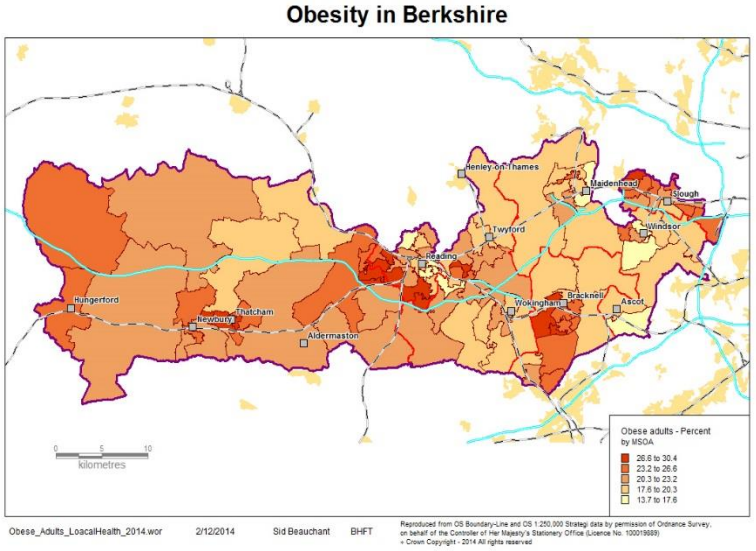
Obesity Mapping

Definition, Data, methods, systems & language

1. Defining tier 3 services
2. Obesity data trends
3. Obesity treatment costs
4. Evidence on ROI for tier 3
5. Why data mapping is difficult?
6. Summary



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Tiers of Weight management services

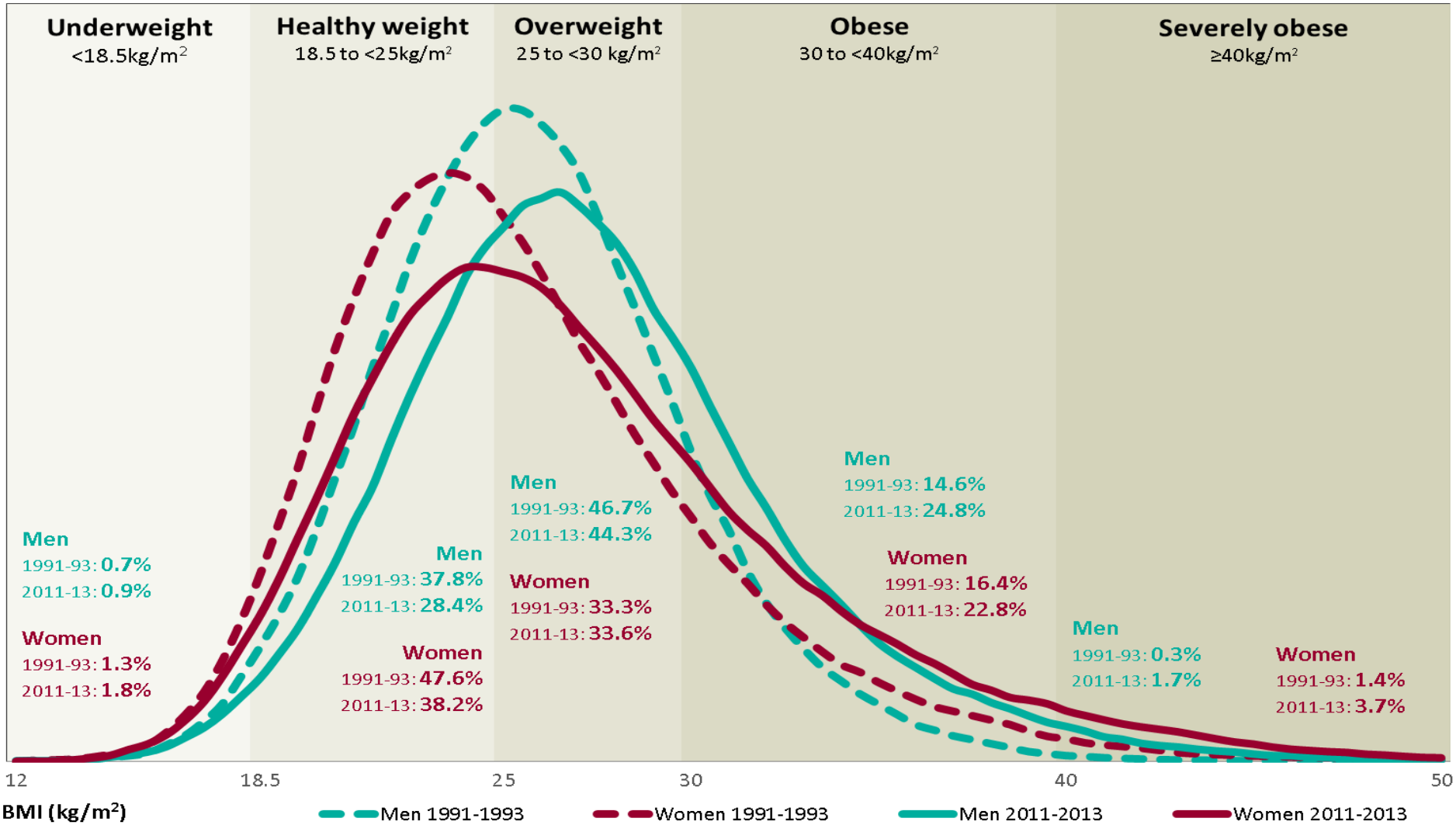
- Different tiers of weight management services cover different activities. Definitions vary locally

