NICE TESTIMONY – WEST AND MID ESSEX LOCAL COMMISSIONING EXPERIENCE - ADRIAN COGGINS
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1. What are the essential elements of a local, community-wide approach to preventing obesity that is sustainable, effective and cost effective?

We have not achieved this in our commissioning – I don't think anyone has, so I can't add a lot to the existing research evidence base. Our efforts are targeted at obesity treatment and management. From a commissioning perspective the only way that community wide obesity prevention would be achieved is through joint commissioning across agencies that include both prevention and treatment in an integrated pathway. Even if both prevention and treatment are jointly commissioned in a pathway the commissioning budget will only be able to intervene with a defined cohort – a subset of all those who are obese or at risk of obesity. The prevalence exceeds even a multi-agency collective budget to intervene with everyone who is obese or at risk of it. Therefore it's important to clarify the specific role of local commissioning relative to other interventions from central government, private sector etc. This is covered in Foresight and other publications. Good commissioning intervenes with a well defined group, using a well defined intervention, and measures outcomes from that intervention group. If the expected outcome is reduction of obesity risk or reduced weight for an entire local population (as was the case with previous Local Area Agreement targets), the dilemma becomes apparent.

However, commissioning issues above aside, key attributes would be:

- Consistency of message and branding (e.g. Use Change 4 Life on all interventions/resources
- A multi-agency action plan which clearly identifies the best contribution of each agency to preventing/reducing obesity (not a vague aspirational aspiration which is owned by everyone in principle but only actioned by those who bear the brunt of the most overtly identified costs of obesity - the NHS
- Integration of obesity actions within core work programmes of partner agencies with clearly defined target groups, outcomes, timescales, evaluation methods, and accountability routes
- Where a commissioner provider relationship exists actions must be built into service specifications with clearly defined outcomes, and ideally, payment based on achieving those outcomes
- Obesity actions integrated with core delivery e.g. Embedded in children's services spec so it's a core part of workforce delivery

2. What barriers and facilitators may influence the delivery and effectiveness of a local, community-wide approach (including action targeting specific groups)?

Factors influencing delivery:

Quality of staff in post, cost and local resources, if there is an obesity champion AND topic specialist locally to drive the agenda, robust contractual arrangements with outcomes based payments

Factors affecting effectiveness:

Quality of staff in post to deliver and monitor, ability to demonstrate achievement of outcomes against objectives i.e. good evaluation, good penetration in to the target audience, through e.g. social marketing

3. Who are the key leaders, actors and partners and how do they work with each other?

Commissioning arms of the NHS (or following national restructure Local Authorities) are likely to be the protagonist. For interventions aimed at weight management/treatment key partners are obesity service providers. For interventions aimed at prevention, these are primarily organisations with a responsibility to modify an environment to make it less obesogenic, e.g local authority highways departments and planning department, but this local potential is a subset of greater potential to change the environment through a legislative framework. Nudge/coercion/persuasion of the population can only go so far if the environment in which they function is predisposed towards unhealthy choices.

Commissioners work with providers needs to stretch providers to raise their game beyond what they can currently deliver, and not give in to provider pressure to only agree to service specs which are based on evidence to date. A good specification pushes the evidence base to improve it. We need to take account of the fact that the NHS needs to find a lasting solution to patient's' obesity, ideally one which manages their obesity risk and ensures maintenance of healthy weight over the life course. Sadly no-one can commission a specification with 30 year outcomes, but 1 year is simply not long enough. Service specs should stretch the providers to deliver outcomes over and above the evidence base. In the absence of evidence the question then becomes one of sharing financial risk between commissioner and provider. This is where effort needs to be put, not in reducing expectations of providers to deliver on an evidence base which is limited and needs growing.

4. What factors need to be considered to ensure local, community-wide approaches are robust and sustainable?

Interventions need to be embedded in core modus operandi of local organisations. For example, building primary care teams to deliver interventions to their patients is more sustainable than commissioning patient places from an external provider to which GPs refer, on a one year contract. However, a three year contract where the delivery team operates within GP practices and grows the culture of primary care to deliver dedicated weight management interventions will be more sustainable.

5. What does effective monitoring and evaluation look like?

First make sure the issue of obesity is capable of being monitored and evaluated. Population prevalence can be monitored (e.g., through NCMP), but expecting interventions to deliver anything more than a cohort specific effect for those people intervened with is unreasonable. A common problem in obesity has been that people have attempted to evaluate an aspirational strategy by expecting interventions to achieve a reduction in population prevalence, when the only intervention with that entire population is a surveillance programme. Effective monitoring and evaluation involves a well defined target group, intervention(s) and clearly quantified outcome measures and evaluation methodology, all within a service specification.

