

Coordinating Weight Management Support Across Large and Diverse Areas

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Case Study: Coordinating Weight Management Support Across Large and Diverse Areas

- ❑ Strategies to cope with the complexity and diversity of needs across districts
- ❑ Key insights into trialling and rolling out a model that works for the community
- ❑ Best practice for providing tailored and consistent referral approaches
- ❑ Proactive methods to tackle the obesogenic environment and incentivise weight loss

Excess weight (in adults)

	2015/16 %	2016/17 %	2017/18 %	2018/19 %	2019/20
England	61.3	61.3	62.0	62.3	62.8
North Yorkshire	60.8	59.5	61	62.9	61.3
Selby	63.8	63.5	69.6	72.8	62.1
Ryedale	59.7	61.9	59.2	57.9	63.5
Scarborough	70.3	60.7	60.0	64.8	69.6
Hambleton	60.3	60	62.9	62.2	63.1
<u>Richmondshire</u>	66.1	59.5	63.6	62.4	62.9
Harrogate	52.5	57.9	57.9	56.9	55.7
Craven	56.9	55.1	57	64.6	54.5

Key:

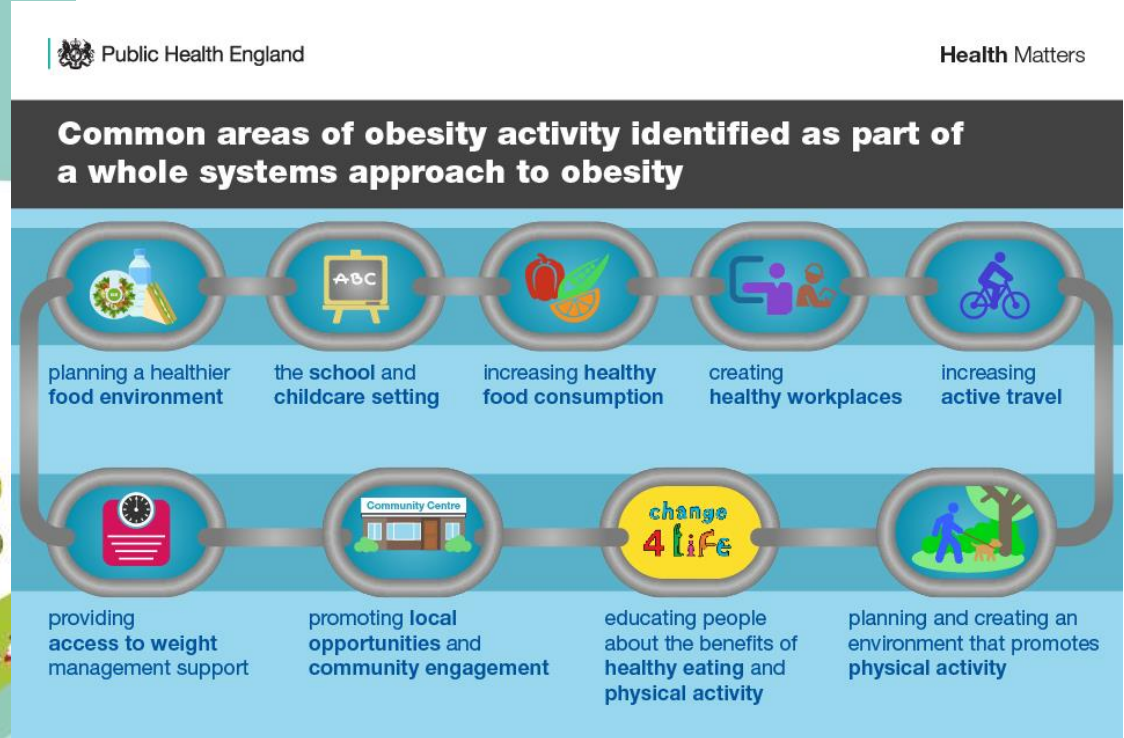
Statistically significantly worse than the England average