- Tier 1 covers universal services (such as health promotion or primary care) (PH/commercial)
- Tier 2 covers lifestyle interventions (PH)
- Tier 3 covers specialist weight management services (CCG)
- Tier 4 covers bariatric surgery(NHSE/to the CCG)

http://www.nice.org.uk/Guidance/PH53/chapter/glossary

Change in the adult BMI distribution

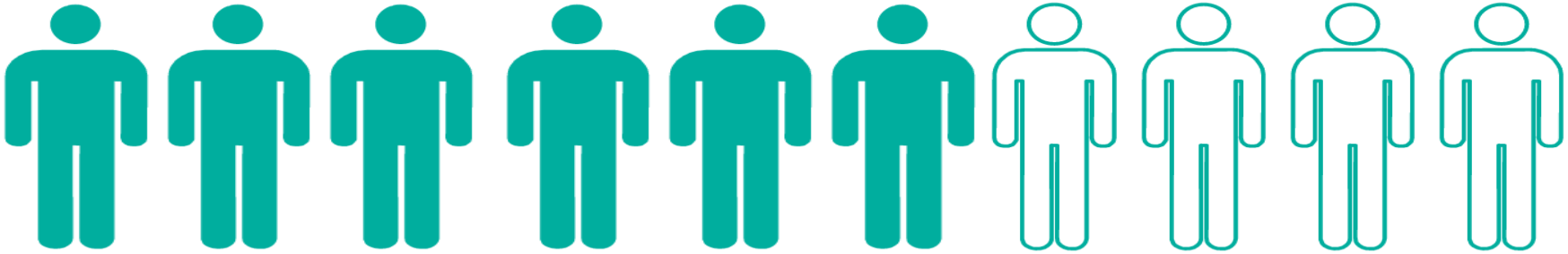
Health Survey for England 1991-1993 and 2011-2013



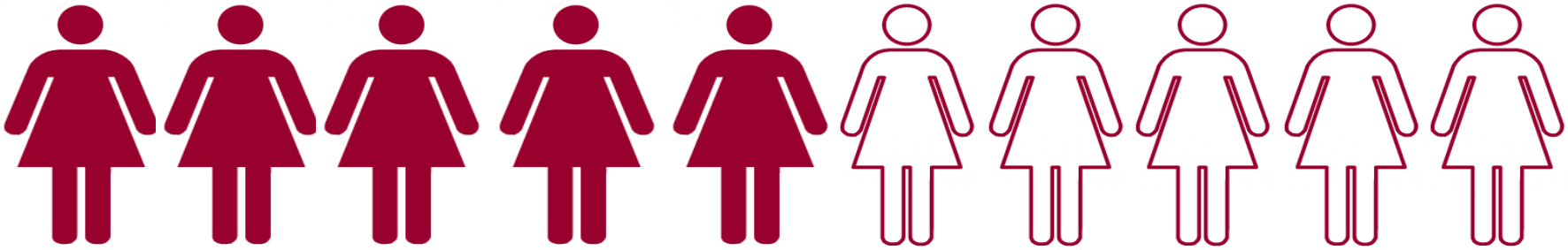
Overweight and obesity among adults

Health Survey for England 2011-2013

More than 6 out of 10 men are overweight or obese (66.2%)