6. Can the cost effectiveness of local, community-wide obesity interventions be established and, if so, what is the best method to use?

This depends on the definition of cost effectiveness. In the longer term this is problematic (as we all know!) because the avoidance of health problems that we use as a rationale to fund the project can only be demonstrated years after the funding for the intervention has run out. However, if we redefine cost effectiveness as avoiding health problems and include specific health care episodes avoided *within a certain timeframe* then it becomes easier. For example, sending someone to a specialist morbid obesity service before they reach the point at which they need to be considered for bariatric surgery will be less costly than bariatric surgery, since the costs of surgery may be deferred for a defined period of time. If the patient loses weight and manages to sustain their lifestyle change then the time period over which bariatric surgery can be avoided may be extended. But there is no guarantee that the patient will never need bariatric surgery at some point in the future. Of key importance is life course follow up through GP practice notes of patients who have had weight management interventions to assess which of those interventions (if any) produced sufficient patient autonomy for patients to self manage their weight over the longer term.

Methods of assessing cost effectiveness should focus in part on the short term ie. in year timescale. There is the pressing issue of QIPP and short term delivery, where programmes are funded on the expectation that every £1 spent will produce more than £1 saved within the same financial year. We cannot use this reductionist approach as the sole basis for assessing cost effectiveness of obesity, but neither can we ignore that fact that many PCTs are in this position and public heath staff are being asked to demonstrate this, so a consensus position is urgently needed.

With respect the NICE cost per QALY threshold may have little currency in a PCT where decisions have to be made about commissioning treatment OR prevention programmes. There are two reasons for this:
1) whilst the patient outcomes are paramount, the health and social system benefit of weight management need to be evaluated. E.g. If a patient loses weight and their co-morbidities improve, do they see their respiratory consultant or diabetologists at the outpatient clinic any less frequently (or even stop altogether), or do they need less medication? Health system benefits are often cited as the reason for setting projects up, but they often fail to deliver on evaluating those benefits.
2) It's too far down the line to use as a case for funding where there would be an expectation of the interventions solving an immediate demand or financial problem. A PCT Chief Executive has an average tenure of 3 years and has to make funding decisions based on in year benefit.

7) What benefits came from being part of a wider programme and what has been the impact once funding has reduced / ceased

Being part of a wider programme helps a raised profile if there is consistency of branding, but this needs a note of caution as local areas do not have the resources to compete with the international profile and branding of the private sector.

When funding ceases, often programmes stop, no matter how much partnership has been developed, things happen because resource is attached to a project, when that resource stops so does the project. This is a general point for programme funding but also applies to obesity. There is a degree of learned helplessness on the part of organisations who are not the protagonist in developing obesity programmes. For example, if specialist services are commissioned and take referrals from primary care, then primary care may be active referrers into the programme but are passive in the sense that they defer any obesity related issues to the provider. If funding is withdrawn and the provider no longer delivers, the practice skill set to deal with obesity may be less than before the provider started delivering

8) How much does success depend on individual staff

Absolutely crucial. No matter how good the system of monitoring and accountability if the staff are not up to the job it will fail. Of course governance is important but partnerships work primarily on personal relationships, and even the tightest service spec is only as good as the people delivering it .

9) How much does the partnership approach cost (in very basic terms) e.g. budget / staff costs /number of meetings.

A partnership approach can be delivered with no budget, but interventions cannot. However partnerships can add value and it is important to be clear at the outset as to the expected contribution of each of the key players. Staff costs are variable - ability is more important than grade, but the ability to influence others is crucial and this may have a bearing on the status of the post required within the NHS pay scale. . Number of meetings also vary but expect to front load the effort which should result in relatively less work later on during contract monitoring stages

10) Measuring return on investment for obesity

already dealt with in 6) above

11) Links to wider determinant interventions (e.g. spatial planning) to obesity outcomes

There need to be links amongst all stakeholders to ensure consistency and a co-ordinated approach, and each obesity stakeholder should know their contribution relative to others' contributions, hence the need for the multi agency action plan described in 1) above. Where there is a logical sequence of stakeholder activity this should be made explicit in the action plan. Eg, spatial planning and subsequent building could usefully precede behaviour change interventions if both are concerned with the same location.

12) Experience working with commercial partners (eg food or sports industry, weight management services)

Extremely variable – some are open for discussion on how to raise their game and are prepared to be flexible with their business model (to realise some of the outcomes described in 3) above. I have tried to move discussion on from just asking providers to deliver what the evidence tells us is possible, to how do you deliver outcomes beyond what the (limited) evidence base tells us and how do we share the financial risk in what is a mutually unknown environment? From a commissioning perspective there is an urgent need to benchmark providers against a common set of criteria. The basis for this criteria can be summarised as what outcome, over what period of time, for what price?