Statistically similar to the England average

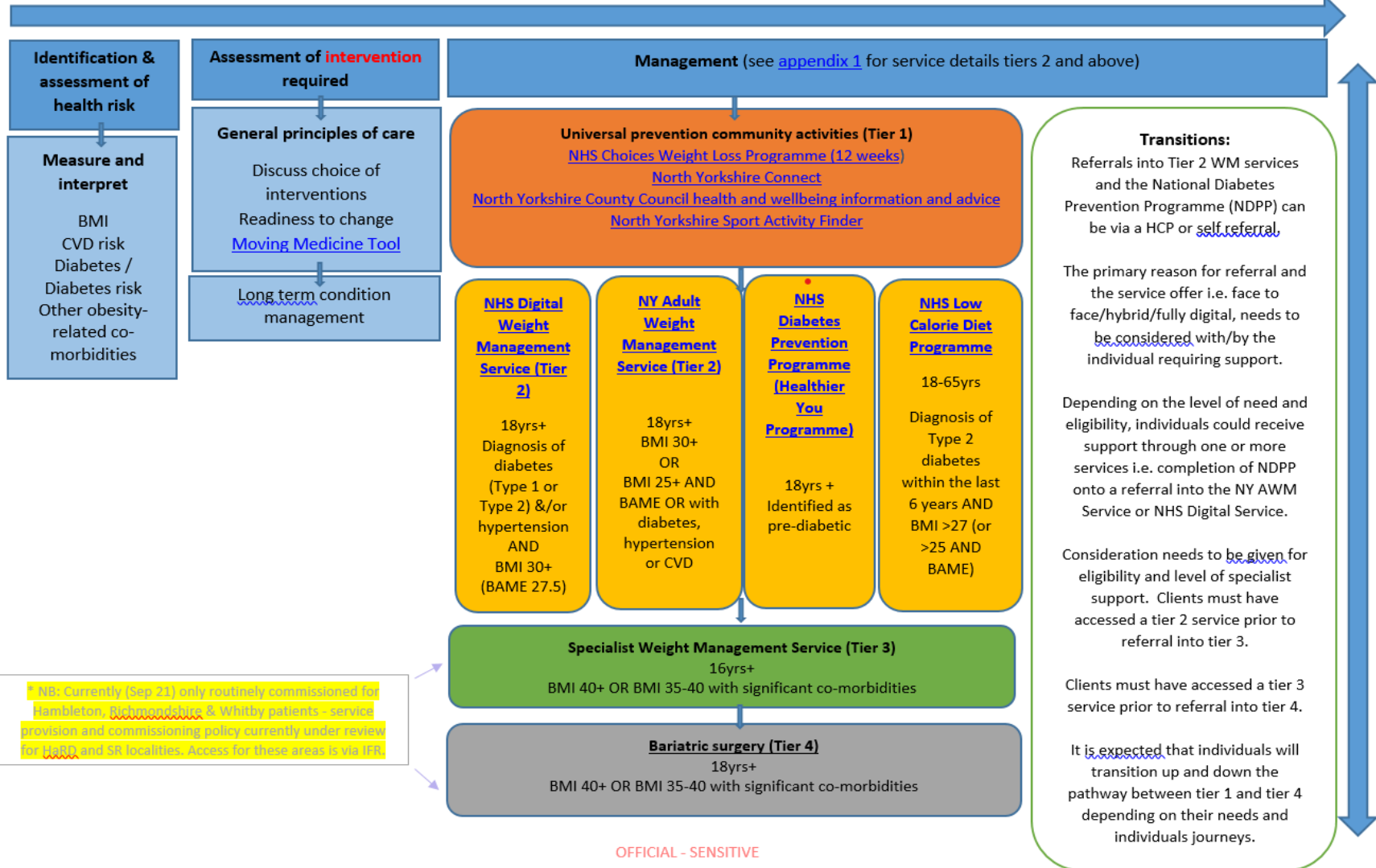
Statistically significantly better than the England average

Strategic approaches

[Healthy weight | North Yorkshire Partnerships \(nypartnerships.org.uk\)](http://nypartnerships.org.uk)