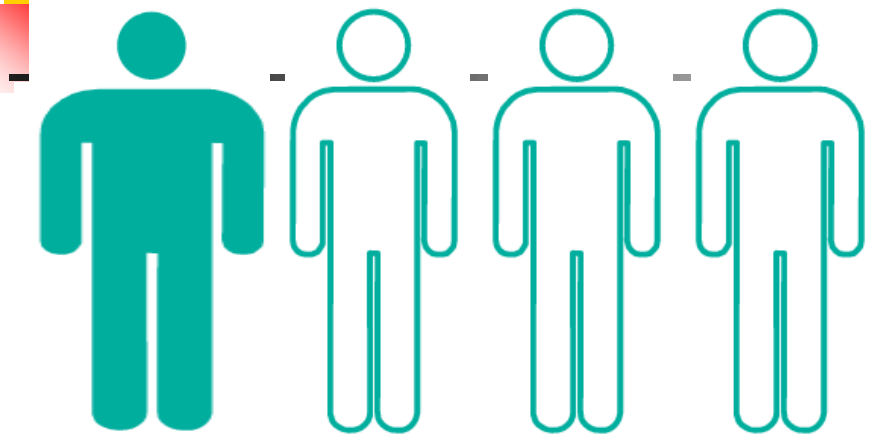
More than 5 out of 10 women are overweight or obese (57.6%)



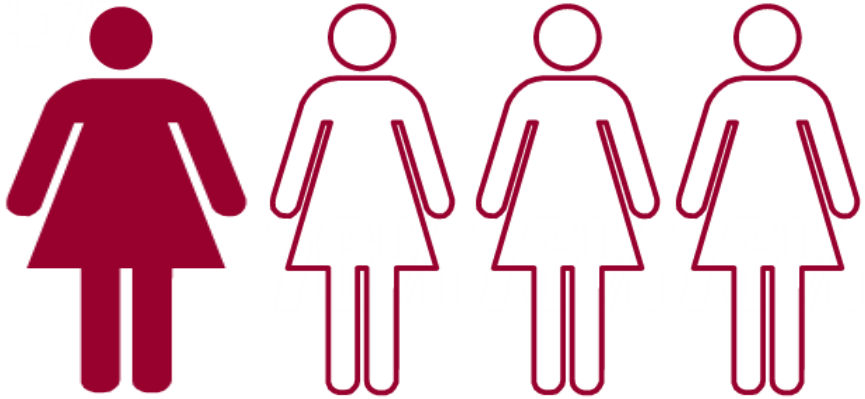
Adult (aged 16+) overweight and obesity: BMI ≥ 25kg/m^2

Obesity among adults

Health Survey for England 2011-2013



One out of four men is obese (24.7%)

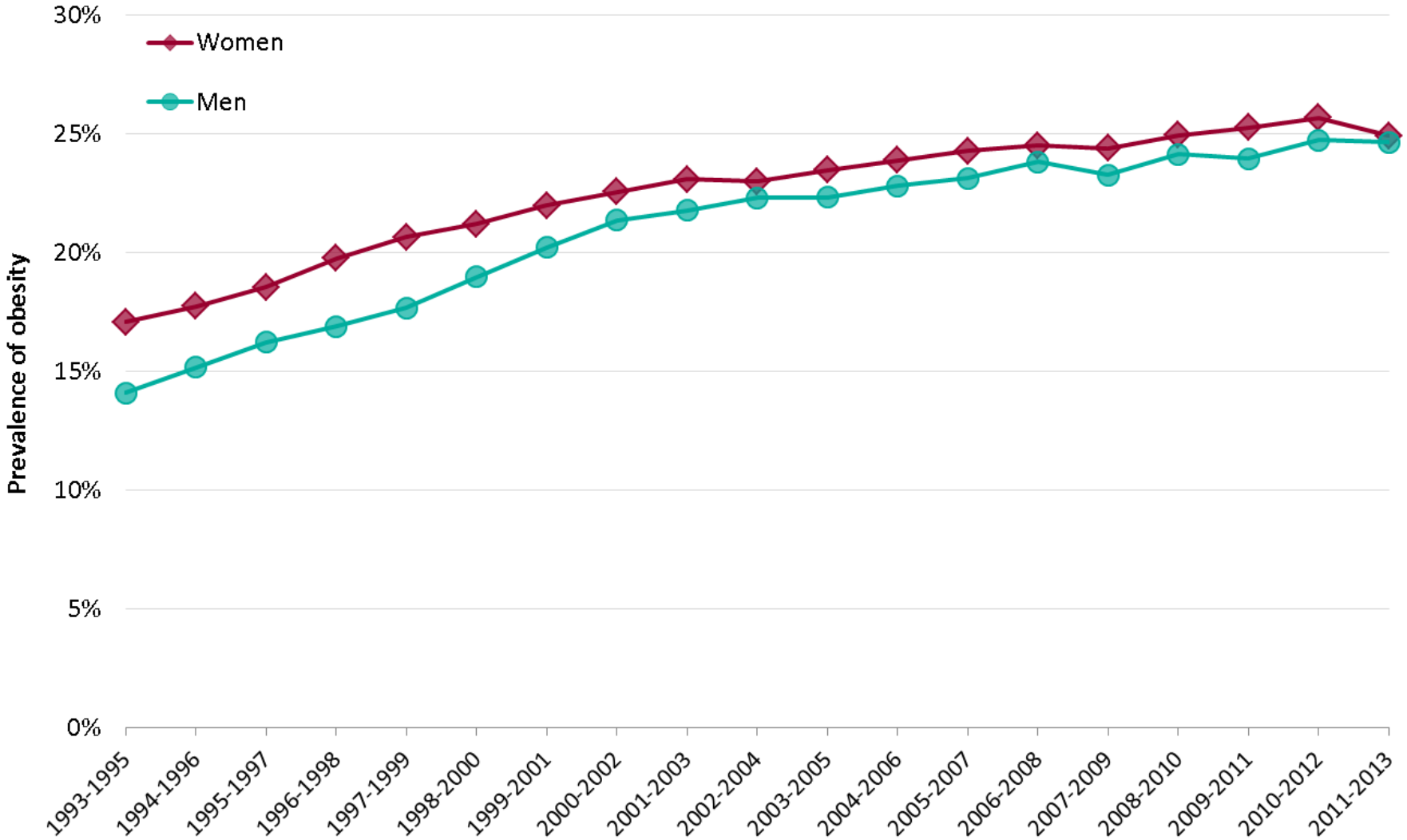


One out of four women is obese (24.9%)

