Weight Management Programmes
– London Evaluation

Review of weight management programmes
commissioned by London Primary Care Trusts,
Spring 2010

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Sponsored by
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**Context: Outline of project**
This is the report of the project undertaken on behalf of the Regional Public Health Group (RPHG) to review commissioning by PCTs of weight management programmes (WMPs) across London.
In brief, the project was asked to review commissioning by PCTs of existing weight management programmes across London, provide a report of this review, set up a database of existing programmes, and advise RPHG and other stakeholders on dissemination of good practice and good value.

In addition, the project was asked to draw conclusions about the development needs of commissioners and providers, with particular reference to smaller scale providers who may be unfamiliar with public sector commissioning and procurement processes, in order to enhance WMP commissioning for London. Finally, the project team was asked to consider how the findings from this project could be relevant to commissioning of other public health programmes across London.
The project was conducted as a study approved by the Ethics Committee of the London School of Hygiene and Tropical Medicine.

**Methods:**

1. **PCT Interviews:**
We developed an interview schedule in order to undertake face to face semi-structured interviews with PCT obesity leads in London PCTs. The Schedule can be found in Appendix 2 to this report. The Schedule was ‘bespoked’ for each PCT about which we had some prior knowledge of WMP commissioning through the survey conducted by RPHG in July 2009 (and to a lesser extent from the survey of child obesity conducted by LTPHN in summer 2008). This background information provided the interviewer with some helpful prompts to facilitate the conduct of the interview and to assist the interviewee.

An invitation to participate in the study was sent by the project lead to all PCT Obesity leads and copied to PCT DsPH for their information. A few calls from PCTs were received by the project team to clarify the most appropriate person/s to be interviewed. A timetable of interviews was set up, matching interviewers to interviewees on the basis of mutual availability and no other criteria. In two instances, the interviewers had worked previously with an interviewee and offered the opportunity to change to a different interviewer, but this was declined and the interviews proceeded satisfactorily.

Interviews were conducted by a small team of interviewers with training and experience of qualitative research and sound understanding of the subject matter. Each interviewer completed an induction with a member of the core team before commencing data collection. In addition each the interview team cross checked recorded interviews to maintain integrity of the interview schedule. Interviews were recorded with the consent of the interviewee(s) and if consent was not forthcoming, the interview was not recorded. All interviewees gave written consent to participate in the study. The reason for recording was to be able to confirm contemporaneous notes made by the interviewers and to have directly quoted, though anonymised, ‘sound bites’ to include in the final report. The absence of a recording does not affect the accuracy or completeness of the interview schedule. A minority of interviewees (n=3) declined to be recorded. They were not required to give a reason for this. The
respondent was also given the opportunity to check the completed interview schedule to enhance the validity of responses.

In order to obtain a clear picture of WMP commissioning practices, we asked about current, recent past and near future commissioning, and also about aborted commissioning arrangements, the latter primarily in case it provided insight that could inform the later stages of the project when we engage with smaller scale providers. This report will focus on current WMP commissioning, but is informed by evidence retrieved from interviewees about past and aborted commissioning.

2. Engaging Small Scale Providers [SSPs]
From the interviews conducted with PCT obesity leads, we identified several small scale providers of WMPs, according to the definition (appended) that was agreed by the project Steering Group. Further exploration of these providers led to some being excluded from the definition. Attempts were then made to contact a sample of these SSPs for whom we traced contact details and, as a result, eight were contacted from the project office by telephone and/or email and invited to participate in the next stage of the project, to ascertain the views and experience of SSPs in regard to PCT commissioning of WMPs. The SSPs were invited to attend a focus group discussion on a choice of dates or, if the dates proved inconvenient, to participate in a 1:1 telephone interview with one of the project team. To increase the number of SSPs reached, we sent an email survey to those SSPs who had expressed interest in the project, but who had been unable to attend the focus group, seeking their input to the project, using the same areas of enquiry as for the focus group.

Results:

1. PCT interviews
Several PCTs identified more than one lead person, commonly one for children and one for adults, but in some cases, a strategic Board level lead and an operational ‘front line’ lead. Wherever possible, we visited each PCT once only to interview whoever the PCT had wished to participate. The maximum, in one PCT, were four interviewees – 2 strategic and 2 operational, for adults and children, respectively. In a small number of PCTs it proved difficult to identify the lead due to staff turnover and one response was provided on behalf of the PCT by a manager from the PCT’s provider arm responsible for delivery of WMPs.

All PCTs were contacted and interviews held with representatives of 27 PCTs. The remaining PCTs were unable to offer face-to-face interview, but agreed to self-complete the interview schedule and return it to the project office, which permitted a 100% response to be achieved.

All interviewees cooperated very constructively with the process of information gathering. In addition to the information gathered at interview, four PCTs provided copies of local reports that they felt might be relevant, including reports of WMPs, health trainer programmes and Joint Strategic Needs Assessment.
The interviews elicited a substantial amount of information about WMP commissioning and provision across London. Although a standard interview schedule was used, different interviewees had different levels of knowledge and engagement with WMPs, so that the detail of some responses was greater than others. Several PCTs have changed their commissioning plans recently in light of the forthcoming difficult financial climate and others are considering doing so. This means that some PCTs that have been commissioning WMPs appear to be planning to reduce their investment in WMPs in 2010/11, solely for reasons of financial stringency and so no conclusions should be drawn on this basis alone about the quality of, or satisfaction with, the WMPs commissioned to date. Whilst a few interviewees believed that obesity was not currently a priority for their PCT, conversely, others reported strenuous efforts to establish robust evidence-based Obesity Pathways for 2010/11, which they thought would lead to commissioning changes, including potential increase in local investment to tackle obesity. Many WMPs were commissioned jointly with local authority partners, and some, usually with focus on physical activity, were funded solely by local authorities.

It is of interest to note that a recent study commissioned by the Kings Fund (Naylor & Goodwin, 2010) reports that 86% of PCT chief executives and directors of commissioning felt that PCTs would take 3-4 years to achieve WCC (broadly in line with Department of Health expectations). We heard from some PCTs that they are commissioning external organisations to help them with WCC and this is reflected in the KF report, with support ranging from short term capacity building to fully outsourcing companies to conduct the whole commissioning process. There is a national ‘framework for procuring external support for commissioning’ [FESC] but this was not mentioned by any interviewee.

2. Engaging small scale providers
Despite interest in the project, just two SSPs attended a focus group discussion and information was gathered from a further three SSPs using 1:1 telephone interview and email survey, using the same areas of enquiry as for the focus group. The main reason given by SSPs for not coming to the focus group was a reflection of their size, namely a lack of capacity in the organisation to allow a staff member to be away from their core work for part of the day unless absolutely necessary. The responding SSPs included providers of both adult and child WMPs from different parts of London. Those with whom we engaged were very willing to speak about their experiences in the marketplace of WMP commissioning. They were also forthcoming with opinions about the difficulties of responding to NHS commissioning and about how the system might be improved.

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WMPs commissioned in London

What follows is a summary of the survey results. Full details are available on the searchable database.

We found that a range of WMPs have been commissioned. At one end of the spectrum, the same providers appeared many times, whilst at the other, a specific programme might have been piloted in one area only. This applied to WMPs for adults and for children. Several WMPs have been commissioned jointly by a PCT with its coterminous LA. Several PCTs have accessed alternative sources of funding with which to finance WMPs in one or more years – e.g. Lottery monies, Sainsbury’s, IAPT monies.