Example Adult WM pathway on a page



Service model

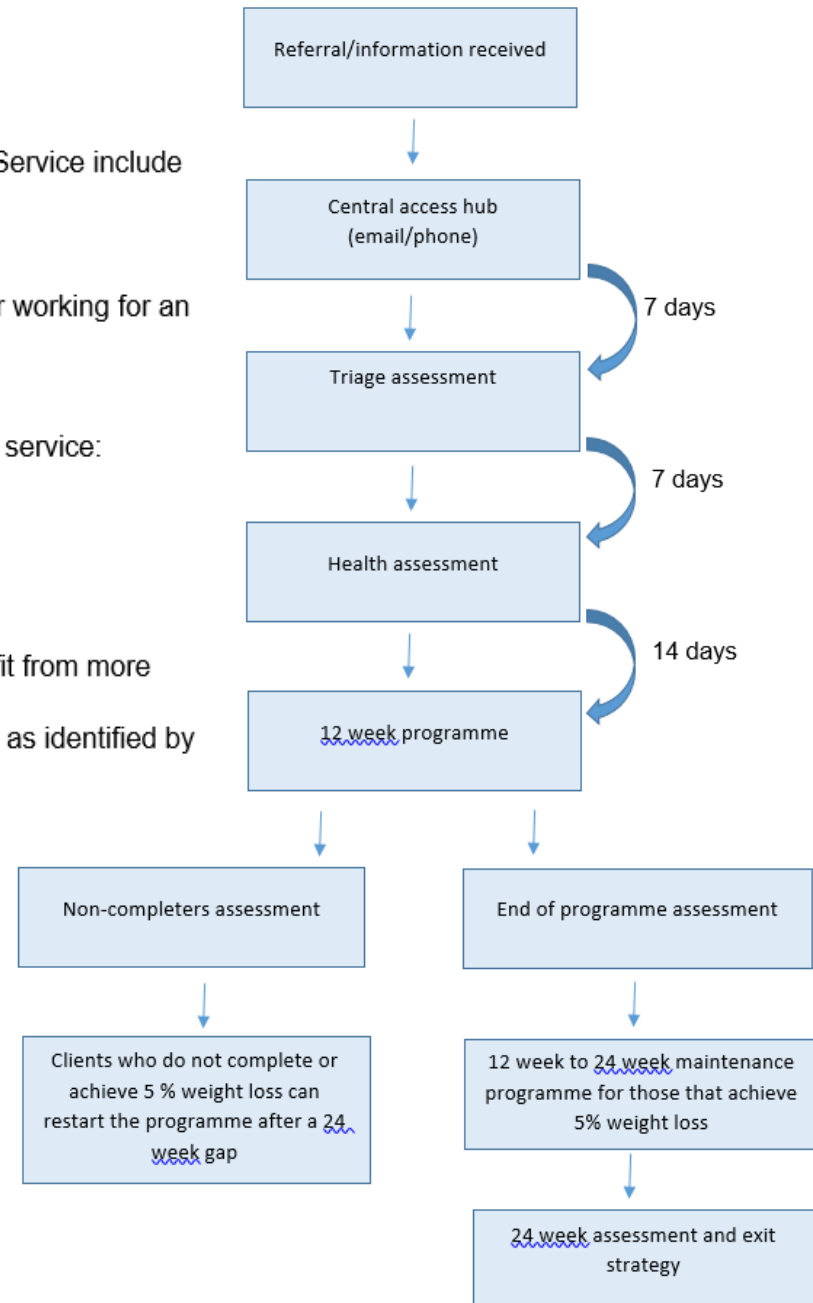
Individuals who are eligible to access the Adult Weight Management Service include those:

- Aged eighteen years or over
- BMI equal to or greater than 25
- Resident or registered with a GP practice in North Yorkshire, or working for an organisation based in North Yorkshire

Individuals meeting the following criteria should be excluded from this service:

- Under the age of eighteen
- Have a BMI of less than 25
- Are pregnant, or breastfeeding
- Have a diagnosed eating disorder
- Have an underlying medical cause for obesity and would benefit from more intensive clinical management from a tier 3 service
- Have a significant unmanaged co-morbidity* or complex needs as identified by their GP or other healthcare professional
- Have had bariatric surgery in the last two years.

Service delivery model overview



The impact

January to December 2019

Target completers (of referrals received)		Target completers who achieve 5% weight loss at 12 wks		Target completers who sustain 5% weight loss at 6 months	
Modelled	Yr 2 actual	Modelled	Yr 2 actual	Modelled	Yr 2 actual
60%	61%	30%	74%	50%	51%

January to December 2020

Target completers (of referrals received)		Target completers who achieve 5% weight loss at 12 wks		Target completers who sustain 5% weight loss at 6 months	
Modelled	Yr 3 actual	Modelled	Yr 3 actual	Modelled	Yr 3 actual
60%	41%	30%	64%	50%	54%

<https://youtu.be/rBNJTq0d6W8>

Lessons learnt

- Triage.
- Timeframe between referral, triage, health assessment and starting a 12 week programme.
- Rolling programme.
- Hybrid offer – supporting particular groups and those living in rural areas. Adaptability and flexibility.
- Disproportionate referrals (men, younger adults).
- Opportunities to create adaptations to increase accessibility.
- Provider network support and advisor peer support.
- Importance of regular support from a dedicated advisor and/or peers between groups (telephone, Teams, social media); personalised support.
- Strong exit route plans for sustainable lifestyle change.

Exciting developments - Government grant fund utilisation

Intervention 1 – provide additional 121 support for individuals whose circumstances have been significantly affected by the pandemic (Covid-related stresses)

Intervention 2 – provide community outreach/bespoke programmes for specific target groups who have been disproportionality affected by the pandemic (addressing inequalities)

Intervention 3 – provide community outreach/bespoke programmes for specific target groups that historically have engaged less with the AWM Service (pre-Covid-19)

Thank you

[Healthy weight and eating well | North Yorkshire County Council](#)

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