Adult (aged 16+) obesity: BMI ≥ 30kg/m^2

Trend in obesity prevalence among adults

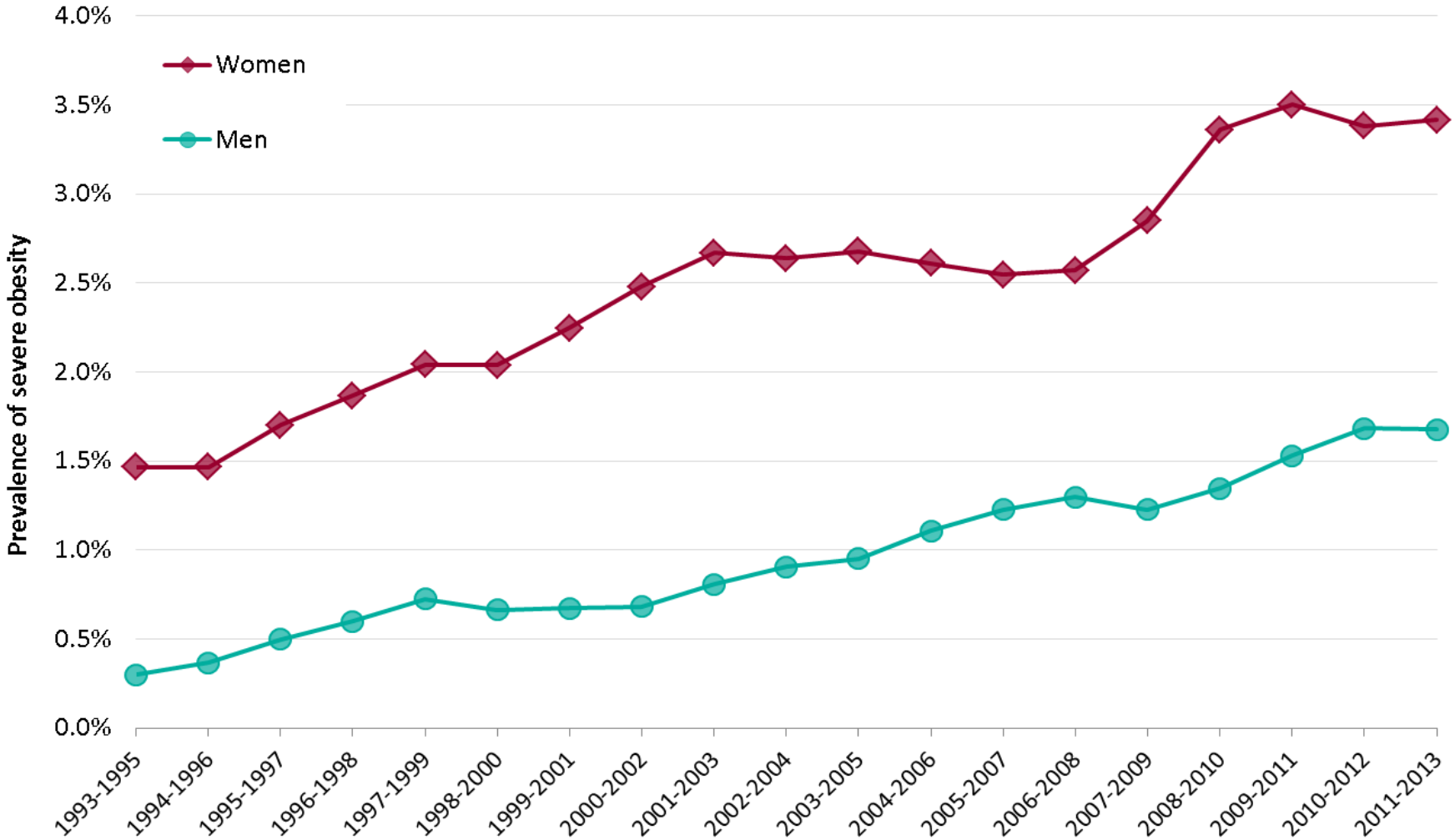
Health Survey for England 1993-2013 (3-year average)



m²

Trend in severe obesity among adults

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



Obesity, Bariatric Sx & drug costs

- UK- BMI of >40 (1.3m); annual incidence- 60,000
- Finished admission episodes with a primary diagnosis of obesity increased by 5 times and finished consultant episodes offering bariatric surgery by13 times since 2003/04
- 53% of these procedures in 45-64 year olds
- Drug costs decreased by 61% since 2009

- **Caveats:** Its only IP activity, not all activity
- Wide variations in clinical practices, coding /recording of obesity and of episodes

Tier 3 services- Evidence, ROI

- Organising a system level, cost-effective tier 3 services for best patient outcomes is challenging since we have very little evidence.
- Commissioners can achieve significant cost reductions in medications, consultations, hospital visits/care & bariatric surgical costs.
- Overlap and sharing of staff between diabetes clinics (with diabetologists/endocrinologists usually the predominant group of bariatric physicians), sleep medicine, dietetics /nutrition, psychology, psychiatry, and physical therapy for instance which would mitigate against new set-up costs.

- *'Action on Obesity: comprehensive care for all'- RCP (2013)*
- *'Measuring up. The medical profession's prescription for the nation's obesity crisis', a report of the Academy of Medical Royal Colleges (Feb 2013)*
- *Commissioning guide- Weight assessment & management clinics (Tier 3)- BOMSS, RCS, 2014.*

Do we speak the same language?

- "Geographical mapping"- not valuable since the HSE data is modelled.
- QOF not geographical relates to a specific condition
- NDA data, NKHG (pre-diabetes) data from NHS Health checks helpful, but not specific for obesity.
- HES & SUS data based on episodes- need for more granularity. Ex: CfV packs through NHS Right care
- No common language between National audit data, LAs, Primary & secondary Care
- Interoperability of data systems;usingDiabetes data

Summary

- Obesity registers, not robust, not dynamic
- Severe obesity- medical R/ options limited
- Tier 3 runs in primary & secondary care
- Need to highlight ROI of Tier 3 vs Tier 4
- Need better data, not modelled HSE data
- GPs need more tier 3 options
- Patients need a seamless, personal journey
- A holistic obesity care pathway- no tiers!!