- Some interviewees offered information about local investment in WMPs, while others declined to provide financial information.
- From analysis of the information gathered from PCT interviewees: In 2009/10, PCTs each commissioned between zero and nine adult WMPs and between zero and 6 child WMPs. In total, PCT interviewees described 300 programmes, but these were then tested against the criteria agreed by the project Steering group, in order to include only those that met the agreed criteria. As a result, a total of 76 WMPs for adults and 65 WMPs for children were being commissioned by PCTs in 2009/10, a grand total of 141 WMPs or a mean of 4.5 per PCT.
- Of the WMPs commissioned, 17 children’s WMPs out of 65, and 17 WMPs for adults out of 76, were provided by organisations that met our definition of ‘small scale provider’.
- There is a broad range of WMPs and the large numbers in some PCTs tend to reflect greater likelihood of commissioning several local, small WMPs, while those PCTs which commission a small number of WMPs tend to commission fewer of these smaller programmes – with the larger scale WMPs being commissioned ubiquitously.
- WMPS being commissioned for children variably target overweight or obese children, or take an inclusive approach with no requirement to be overweight in order to participate. Whilst the NOO describes WMPs for children as targeting overweight children, using our agreed definition, we included all WMPs aimed at children, including those with an inclusive approach.
- In contrast, adult WMPs are generally open only to people who are currently (at the time of referral or first attendance) overweight or obese.
- Information about the numbers of people participating in WMPs was very patchy, so that it has not been possible to make a useful estimate for London as a whole. For example, in addition to those interviewees who were unable to provide quantitative data, there were variables such as a WMP coming on-stream mid-year or a lack of clarity between the number of places available and the number of participants actually attending, which would make an estimate unreliable.

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2 Improving Access to Psychological Therapies – a Dept of Health (England) initiative
Summary of the state of the WMP Market in London

We have found a large number of WMPs provided by a mix of providers. Some providers have a portfolio of programmes and have become known as specialists in this area of service provision, while others have a single product by which they are known.

Some generic programmes are provided by several different providers. Public sector providers continue to be major players – with PCT provider arms often the preferred provider for a PCT. Local authority provision is usually provided through leisure services. Depending upon the maturity of the local contracting environment, it is often still be much simpler for PCTs to elect to contract with the local NHS provider(s) than to go out to external or open competitive tender.

Those PCTs that have embraced tendering more enthusiastically have, as a result, a wider range of providers. A minority of PCTs have, in line with local commissioning policy, intentionally sought to engage small scale providers, particularly third sector organisations. So the marketplace varies across the capital, with some PCTs looking only to their own ‘back yard’ for provision of WMPs, and others drawing on, and stimulating, a wider provider market. So, for example, at one end of the spectrum, a PCT commissioned a total of 21 WMPs in 2009/10, of which ten were delivered by small scale providers, whilst another commissioned no WMPs that met the project’s definition for inclusion. 14 of the 31 PCTs commissioned at least one SSP.

Who are the WMP Providers?

Three main providers of WMPs emerged:

The NHS: commonly the PCT Provider arm had been commissioned to provide one or more WMPs, usually community-based and provided typically by dieticians or nurses. Less commonly, a local NHS acute Trust was a provider, usually of specialised medically led WMPs, although in some cases hospital- or community-based Dietetics services providing a targeted WMP for people with significant co-morbidities; in one example, the merged provider arms of neighbouring PCTs had been commissioned by three PCTs to provide WMPs for all of them in partnership – this had led to greater consistency of WMP provision across the area covered;

Local authorities: Whilst many London Boroughs were involved in commissioning WMPs, some were also active WMP providers, mainly through Leisure Services – with the emphasis here on physical activity;

Independent/non-statutory providers: these are a diverse mix of commercial and not-for-profit providers, ranging from nationwide commercial organisations, such as WeightWatchers, through to social enterprises, small local charities and sole trader private providers.

Weight Management Programmes

In terms of spread across London’s PCTs, among the children’s WMPs, the most widespread was ‘MEND’, which served 19 PCT/LBs in 2009/10. Not all PCTs reported MEND as targeting the same age range – this varied from 5/7/8 – 11/12/13 years of age. Of those which commission MEND, 3 PCTs also commission ‘MendGraduates’ (or Graduate MEND – for the same age group as MEND) to follow on after completion of the initial MEND programme. Only one PCT (which was already commissioning MEND) reported commissioning ‘Mini-MEND’ (for 2-4 year olds). MEND appears to have been funded initially chiefly from non-NHS sources,
notably Big Lottery and Sainsbury's, and whilst some PCTs had already made a decision regarding future commissioning, several PCTs referred to current deliberations concerning the future commissioning of MEND and/or other WMPs for children on cessation of those external funding sources.

Among adult WMPs there was much less commonality of provision. For instance, the most common WMP was 'Exercise on Referral' - or 'on Prescription', commissioned by 13 PCTs. However, in practice this appears to be a generic term for a non-standard product. Providers for Exercise on Referral were diverse, including: PCT Provider Arms, Local Authority Leisure Services and local 3rd Sector organisations. Somewhat surprisingly, only two respondents referred to the PCT commissioning WeightWatchers for adults, which is the UK's biggest commercial WMP.

Exercise on referral was not the only 'generic' name used for WMPs: some other WMPs with the same name also turned out not to be the same programme – eg 'Cook and Eat' was provided in different PCTs, variably by statutory and voluntary sector providers, and targeting adults and/or children.

So, to summarise this issue of terminology: some WMP providers have more than one WMP product (ie programme) - eg MEND, while other WMPs actually comprise several different products provided by different providers, but share the same name – eg Exercise on Referral.

**Specially Targeted Programmes:**
Few adult WMPs were targeted explicitly at particular groups within the population. Most commonly, the venue at which the WMP is delivered defined the catchment population – commonly a relatively deprived area, that had been chosen intentionally; but a small number of WMPs targeting specific groups, including: Black and Minority Ethnic [BME] groups, elderly people, people with learning disabilities, and men, were identified.

Among WMPs for children, there is usually a target age range. Because MEND is by far the biggest current provider, the age range covered by their programme is best covered, but there are some commissioned WMPs targeting pre-school children and teens. For the youngest age groups, breast and infant feeding initiatives were mentioned by some interviewees, though these are generic health promotion interventions rather than WMPs and, as such, have not been included in the count or analysis of WMPs.

**Additional obesity related work of note**
We came across some initiatives which, although they do not meet the definitional criteria of WMP, are worthy of mention. For example, some PCTs told us about online resources: one PCT had used ‘Map of Medicine’ to enable them to develop their on-line care pathways for tackling obesity in adults and children; another had developed an interactive online resource for learning about obesity. Several PCTs cited generic health improvement programmes, which are not targeted at reducing obesity: these included a Food Co-op, various initiatives to improve school meals, and various community-based Cooking Groups for adults or children. One PCT employs a trainer whose remit is to build capacity among primary care professionals, who are then expected to undertake weight management interventions with their patients.
Relationships between WMPs and allied local services

No exclusions were made at the interview stage of this project, but it was recognised that a working definition of WMP would be needed later in the project, particularly in order to build a database of WMPs. Further, at the outset, RPHG wished the project to identify and make recommendations to support development of smaller, emerging WMPs, which would probably be provided by non-statutory sector organisations. As a result, the definitions were developed and agreed by the project Steering Group at its first meeting in March 2010 – please see Appendix 1 for these.

As far as analysis of the interview data is concerned, where information from a PCT respondent included ‘generic’ health promotion interventions, such as ‘Health Checks’, which we would not regard as targeted WMPs, these have been excluded from the count of WMPs. This means that for some PCTs, the number of WMPs counted is considerably less than the number of programmes described at interview: there is no intention to undermine the extensive effort and investment taking place in PCTs in this area, but simply to recognise that many of the initiatives described are not weight management programmes in terms of the definitions used in this project. In the event, the range of services included by interviewees as WMPs was interesting. For example, some included healthy school meals – usually viewed as a generic health promotion/primary prevention measure; while others included certain IAPT [Improving Access to Psychological Therapies] services, which, only where specifically targeted at weight management, would constitute a WMP. These examples demonstrate not only the diversity of service provision concerning weight management and the achievement of healthy weight, but also the diversity of funding sources ‘tapped’ for this purpose. It was also apparent that some PCT leads take a more holistic or social marketing approach to weight management, for example, through consideration of determinants such as mental health and unemployment, and their relationship with healthy weight. Where a ‘generic’ intervention has been tailored and targeted to provide a WMP, then it has in those instances been included in the count of WMPs – for example, specific local 1:1 or group targeted interventions to tackle unhealthy weight within the overall Healthy Schools Programme and some targeted local Health Trainer initiatives.

It was apparent from interview responses that PCTs want services that are flexible to meet the needs of their local population, and this arose especially in respect of BME communities, for whom some larger scale providers are reported from PCTs’ experience, as having been found to have ‘too rigid’ an approach that failed to engage these communities.

Evaluation of WMPs by commissioning PCTs

A requirement for evaluation was commonly built into the tender and interviewees reported finding the NOO’s Standard Evaluation framework (SEF)\(^3\) helpful; however, often self-evaluation by the provider was acceptable, with much less evidence of external or independent evaluation being conducted. Evidence from evaluation usually came from process evaluation – typically comprising numbers attending and retention rates, and with some exceptions, less often outcomes such as weight reduction or change in BMI or behaviour, although several PCTs reported an intention to undertake or commission longer term outcome evaluation to understand

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3 Standard Evaluation Framework, NOO, 2009
the real value of a WMP. Some WMPs were commissioned with clear outcomes specified, eg weight reduction for CounterWeight. Where a PCT had undertaken formal external evaluation of a WMP, this had sometimes influenced commissioning decisions: for example, evaluation of a substantial contract for a children’s WMP had shown high drop-out rate and poor adherence with learned healthy behaviours soon after participation, leading to a subsequent decision by the PCT concerned not to renew the contract. Most PCT interviewees had considerable knowledge of WMPs that they had commissioned and were able and willing to praise or criticise locally provided WMPs. Some comment was based on the results of formal evaluation, but others (more often) on the opinion of the interviewee from his/her own engagement with the WMP provider. We gained an overall impression that to date there has been, with a few exceptions, little partnership work with providers to ensure compliance or quality improvement and, in general, monitoring systems are simple, limited to ensuring basic provision of service. As the commissioning process matures, it is reasonable to expect that these aspects will become standard: our discussions with providers suggest that they are seeking this type of engagement with commissioners.

Commissioning and procurement
Local arrangements for commissioning and procurement vary widely. To provide an impression, most interviewees were familiar with the World Class Commissioning framework, though reported training was variable. Typically, it seems that several PCT directorates are involved in commissioning WMPs – for example: Public Health, Finance, Commissioning, Service Improvement, Performance; and if jointly commissioned, a complex network of directorates across two – Local Authority and NHS - organisations is involved. None of the respondents referred to the potential or actual role of Children’s Trusts in relation to WMPs. Several respondents described the commissioning process using words including “bureaucratic”, complex”, “fair”; but some also used terms including “inconsistent”.

As far as procurement was concerned, some obesity leads had responsibility for procurement, while others did not. Among those who did, some described situations where contracts had been drawn up by members of PCT staff without training in this area and in some cases difficulties had subsequently arisen, leading to additional costs to the PCT involved and/or failure of WMP provision. Where the obesity lead did not manage procurement him/herself, a centrally led PCT-wide process managed by finance colleagues, with consideration of financial and legal issues, was usually described.

Engagement of Practice Based Commissioning
Several PCTs cited PBC as being engaged with local commissioning decisions through the involvement of GP representatives in PCT commissioning proposals, but not actually commissioning WMPs through PBC, which seemed to be uncommon. In some PCTs, pharmacists and general practitioners are commissioned as WMP providers, eg contractually via a locally enhanced service [LES], by which they would be remunerated. Such a service might involve offering BMI checks and/or offering
brief intervention and/or prescribing medication (orlistat). Some interviewees thought these interventions may be subsumed by the ‘health checks’ that are being introduced via a national initiative. One PCT reported a tender for which one of the tenderers had been a group of GPs.

Innovation and Good Practice

We encountered a number of examples of innovative practice. Clearly, innovation does not equate to good practice, but we have selected examples of innovation that seem, at this stage, to represent good practice. It is not yet possible to correlate these examples with improved health outcomes, but longer term evaluation could provide valuable evidence:

Engagement with local professionals

- One WMP involves professional staff from the local acute Trust, who train mentors from local communities to deliver the programme – this seems to make best use of scarce professional expertise, whilst at the same time, encourages the development of local capacity to deliver a WMP within their local community
- ‘Health Checks’ programme: although not a WMP, several interviewees referred to this programme, which is being rolled out nationally. One PCT reported that the engagement of overseas medical graduates, who are not yet registered to work in the UK as doctors, as mentors on the programme locally, provided valued work experience on their personal ‘route to employment’

Targeting of programmes

- A WMP that targets people from BME communities is run by a local university deploying relevant academic expertise: this programme illustrates the deployment of expertise from the higher education sector in development and delivery of a WMP
- Some PCTs have noted successful uptake and retention for targeted WMPs designed specifically for people with special needs – eg with learning disabilities: PCTs grapple with the tension between a ‘one size fits all’ approach to WMP commissioning and provision and a more tailored approach to meet the needs of specific groups within the population – this example demonstrated the impact of a tailored approach to engagement with this particular client group, known to have significantly higher than average prevalence of unhealthy weight
- One PCT developed inhouse a WMP tailored to meet the needs of a local minority community, having assessed the need, following the lack of take-up of one of the large scale nationwide providers. This PCT learned from its contract monitoring process that uptake of a ‘standard’ WMP was poor in one community, and used the experience to develop and deliver a new needs-based programme for that community

Evaluation issues

- Some PCTs specify in tender documentation the requirement for WMP providers to use the NOO Standard Evaluation Framework (SEF): respondents who referred to the SEF reported finding it helpful. The inclusion
of a requirement to use the SEF in tender documentation is a relatively easy way to seek validated evidence of quality assurance in WMP provision. Such a tactic may fail, however, if the commissioning PCT fails to follow through its commissioning intention, by holding the provider to account regarding use of the SEF – to put it bluntly, simply putting the SEF in the tender documentation is not enough: they need firstly to state how compliance will be monitored and secondly, to ensure that monitoring is carried out and has real potential impact on the contract.

Stimulating the market
- Engagement of the local Voluntary Sector Council (VSC) to work with and support 3rd sector WMP providers. This PCT believed that small scale WMP providers were unable to compete effectively in the tendering environment, so worked with the VSC, who were able to help these providers participate in the next round of WMP procurement.
- A small number of PCTs have made strenuous efforts to work with 3rd Sector providers as a matter of policy and, as a result, have a mixed economy of mainly small scale WMP providers including 3rd Sector, which usually target specific groups within their local population.

Lessons learned
In response to the invitation to share what went well or was challenging, several valuable points were made, including:

Commissioning and procurement practices
- There has been recognition of the fragmented approach to commissioning, which had led to a planning exercise to improve coherence across pathways, which will impact on future commissioning.
- The difficulty of engaging primary care, especially since obesity per se is not prioritised nationally in terms of financial incentives in primary care; a number of local enhanced services have been introduced by PCTs as an incentive for primary care contractors to engage in weight management.
- Some PCTs had decided for the avoidance of complexity and to ensure a local solution, to commission only their own Provider Arm as a community based provider of WMPs; it is unclear whether tendering rules and the possible reconfiguration of these provider services will permit this practice to continue.
- Some PCTs had found the larger, widely provided WMPs insufficiently flexible for meeting the needs of their diverse populations, with particular reference to Black and Minority Ethnic [BME] groups and people living in more deprived areas.
- Where commissioning had led to failure of WMP provision, some interviewees highlighted the recognised risks to the PCT – financial, legal and reputational, which had not been planned for at the outset by prospective systematic risk assessment.
• Most PCTs had begun commissioning WMPs in response firstly, to Choosing Health\textsuperscript{4}, and subsequently, Healthy Weight, Healthy Lives\textsuperscript{5}, in absence of first conducting a comprehensive needs assessment. Some were now holding back on further investment in WMPs, until a (belated) needs assessment had been completed. To the sceptical observer, and without excellent public relations, this could look like arbitrary disinvestment from valued services, rather than a rational process of ensuring good commissioning;

• Much of a PCT’s commissioning capacity is occupied with acute sector commissioning, so that the impact of implementation of World Class Commissioning might be less apparent for community services including WMPs; this is explored further in Appendix 5.

• PCTs had found that writing specifications required time as well as expertise – PH and Commissioning directorates frequently had competence/capability, but not capacity: hiring someone on a short term contract specifically to write specification was considered sensible.

Provider issues

• Tendering procedures appeared to favour commercial providers that are familiar with this way of doing business, but public and 3rd sector providers can become competent in the process and some were winning tenders

• Somewhat unexpectedly, prior knowledge of a provider was rarely cited as an important factor in WMP procurement decisions: if a provider met the tender specification, that was the prerequisite for being shortlisted, so new WMP providers could be successful as long as they demonstrated compliance with the specification;

Engaging with local partners

• Lack of PBC engagement might be of practical significance: eg insufficient GP buy-in was cited as the reason for withdrawal of the ‘Exercise on Referral’ programme in one PCT.

Experience of engagement with small scale providers [SSPs]:
One view that was expressed from a PCT informant was that “actual support is needed, not just advice”, for SSPs to develop and submit potentially successful bids. The suggestion arose that a local 3rd sector umbrella organisation might provide support to other 3rd sector providers including providers of WMPs. In at least one PCT, the local Voluntary Services Council is already engaged in this role, as referred to under ‘good practice’ above.


\textsuperscript{5} Healthy weight, Healthy Lives; DH 2008 - http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_084024.pdf
Usefulness of freely accessible information about WMPs, including about their commissioning and evaluation

Most respondents were familiar with resources available from the National Institute for Clinical and Health Excellence [NICE], the National Obesity Observatory [NOO] and information from the National Child Measurement Programme [NCMP] and had used some or all of these. The NICE documentation was described by one as difficult to navigate. Few referred to the FPH-NHF Obesity Toolkit. Most commissioners were familiar with World Class Commissioning competencies, but had not necessarily received training relating to them. The NOO’s Standard Evaluation Framework [SEF] was mentioned by several PCTs, and was being used variably. Some PCT interviewees referred to their use of the DH Provider Framework for children’s WMPs. Some mentioned that the Framework, published in March 2009, was now of limited use as it contained only those providers active at the time of the document being constructed, while the market has developed substantially since that time.

Other pertinent facts emerging from interviews:
Obesity pathway: in one PCT, age ranges 0-4, 5-11, 12-19 had been agreed for children’s pathway development, alongside a separate integrated adult pathway, all of which are in development.
Some PCTs view pregnant women and those who have recently had a baby as a special target group for WMPs.

Spending on WMPs
Interviewees were invited to share information about the amount spent on WMPs. Responses varied: some declined to talk about money, either because they lacked knowledge or because they had been briefed not to disclose financial or commercially sensitive information; others told the interviewer the spend per annum on each WMP or the cost per participant for each WMP. Investment varies from a few hundred pounds per annum on some small pilot programmes to substantial six figure sums for some established WMPs. As mentioned earlier, investment comes from different sources, the most common being: PCT, LB, joint PCT-LB investment (sometimes as a result of the Local Area Agreement, LAA), and also Big Lottery, Sainsbury’s.
The lack of comprehensive financial information precludes detailed analysis or conclusions being drawn. However, it is clear from the number and range of WMPs being commissioned, and the lack, in the main, of coherent needs based investment plans and comprehensive or consistent obesity pathways, that PCTs’ investment in WMPs varies very greatly at present. It has been pointed out [in the Child weight management programme and training providers framework, 2009] that providers price their programmes differently, so that an overall impression of value for money might be more helpful than the price per se.
The two main financial issues for PCTs and/or Local Authorities seem to be:

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6 Healthy Weight, Healthy Lives: Child weight management programme and training providers framework; Cross Government Obesity Unit. March 2009
The funding allocated to WMPs: ie the extent to which WMPs are being commissioned at all – and future plans for commissioning, particularly given current pressure on NHS expenditure, and
Whether or not a PCT is getting value for money from the WMPs commissioned.

Interpreting the findings
This analysis of the findings of the survey demonstrates a richness and diversity of WMPs being commissioned and provided across London. This could easily be interpreted as an inequitable situation, the residents of some London Boroughs having much greater access to WMPs for adults and/or children than others. Those PCTs that apparently invest little in programmes meeting this project’s inclusion criteria may provide relatively generous access to generic health promotion and lifestyle interventions for their residents. So numbers of WMPs should not be equated with good practice and conversely, the lack of WMPs cannot be assumed to denote poor performance. When interviewees were asked about future plans for WMPs, the responses ranged from robust evidence-based implementation plans to tackle obesity, built on a care pathway approach, to a more negative view that disinvestment would be the norm in the current economic climate.

To summarise, several PCTs appear to be currently in the process of assessing needs for WMPs, with a view to establishing a coherent pathway and commissioning services in line with local needs. However, several limitations were exposed including:

• Projected reductions in available commissioning funding for all services, including WMPs;
• Concern about the future of community services that until now have been provided by the Provider Arm of the PCT, with the introduction of new Trust configurations;
• Concerns expressed about the capacity of PCT commissioning teams, due to other areas of care being viewed as higher priority than community based, often preventive, services;
• Uncertainty regarding the future of PBC and the need to engage primary care professionals;
• The lack of evidence of effectiveness of most WMPs, and the reduced opportunity to develop, test and evaluate new programmes. Whilst innovation requires creativity and some risk taking, it is perhaps particularly challenging in an adverse financial climate;
• Difficulty in deciding if or how to prioritise either adult or child WMPs, which are seen as competing for the same limited resource, in an adverse financial climate
An example of a PCT that has recognised the importance of locally tailored commissioning including engagement with small scale providers, was captured thus:

“It’s becoming more and more paramount that services are commissioned very specifically in relation to our target communities, so I think that’s when, you know, our, sort of, rich pool of community organisations is really becoming more and more apparent and utilised as well through commissioning” [PCT, Health improvement Lead].

Box 1 Identified methods used by PCTs for reaching a wider network of provider organisations

- Tenders sent to umbrella organisation of community and voluntary sector organisations, who are able to cascade to wider network, and also have means to distribute further through networks and word of mouth.

- Use of Patient and Public Involvement (PPI) within the PCT, the Assistant Director for PPI has a diverse team with a lot of contact with service users and community groups, so this is a beneficial avenue.

The potential role of small scale providers
At the outset of the project, RPHG was keen to understand the issues faced by SSPs, and understand the role that such providers might play in developing WMP capacity in London, particularly in respect of innovative approaches to programmes. In addition, the Cross-Government Obesity Unit had previously explored the WMP marketplace nationally, including seeking the views of large scale providers, and RPHG wished to compare those findings with the experience of SSPs.

We found that many commissioners were similarly interested in this area, but that few SSPs had been successful in tendering to provide WMPs. SSPs, in turn, argue that they are indeed best-placed to provide services in the community where they are trusted and where they understand and are responsive to the culture of their neighbourhood. Having said that, somewhat contradictorily, we found that SSPs felt able to scale up their operation beyond their locality. We did not have contact with large scale providers, who are the majority of WMP providers at the present time. However, PCTs offered a mixed message: that SSPs would be effective in engaging the local community ‘in greatest need’, but that large scale providers could also meet those needs if commissioned to do so.

It is difficult to draw conclusions from all of this: clearly, at present few SSPs are being successful in the WMP marketplace and this would seem to be an inequity. However, expert commissioning should manage to create a level playing field for all providers, regardless of their size, in which SSPs would be able to compete fairly with larger providers. To date, few PCTs seem to have achieved this standard of commissioning and we address how this might be rectified this later in the report.

Engaging Small Scale Providers
This section summarises the findings of our discussions with SSPs.

At the provider end, the observation by commissioners that commissioning is a time-consuming exercise was certainly mirrored by the small scale providers with whom we have engaged. We have learned much about the challenges associated with the
process of commissioning from the WMP provider side and, given the brief set for this project, our intelligence comes exclusively from small scale providers. The extent to which their experience differs from larger scale providers is explored later in this Report under ‘Common Issues faced by large and small scale WMP Providers’.

Challenges include:

a) **Issues of SSP capacity**

- By definition SSPs comprise small core teams operating from small local offices. There are limitations in the number of hours that can be devoted to scanning potential commissioner sites for tenders. One respondent summed up as follows: “*This seemed to be nearly a whole job in itself – just locating the appropriate tenders*”[SSP]

- The practice described to us within some PCTs of recruiting the appropriate expertise to write tender documentation might well be matched by providers recruiting the equal and opposite skills to respond effectively to tender documentation. However, for SSPs the additional cost of bringing in this expertise may be prohibitive, unless sourced and funded by an appropriate intermediary, such as a local Voluntary Sector Council or similar

- Finding out about tenders requires substantial resource, since sources include local papers, specialist journals and via information sent to the commissioner’s database of providers – not all commissioners appear to have such a database

- Finding out about tenders in sufficient time to decide if investment should be made in responding to the tender, and if so, to attend any briefing session provided by the PCT, and to compose and submit a bid. It was put to us that a small organisation will not have the capacity to have someone constantly looking out for tenders, so that they may miss them completely or find out relatively late

- Individual SSP policy that leads to the provider responding to all tenders, rather than being selective in their response. This was attributed to a culture of fear of being left out, and a lack of clear specification, so that a SSP may not know whether it can meet the requirement of the tender in terms of either prior experience or capacity to deliver

- SSPs need to identify team skills and make time to invest in the important activity of finding and filtering appropriate tenders

- Potential commissioners need to receive information about the work being done by SSPs, even between tenders

- We were told about various ways that SSPs manage to build their own internal capacity: some SSPs reported accessing training for small businesses, such as that available via the Department for Business. In addition, informal professional and social networks were used to access advice on responding to specific bids

- SSPs need to get themselves on databases of local umbrella organisations for third sector or small companies.

b) **The procurement process**

- Some PCTs’ pre-qualification questionnaires (PQQs) asked for detailed information, but questions appeared to be framed to fit answers by well established (larger) providers, rather than being open questions applicable to
any provider – this made it very difficult to answer questions adequately or to provide valuable information about SSPs’ WMPs

• Some commissioners are reportedly seeking evidence from randomised controlled trials (RCTs): in reality few, if any, WMPs can currently provide this level of evidence, but the expectation seems to serve as a deterrent to SSPs

• Q&A Sessions run by commissioners for potential tenderers: whilst these were perceived as valuable, SSPs noted that they took at least a half-day out of the diary and may be some distance away – thus constituting a large opportunity cost to a small organisation. One suggestion was that a teleconference option could be made available for these sessions.

• The language of tenders was criticised for its complexity, use of jargon and, in particular, use of NHS-speak, without providing links to relevant source documents or a glossary. For small non-NHS bodies, having to conduct research in order to comprehend what commissioners want prior to being able to commence writing a bid, presents a significant deterrent

• It would be helpful for SSPs if there could be unstructured sections in the tender document in addition to the structured pro forma, as their programmes do not always fit a rigid predefined framework

• A checklist of commissioning process deadlines and documents required could helpfully be provided prior to the tender being published

• Provision by the PCT of relevant information about the area, demographics and target audience for the WMP would assist potential providers, all of whom would otherwise independently have to conduct the same research to ascertain these data: for SSPs this would address a significant capacity issue

• There was some cynicism expressed about public sector tendering processes; for example, a view that the provider had already been chosen, but that a formal process of tendering had to be completed to meet legal requirements; or a SSP might be asked to interview although already rejected, wasting the time of all concerned. For example: “Often we would be asked to give a presentation and we would know that we had been unsuccessful and had only been asked as they [the PCT] needed to have three organisations at that stage..” [SSP]

• Lack of constructive feedback to unsuccessful bidders was mentioned: providers want timely, constructive feedback in response to their submissions; lack of feedback was cited as a reason for SSPs’ defaulting from attempting to submit subsequent bids as there had been no guidance as to why previous bids had failed

• PCTs were criticised for a perceived lack of contract monitoring after a tender was let – providers being ‘left to their own devices’ was felt to be a weakness of the contracting process

• Preference for familiar providers, including in-house provision (PCT or LA) - allowing commissioners to remain in their comfort zone, was a perceived shortcoming of the commissioning process

• In response to this problem, SSPs suggested that PCTs or LAs should commission pilot programmes which would be evaluated, in order to encourage and enable new, effective programmes to be developed

• Specific support required by SSPs in writing bids could include: a “style guide” for writing NHS Tenders, one to one support and mentoring support.
• It would be helpful if commissioners could make more effective use of modern technology, for example: provide a dedicated website to promote weight management tender opportunities and use e-mail for notification of tenders.

c) Effective communication with PCTs
• From the PCT perspective a knowledge gap was acknowledged about the range of local providers and interventions available, but there was also wise advice to SSPs to “tell us you are there” [PCT Obesity Lead]
• SSPs felt that establishing rapport with a relevant person at the PCT was helpful, but noted that staff turnover or changes of responsibilities meant that this person often changed frequently
• Maintaining open communication channels could provide a way to update PCTs and LAs of local providers on a regular basis
• Some commissioners encouraged collaboration between providers. Whilst this could be helpful, one respondent had found that the successful bid in such a situation had resulted in sharing a small fund among a number of providers leading to insufficient funds for any provider to run the programme specified; another pointed out that such collaborative arrangements can lead to the larger partner having an advantage
• Potential commissioners need to receive information about the work done by SSPs, even between tenders
• At a very practical level, electronic submission of bids was welcomed, but it was felt that there was no recognition of the limited IT facilities of small providers that might make it impossible to submit a very large file: the option to submit more smaller files would have been helpful
• SSPs proposed that PCTs could make better use of local news media to advertise tenders
• SSPs also asked that any questions about the tender document be answered in a timely manner
• One SSP described being able to recruit and retain participants in a WMP where the previous large scale contractor had failed. They attributed their success to an ‘intimacy’ with local commissioners and potential referrers, which, they asserted, could not be achieved by a large scale provider.

Box 2 Commissioning process enhancement

<table>
<thead>
<tr>
<th>By Commissioners</th>
<th>By SSPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>o A dedicated website with weight management tender opportunities</td>
<td>o Identify team skills and time to invest in important activity of finding and filtering appropriate tenders</td>
</tr>
<tr>
<td>o E-mail of notifications of tenders</td>
<td>o Disseminate work done to potential commissioners in between tender calls</td>
</tr>
<tr>
<td>o Use of local media to advertise tenders</td>
<td>o Ensure SSP is on database for any local umbrella organisations for third sector or small companies</td>
</tr>
<tr>
<td>o A consistent method of updating PCTs and LAs of local providers</td>
<td>o Option of teleconferencing at information days</td>
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<tr>
<td>o Option of teleconferencing at information days</td>
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</table>
The Aspirations of Small Scale Providers
In the context of a wish expressed by a number of PCTs to commission more SSPs, and the wider ambition to develop capacity in London, it is helpful to understand how SSPs themselves see their role developing.
There is diversity among SSPs so their aspirations and ambitions also differ. Our sample was small and it might be that those SSPs with limited, local aspirations did not respond to our efforts to engage them. Those that did respond, however, were interested in further development and in scaling up their operation.
With regard to scaling up, none of the SSPs involved in this study felt any tension between their strength in providing a locally relevant service and scaling up Londonwide or even nationwide.
However SSPs had faced challenges from commissioners who had questioned how a locally based organisation could operate nationally and felt excluded on this basis. A case for efficiency had successfully been presented by one SSP who had been successful in the national market.
One SSP had validated their ability to provide on a larger scale from the experience of acting as local provider [effectively outsourced by the large scale provider as local ‘agent’] for a large scale provider.

Box 3 Example of small scale provider outsourced by a large scale provider highlighting strength of SSP

This SSP has been outsourced by a large provider to support and deliver the programme locally. The programme had struggled to recruit and retain families. Since the SSP has taken over delivery, uptake and retention has improved significantly.

The SSP used this example to validate their belief that as a SSP they can scale up and provide nationally and funding is the only barrier.

“we can do this – we have the required intimacy which (large provider) were not able to offer – but we did. This is our strength”

Common Issues faced by large and small scale WMP Providers
Feedback from the Cross-Government Obesity Unit suggests a number of similarities between the views and experiences of large scale national providers and those of the smaller scale providers we interviewed.

- Lack of funding for weight management services – in particular, PCTs trying to develop in-house services rather than look externally to specialist WMP providers
- Identifying obesity leads problematic – an up to date, maintained, readily accessible directory of lead contacts at PCTs would be helpful
- Difficulty in persuading PCTs of innovative approaches
- PCTs highly reliant on NICE guidelines

So, importantly, there is substantial common ground between large and small scale providers, insofar as the challenges they face in relationships with PCTs. It is

7 CGOU Market Assessment, 2009 (unpublished)
reasonable to assume that SSPs may lack the administrative capacity to respond effectively to the PCT commissioning process. This is borne out by the feedback from both PCTs and SSPs in this project. However, whilst the experiences that SSPs have described to us do suggest some features of NHS commissioning that are unsupportive of SSPs, many of the issues are not unique to SSPs. The belief that small, community-based providers may be better placed than larger scale providers to meet the specific needs of a local population was shared by SSPs and some PCTs, but it is conceivable that larger providers could also meet those needs if clearly set out in the tender specification.

Advice and recommendations to PCTs, Providers and RPHG

PCTs

1. Many PCTs began commissioning WMPs in earnest following publication of the government’s policy Healthy weight, healthy lives [2008], although in some PCTs there had been considerable activity in this area of commissioning previously. Although this response is understandable in the context of publication of national policy and encouragement of local action on obesity, it is recommended that local needs normally be assessed and local priorities agreed and commissioning plans presented as a clear pathway, prior to commencing commissioning: we are aware that work elsewhere is identifying good practice in relation to Obesity Pathways.

2. There is a tension created by current policy between addressing the longer term needs and health outcomes of the population and responding to shorter term priorities such as vascular disease prevention in adults. PCTs are encouraged to address this tension transparently and agree local strategic priorities, which can be subject to regular review. In the case of obesity, the balance between services for adults and children, and between prevention and management, need to be considered, as well as the overall position of obesity versus other priority areas for commissioning, particularly at a time of adverse financial conditions, where reductions in investment by the PCT are very likely.

3. Further tensions clearly exist between population wide public health interventions and WMPs: and not all interventions are dependent on PCT funds: eg a jointly appointed DPH encouraging their local authority to invest in environmental initiatives that are likely to support progress towards healthier weight in the population – eg cycle and walking tracks

4. Evidence from this survey suggests that not all PCTs have integrated commissioning and procurement functions led by one directorate, which may have led to difficulties such as some of those described to us – for example, public health staff dealing with commissioning and/or procurement processes with which they were unfamiliar and ill-prepared. Whilst this is not unique to WMPs, the risks – financial and legal as well as professional – of such exposure encourage the recommendation that processes are reviewed, so that only people able to demonstrate World Class Commissioning competencies should lead commissioning process and only those with an adequate understanding of procurement should be responsible for procurement.
5. We encountered examples of joint commissioning between PCT and LA, which seemed to enhance local joint working and support the co-ownership of health and wellbeing across sectors. Management of obesity, with its obvious link to physical activity, is a health issue with which local government can often see its role clearly, so that this presents an opportunity for increasing engagement and joint working.

6. Built into tenders should be the requirement to provide timely, accurate information in order for the National Obesity Observatory’s Standard Evaluation Framework to be used routinely.

7. There is evidence that targeted interventions are more likely to be effective than generic provision, particularly in traditionally ‘hard to reach’ groups. However, we found few examples of WMPs targeted at specific local communities based, for example, on age (other than children), gender, ethnicity, geography, language. PCTs might wish to review provision to match the good practice of those PCTs who do have targeted provision.

8. The recent publication of the Mayor’s Health Inequalities Strategy and its ‘First steps to delivery’ expects the NHS organisations to be active partners in its delivery. This may present an opportunity to influence PCT Boards to prioritise initiatives to reduce inequalities, which could include targeted WMPs.

Providers

1. WMP providers are very diverse and so recommendations for some may be inapplicable to others. It was reported to us that larger providers tend to offer a ‘one size fits all’ approach to tenders, with PCTs wanting to see local services tailored to meet the needs of their population. Larger providers may therefore want to consider how best they can improve flexibility in order to tailor their product to meet local needs. To do this it may be helpful for PCTs to construct their tender documents to reflect clearly the particular needs within the local population that must be met by a WMP.

2. We heard evidence that some providers have difficulty responding to tenders effectively, due to insufficient capacity to respond in the time frame, and/or to lack of competencies in the NHS contracting environment. If these providers are to compete fairly in the market, there is a need to upskill them or to provide independent support to enable them to respond to opportunities to tender. The example of a LVSC supporting local 3rd sector providers in this way is one option and appeared to be good practice.

3. Providers are often experts in their field and are in a position to present innovative proposals to commissioners. There is a need for early dialogue with commissioners to ensure commissioning for ‘best practice’ and opportunities for innovation in the context of thorough evaluation. Commissioners will be careful not to prejudice some providers through such mechanisms and may wish to seek advice on best practice from distant, ‘disinterested’ providers – collaboration between PCTs may facilitate this.

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8 Health Inequalities Strategy; GLA, 2010

9 Health inequalities strategy ‘First steps to delivery; GLA, 2010:
http://www.london.gov.uk/sites/default/files/HISdeliveryplan.pdf
Regional Public Health Group

1. Commissioning of this study and other work, eg on developing an Obesity Pathway and a shared Database of WMP providers, are helpful initiatives for supporting PCTs. The creation of the Obesity Learning Centre website, with a dedicated London page, will enhance the visibility and accessibility of the outputs of regional projects.

2. Whilst a dedicated resource to support local commissioning for healthy weight and to tackle obesity is clearly valuable, RPHG might consider supporting PCTs in the wider context of its priority areas – to support skills development for collaboration with local government, joint commissioning, commissioning evaluations, working with the 3rd sector, for example

3. We have identified a number of innovative local programmes, that may look attractive to other PCTs. However, robust evaluation is needed before a WMP can be sensibly rolled out. Maintaining an oversight of, promoting and supporting, evaluation, especially of new initiatives, would provide a valuable contribution to achieving evidence-based commissioning.

4. The RPHG might consider providing support for needs assessment, particularly in relation to establishing best practice in achieving the optimal balance of personal interventions to environmental interventions for many areas of health improvement, including achievement of healthy weight.

Local Authorities

1. Local authorities were not interviewed as part of this work, but are clearly of great importance in addressing obesity in their local population. Several of our PCT interviewees already work closely with colleagues in their coterminous London Borough and some described joint commissioning initiatives, but these experiences were not universal. Given local authority responsibilities for leisure services, planning and environment, there is substantial scope for good practice in relation to access to open spaces for play and other forms of physical activity, provision of affordable access to facilities such as swimming pools, and provision of well-lit walking and cycle paths, and access to local shops selling wholesome food.

2. In addition to their own direct responsibilities, the local authority overview and scrutiny role in relation to health services, could decide to take an active interest in the local provision of WMPs and other services to prevent and tackle unhealthy weight.

3. In view of the potential influence of local government in the area of preventing and tackling obesity, a joint approach to this challenge by each London Borough with its coterminous PCT would seem desirable. Joint strategic needs assessment (JSNA) and Local area agreement (LAA) offer mechanisms to establish formally a joined up approach in an aspect of public health that clearly call for a joined up approach between statutory agencies, for maximum impact and efficient deployment of local resources.

Recommendations for Commissioning of other Public Health Programmes across London

This project looked exclusively at the experience of NHS commissioners of weight management programmes and some of their providers across London. Whilst we
have no firm evidence that the findings in relation to WMPs would be replicated in respect of other public health programmes, it seems likely that there would be common issues.

For example, public health or preventive programmes tend to be provided outside large Foundation Trust providers and tend to comprise a relatively small proportion of a typical PCT’s commissioning budget. Further, the evidence base for public health interventions is still being developed, so that it is commonplace for only limited evidence of effectiveness of particular interventions to be available. And in relation to public health interventions, it is clear that interventions at a number of points along a spectrum are possible – from population-wide to individual – and the PCT’s role and priorities along this spectrum should be agreed early on with local partners, in particular the local authority, in the context of JSNA\textsuperscript{10} and LAA\textsuperscript{11}.

Extrapolation from our findings on WMP commissioning leads us to recommend:

1. A needs based approach to commissioning all public health programmes
2. An evidence-based approach to commissioning, using best available evidence of effectiveness of interventions
3. Commitment to outcome as well as process evaluation of commissioned services, in order to strengthen the evidence base
4. Development of a locally agreed, preferably multi-agency, comprehensive care pathway for every public health priority area, prior to embarking on commissioning a particular service
5. Deployment of staff who are appropriately trained/experienced in commissioning and procurement, just as for any other interventions – that is, to ensure successful, safe commissioning this relatively small proportion of PCT investment should not be taken less seriously in terms of commissioning and procurement than bigger contracts
6. Engagement with providers fairly and transparently.

\textsuperscript{10} JSNA: Joint Strategic Needs Assessment
\textsuperscript{11} LAA: Local Area Agreement
Acknowledgements
The project team would like to thank all who participated in this project, including the PCT respondents and representatives of small scale providers, who were so generous with facts, opinions and time, steering group members, and colleagues at the Regional Public Health Group who commissioned this work.
APPENDICES

Appendix 1 – Definitions

London Weight Management Programmes Evaluation Project

A. Definition of Weight Management Programme
A programme that explicitly sets out to manage or reduce body weight (including the primary prevention of weight gain). This includes programmes focussing on diet, physical activity, or both in combination. It is intended to be applicable to a range of approaches including interventions conducted with individuals on a one-to-one basis or in groups, and in clinical or community settings. For children, WMPs may be conducted with children only or with other family members or whole families. WMPs normally comprise attendance or other interaction with the programme on several occasions, with no optimal number of attendances emerging from the available evidence.

For this project, the following would be excluded:
- medical interventions including surgery or medications;
- wider environmental interventions such as building projects, parks, etc, that are aimed at whole communities;
- routine clinical practice that might include opportunistic management of weight in the context of a consultation for another long term condition
- brief interventions that address weight
- any interventions comprising a single interaction with the provider


B. Criteria for classification of providers

Background:
RPHG is particularly interested in understanding the development needs of smaller, non-commercial WMP providers, which it believes may be disadvantaged in existing commissioning and procurement processes. This belief is fuelled by the finding from previous surveys in London that most PCTs are commissioning programmes from a relatively small number of the larger, and mainly quite well known, WMP providers across London, with little evidence of achieving a local response to local needs as might be expected from a fully functional World Class Commissioning system.

As part of this project we have been asked to collect information about existing and recent commissioning behaviour to find out more about how local commissioning decisions about WMP are made. We shall subsequently be constructing a database of WMPs across London, on which RPHG wishes to focus particularly on “non-
commercial” WMPs. It is therefore critical that we have an agreed working definition of what is meant and understood by the term ‘non-commercial’ WMP.

In reality, the main features that are likely to distinguish locally focussed services in the context of WMPs are those of scale and of proximity and responsiveness to the community/ies served, rather than whether or not they are explicitly ‘commercial’ in orientation. The advent of Social Enterprises has meant, for example, that some of the larger providers that might be considered to be ‘commercial’ in orientation are, in fact, social enterprises. We would like to propose a variation on the terminology, which we hope will be helpful.

Further, if, as is being considered elsewhere, healthcare commissioning behaviour is to shift towards the use of 2nd or 3rd ‘tier’ 3rd sector organisations acting on behalf of several smaller providers, then these definitions will be of assistance.

Currently, WMPs are provided by several types of provider, including: primary care trust (PCT) provider arm, Foundation Trust, third sector, independent and commercial sector, local partners (eg local authority).

Proposal:
Rather than using the term commercial WMP – we suggest referring to ‘large scale’ WMP
Similarly, in preference to the term non-commercial WMP – we suggest referring to ‘small scale’ WMP

Whilst the differences ‘on the ground’ may be subtle, we think there are some features of large scale WMP providers that sets them apart from small scale providers, as set out below.

A small scale WMP is likely to be
Available in one or up to a few London Boroughs [might be viewed as an ‘emerging’ provider]
Provides WMP in response to local needs
Where provided from premises, these are readily accessed by the target population
Delivered in the language/s most likely to be understood by the target population
Run by a not for profit organisation, that might be a voluntary/community sector [3rd Sector] organisation, including, but not exclusively, charities
Poorly equipped in terms of advertising, promotion and website

A large scale WMP is more likely to be
Available in many PCT or local authority areas, within and/or outside London
Providing WMP based on the same template wherever delivered
Where using premises, they are commonly (but not exclusively) run from publicly managed [eg local authority or NHS] premises
Delivered in English wherever the Programme is provided
Run by either a commercial (for profit) company or a Social Enterprise (not for profit) company
Well equipped with effective advertising, brand promotion and website

Decision:
The Steering Group, at its meeting in March 2010, agreed to the definition, exclusion criteria and classification of small scale and large scale as described above, in the context of permitting the project to address the different needs of WMP providers, commissioners and potential clients across London.
Appendix 2 - Interview Schedule

Weight Management Programmes – London Evaluation
Interview schedule for PCT leads

1. Introduction
The London teaching Public Health Network has been commissioned by RPHG to carry out a study of commissioning for weight management programmes in London. The main aims of the study are to share learning and good practice, and also provide guidance for potential providers. These together will contribute to the overarching aim of developing a fully functional World Class Commissioning system.

The study will consider Weight Management Programmes (WMP) for people of all ages, with or without other medical conditions, but will exclude dietetic and allied services routinely provided as part of secondary care services.

We would like information about all WMPs currently commissioned, commissioned in the recent past and also planned for the near future. We would like to focus, in particular, on any ‘non-commercial’ programmes so far considered or commissioned.

Before we proceed with the interview we will need the attached consent form signed. We would also like, with your consent, to audio-tape the interview to allow an accurate capture of your perceptions.

Please be assured that your views and comments will be reported anonymously.

Factual details of commissioned providers will be shared through a dedicated database.

If you have any questions about the interview or study please do not hesitate to contact LTPHN Office at 020 7972 8286 or fiona.sim@lshtm.ac.uk.

Glossary: WMP – Weight Management Programme; PCT; Primary Care Trust; PBC – Practice Based Commissioning; the 3rd sector includes voluntary, community and faith based organisations.

2. Respondent details

Name
Job Title
Time in this role
Involvement in commissioning
Directorate

3. Current weight management programmes
Please tell me about ALL current weight management programmes, providing details of each programme as indicated in the tables below.

Currently commissioned for adults

<table>
<thead>
<tr>
<th>Name of programme</th>
<th>PCT or joint with LA</th>
<th>PBC</th>
<th>Provider Type: ‘commercial’, non-commercial, social enterprise, 3rd sector, other</th>
<th>Age range</th>
<th>Targeted at particular groups (gender, ethnicity, geography, other)</th>
<th>amount invested /spent in 2009/10</th>
<th>Number of clients accessing each programme/or no of places purchased on each programme</th>
<th>Duration of contract</th>
<th>Evaluation</th>
</tr>
</thead>
</table>


### Currently commissioned for children

<table>
<thead>
<tr>
<th>Name of programme</th>
<th>PCT or joint with LA</th>
<th>PBC</th>
<th>Provider Type: 'commercial', non-commercial, social enterprise, 3rd sector, other</th>
<th>Age range</th>
<th>Targeted at particular groups (gender, ethnicity, geography, other)</th>
<th>amount invested/spent in 2009/10</th>
<th>Duration of contract</th>
<th>Evaluation</th>
</tr>
</thead>
</table>

### 4. Intended weight management programmes

Please tell me about ALL weight management programmes that are intended in the next financial year if different from section 3 (above),

**Intended WMPs for adults**

<table>
<thead>
<tr>
<th>Name of programme</th>
<th>PCT or joint with LA</th>
<th>PBC</th>
<th>Provider Type: 'commercial', non-commercial, social enterprise, 3rd sector, other</th>
<th>Age range</th>
<th>Targeted at particular groups (gender, ethnicity, geography, other)</th>
<th>Amount intended to invest/spend (year)</th>
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</table>

**Intended WMPs for children**

<table>
<thead>
<tr>
<th>Name of programme</th>
<th>PCT or joint with LA</th>
<th>PBC</th>
<th>Provider Type: 'commercial', non-commercial, social enterprise, 3rd sector, other</th>
<th>Age range</th>
<th>Targeted at particular groups (gender, ethnicity, geography, other)</th>
<th>Amount intended to invest/spend (year)</th>
</tr>
</thead>
</table>

### 5. Previous commissioned weight management programmes

a) Do you have information on previously commissioned WMP within the last year or so, that are no longer commissioned? Yes/No

b) If yes, please tell me about these programmes

**Previously commissioned WMPs for adults**

<table>
<thead>
<tr>
<th>Programme name</th>
<th>Date</th>
<th>Reason for discontinuing contract</th>
</tr>
</thead>
</table>

**Previously commissioned WMPs for children**

<table>
<thead>
<tr>
<th>Programme name</th>
<th>Date</th>
<th>Reason for discontinuing contract</th>
</tr>
</thead>
</table>

### 6. Weight management programmes previously intended but not commissioned

a) Do you have information on previously intended WMP within the last year or so which did not proceed to be commissioned? Yes/No

b) If yes, please tell me about these programmes [provide details in tables below]

**Previously intended WMPs but not commissioned – for adults**

<table>
<thead>
<tr>
<th>Programme name</th>
<th>Date</th>
<th>Reason for not proceeding</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Programme name</th>
<th>Date</th>
<th>Reason for not proceeding</th>
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Previously intended WMPs but not commissioned – for children

<table>
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7. Please tell me more about the commissioning process of WMPs locally. The following are some areas I would like to explore in relation only to WMPs:

- