthy eating	96%
Available and affordable fresh fruit and vegetables	95%
Access to local leisure facilities	91%
Weight loss classes	90%
Local walks led mostly by volunteers	87%
Helping people with healthy eating	81%
Health Trainers	80%
Exercise classes that your GP tells you to go to	79%
Having one to one meetings with an adviser	79%
Taking part in sport?	77%
Attending a weight loss class	76%
Classes that help pregnant women to be a healthy weight	75%
Being able to walk and cycle near to where you live	47%

13.34 A short questionnaire was also designed and tested with a group of young people. It was completed by 120 children aged 11-12 in a school and 12 young people aged 13-

24 in a youth setting. It was also posted on SurveyMonkey. In total there were 178 responses. The respondents thought that the best way to deliver health messages would be through TV adverts. To enable families to be more active free gym passes and family activities should be provided so that they get more exercise.

13.35 The young people also thought healthy food should be more accessible and there was a need to promote messages such as the five a day campaign. In order to deliver these messages young people think that getting a professional athlete or celebrity on board to promote the messages would encourage families to act. Young people think that it is important to be educated and given information about being overweight, or how to avoid putting on weight. The channels for this should be social media such as Facebook. Access to free gyms or exercise groups was also a highly suggested recommendation.

13.36 **Stakeholder Views - the Big Weight Debate summary**

Stakeholders attending the Big Weight Debate workshop on 8 December 2014 told us they wanted:

- locally tailored services
- enhanced community capacity
- additional resources for targeting services in areas of greatest inequality.

Key themes that emerged were:

- **Strategic Direction** joint priority setting, agreement on strategy, common goals and outcomes
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13.37 **Views from primary care**

Three GPs in Dartford Gravesham and Swanley and two GPs in West Kent responded to a short questionnaire about their views about tackling obesity. The GPs pointed to issues of embarrassment and denial when discussing weight with parents and one GP said that in the discussion there was often a lack of understanding of causes and solutions. Concern was expressed about stigma and a reluctance to disrupt the professional relationship by causing offence. One GP stated that because patients are not coming to primary care because of weight issues, there is not time within the consultation to discuss obesity. The respondents were unaware of some of the service provision that is in place, particularly for families but also that there was longer term non-surgical psychological based support for people with a lot of weight to lose. Other professional support that was mentioned included dietetics, school nursing, health

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13.39

Summary

- **NHS Thanet CCG has similar levels of child obesity in year 6 compared to England and worse adult obesity rates.**
- **Three community hospitals, 32 GP practices, 42 pharmacies, 27 dental practices, 15 children's centres and 86 schools as well as NHS and local authority workplaces are key settings for prevention, achieving this will require training.**
- **Family weight management services are under-used and there are no programmes for teenagers.**
- **Maternity services do not meet NICE guidance as not all eligible women see a dietician during pregnancy.**
- **Further work needs to be undertaken to ensure there is a complete healthy weight pathway in NHS South Kent Coast CCG for both adults and children and young people.**

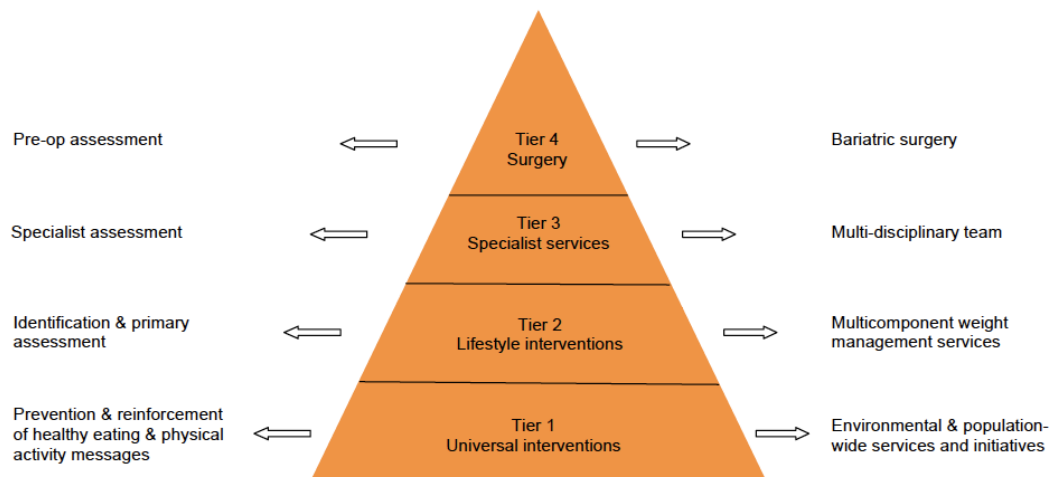
14. Kent Overview

14.1 Background

Kent has a resident population of just over 1.5m, 17.6% of this number have an illness or condition which limits their day to day activities (Kent County Council). This is a huge burden of ill health to which obesity will have contributed. For those with an obesity related limiting condition losing and maintaining weight loss over a lifetime will have positive impacts on health. As 771,476 people in Kent are either overweight or obese and an estimated 64,000 meet the criteria for bariatric surgery, the problem has to be tackled at scale.

14.2 All of the population should be encouraged to participate in universally available opportunities to eat well and be physically active. For those who struggle to control their weight there are recommended tiered interventions shown in Figure 6 below ⁽³⁷⁾.

**Figure 6: Adult Healthy Weight Pathway
Clinical Care Components Commissioned Services**



British Obesity and Metabolic Surgery Society (2014)

14.3 Tier 1 universal services

Across Kent there are a range of universal services and opportunities for physical activity, including commercial and local authority sport and leisure services, outdoor and natural environment organisations and workplace initiatives. NICE guidance ⁽⁴⁶⁾ recommends that services should include both top down approaches such as planning cycle routes and food procurement specifications and bottom-up approaches such as running activities in local parks.

14.4 Kent Sport provides an extensive number of cycling and walking programmes across Kent as well as supporting sports clubs. They also manage coaching and volunteering programmes. Kent County Council Public Health commissions and delivers Sky Ride in partnership with KCC Highways and Transportation and Kent Sport. Other Kent County Council departments offering opportunities for physical activity include Country Parks and Explore Kent. Evidence of effectiveness is important and the use of outdoor gyms are currently being evaluated.

- 14.5 Public Health commissions Healthy Walks from Kent Community Health Foundation Trust and they also provide an opportunity for 30 people in East Kent to be trained as food champions. Community Chefs are also commissioned in Swale, Maidstone, Gravesham and Dartford.
- 14.6 Healthy Living Centres in Sheppey, Thanet, Dartford, Gravesham, Sevenoaks, Maidstone, Tunbridge Wells and Tonbridge also offer:
- Provision of opportunities for drop-in sessions on healthy eating, bring and share and recipe swaps, fruit and veg bags, home growing of produce and where kitchen space is adequate, cooking skills/cook and eat sessions for young parents;
 - Provision of opportunities for indoor and outdoor physical activity through support and signposting to group activities such as swimming, health walks, line dancing/other types of dancing and various sporting activities either directly or through partners. This will include a new cycling fitness project;
 - Act as a base from which health trainers can promote increased participation in community based projects in support of health and wellbeing;
 - Provide evidence of all the above for quarterly monitoring
- 14.7 **Tier 2 lifestyle weight management services**
NICE recommends that lifestyle weight management services (Tier 2) should focus on long term change rather than short term weight loss. The more weight an individual loses the greater the health benefits, particularly if someone loses more than 5% of their body weight and maintains this for life. On average, people attending a lifestyle weight management programme lose around 3% of their body weight, but this varies.
- 14.8 The Fresh Start programme is provided by Kent Community Health Foundation Trust and was formerly commissioned by Eastern Coastal Kent Primary Care Trust. The Fresh Start Scheme is provided in the East Kent area and predominantly delivered in pharmacy settings. Approximately 40 community pharmacies, eight health trainers and one GP surgery deliver the scheme across the area. A total of 75 advisers are delivering the scheme across East Kent.
- 14.9 The Balmoral practice has been offering an in-house Tier 2 weight management programme for its own and neighbouring patients in Deal since 2008. The programme is open ended and some patients have been attending the programme from the beginning. It is run by a dietician and a health care assistant with support from other members of the primary care team. There had formerly been an exercise component but the provider left and the practice is seeking to re-instate this. The programme runs one half day a week.
- 14.10 In the former West Kent PCT localities community weight management programmes are provided by the borough and district councils. The Why Weight adult weight management programme is run primarily in Dartford town centre at Peppercorns, a local community hall with a fitness studio. Since January 2013, courses have been delivered in an outer parish of the borough.
- 14.11 The Gr@nd provides a 12 week programme in Gravesham which is tailored to the needs of specific target groups including Black, Minority and Ethnic (BME) communities, rural groups, deprived areas and men. At the end of the intervention participants are offered a free one week pass at Cascades, Cygnets or Swanscombe

Leisure Centres and a free swimming session at Cascades or Cygnets. Participants are invited back to exercise sessions and signposting to free exercise or relevant events and are offered reduced gym membership for 12 months.

- 14.12 The Sevenoaks Why Weight 12 week programme is based on the Counterweight model and delivered in locations based on need and deprivation in the district. The adult weight management programme is run in both towns and villages, primarily in leisure centres in the three largest towns: Swanley, Sevenoaks and Edenbridge, with additional classes being run in New Ash Green and West Kingsdown. The Get Sorted service is based at the local leisure centres in the district, offering 1:1 sessions to completed Why Weight participants. Each participant is offered 6 x 1:1 sessions throughout the year to achieve their long term and short term goals.
- 14.13 Maidstone Borough Council offers the Counterweight programme aimed at giving people the skills to manage their weight for life and a 10 week adult weight management programme run by Maidstone Leisure Centre. Maidstone Leisure Centre provides a programme that includes weekly seminars, weigh-ins, exercise classes, gym sessions and a supermarket trip on what foods to buy to manage weight.
- 14.14 Tonbridge and Malling Borough Council provides the Counterweight Programme which is a programme that promotes behavioural strategies, which seek to change eating habits, activity levels, sedentary behaviours and thinking processes that contribute to an individual becoming overweight or obese. The programme promotes active weight loss for three to six months, followed by long term weight loss maintenance.
- 14.15 Tunbridge Wells Borough Council provide a 10 week programme at venues across the Borough called Weight for It. They also offer exercise referral and health trainer services and direct the individuals to the most beneficial intervention to meet their needs.
- 14.16 **Tier 3 specialist weight management services**
There are two specialist weight management programmes (Tier 3)) that run in Kent, 4 healthy weight which has been in place since April 2013 and provides a service across Kent with the exception of Swale. The pre-existing programme Swale Weight Management Service (SWMS) provides services for Swale only.
- 14.17 **4healthyweight**
4healthyweight is a psychologically led service which puts the clients mental health needs at the centre of their care. There is an initial motivational interview and patients who are not motivated are offered alternative options. A multi-disciplinary team assessment is undertaken by a bariatric physician, Dietician, exercise specialist and psychologist and is followed by an initial 12 week intensive phase. This is followed by a nine month maintenance programme for patients following the non-surgical route. Patients following the surgical pathway will have a referral to Tier 4 from six months onward. Patients on the non-surgical pathway will at the end of the 12 month period be referred back to the general practitioner and to the local Tier 2 service to ensure that progress is maintained. Patients on the surgical pathway are followed up by the tertiary centre for 24 months and may then be referred back into Tier 3 if necessary.
- 14.18 In 2013/14 530 patients were referred. Three quarters of all referrals were from the 35-64 age group, this has continued through 2014/15. 55% of all referrals were for females aged 35-64 compared to 19% for males. 428 started the intervention (of those

not starting, 21 were referred back to Tier 2).

4 healthy weight has patients with a higher starting BMI with 52.3% of their patients having a BMI of 45 or more.

14.19 **Table 6: 4 healthy weight mean weight and BMI reduction 2013/14**

	weight kg	BMI
mean initial measurement	129.8	46.4
Mean end measurement	120.7	44
Total reduction percentage	7.50%	5.365

4 healthy weight provides support to prepare those patients who choose surgery as it is well-known that prepared patients have better outcomes. Ninety nine patients from Kent were on the surgical pathway in 2013/14

14.20 **Swale Weight Management Services**

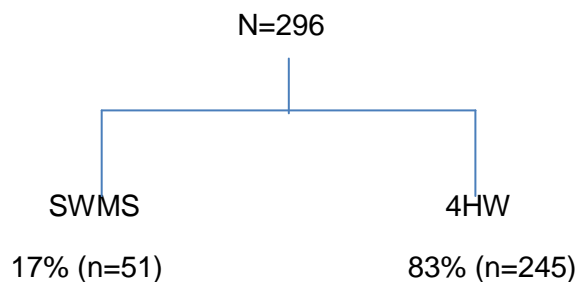
SWMS is a 12 month programme split into two phases. All clients are initially assessed by the multi-disciplinary team (MDT). A specialist dietitian assesses a client’s nutritional needs and discusses how food fits into their lifestyle. Individual goals are developed in conjunction with the client to suit their personal needs. A specialist exercise physiologist assesses physical ability and fitness levels. Specialist advice is given on exercise and individual goals are set to encourage and support regular physical activity. A specialist therapist supports and encourages clients to look at and explore any emotional issues surrounding weight management and the different coping strategies available. The MDT does not have a bariatric physician and cannot therefore refer onto the surgical pathway.

14.21 **Table 7: Patients completing SWMS interventions 2013/14**

	number	percentage
Completed 3 months	79	41.6%
Completed 12 months	55	28.9%

BMI reduction is comparable across Kent but mean weight loss is lower than 4 healthy weight.

14.22 **Figure 7: Percentage of Kent Tier 3 12 month completers by Provider**



14.23 There are problems with both services. Currently 4 healthy weight is exceeding its contracted capacity and SWMS does not have a bariatric physician within its MDT. National changes will impact on local decisions.

14.24 Children's healthy weight services

Only Tier 1 and Tier 2 services are available for children and families in Kent. Health visitors promote infant led weaning as part of their universal offer and provide public health advice and interventions that encourage healthy eating and physical activity to parents and carers and their young families. Across Kent, the 'Born to Move' initiative is a health visitor led project to raise awareness of the importance of human interaction between parent /carer and infant or child to enable optimal development, physically and emotionally which may have some impact on childhood obesity. Early Help, including Children Centre staff and youth provision have a responsibility for creating an environment that promotes healthy eating and physical activity and this is part of an agreement between Public Health and the Children's Centre which is subject to monitoring and audit.

14.25 At Tier 1 there are a number of initiatives commissioned by Public Health in Kent County Council that are delivered in Children's Centres. These include the Community Chef provided by Healthy Living Centres in Swale, Dartford, Gravesham and Maidstone, Food Champions provided by Kent Community Health NHS Foundation Trust (KCHFT) in the former Eastern Coastal Kent area. KCHFT have previously delivered training on consistent messages for both physical activity and healthy eating e.g. Acorns to Oaks training which was to support Children's Centre staff to raise the issue of weight and be able to support families locally. In Swale and Tunbridge Wells there are dedicated Children's Centre based Community Chef programmes.

14.26 The school nursing team undertakes the National Child Measurement Programme in years 6 and reception and offers support to parents following receipt of the result letters. The school nursing team operates an open referral process for a package of care i.e. four contacts with a child/young person, in addition they can refer to dietitians, paediatricians, Kent Community Health Foundation Trust and borough council community healthy living/exercise programmes which vary across Kent.

14.27 The Healthy Schools team in Kent Community Health Foundation Trust is currently working intensively with targeted schools across Kent. In addition all schools have access to schools premium funding to optimise physical activity and access to school sports interventions. For families who struggle with their weight there are fun oriented programmes aimed at families with junior school aged children in all district localities in Kent. Some are at Tier 1 level with more intensive Tier 3 family weight management programmes provided across Kent. Local National Child Measurement Programme Groups work in partnership to support the measurement programme and to maximise the impacts of nutrition, physical activity and self-esteem enhancing interventions and to promote joint working and onward referrals.

14.28 Tier 2 family weight management programmes

In the former Eastern Coastal Kent PCT area family weight management programmes are provided by the Healthy Weight team within Kent Community Healthcare Trust. Ready Steady Go is a 12 week programme for families with children between seven and 11 whose weight is equal to or above the 91st centile. In 2013/14 there were 82 referrals, 48 participants engaged with the service and 23 participants completed the course. Recruitment into these programmes is a challenge and to help with recruitment an intervention that is more acceptable needs to be provided.

14.29 Tunbridge Wells Borough Council provides a 10 week programme called Learn Eat

and Play (LEAP) which includes physical activity, healthy eating and behaviour change and as part of this has a practical cookery session every other week. It replaced Mind, Exercise, Nutrition Do it! (MEND) as very few families attended. The partnership works across Tunbridge Wells and Tonbridge and Malling and consists of a community chef, four nutritionists and three exercise/ dance specialists. In the weeks before LEAP is planned to start, a separate four week cookery course called Cook and Eat is offered, this is done in much the same way as other programmes as a more acceptable intervention that could be a gateway to the LEAP programme.

- 14.30 Maidstone Borough Council uses a programme Go For It! provided by Zeroth which is a 12 week course run in term time using a different model to most of the other programmes. The children and young people are invited to attend 20 activity sessions. These include a mix of activities to improve strength, cardiovascular fitness, flexibility and motor skills through studio based activities, team games and working out in the Zeroth gym, if old enough. For every child registered, at least one parent/guardian had to commit to attending the adult workshops.
- 14.31 Sevenoaks District Council runs a Fun Fit and Active programme which is delivered in five schools.
- 14.32 The Gr@nd Healthy Living Centre in Gravesham provides the 12 week Family Healthy Weight programme which engaged 60 participants from 35 families in 2013/14. It also provides less intensive interventions through the Don't Sit, Get Fit programme. A nutritionist from Dartford and Gravesham NHS Trust works across Dartford and Gravesham to provide nutritionist support to these programmes.
- 14.33 As well as providing Don't Sit, Get Fit interventions in schools and the community supported by the nutritionist, Dartford Borough Council provides the Dynamo Club for families with children above the 91st centile. In 2013/14 12 children and their families were engaged in this programme.
- 14.34 **Specialist children's and maternal services**
There are no dedicated Tier 3 services for children in Kent; therefore access to a specialist dietician is important. This access is variable across Kent.
- 14.35 Maidstone and Tunbridge Wells NHS Trust provides consultant only referrals for children who have diabetes. Children with obesity (only) will be seen by the paediatric dieticians employed by Kent Community Healthcare Foundation Trust (KCHFT). The KCHFT paediatric team has a 0.2 w.t.e.team leader with two paediatric dieticians and one assistant working across Kent. The team provides the totality of dietetic services for children in the whole of West Kent and East Kent (not Dartford Gravesham and Swanley).
- 14.36 In West Kent there are two weekly clinics run in the hospital for consultant only referrals and one clinic for GP referrals from the Tonbridge and Tunbridge Wells areas only. Each clinic has the capacity to see six patients. In East Kent both consultants and GPs can refer into the service but there is higher demand than in West Kent. Across Kent KCHFT report waiting times of six months and this has been added to the Trust risk register.
- 14.37 Acute and community Paediatric Dietetic services are provided in the Dartford Gravesham and Swanley CCG area by the Nutrition and Dietetic Department within the

Dartford and Gravesham NHS Trust. The acute service is provided at Darent Valley Hospital and the community base is at Archery House, also in Dartford. Their draft weight management referral pathway for children describes interventions at 75th -91st centile, above the 91st centile and above the 98th centile. Communication between Tier 2 and Tier 3 is facilitated by a 0.8 wte dietician's time as part of the family weight management programme.

14.38 Provision of support for healthy weight in pregnancy is variable across Kent. It is of concern that no Kent Trusts meet NICE guidance (47) for all women with a BMI of 30 or over.

14.39 Consultation and engagement has been undertaken with adults, children and young people, wider stakeholders and with GPs, copies of questionnaires are in Appendices 2-5

14.40

Summary

- **The capacity for a wider range of organisations to contribute to tackling obesity needs to be assessed and mobilised.**
- **Commissioned services only provide interventions for a fraction of the population at risk, there is a need for front line workers to better understand what they can do and to be provided with the tools to do it.**
- **Family weight management services are under-used and there are no programmes for teenagers.**
- **Maternity services do not meet NICE guidance as not all eligible women see a dietician during pregnancy.**
- **Further work needs to be undertaken to ensure there is a complete healthy weight pathway for both adults and children and young people.**

15. Model of Care

15.1 Pathways

NICE has produced extensive guidance on approaches to tackle obesity and has published three specific pathways on: obesity, working with local communities and preventing type 2 diabetes. The pathways do overlap and reflect the importance of a joined up approach which is in line with the definition of public health of “improving health and prolonging life through the organised efforts of society”.

15.2 The Obesity Pathway ⁽⁷¹⁾ has three overarching sections on

- Prevention
- Identification
- Management

The pathway has 14 paths as listed below based on both clinical and public health guidance. It also links to other related guidance and pathways including maternal and child diet and smoking for example. The pathways are all underpinned by evidence and the detail is provided.

- Preventing obesity
- Helping people maintain a healthy weight
- Interventions to prevent obesity
- Identifying people who are overweight or obese
- Managing obesity
- Interventions led by healthcare professionals to prevent overweight
- Workplace interventions to prevent obesity
- Pre-school and school based interventions to prevent obesity
- Overweight and obese children and young people
- Managing weight through lifestyle change in children and young people
- Overweight and obese adults
- Managing weight through lifestyle change in adults
- Surgery for obese adults

15.3 The working with local communities pathway describes the steps needed for developing a community approach which is both strategically led and top down and also bottom up. Its seven paths are listed below and are based on specific NICE guidance ⁽⁴⁹⁾.

- Working with local communities overview
- Developing a sustainable approach and leadership
- Communication
- Co-ordinating local action
- Integrated commissioning
- Training and development
- Monitoring and evaluation, cost effectiveness and scrutiny

Within each path there are recommendations taken from NICE guidance.

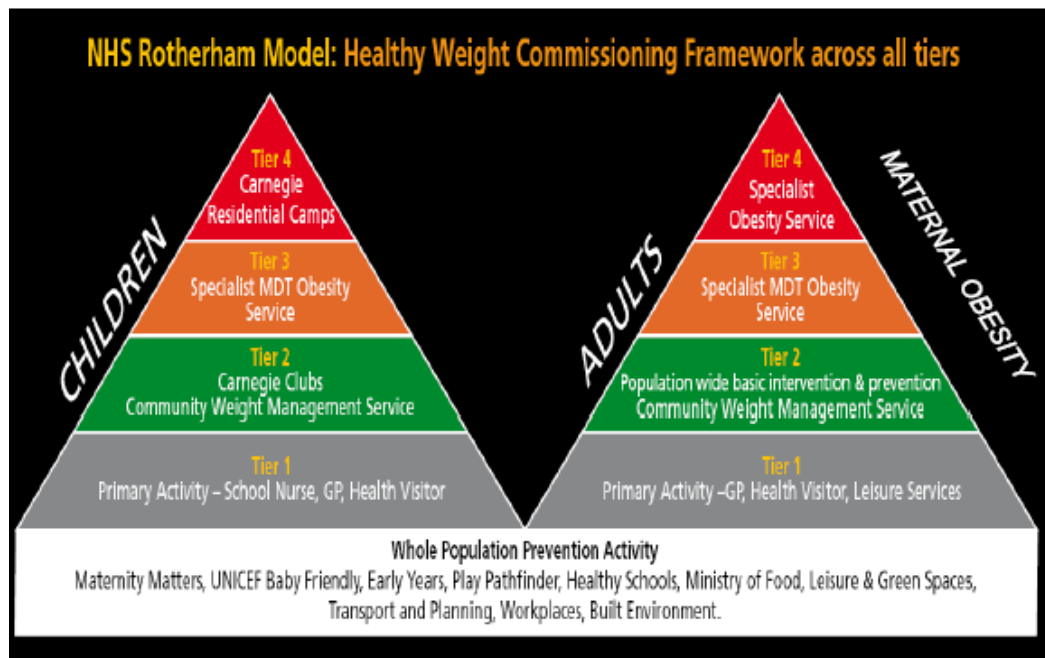
- 15.4 The preventing type 2 diabetes pathway has eight paths which are based on specific NICE guidance.
- Preventing type 2 diabetes overview
 - National strategy and policy to prevent type 2 diabetes
 - Local action to prevent type 2 diabetes including strategy, policy and commissioning
 - Encouraging people to have a risk assessment for type 2 diabetes and identifying those at risk
 - Managing risk of type 2 diabetes
 - Training to prevent type 2 diabetes
 - Population and community interventions
 - Group and individual level interventions to prevent type 2 diabetes among people at high risk

15.5 **Good Practice Model**

NHS Rotherham CCG commissions Rotherham Obesity Institute to provide obesity services. A full four tier service is in place for both adults and children and is nationally considered to be an outstanding model.

Rotherham Healthy Weight Pathway

Model and Pathway



- 15.6 In Kent there is a published pathway for children and young people but it has not been well implemented and needs to be reviewed by commissioners as an approach to tackling childhood obesity, both prevention and management. There is a real gap in provision for older children whose needs are likely to be more complex and are likely to benefit more from 1:1 interventions. There are no

specialist weight management services and surgery is not normally recommended for children. Across most of Kent, access to dietetics and paediatrics is limited for children in the absence of other conditions.

- 15.7 Services for adults at all tiers exist but local and national changes in commissioning are likely to impact on availability of specialist services for people with severe and complex obesity. At the other end of the spectrum there are potentially many universal interventions available in communities and a mechanism for engaging with, and motivating people to access them, rather than commissioning further interventions needs to be considered.
- 15.8 New models need to be designed to enable interventions to be commissioned at scale with consideration given to follow up and maintenance. It may not be useful to commission programmes for healthy weight independently of other related interventions such as smoking alcohol and emotional health and well being. Currently details about people accessing services are held within that service and patient identifiable data is not shared so it is not possible to follow the individual to measure outcomes across a number of interventions provided by a range of services to know what is most effective.
- 15.9

Summary

- **There are robust published pathways and recommendations for the approach to prevention, identification and management of obesity.**
- **There are well regarded models of good practice available elsewhere that Kent could learn from.**
- **It will need a clear strategic direction to integrate all the action that is necessary and co-commissioning should be considered.**
- **An integrated model for obesity should be defined and include paths to other related health improvement strands such as emotional health and wellbeing, smoking and alcohol.**
- **Identifiable data sharing with consent will enable better measurement of individual outcomes to robustly measure the impact of interventions.**

16. Commissioning Intentions

- 16.1 It is clear from this needs assessment that there is a historical imbalance in the services that are commissioned across Kent and any commissioning intentions should address this, taking into account the variable prevalence of obesity in children and young people and adults in different parts of Kent. However, with two thirds of the adult population either overweight or obese it is logical that a proportionate universalist approach should be taken.
- 16.2 It is also clear that obesity is an expensive condition due to the cost of treating obesity itself and the impact on other non-communicable conditions. It will not be possible to fund prevention in the way we are currently if we want to make a difference and it is necessary to look at all the parts of the system that could work at a scale to contribute to a better model in Kent.
- 16.3 Other non-communicable disease prevention services invest more heavily in training. Training that is available is not provided across the whole of Kent, for example the Food Champion programme that is available only in the former Eastern Coastal PCT area. This is particularly urgent as services in receipt of 're-badged' public health funding will need training to fully carry out a role for promoting healthy weight.
- 16.4 Where some limited training has been provided in the past it has not always been effectively implemented due to the reluctance of the front line work force to raise the issue of weight. The need for training is highlighted in guidance and in the recommendations contained within the NICE Obesity pathway which states that:

Health and other relevant professionals are trained to be aware of the health risks of being overweight and obese and the benefits of preventing and managing obesity. This training should include:

- understanding the wider determinants of obesity (such as the impact of the local environment or socioeconomic status)
- understanding the local system in relation to the obesity agenda (such as who the key partners are)
- understanding methods for working with local communities
- knowing the appropriate language to use (referring to achieving or maintaining a 'healthy weight' may be more acceptable than 'preventing obesity' for some communities)
- understanding why it can be difficult for some people to avoid weight gain or to achieve and maintain weight loss
- being aware of strategies people can use to address their weight concerns
- being aware of local services that are likely to be effective in helping people maintain a healthy weight
- being aware of local lifestyle weight management services that follow best practice outlined in the obesity pathway.

- 16.5 Specific groups with particular needs have been identified by NICE and their needs should be considered in any commissioning plans across partners, these include pregnant women, those from black and Asian ethnic origin, people with disabilities, particularly people with learning disabilities. In addition interventions for teenagers are lacking and men are under-represented in Tier 2 community weight management

services.

- 16.6 Integration of services commissioned by different organisations and co-commissioning will be central to the success of any model. The working group for Joined up Clinical Pathways for Obesity ⁽⁷³⁾ recommended that commissioning responsibilities for tier 4 lay with NHS England, Tier 3 with Clinical Commissioning Groups and Tiers 1 & 2 with local authorities. NHS England has more recently consulted on Tier 4 transferring to CCGs and a transfer in April 2016 was recommended, however no details are yet available.
- 16.7 With closer working it will be important to demonstrate to all partners what is effective, and more robust research and evaluation are critical. Funding for this should be designed into any model prior to procurement.
- 16.8 It will be necessary for the whole system to review the contracts and agreements that it places to include the implementation of relevant policy, for example healthy eating and snacks, travel and workplace health policies. NHS and local authority organisations should be exemplars.
- 16.9 Much commissioning to date has seen different strands of health improvement commissioned independently in silos, despite some obvious inter-dependencies. A more holistic integrated model needs to be designed, supported by data sharing agreements so that services are better informed about the needs of individuals.
- 16.10 With limited funding available in the future, consideration needs to be given to defining what services should be commissioned, who they should be commissioned by and who they should be commissioned for. We know there is an association between obesity and health inequalities. There is data provided by Kent and Medway Public Health Observatory and from other sources about where the highest rates of obesity are found and these should be used to design local partnership interventions for specific neighbourhoods. (See locality maps in appendix 1.)
- 16.11 Providers should be required to gain consent from participants for their data to be shared to enable a better understanding of the individuals' use of services and the impacts and outcomes on their health.

16.12

Summary

- **There will be less funding in the future so a commissioning model that better integrates services and budgets across organisations will be necessary.**
- **There is a huge potential front-line workforce who knows the individuals and families at risk but needs the skills and tools to have those conversations. Training must be a high priority.**
- **A model which better integrates all the relevant health improvement strands needs to be designed, to include healthy weight, research and evaluation should underpin implementation of the model.**
- **Services for specific groups who are most at risk should be commissioned, including pregnant women, those of Black and Asian origin, those with disabilities, particularly learning disabilities. In addition there is a lack of provision for teenagers and men.**
- **Contracts and agreements with suppliers and providers should include measures for health gain, including healthy weight.**
- **Top down and bottom up approaches need to be taken, to include work at community levels in areas of highest need.**
- **Better data sharing across the system will enable more robust measurement of outcomes and inform commissioning of**

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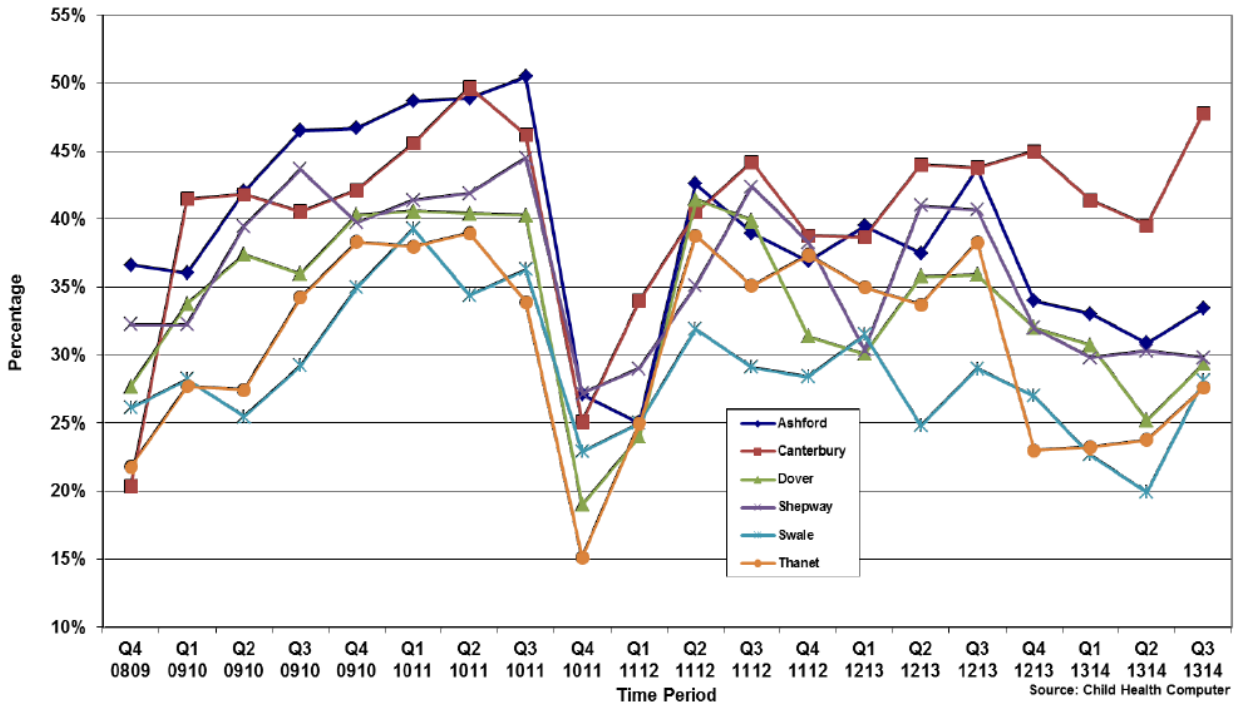
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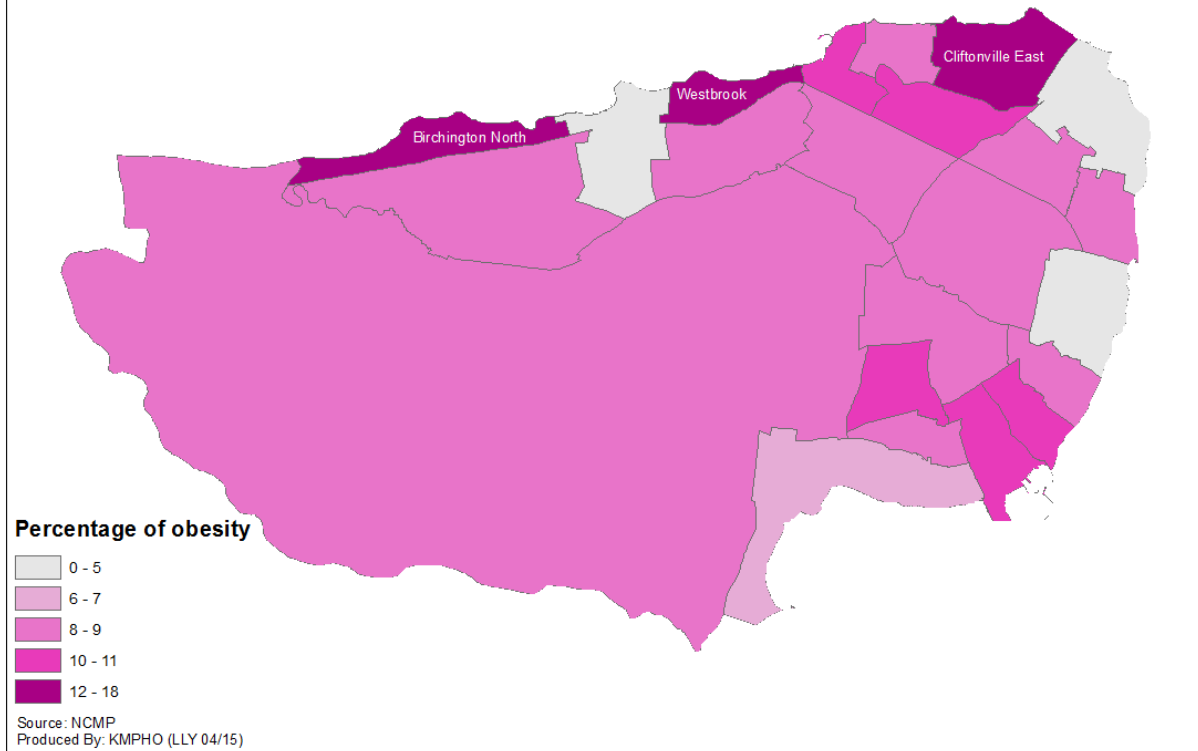
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Thanet

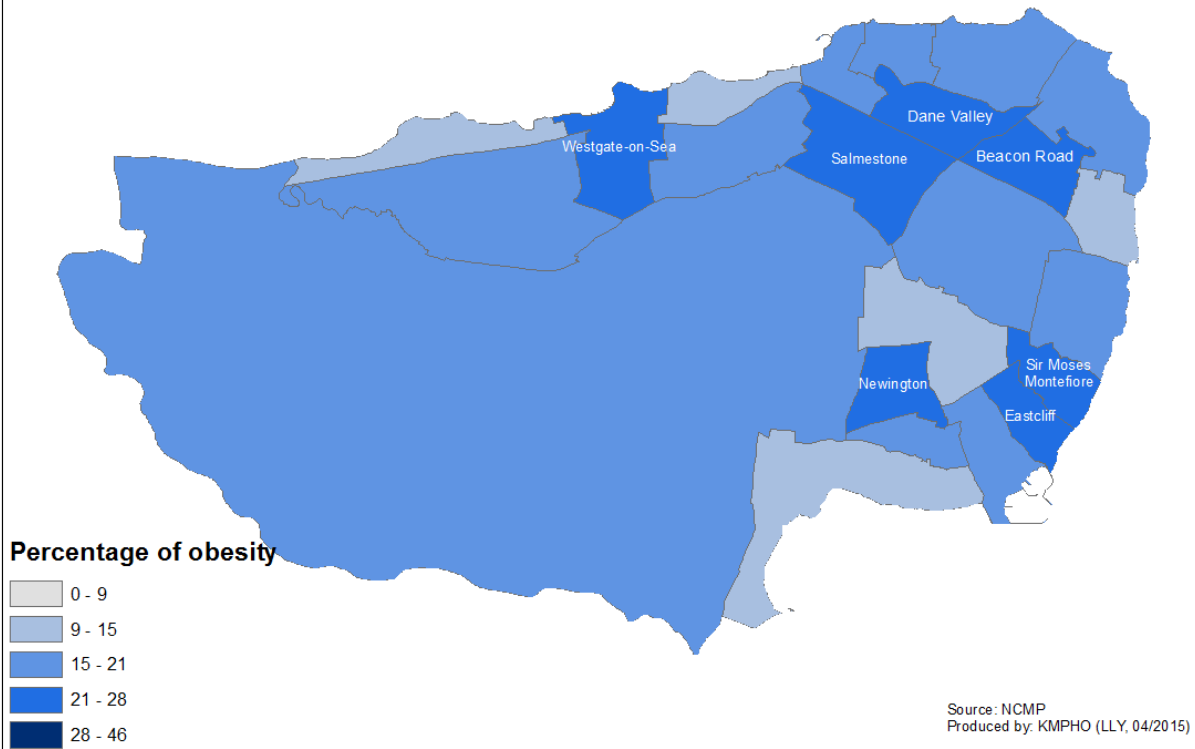
6-8 week breastfeeding prevalence by quarter from Jan 09 to present - by local authority



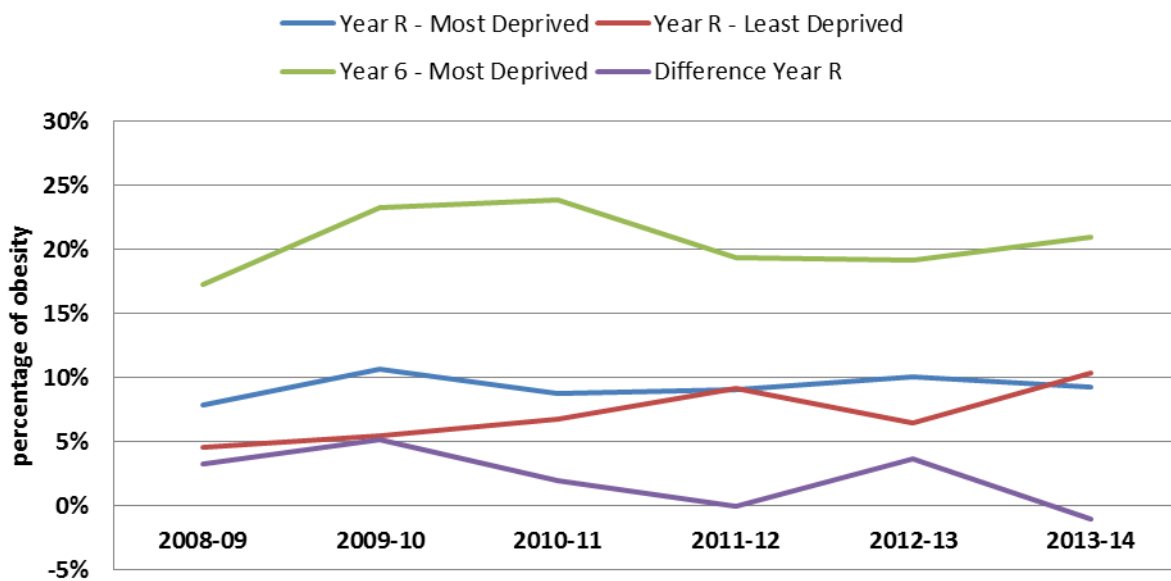
**National Child Measurement Programme, 2011/12 - 2013/14
Level of Obesity in Reception Year**



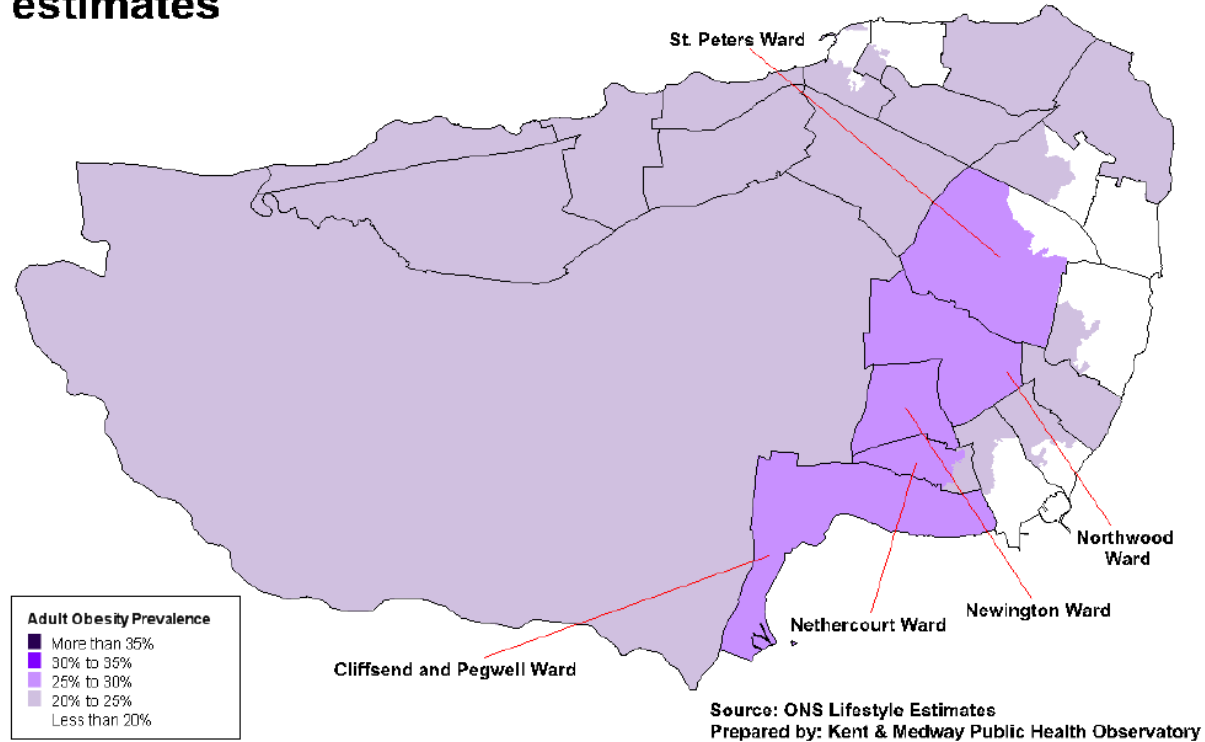
**National Child Measurement Programme, 2011/2012 - 2013/14
Level of Obesity in Year 6**



**Inequalities in the percentage of obese children
by IMD quintile, Year R and Year 6, Thanet,
2008/09 to 2013/14**

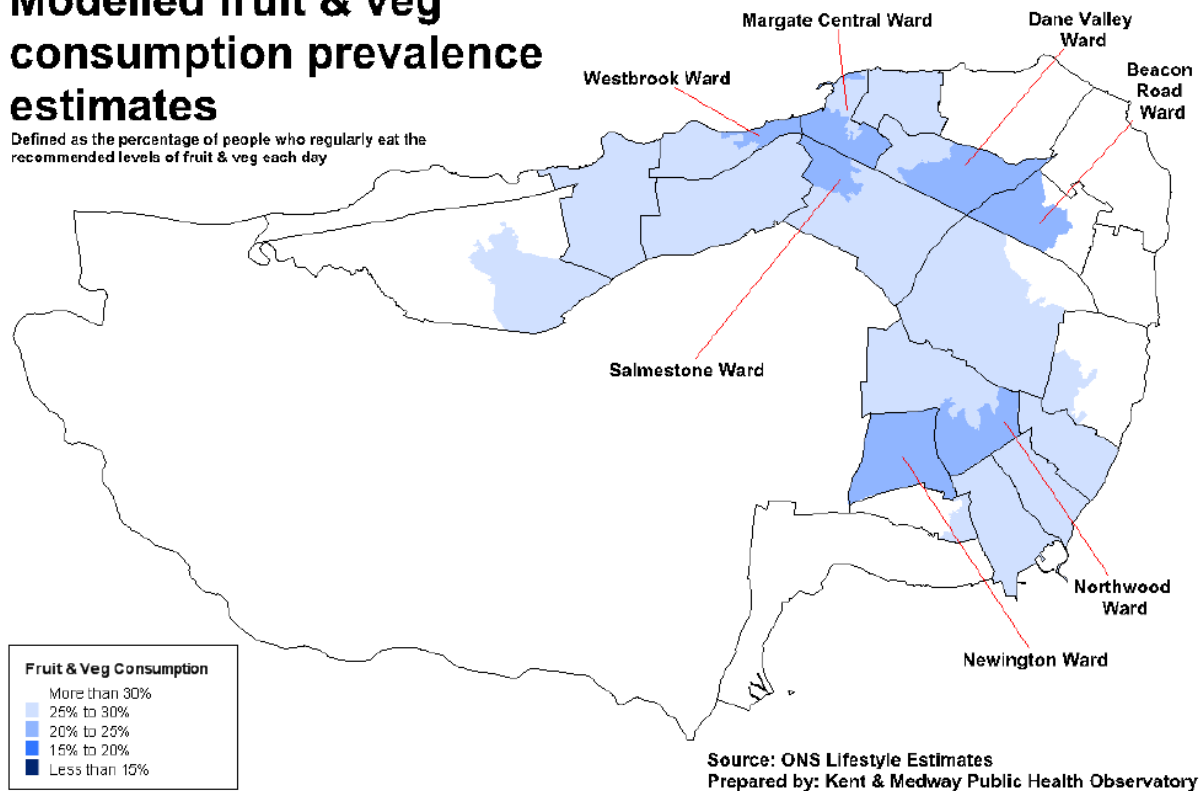


Modelled adult obesity prevalence estimates



Modelled fruit & veg consumption prevalence estimates

Defined as the percentage of people who regularly eat the recommended levels of fruit & veg each day



Appendix 2

The Views of the Public and Stakeholders

Adult Healthy Weight Consultation

A consultation questionnaire was designed to ask the adult public about their own circumstances and their views on what interventions should be provided to help people stay a healthy weight. It was posted on the Kent County Council website in standard and easy read formats. An e-mail was sent to a broad range of partners for promotion. Six hundred and two responses were received, over the sample size required.

The majority of responses were from women and from people over 46. Ten per cent of respondents were from BME groups and 11% considered themselves disabled, most wanted to lose more than a stone in weight. Nearly 50% said they wanted to feel better about themselves, over 40% said they wanted to live healthier lifestyles, were concerned about their health or wanted to change how they looked. The majority were already taking action; 33% were confident of their ability to change, 25% said they struggled to keep maintain weight loss and 22% said they'd like some help. Job responsibilities and cost were cited as the main barriers.

The majority of people wanted either one-to-one or group sessions. The majority (40%) said they would need most support increasing physical activity. Most (over 35%) said they would prefer the service to be near to home, 15% said they would like to visit a leisure centre, 14% wanted on-line support, about 12% said they would like a service offered in their GP surgery and 6% would use a pharmacy, about 2% would prefer a home visit. Telephone support was least popular.

People were asked what were the most important things to help people lose weight and the results are shown in Table 16 below.

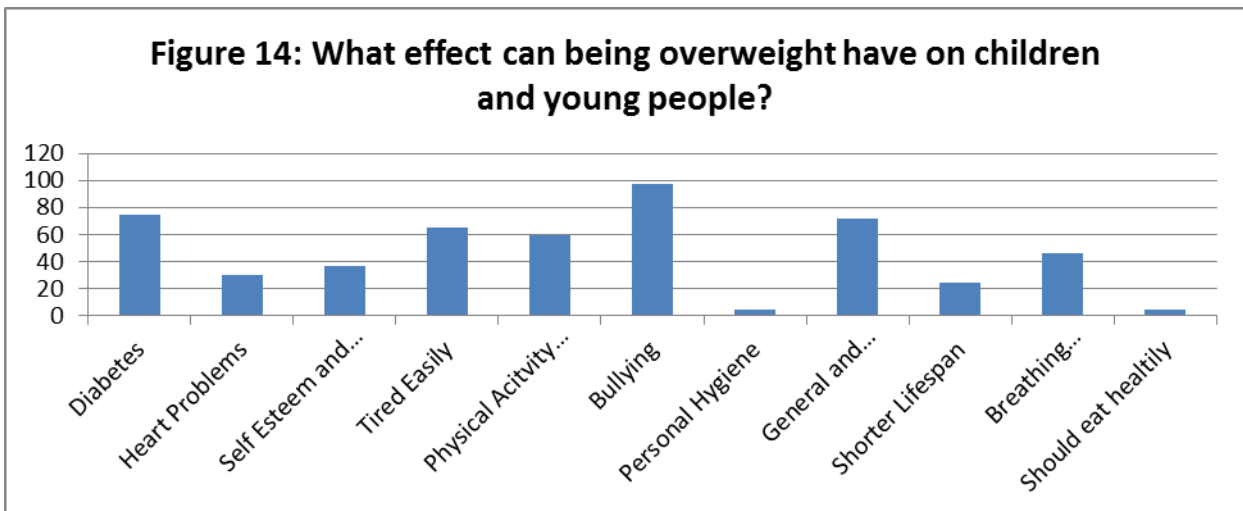
Table 14: Interventions that Kent adults agree would help with weight loss

Agree or strongly agree what would help?	
Having advice on healthy eating	96%
Available and affordable fresh fruit and vegetables	95%
Access to local leisure facilities	91%
Weight loss classes	90%
Local walks led mostly by volunteers	87%
Helping people with healthy eating	81%
Health Trainers	80%
Exercise classes that your GP tells you to go to	79%
Having one to one meetings with an adviser	79%
Taking part in sport?	77%
Attending a weight loss class	76%
Classes that help pregnant women to be a healthy weight	75%
Being able to walk and cycle near to where you live	47%

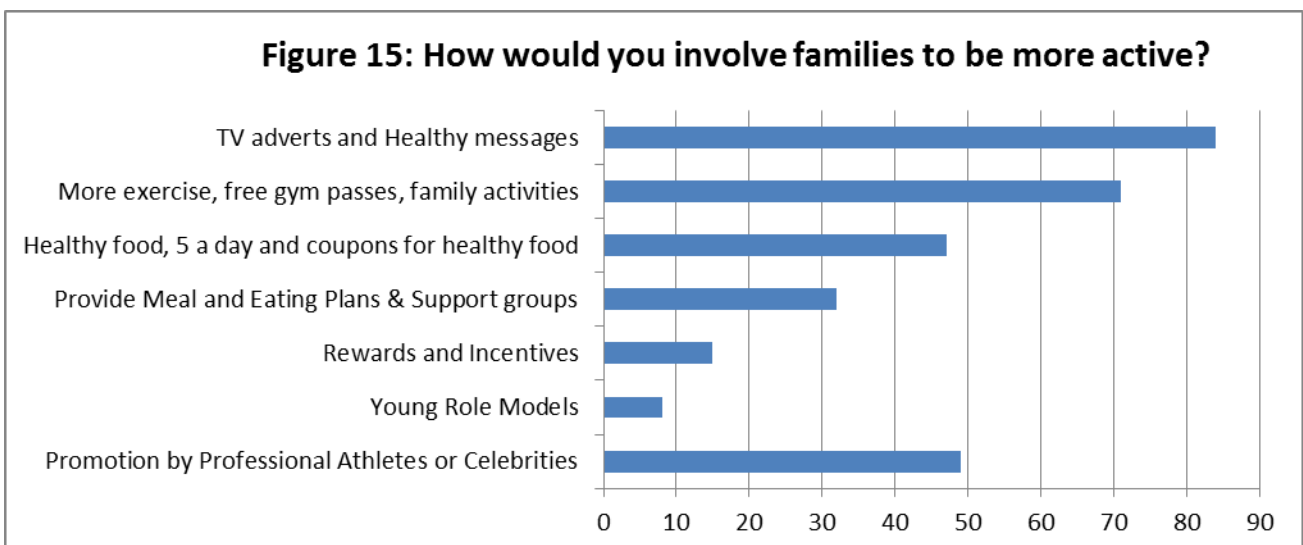
Children and Young People’s Consultation

A short questionnaire was also designed and tested with a group of young people. It was completed by 120 children aged 11-12 in a school and 12 young people aged 13-24 in a youth setting. It was also posted on survey monkey. In total there were 178 responses. A copy of the survey is in appendix 6. The answers were free text and then grouped in the analysis.

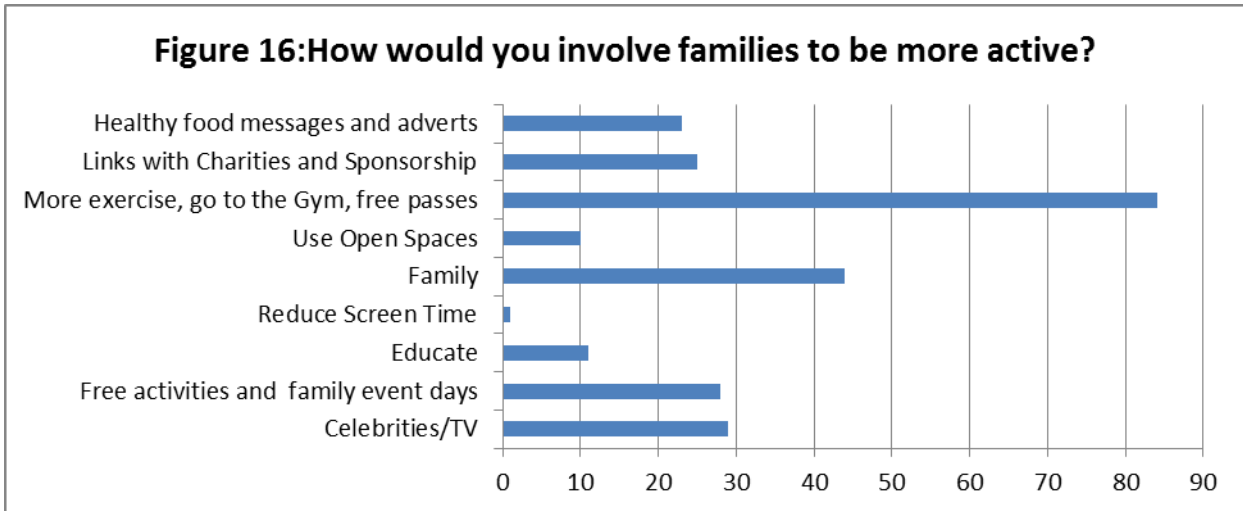
The young people that responded to the survey understood that being overweight caused health conditions such as diabetes, heart issues and breathing problems. The most reported answer is that young people who are overweight are likely to be bullied. Overweight young people also have problems with physical activity and not being able to take part in activities. The results are shown in Figures 14 and 15 below



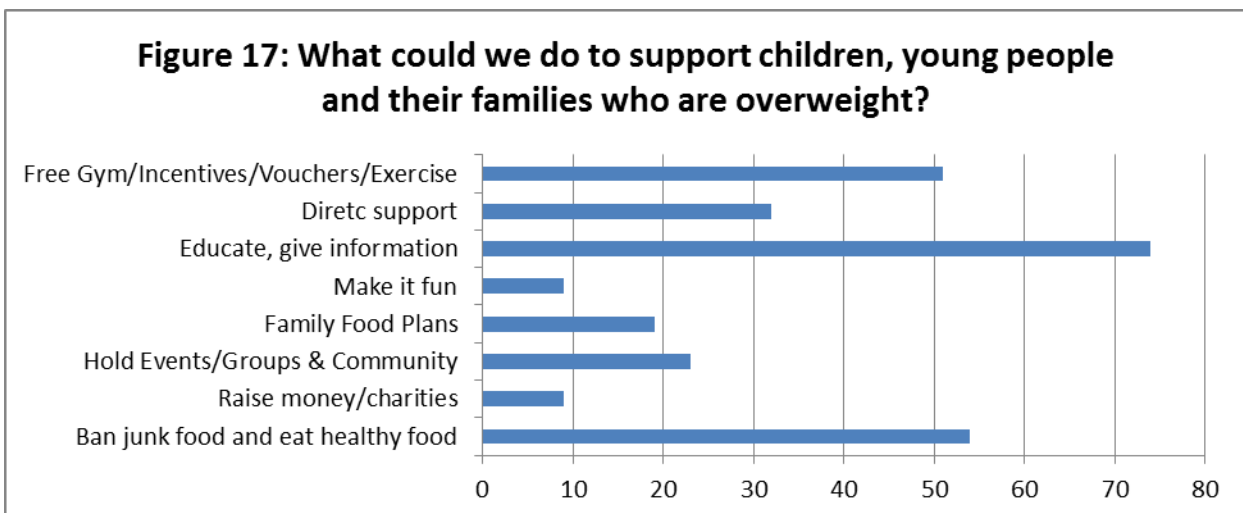
The respondents thought that the best way to deliver health messages would be through TV adverts. To enable families to be more active free gym passes and family activities should be provided so that they get more exercise.



They also thought healthy food should be more accessible and there was a need to promote messages such as the 5 a day campaign. In order to deliver these messages young people think that getting a professional athlete or celebrity on board to promote the messages would encourage families to act.



Young people think that it is important to be educated and given information about being overweight, or how to avoid putting on weight. The channels for this should be social media such as Facebook. They also believe that families need to be encouraged to eat healthy foods and have support at the same time. Again, this informs us that healthy food needs to be more accessible to families. Access to free gyms or exercise groups was also a highly suggested recommendation.



Stakeholder Views-The Big Weight Debate Summary

Stakeholders attending the Big Weight Debate workshop on 8 December 2014 told us they wanted:

- locally tailored services
- enhanced community capacity
- additional resources for targeting services in areas of greatest inequality.

Key themes that emerged were:

- **Strategic Direction** joint priority setting, agreement on strategy, common goals and outcomes
- **Commissioning** needs to reflect differential levels of obesity, put measures into specifications
- **Service Users** acceptability, accessibility, building trust, holistic offer, social and fun
- **Workforce** huge potential untapped front line work force with training needs
- **Communication** simple clear consistent messages, knowing what interventions are in place
- **Pathways** life course approach, knowing referral process and motivation key
- **Into practice** signage, walking routes and using stairs; workplace interventions.

Views of Primary Care

Three GPs in Dartford Gravesham and Swanley and two GPs in West Kent responded to a short questionnaire about their views about tackling obesity. The GPs pointed to issues of embarrassment and denial when discussing weight with parents and one GP said that in the discussion there was often a lack of understanding of causes and solutions. Concern was expressed about stigma and a reluctance to disrupt the professional relationship by causing offence. One GP stated that because patients are not coming to primary care because of weight issues, there is not time within the consultation to discuss obesity. The respondents were unaware of some of the service provision that is in place, particularly for families but also that there was longer term non-surgical psychological based support for people with a lot of weight to lose. Other professional support that was mentioned included dietetics, school nursing, health visitors and surgery.

One respondent was concerned that this was a societal issue and not a medical one and cited the Finnish heart disease programme in the 1970s which worked when the total country took responsibility for the issue. A key issue raised was motivation that people often felt that they had tried and failed in the past, people needed to want to take action. An advantage of provision that they knew about was that it was free. Ideas that were given for what else could be done included pathways, practice based programmes, starting early i.e. ante natally, providing fun accessible programmes for children and young people and taking a family approach, more referrals to exercise programmes and looking at what works. One GP was unsure about where responsibility lies for tackling childhood obesity, whether it was school nurses, public health, GPs or schools and called for a more integrated approach across local authority, social care and NHS and that cultural change was more important than pathways.

Appendix 3 Adult Consultation Questionnaire



Healthy weight questionnaire

Kent County Council has undertaken a review of the public health services it buys that are aimed at the following:

- keeping people active,
- increasing healthy eating,
- losing weight and maintaining a healthy weight.

In the past there has been greater provision of services that keep people active and improve healthy eating in the former Eastern Coastal Kent PCT area (Swale, Thanet, Ashford, Canterbury, Dover and Shepway) and less in the former West Kent PCT area (Dartford, Gravesham, Sevenoaks, Maidstone, Tonbridge and Malling and Tunbridge Wells).

Programmes for people who specifically want to lose weight have been provided across the whole of Kent, these take a behaviour change approach and typically run for 10-12 weeks and include advice about healthy eating and physical activity. Exercise Referral schemes which provide mainly gym based courses for people with specific medical conditions are mainly found in the east of the county.

Kent County Council intend to commission services for the population of Kent regardless of where they live.

Healthy weight is a public health issue because two thirds of the population are either overweight or very overweight. This can lead to conditions like diabetes and mobility problems. Recent NICE guidance Managing overweight and obesity in adults-lifestyle weight management services (May 2014) recommends that local authorities commission programmes that reduce weight and prevent weight gain. Evidence suggests that even a small amount of weight loss, if maintained, has benefits for longer term health.

All weight management programmes need to be effectively measured to show they have been effective as measured at 12 months and/or beyond. This means that services need to ensure that programmes they provide are acceptable to the public and follow-up takes place for some time after the initial programme has been completed.

To help us to commission programmes that will meet national guidance we are asking the people of Kent what would help them to achieve a healthy weight. We would therefore like to know a bit about you and what kind of activities you and your family would use. We are asking if you would take a few minutes to have your say.

UNLESS OTHERWISE STATED ONLY ONE BOX SHOULD BE TICKED PER QUESTION

Which of the following most closely reflects your feelings about your current weight?

- I would like to put weight on
- I'm close to my ideal weight, but would like to gain a little bit
- I'm close to my ideal weight, but would like to lose a little bit (under a stone)
- I would like to lose a reasonable amount of weight (more than a stone)
- I would like to maintain my present weight

Why do you feel that this change is necessary? (Please select all that apply.)

- I am worried about the risk to my health in the future
- I am worried about my health now
- I want to change how I look
- I've been told by my GP or other medical professional that I need to lose weight
- I want to feel better about myself
- I want to live a healthier lifestyle
- I want to be more active
- Other

When do you feel that these changes are needed?

- I'm already trying to make these changes
- I've already started doing something about it, but it's early days
- I feel ready to change now and I intend to start very soon
- I am thinking about making a change, but I'm not sure how or when
- I know I need to change my weight, but I don't feel I can do it yet
- I do not feel ready to change and it's unlikely I'll do anything in the next few months
- I'm not sure

How confident do you feel in your ability to make this change?

- I know how to do it, and I'm sure it will work
- I have some ideas of how to change my weight, but I'd like some help
- I've tried this in the past with limited success
- I can change my weight when I try, but I struggle to stay like that
- I don't really know where to start
- I have no idea how to change my weight

If you feel that a change in your weight is necessary, what do you believe are the main reasons holding you back? (Please tick all that apply.)

- My health prevents me from taking part in normal weight loss activities
- I have medical conditions that make it difficult for me to change my weight
- I do not feel good about myself so do not feel confident to make a change
- I've tried before but it didn't work
- My job makes it difficult
- My family and friends take up all my time
- It costs too much
- There are no places close to me that I can get to (Leisure centres, slimming groups etc)
- I don't know
- Other

If you were to receive help in losing weight, what kind of help would you prefer?

- I would like to talk to someone one to one
- I would prefer to join a group with other like-minded people
- I'd like a combination of one to one and group support and to also join a group
- I would like online support
- I'd like telephone support

When it comes to losing weight, which of the following do you feel you'd need the most support with?

- Moving more and being more active
- I would like to know more about what I should be eating
- I know what I should be eating, but I'd like to learn how to cook
- I need to measure myself every week to check how much weight I am losing

If weight management support was available, which of these options would you agree with?

- I would be more likely to attend sessions if they were free
- I'd go to a session if my doctor or nurse told me
- I'd find it easier to attend at the weekend
- I'd prefer sessions outside 9-5 Monday to Friday
- I'd prefer sessions on a weekday
- I could attend during the day
- If it were in a group, I'd prefer it to be women only
- If it were in a group I'd prefer it to be men only
- If it were in a group, I'd prefer it to be a mixed group
- I would like to attend with other people I know

- It would help if I could bring my children along
- Other

Should you require them, how would you travel in order to access these services?

- I'm not able to travel because I have problems walking
- I'm not able to travel because I cannot afford fares/petrol
- I can walk up to 10mins
- I can walk up to 30mins
- I have access to local public transport services so could attend sessions on public transport routes
- I have a car, or can get a lift from a friend or family member

If you were to access a weight loss service, where would be your preferred location?

- My GP practice
- I would like to meet in a private room in my local pharmacy
- At a centre near to where I live, for example village hall or library
- I would like to go to a leisure centre
- I'd prefer it if someone would come to my home
- I'd like telephone support
- I use the internet, so would like online support
- I would like help via my mobile phone (e.g. an app or internet based service)
- Other

What do you think are the most important things that will help people to lose weight?

Access to local leisure facilities e.g. leisure centres, swimming pools, gyms

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Being able to cycle or walk near where you live

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Having advice on healthy eating

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Taking part in sport

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Attending a weight loss class

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Having one to one meetings with an adviser

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Available and affordable fresh fruit and vegetables

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

How important do you think the following services are?

Health Walks Programme (local walks led mainly by volunteers)

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Food Champions (helping people with healthy eating)

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Health Trainers

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Weight loss

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Classes that help pregnant women to be a healthy weight

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Exercise classes that your GP asks you to attend

- Strongly Agree
- Agree

- Disagree
- Strongly Disagree
- Don't Know

How would you prefer to find out about what is available in your area?

Kent-wide website with all services advertised

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Kent-wide web-site that has details of weight loss classes, healthy eating and ways you can be more active

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

A page on the Kent County Council website

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Written information, such as leaflets and posters in GP practices, libraries, council offices etc.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Being told by your GP, pharmacist or other health or social professionals

- Strongly Agree
- Agree
- Disagree

Strongly Disagree

Don't Know

About you

We want to make sure that everyone is treated fairly and equally, and that no one gets left out. That's why we're asking you these questions.

We won't share the information you give us with anyone else. We'll use it only to help us make decisions, and improve our services.

If you would rather not answer any of these questions, you don't have to.

Are you:

- Male
- Female
- I prefer not to say

Which of these age groups applies to you?

- Under 18
- 18-25
- 26-35
- 36-45
- 46-55
- 56-60
- 61-65
- 66-75
- 76+
- I prefer not to say

What is your postcode?

To which of these ethnic groups do you feel you belong? (Source: 2011 census)

- White British
- White Irish
- White Gypsy/Roma
- White Irish Traveller
- White Other
- Mixed White and Black Caribbean
- Mixed White and Black African
- Mixed White and Asian
- Mixed other
- Other ethnic group
- Asian or Asian British Indian
- Asian or Asian British Pakistani
- Asian or Asian British Bangladeshi
- Asian or Asian British other*
- Black or Black British Caribbean

- Black or Black British African
- Black or Black British other*
- Arab
- Chinese
- I prefer not to say

If your ethnic group is not specified in the list, please describe it here:

The Equality Act 2010 describes a person as disabled if they have a longstanding physical or mental condition that has lasted, or is likely to last, at least 12 months; and this condition has a substantial adverse effect on their ability to carry out normal day-to-day activities. People with some conditions (cancer, multiple sclerosis and HIV/AIDS, for example) are considered to be disabled from the point that they are diagnosed.

Do you consider yourself to be disabled as set out in the Equality Act 2010?

- Yes
- No
- I prefer not to say

Do you regard yourself as belonging to any particular religion or belief?

- Yes
- No
- I prefer not to say

Thank you for providing this information.

Kent County Council (KCC) collects and processes personal information in order to provide a range of public services. KCC respects the privacy of individuals and endeavours to ensure personal information is collected fairly, lawfully, and in compliance with the Data Protection Act 1998.

Please return to:

**Val Miller Public Health
Specialist
Public Health
Kent County Council
Room 3.45 Sessions House
County Road
Maidstone Kent
ME14 1XQ**

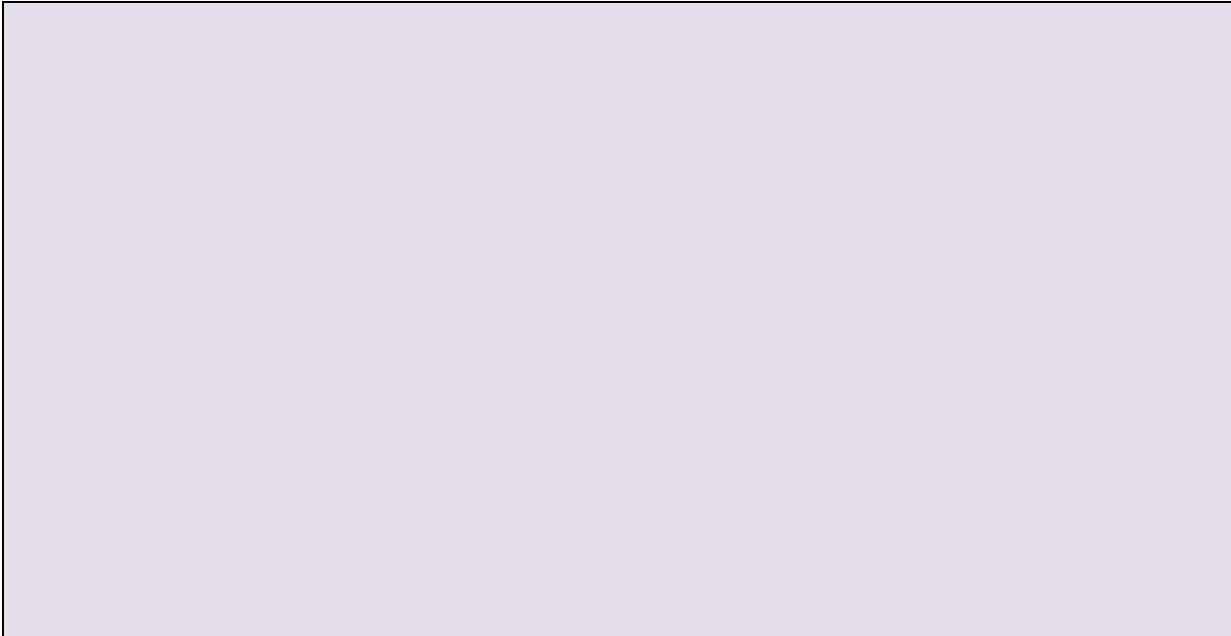
Appendix 4 Children and Young People Consultation Questionnaire

Healthy Weight

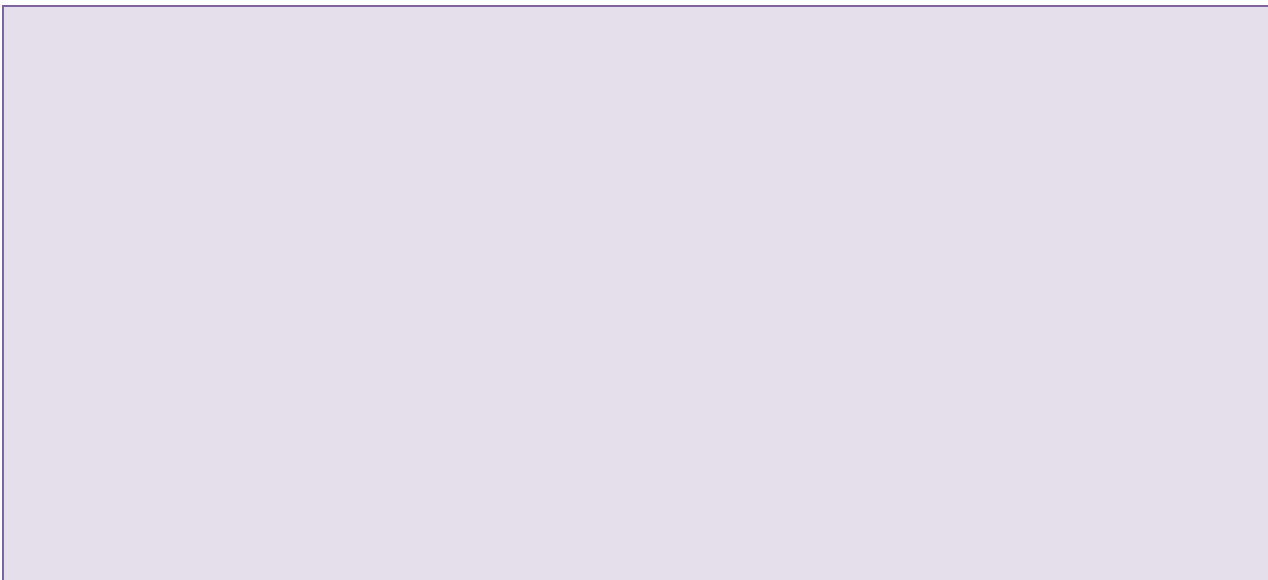
Please complete this survey and place it in the envelope supplied. This is not a test, there are no right answers to the questions.

It's anonymous so no one will know what your answers are but if there is something that you need help with now, do speak to a worker , teacher or parent about it... they might be the person in your life who can help you.

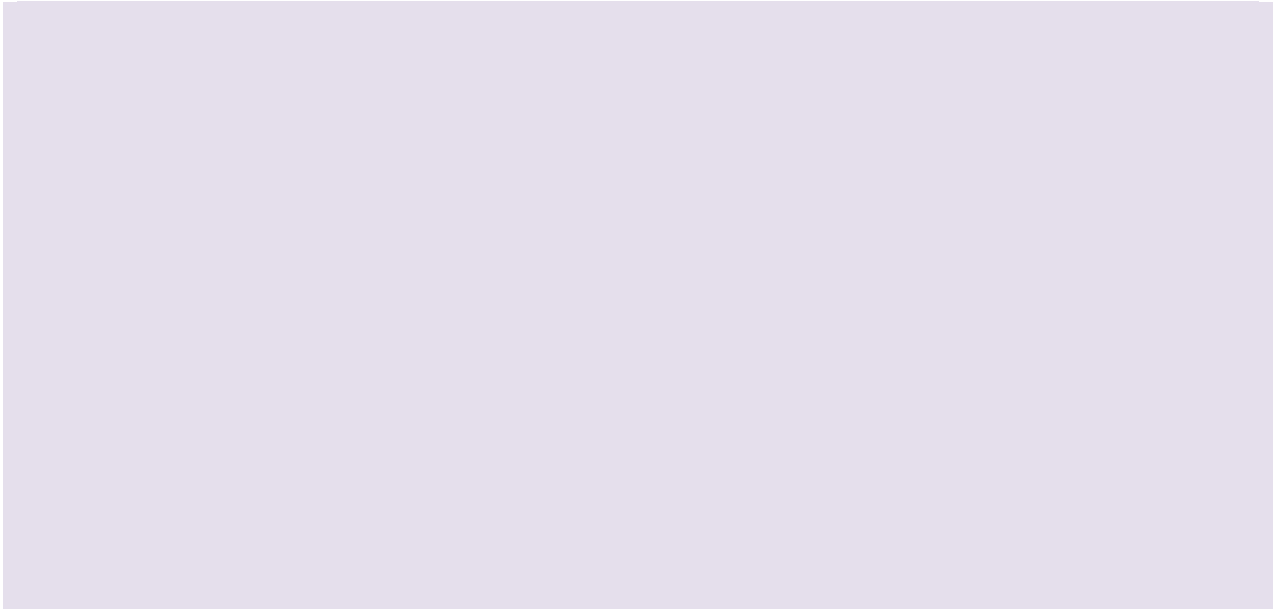
1. What effects can being overweight have on children and young people?



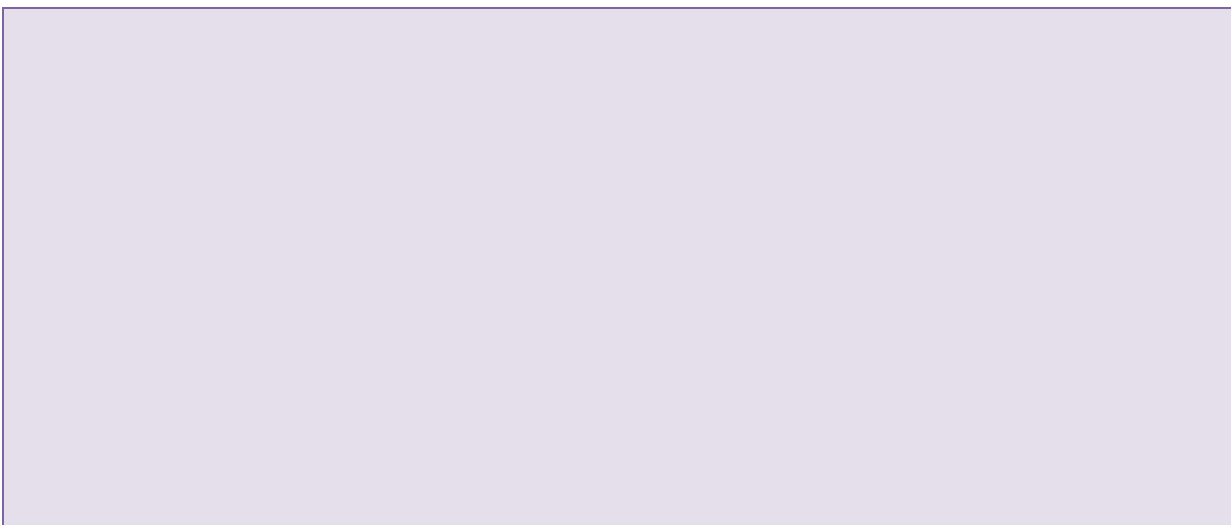
2. What do you think would encourage young people to be more active and eat healthier foods?



3. How would you involve families to be more active?



4. What could we do to support children, young people and their families who are overweight?



A bit of information about you:

My age is:

10	11	12	13	14	Other
15	16	17	18	19	

Gender:

Girl		Boy	
------	--	-----	--

I would describe my ethnicity as:

--

Disability:

I have a disability		I don't have a disability	
---------------------	--	---------------------------	--

The district that I live in is (tick box):

Dartford	Gravesham	Sevenoaks	Tunbridge Wells	Maidstone	Tonbridge & Malling
Swale	Ashford	Canterbury	Thanet	Shepway	Dover

Appendix 5 General Practice Obesity Questionnaire

QUESTION CHILDREN & FAMILIES	RESPONSE	QUESTIONS ADULTS	RESPONSE
1. What are the major challenges you face with obesity for children and families?		1. What are the major challenges you face with obesity for adults?	
2. What services are there available for you to refer patients onto?		2. What services are there available for you to refer patients onto?	
3. What are the strengths in existing provision?		3. What are the strengths in existing provision?	
QUESTION CHILDREN & FAMILIES	RESPONSE	QUESTIONS ADULTS	RESPONSE
4. What are the gaps in existing provision?		4. What are the gaps in existing provision?	
5. Do you have any proposals for future service provision?		5. Do you have any proposals for future service provision?	

Appendix 6

The Big Weight Debate – toward a strategy for tackling obesity in Kent

Introduction and context

This paper summarises the outputs from a large engagement event organised by the Public Health Team in Kent County Council on 8th December to inform the development of a strategy to tackle the growing problem of obesity. A more specific objective was to provide advice about how Public Health should handle the recommissioning of Healthy Weight Services. It is Council policy that all services commissioned or provided by the council are recommissioned or market tested to demonstrate that they are offering best value to Kent citizens.

Setting the scene for the day, Jamie Blackshaw from Public Health England (PHE) reminded participants that despite a good deal of local and national work to tackle obesity there remains an ongoing problem and that rates of obesity are worsening in some sections of the community (e.g. children in year 6). This is a problem for the health of the individuals concerned but it also has wider implications in terms of national productivity and increased demands on NHS resources. Reducing the level of obesity is therefore one of PHE's top priorities. Jamie outlined some of PHE's current and planned activities to tackle the problem. Andrew Scott-Clark, Interim Director of Public Health for Kent County Council (KCC) explained that there are quite marked variations in the scale of the obesity problem across the county by geography, gender and social groups. Andrew explained that that the county had the Public Health grant to invest in services to promote and maintain healthy weight and that he hoped the event would generate helpful advice on how this money could be best deployed. However, this resource would not in itself be sufficient to tackle Kent's obesity problem – a broad programme of activities is needed involving district councils, employers, schools, health care commissioners and providers and many other interest groups.

This report provides a summary of the outputs from two group discussions. The first of these looked at what needs to be done to address the 'obesogenic'¹ environment and to change individual behaviour. These discussions covered children and young people as well as adults and both food production and consumption and physical inactivity. The second set of discussions focused more specifically on the commissioning of healthy weight services. The final part of the report summarises the results from individual voting about the preferred approach to commissioning these services.

Tackling obesity through changing the obesogenic environment

Participants identified a number of issues that prevent people from managing their weight or being physically active. They included:

¹ Obesogenic means an environment that tends to lead to obesity; examples include more sedentary working, screen time, increased use of cars, fear of cycling on the roads, more outlets available to purchase foods dense in fat and sugar etc.

- For children and young people in some parts of the county the nutritional value of school meals is still problematic;
- It is more challenging to encourage girls to take part in physical activities, particularly in secondary schools;
- Housing design is an important factor yet one which is difficult to address. For example, it was suggested that families find it more difficult to follow principles of healthy eating if they do not have the space for a table where they can all eat together. Lack of affordable housing means that housing associations and developers are under pressure to build units that are small and where unit costs are low. District Councils noted that they sometimes had to make trade-off between housing quantity and quality.
- Lack of access to opportunities for physical activity is not an issue in most parts of the county – Kent has some of the best resources in the country. The bigger challenge is encouraging people to change their behaviour in favour of increased physical activity. Cost may be a barrier for some people.
- Some participants felt that most significant actions to address the obesogenic environment were the responsibility of central rather than local government – taxing of sugar and food labelling for example.
- At a local level district councils have to balance their responsibilities for economic regeneration with concerns about health. Decisions about whether to block the development of fast food outlets for example may not always be straight forward if there are concerns about job creation.

Actions which could be taken to address the obesogenic environment in Kent that were identified include:

- Using some of the resources earmarked for managing healthy weight for upstream preventive services targeted at children and young people.
- The consideration of cashless reward cards to increase access to healthy activities or leisure centres. These arrangements have been trialled in Barking and Dagenham.
- Ensuring that vending machines in public premises such as leisure centres offer healthy options.
- Embed the notion of physical activity in the way schools operate so that these messages are not simply restricted to PE lessons.

Individual behaviour

Behaviour change is complex. Several participants highlighted the lack of firm evidence about what works, including ways to shift public opinion about the unacceptability of obesity as a social as well as an individual matter. There were also comments that people can be confused about the lack of consistency in the national and local messages about healthy eating, the health benefits and risks of different foods and levels of exercise. Health and care professionals

can also be reluctant to raise the subject with their patients/clients as weight is a more sensitive and personal matter than smoking. There were particular concerns about children in year 6 as obesity in this age group is rising and Kent performs worse than others similar areas in the South East.

On balance participants felt that it was easier to encourage people to be more active than it was to change attitudes to food consumption or weight. Practical actions that participants suggested to help people to change their behaviours, both around food and activity included:

- **Environmental cues.** Signs that encourage people to walk or use the stairs could be more widely used. Signs in parks or streets for example could indicate approximate times to walk between landmarks. For children, the walking signs could be made more attractive by having a 'treasure hunt' theme e.g. 'can you find/see';
- **Clear and consistent messages across Kent** about what people can do to maintain healthy weight and be physically active. These can be reinforced through each contact that people have with the health and care system (see making every contact count below);
- **Educate parents** – ensuring that healthy eating is discussed with new parents e.g. through health visitor checks and through child minders through registration arrangements. Opportunities to explain to parents that children need to continue with physical activity during secondary school were also noted;
- **Normalise healthy choices.** People should be encouraged to build in physical activity into everyday tasks such as cleaning or bending or families playing together. This would also help to address perceptions that physical activity is expensive. Some noted that was an ongoing issue for PHE and others to address what constitutes a 'normal' or desirable weight;
- **Promote awareness and uptake of digital assets such as health apps and exercise trackers;**
- **Encourage employers** to invest in work place health programmes as this helps promote productivity. A Kent wide reward/recognition scheme for health promoting businesses might be a further incentive.
- **A focus on young people.** Inviting young people in secondary schools to identify what they could do to be more active and what support schools could offer. There may need to be more imaginative approaches that are more attractive to young people than conventional games lessons.
- **Using life courses as opportunities.** Focusing advice and support at key points in people's lives where they are amenable to change was felt to be an effective approach.

Commissioning healthy weight services

There are different arrangements for the provision of healthy weight services across the county. The discussion sessions were organised around six key themes relating to different aspects of services to promote healthy weight

Across the groups there were some general comments made about the shift from the current arrangements to a new service model.

- **Investment needs to reflect the differential levels of obesity** across the county
- KCC should take the opportunity to **learn from current services** in Kent and elsewhere about what works or is ineffective.
- **The important contribution of district councils** to tackling obesity should be recognised.
- **Cost effectiveness** is a critical issue for commissioners and providers and also for service users. Some participants suggested that co-payments should be considered for those individuals that could afford to make a contribution.
- **Bringing services to people who are isolated.** Some people who need weight management support may be housebound or socially isolated. Commissioners need to ensure that there is provision to reach these people.
- **Ensuring that there are systematic management arrangements for all parts of the pathway.** It is important that new arrangements tackle some of the weak points in the system which currently exist e.g.
 - follow up arrangements to check the outcome of people referred to weight management support
 - data missing on obesity levels for some sections of the population
 - capacity problems e.g. for health trainers.

Establishing a central directory of services

In the consultation work to date a number of suggestions have been made about improving access to information and signposting to the various resources and support available in Kent to help tackle obesity. These have included paper or on-line directories or registers and a referral portal that would provide some form of screening to ensure people were pointed to the services most appropriate to their needs and preferences. Participants were asked whether they would support this general approach and if so how it should work in practice.

There was little support for a directory of services - experience with these suggests that they have are not always regularly updated. If this option were to be pursued it was suggested that there should be both paper and online versions available and clear responsibilities in each organisation for keeping the information current.

Some suggested that a clear referral pathway illustrating the different options available in different places was more important than a directory of services. Others pointed out that referrals to weight management services were likely to be of limited value unless there had been a) the right conversations with the patient at the outset to encourage commitment to

changes in behaviour and b) arrangements to follow up whether the referral opportunities had led to action on the part of the individual needing help.

A more general comment made was that while referral pathways and service directories have become increasingly popular solutions it is important to consider the problems that they are designed to address. Several contributors noted that relationships between health and care professionals in different services, organisations and sectors have been fragmented over the past few years - this makes it harder for them to know who to refer to and what is available. Rebuilding connections between health and care professionals in each locality was thought to be as, if not more important, than providing information and referral pathways.

Making every contact count

Skilling up the frontline workforce to give brief and opportunistic advice about physical activity and healthy weight were emphasised throughout the workshop. It was suggested that brief interventions could be reinforced by other sectors or professions e.g. housing or homelessness officers or neighbourhood management staff.

Some participants suggested that training to make 'every contact count' should be broader than the issue of obesity. For example, staff might also be equipped to highlight issues of alcohol consumption. There was agreement that it was easier to open up the discussion through physical activity than weight per se, as this can be a more sensitive issue. Training could include:

- How to start the conversation e.g. 'how do you feel about your health'
- Ensuring people are aware of the support that is available including online resources and health apps
- Information on who people should see/call
- What constitutes physical activity - how people can use everyday activities to improve their fitness
- Consistent messages that can be easily communicated and imaginative ways of tailoring them to different groups

The group discussing this topic also considered how that training might be undertaken. They suggested networking sessions as well as conventional training and the use of a 'train the trainer' cascade.

Children in primary and secondary school were identified as an important target group. Beyond PE lessons there were various methods that schools could consider to encourage students to 'keep moving'.

While consistent messages and training can help to 'make every contact count' they may have limited impact unless health and care professions believe that opportunistic health advice is part of their responsibility. Senior leaders need to be signed up to the approach and actively promote these activities in their organisation.

Finding people who need support

Participants acknowledged the challenges of identifying young people and adults who are obese or at risk of becoming so. For example, health checks only cover the population between 40 and 75 and don't reach everyone in that age group. There are no mandatory weight measurements taken for children in secondary schools so there are gaps in knowledge about

weight and health habits. It was noted too that there is no systematic way of promoting Healthy Weight services via GPs.

GPs and Schools are two arenas where there is a registered list so participants recommended that efforts should be made to undertake systematic measurements of weight in these settings.

Overall, there was agreement that it is more effective to have a system which involves a broad range of health and care professionals to identify people at risk rather than relying on one group such as GPs. There were several references to GPs not having time to provide advice, signpost or follow up their patients effectively due to competing pressures on their time. Some improvements could be made here by making use of other community health professionals e.g. health trainers to follow up health checks or referrals made by GPs. However, some participants noted that trainers have limited capacity to be able to do this.

Deprivation can be a contributory factor to obesity, albeit in complex ways – some people for example do not have enough food, let alone enough of the right sort. It was suggested that Healthy Weight services should be located in areas of highest deprivation linked to programmes that have existing relationships with this section of the population e.g. Job Centres, housing associations, the troubled families' programme, family liaison officers, health visitor contacts with families with young children. In Ashford there have been attempts to target at risk groups via housing associations but the success of the approach is constrained by the fact that these organisations do not perceive that they have a role in health and wellbeing. At a district level participants argued that public service organisations should establish some common goals and outcomes around obesity. Data sharing protocols may need to be looked at to enable information to be passed between professionals and organisations, but this would be easier within the context of shared organisational objectives.

Identifying and supporting people with the highest risk

NICE has recommended that people who are obese should have a 12 week programme that covers physical activity, healthy eating and behavioural advice and support. Participants were asked about how these services could be delivered cost effectively. Much of the discussion appeared to focus on sharing information and how NICE guidance had been interpreted by current services in Kent. Those who had been involved in delivering such programmes noted that it was increasingly important to find ways to tailor programmes to fit in with people's work commitments, although it was not possible to meet everyone's needs, given the diversity of work patterns. It was also suggested that it might be appropriate to relax the focus on '12 weeks' - the priority should be regular contact and activities rather than a specified elapsed time.

Supporting people to maintain changes in behaviour to support healthy weight

There may be complex, personal reasons behind individual decisions to change their lifestyle. Participants noted that evidence about motivation may offer some pointers, but it was also important to acknowledge the context in which people are trying to keep active and tackle their weight. If they have other challenges such as debt, housing or unemployment these may assume a higher priority than following a healthy lifestyle. A further comment was that different approaches might be needed for people who are already obese versus those who were 'at risk'

The key theme in the discussion was normalising those activities that contribute to healthy weight. For example, stressing daily activities that could help people to be physically active

such as walking to and from the shops. Linked to this point it was noted that local authorities should pay attention to environmental design so that people feel safe to walk and cycle. It was suggested that there may be a seasonal aspect to physical activity, so communications or campaigns to promote more activity might be more effective if timed with changes to daylight and weather. Pregnant women were identified as an important target group as there are opportunities to reinforce the message about breastfeeding being positive for the child and the mother and to follow up on healthy weight at the 2 year health checks by health visitors. There were different opinions about whether people should be encouraged to weigh themselves regularly. Some suggested that a simpler way of getting the message across to people was that if their clothes no longer fitted they should consider losing weight.

Expected outcomes for healthy weight services

This group were asked for their advice about what outcomes might be expected from the type of healthy weight services that had been discussed in the seminar. There was agreement that there should be both short term and long term measures of success and some proxy measures which might *include* the following:

Short term

- An increase in knowledge and healthy weight (measured through surveys) and spread of that knowledge across the population
- Uptake of breastfeeding

Long term

- Weight management outcomes – weight loss and maintenance
- No/% of people getting the support that they need
- Reductions in incidence and prevalence of type 2 diabetes
- Cost impacts of obesity

The group also considered how a return on investment from weight management interventions might be assessed. They suggested that there may be national research from the National Obesity Observatory that could support this work but it was also important to consider changes in associated factors related to obesity, either as determinants or consequences –general mental health and wellbeing including stress and back pain were noted here.

Commissioning Healthy Weight Services – priorities for the future

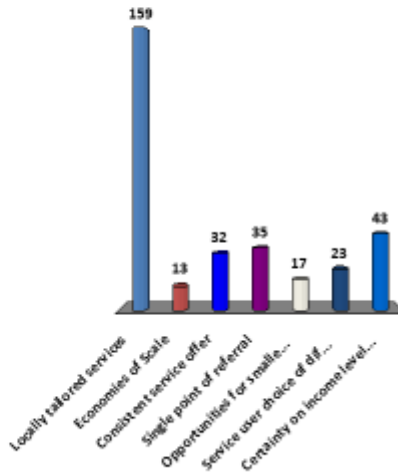
In the final discussion session a computerised voting system was used to identify participants' preferences for the commissioning of Healthy Weight services. The public health team did not take part in this process. It should be noted that a significant number of participants were current providers of healthy weight services and so this would have had a bearing on their responses. The key responses are reported below – the methodology used did not enable responses by stakeholder group or by geography to be analysed.

The first question focused on the key priorities to be reflected in the way healthy weight services are commissioned. As the graph below shows that the overriding priority is that services should be tailored to meet local needs and circumstances.

Service Delivery Model

Choose your top three in order of preference.

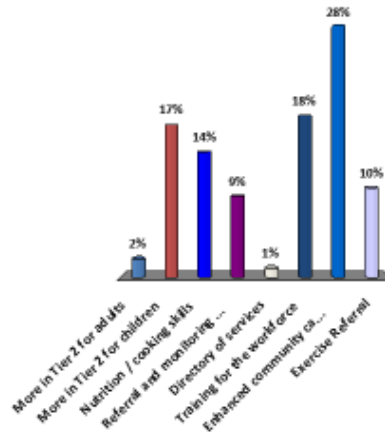
1. Locally tailored services
2. Economies of Scale
3. Consistent service offer
4. Single point of referral
5. Opportunities for smaller organisations
6. Service user choice of different providers
7. Certainty on income levels for providers



The second question asked participants to consider the hypothetical situation that if 75% of the grant allocated for healthy weight services were to be assigned to weight management programmes for adults and families, how should the remainder be allocated? Participants were asked to indicate their top 3 priorities. The graph below shows these preferences based on weighted choices. It demonstrates that although there are quite mixed views there would be little support for investing more in weight management programmes for adults or in a directory of services. In the discussion participants talked about gaps in provision for young people as there are currently age boundary restrictions that are unhelpful. The priority given to enhancing community capacity echoes the point above about tailoring services to local needs.

Priorities for investment in healthy weight management

- A. More in Tier 2 for adults
- B. More in Tier 2 for children
- C. Nutrition / cooking skills
- D. Referral and monitoring system
- E. Directory of services
- F. Training for the workforce
- G. Enhanced community capacity (e.g. walking schemes, gym clubs)
- H. Exercise Referral

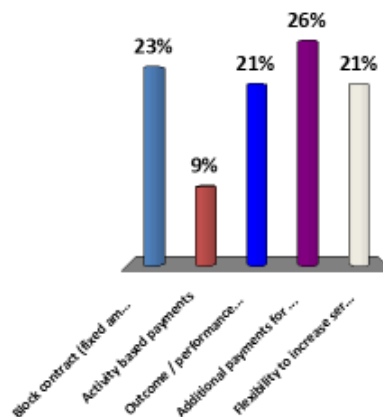


The third question asked participants about the geographical basis for organising healthy weight services. Again given the preferences above it was not surprising that there was a slight majority who preferred services to be organised at district level, although the percentage in favour of organisation at county level is interesting...

Finally participants were asked about payment arrangements. Interestingly, activity based payments attracted the least support with similar numbers preferring the other methods. Perhaps the most striking response is the degree of support for outcome based payments, given some of the challenges in supporting people to maintain a healthy weight.

Here are some possible payment arrangements Choose your top three in order of preference

- A. Block contract (fixed amount)
- B. Activity based payments
- C. Outcome / performance payments
- D. Additional payments for targeting services at areas of greatest inequality
- E. Flexibility to increase service capacity if partner funding is made available



Conclusions

Concluding the event Andrew Scott Clark noted that there would be further conversations with key interest groups – no firm decisions had been made about the type of services to be commissioned or the procurement process. It was noted that the consultation today only represented some key stakeholders and that other consultation activity would be important in gaining as full information as possible to determine future provision. Andrew noted that the event had underlined the importance of three key themes:

- Establishing a systematic way of measuring outcomes and evaluating the impact of services and support to tackle obesity
- Consistent messages about the risks of obesity and the options for addressing them (both physical activity and food) as well as some clear outcomes agreed by all partners
- The need for clear pathways that enable people to access the support they need quickly and simply.

Thanking participants for their time and contribution Andrew noted that his team expected to have an agreed approach about the specification and approach to commissioning by May 2015.

Thanet Health Inequalities Group – Terms of Reference

1. Introduction.

Health inequalities are avoidable variations in health status of groups and individuals and are a complex issue. There is evidence that populations in areas with high deprivation experience higher morbidity and mortality than those areas with low deprivation, however some less deprived areas may contain pockets of high mortality. Thanet has the widest gap in health inequalities out of all of the districts in Kent. There is a need to ensure that there are clear strategic actions that tackle relatively short, medium and long-term interventions. The interventions that can potentially have an effect in the short-term are those that reduce the risk of mortality in people with established disease (i.e. ensuring those with heart disease are diagnosed and treated so that their blood pressure/cholesterol is under control). Medium term interventions focus on lifestyle interventions such as stopping smoking and weight management and longer term solutions include those that tackle worklessness, increasing community resilience, improving poor educational attainment and reducing poverty.

2. Aims and Objectives of the Group.

The Thanet Health Inequalities group will lead the multi-agency approach to address health inequalities across the district. The purpose of the group is to provide the leadership and co-ordination for reducing health inequalities and improving health and wellbeing across Thanet. This will be achieved by bringing together stakeholders from the public sector, third sector and the community to plan and deliver actions / services.

The group will have a number of functions that include;

- Establish a shared understanding of what is meant by 'health inequalities' across the Community
- Provide leadership to promote effective partnership working to reduce health inequalities
- Support implementation of the Joint Health and Well Being Board (HWB) Strategy
- Establish performance measures to provide a clear indication of progress to reduce health inequalities.
- Identify and progress actions that will contribute to outcome measures for reducing health inequalities, monitor and report on these to demonstrate impact
- Involve a wide range of stakeholders especially communities in activities which are aimed at reducing health inequalities and building community resilience.
- To ensure that there is good linkage with the Integrated Commissioning group
- Ensure that robust evaluation, including cost effectiveness is an integral part of local initiatives aimed at reducing health inequalities
- Identify and share the evidence base and good practice
- The group should have a strategic association with health inequality plans produced at county level.

3. Membership of the Group.

The group will consist of individuals from the following organisations.

- KCC, Public Health Consultant
- KCC, Public Health Specialist
- KCC, Social Services representative
- Thanet CCG – Clinical lead for health inequalities
- Thanet CCG – Lay member
- Thanet CCG – Head of Strategic Planning and Commissioning
- Thanet CCG – Head of Membership Development
- Thanet District Council representative
- Voluntary and Community Sector representative
- Department of work and pensions representative
- Kent Police – Margate Task Force lead

The chair of this group will be nominated by the group. A vice chair will also be nominated.

Individuals or organisations may be co-opted onto the group as and when required.

4. Operation of the Health Inequalities group

Frequency: The Health Inequalities group will meet bi-monthly and be convened by the Chair in consultation with the nominated representatives of Thanet CCG, Thanet District Council and Kent County Council.

Quorum: At least 1 member must be present from Thanet CCG, TDC and KCC for a decision to be taken

Servicing Arrangements: Action notes of meetings will be shared with group members. Papers will be published five working days before each meeting. Where the group is required to make a decision a written report will be provided and the lead officer requested to attend the meeting to present and answer questions

5. Governance Arrangements.

The Health Inequalities group will be accountable to the Thanet Health and Well Being Board and respective executive decision making structures of KCC, Thanet CCG and TDC. The group will be advisory and make recommendations to the Health and Well-Being Board. It will provide detailed proposals so that informed decisions can be made. Proposals will be specific and individual organisational support will be needed at the appropriate times.

6. Administrative Support to the Group.

To be agreed, but responsibilities will include:

- Agenda setting, in consultation with the Chair.
- Booking of rooms.
- Taking of, and distribution of, notes of the meeting.

7. Review of Terms of Reference.

These will be reviewed annually

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Thanet Local Partnership Group for Integrated Commissioning

1. Introduction.

The Local Partnership Group (LPG) for Integrated Commissioning is responsible for ensuring that there is a coordinated and consistent approach to commissioning services on behalf of partner agencies in Thanet. It aims to ensure a joined up approach to strategic planning and service delivery in order to maximise best use of public resources and deliver seamless services by working across organisational boundaries

The membership of the group will include a wide range of partners from across the public and voluntary sectors and it is expected that the membership will represent the entirety of services provided across the district.

2. Aims and Objectives of the Local Partnership Group.

The purpose of the LPG is to develop integrated commissioning responses between Kent County Council (KCC), Thanet Clinical Commissioning Group (CCG) and Thanet District Council (TDC) to drive up quality, achieve value for money, increase productivity and improve outcomes by:

- Developing joined up commissioning intentions to support implementation of the Joint Health and Well Being Board (HWB) Strategy
- Developing a blueprint for change by producing costed action plans to support delivery of the joint HWBB strategy
- Engaging providers through Implementation Projects in order to ensure timely, appropriate service change takes place and new models of service are put in practice
- Taking an evidence based approach to promoting innovation to improve services outcomes
- Proposing changes to the processes of integrated commissioning so that stakeholders can commission better together.

As a sub group of the Thanet Health and Well Being Board, the LPG is committed to accelerating the transformation and integration of commissioned services so that they better serve the people and communities in our area and reduce inappropriate reliance on public sector funding. The plans will result in integrated care teams becoming the bedrock of person-centred, co-ordinated care. Through clinical leadership and engagement these teams will be rooted in our communities and have a strong capability to prevent and intervene earlier. In pursuit of this goal, we will draw on the assets available from individuals, communities and organisations to achieve the following objectives:

- Giving people a bigger say in their health and care by being involved in priority setting, engaging with people to commission services on behalf of the communities we serve and by supporting and enabling people to take greater responsibility for their own and their children's health and wellbeing.
- Commissioning services to meet people's needs and give them better experiences of health and care services. In practice, this means designing care and providing services around people's needs to remove duplication at every stage so that people who need care can be supported to stay in their homes and return to their communities for as long as possible.

- Commissioning services to reduce inequalities in access to health and care service access
- Commissioning services to continue to support and develop a motivated, flexible workforce with the right staff and resources in the right places
- Commissioning in a way that ensures we manage demand.

3. Membership of the Group.

The group will consist of individuals from the following organisations.

- Thanet CCG – Commissioning Manager
- Thanet CCG – Clinical Commissioner
- Thanet District Council.
- KCC, Public Health
- KCC, Social Services
- VCS rep (TBC)
- Chair of the LPG for Mental Health
- Chair of the LPG for Children
- Chair of the LPG for Frail Elderly
- Chair of the LPG for Inequalities

The chair of this group will be the Head of Strategic Planning and Commissioning for Thanet CCG. A vice chair will be nominated

Individuals or organisations may be co-opted onto the group as and when required.

4. Operation of the LPG

Frequency: The LPG will meet bi-monthly and be convened by the Chair in consultation with the nominated representatives of Thanet CCG, Thanet District Council and Kent County Council.

Quorum: At least 1 member must be present from Thanet CCG, TDC and KCC for a decision to be taken

Servicing Arrangements: Action notes of meetings will be shared with the LPG members. Papers will be published five working days before each meeting. Where the LPG is required to make a decision a written report will be provided and the lead officer requested to attend the meeting to present and answer questions

5. Governance Arrangements.

The LPG will be accountable to the Thanet Health and Well Being Board and respective executive decision making structures of KCC, Thanet CCG and TDC. The LPG will be advisory and make recommendations to the Health and Well-Being Board. It will provide detailed proposals so that informed decisions can be made. Proposals will be specific and individual organisational support will be needed at the appropriate times.

The LPG will be responsible for performance managing implementation projects. The Implementation Projects will be responsible for delivering service transformation plans.

The governance structure below outlines reporting arrangements:

(to be inserted)

Members will also be responsible for escalating barriers and blockers to the relevant organisations for resolution.

6. Dealing with sensitive matters and possible conflicts of interest

The LPG may at times have to consider confidential information on matters related to commissioning, procurement or performance. Members are individually required to declare known conflict of interests prior to commencement of meetings. The LPG will determine whether or not any declaration necessitates exclusion from discussion on specific issues

7. Administrative Support to the Group.

To be agreed, but responsibilities will include:

- Agenda setting, in consultation with the Chair.
- Booking of rooms.
- Taking of, and distribution of, notes of the meeting.

8. Review of Terms of Reference.

These will be reviewed annually

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Thanet Local Partnership Group for Mental Health

1. Introduction.

The membership of the group will include a wide range of partners from across the public and voluntary sectors who work with adults with mental health issues and it is expected that the membership will represent the entirety of services provided across the district.

The group will provide a connection between countywide strategic bodies and those working with adults with mental health problems at a local level. There will also need for close working with other Local Partnership Groups (LPG) to ensure consistency of plans, eg the children's LPG which will be responsible for mental health services for children and young people.

2. Aims and Objectives of the Local Partnership Group.

The primary objective of the LPG for mental health is to drive improvement in outcomes for adults in Thanet with mental health problems. The work of the LPG will be focussed, data-driven and underpinned at all times by delivering a measurable improvement in selected indicators. The work of the LPG will be aligned to the work of the Thanet Health and Wellbeing Board (HWB).

The aims of the group will be to:

- Share information to provide an understanding of the range of local services, their remit, activity and capacity.
- Identify local needs and gaps in service provision.
- Develop proposals to eliminate gaps in service provision.
- Identify areas for joint commissioning and provision of services.
- Facilitate the pooling of resources to meet the needs of local adults with mental health problems.
- Identify areas of duplication and streamline service provision.

3. Membership of the Group.

The group will consist of individuals from the following organisations.

- Thanet CCG commissioner.
- Thanet CCG clinical lead.
- Thanet District Council.
- KCC – public health.
- KCC – social services.
- The police.
- Kent and Medway Partnership Trust.
- Strategic Partner for Community Mental Health and Wellbeing Service.
- Voluntary sector organisations (to be agreed).

The group will nominate or elect a Chair.

Individuals or organisations may be co-opted onto the group as and when required.

4. Frequency of Meetings.

To be agreed.

5. Governance Arrangements.

The group does not have any formal decision making powers, but will report to the Local Partnership Group for Integrated Commissioning and will provide regular updates to the Thanet HWB (frequency to be agreed). All members of the group will be responsible for reporting back to their own organisation and using appropriate governance structures to obtain any decisions required to support the work of the group.

Members will also be responsible for escalating barriers and blockers to the relevant organisations for resolution.

6. Dealing with sensitive matters and possible conflicts of interest

The LPG may at times have to consider confidential information on matters related to commissioning, procurement or performance. Members are individually required to declare known conflict of interests prior to commencement of meetings. The LPG will determine whether or not any declaration necessitates exclusion from discussion on specific issues

7. Administrative Support to the Group.

To be agreed, but responsibilities will include:

- Agenda setting, in consultation with the Chair.
- Booking of rooms.
- Taking of, and distribution of notes of the meeting.

7. Review of Terms of Reference.

These will be reviewed annually.

Thanet Local Partnership Group for Frail Elderly

1. The Purpose

To develop an integrated frailty pathway that is understood across the health and social care system thus ensuring they are provided with the right care at the right time and are supported to make more efficient use of existing health and social care services and resources at a time of increasing demand and reducing available budgets.

The pathway will be designed within current resources and will be sustainable at a time of increasing demand and reducing budgets. It will include the journey starting with preventative measures as well as how to cope in a crisis when it occurs – with the constant theme to care for frail people in their own home where possible

Reference to best practice examples across England and evidence from national organisations for example the British Geriatrics Society and NICE guidance will be included.

2. Aims and Objectives of the Local Partnership Group.

The purpose of the LPG is to develop a frailty pathway across Thanet which will include the following: Thanet Clinical Commissioning Group (CCG) Kent County Council (KCC), TDC and other health and social care providers including the voluntary sector to drive up quality, achieve value for money, increase productivity and improve outcomes by:

- Create a map of existing services to include any falls provision
- Agree action plan with achievable timescales
- To review current and future workforce issues
- Develop a frailty toolkit
- Require a shared IT record which will be available which will have the ability to link to EOL care records.
- Implement assistive technologies ,where appropriate, for frail elderly

3. Membership of the Group.

The membership of the group will include a wide range of partners and stakeholders and will consist of individuals from the following organisations.

- Thanet CCG – Commissioning Manager
- Thanet CCG – Clinical lead
- TDC
- KCC, Public Health
- KCC, Social Services
- EKHUFT
- KCHFT
- IDT
- Secamb

- Voluntary sector organisations eg. Age UK and Crossroads care

The chair of this group will be the Clinical lead from either SKC or Thanet CCG. A vice chair will be nominated

Individuals or organisations may be co-opted onto the group as and when required.

4. Operation of the LPG

Frequency: The LPG will meet monthly and the administrative support to the Group will be shared between Thanet and SKC CCGs and responsibilities will include:

- Agenda setting, in consultation with the Chair.
- Booking of rooms.
- Taking of, and distribution of, notes of the meeting.

Action notes of meetings will be shared with the LPG members. Papers will be published five working days before each meeting.

5. Governance Arrangements.

The LPG will be accountable to the respective CCGs and executive decision making structures of organisations represented. The LPG will ensure that any recommendations or proposals are escalated via the CCGs so that informed decisions can be made. Proposals will be specific and individual organisational support will be needed at the appropriate times.

The LPG will be responsible for performance managing implementation projects. The Implementation Projects will be responsible for delivering service transformation plans.

Members will also be responsible for escalating barriers and blocks to the relevant organisations for resolution.

6. Dealing with sensitive matters and possible conflicts of interest

The members of the group have a duty of confidentiality regarding all information disclosed, shared and discussed between and during meetings. If deemed confidential, there will be occasions when selected information must not be disclosed outside the group. The person disclosing such information to the group is responsible for identifying it as confidential at the time it is given, and for ensuring that its confidential status is identified in all relevant written material.

Members are individually required to declare known conflict of interests prior to commencement of meetings. The LPG will determine whether or not any declaration necessitates exclusion from discussion on specific issues

7. Review of Terms of Reference.

These will be reviewed annually



Report to:	Thanet Health and Wellbeing Board
Title of Report:	Update on Thanet Better Care Fund Programme Delivery
Author:	Fay Gooderson – Commissioning Manager, Thanet CCG

1.	Purpose of Paper
To update the board on the programmes in place to support the delivery of the Better Care Fund.	

2.	Introduction/Background
The aim of the Fund is to deliver the health and social care services within this Section 75 agreement to the people of the area maximising quality and value for money. A key element of the agreement is a commitment to drive continuous improvement of services within resources available. To this end, the services each party have included in the agreement are those which must work most closely together to benefit the provision of out of hospital health and social care services to local people.	

3.	Thanet’s Vision for Health and Social Care Services by 2020
<p>Thanet’s vision for integrated health and social care service includes:</p> <ul style="list-style-type: none"> • GPs taking a lead for coordination • Multi-Agency Integrated teams • Delivering wraparound care to patients • Delivering community care through a single point of access • Delivering shared access to patient information • Delivering enhanced support to carers • Supporting independence & self-management • Providing seamless end of life care <p>We recognise the need for transformational change and that no single agency can deliver the improvement working in isolation</p> <p>Under the Better Care Fund, we aim to provide care that crosses organisational boundaries that best services the population needs</p>	

4.	Better Care Fund Schemes
<p>The Better Care Fund for Thanet is composed of the following schemes:</p> <ul style="list-style-type: none"> • Enhanced Primary Care • Integrated Health and Social Care teams including enhancing community teams and care co-ordination • Flexible use of Care Homes and Westbrook House • Falls Prevention • Improving End of Life Care 	

5.	Enhanced Primary Care
<p>Objectives:</p> <ul style="list-style-type: none"> • GP practices working together to enable different access opportunities for patients • GP in Accident and Emergency at the acute hospital in Margate to build links between the acute hospital staff and Primary care colleagues. • Patients supported to inform and take ownership of their care plans which includes electronic sharing of care records with the patient and between health and social care professionals; 	
<p>Update:</p> <ul style="list-style-type: none"> • Developments of Thanet based Integrated Care Organisations, which equates to 4 locality clusters (Quex, Margate, Ramsgate and Broadstairs) • Developments in 8-8, 7 day working programme to support patient access to core primary care services • Developments of integrated primary care hub, underway with QEQM to support reduction in attendances and patient education • Improved coordination for Enhanced services for Long term conditions • Development of core pathways starting with prevention and self-care with management to end of life care • Established Integrated Discharge Teams working within acute sites to support multi-disciplinary and early discharge from hospital • Developments of a shared care plan for patients under the umbrella of the Multi Interoperability Gateway (MIG) 	
6.	Integrated Health and Social Care Teams
<p>Objectives:</p> <ul style="list-style-type: none"> • Deliver access to services seven days a week • Share clinical information to assist with decision making out of hospital • Access to a rapid response service for patients at high risk of acute admission • Coordinated community intermediate care providing patient centered wraparound support • Robust integrated discharge process with post-discharge community support 	
<p>Update:</p> <ul style="list-style-type: none"> • Developments of Thanet based Integrated Care Organisations, which equates to 4 locality clusters (Quex, Margate, Ramsgate and Broadstairs) • Development of wraparound patient services under targeted and holistic model of care within community and social provision 7 days per week • New discharge to assess work programmes to support prevention of admission and reduction in length of stay • End of life strategy to support high quality end of life care • Development of whole system pathways for better care co-ordination across the health economy 	

7.	Flexible Use of Care Homes
Objectives:	
<ul style="list-style-type: none"> • Delivery of improved community solution offering flexible service • Reduction in need for acute admission • Support for early discharge of patients from hospital 	
Update:	
<ul style="list-style-type: none"> • Development and implementation of a revised model of care • Links to frailty work programme as part of whole pathway including education and better patient outcomes • Model of 'step up' and 'step down' beds for health and social care support 	
8.	Scheme 04 – Falls Prevention
Objective:	
<ul style="list-style-type: none"> • To reduce the number of unplanned admissions due to falls • To improve quality of life for Thanet residents • To lessen the effects of ill health relating to falls 	
Update:	
<ul style="list-style-type: none"> • Development of a multi-agency frailty programme which is clinically led • Development of frailty pathways which start and end in the community to support self-care/prevention to end of life care. • Development of a protected frailty unit based at QEQM to prevent admission and support early discharge • Increase support of care homes through over 75s schemes including wider use of care plans 	
9.	Improving End of Life Care
Objectives:	
<ul style="list-style-type: none"> • To improve overall coordination of end of life care • To ensure patient wishes are recorded • To ensure patients are given their choice of place of death wherever possible 	
Update:	
<ul style="list-style-type: none"> • Development of a layered end of life care strategy • Development of a shared care plan between organisations • Development of education for workforce to support advanced communication skills for end of life care. 	

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THANET DISTRICT COUNCIL DECLARATION OF INTEREST FORM

Do I have a Disclosable Pecuniary Interest and if so what action should I take?

Your Disclosable Pecuniary Interests (DPI) are those interests that are, or should be, listed on your Register of Interest Form.

If you are at a meeting and the subject relating to one of your DPIs is to be discussed, in so far as you are aware of the DPI, you **must** declare the existence **and** explain the nature of the DPI during the declarations of interest agenda item, at the commencement of the item under discussion, or when the interest has become apparent

Once you have declared that you have a DPI (unless you have been granted a dispensation by the Standards Committee or the Monitoring Officer, for which you will have applied to the Monitoring Officer prior to the meeting) you **must:-**

1. Not speak or vote on the matter;
2. Withdraw from the meeting room during the consideration of the matter;
3. Not seek to improperly influence the decision on the matter.

Do I have a significant interest and if so what action should I take?

A significant interest is an interest (other than a DPI or an interest in an Authority Function) which:

1. Affects the financial position of yourself and/or an associated person; or Relates to the determination of your application for any approval, consent, licence, permission or registration made by, or on your behalf of, you and/or an associated person;
2. And which, in either case, a member of the public with knowledge of the relevant facts would reasonably regard as being so significant that it is likely to prejudice your judgment of the public interest.

An associated person is defined as:

- A family member or any other person with whom you have a close association, including your spouse, civil partner, or somebody with whom you are living as a husband or wife, or as if you are civil partners; or
- Any person or body who employs or has appointed such persons, any firm in which they are a partner, or any company of which they are directors; or
- Any person or body in whom such persons have a beneficial interest in a class of securities exceeding the nominal value of £25,000;
- Any body of which you are in a position of general control or management and to which you are appointed or nominated by the Authority; or
- any body in respect of which you are in a position of general control or management and which:
 - exercises functions of a public nature; or
 - is directed to charitable purposes; or
 - has as its principal purpose or one of its principal purposes the influence of public opinion or policy (including any political party or trade union)

An Authority Function is defined as: -

- Housing - where you are a tenant of the Council provided that those functions do not relate particularly to your tenancy or lease; or
- Any allowance, payment or indemnity given to members of the Council;
- Any ceremonial honour given to members of the Council
- Setting the Council Tax or a precept under the Local Government Finance Act 1992

If you are at a meeting and you think that you have a significant interest then you **must** declare the existence **and** nature of the significant interest at the commencement of the

matter, or when the interest has become apparent, or the declarations of interest agenda item.

Once you have declared that you have a significant interest (unless you have been granted a dispensation by the Standards Committee or the Monitoring Officer, for which you will have applied to the Monitoring Officer prior to the meeting) you **must**:-

1. Not speak or vote (unless the public have speaking rights, or you are present to make representations, answer questions or to give evidence relating to the business being discussed in which case you can speak only)
2. Withdraw from the meeting during consideration of the matter or immediately after speaking.
3. Not seek to improperly influence the decision.

Gifts, Benefits and Hospitality

Councillors must declare at meetings any gift, benefit or hospitality with an estimated value (or cumulative value if a series of gifts etc.) of £100 or more. You **must**, at the commencement of the meeting or when the interest becomes apparent, disclose the existence and nature of the gift, benefit or hospitality, the identity of the donor and how the business under consideration relates to that person or body. However you can stay in the meeting unless it constitutes a significant interest, in which case it should be declared as outlined above.

What if I am unsure?

If you are in any doubt, Members are strongly advised to seek advice from the Monitoring Officer or the Democratic Services and Scrutiny Manager well in advance of the meeting.

DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS, SIGNIFICANT INTERESTS AND GIFTS, BENEFITS AND HOSPITALITY

MEETING.....

DATE..... AGENDA ITEM

DISCRETIONARY PECUNIARY INTEREST

SIGNIFICANT INTEREST

GIFTS, BENEFITS AND HOSPITALITY

THE NATURE OF THE INTEREST, GIFT, BENEFITS OR HOSPITALITY:

.....
.....
.....

NAME (PRINT):

SIGNATURE:

Please detach and hand this form to the Democratic Services Officer when you are asked to declare any interests.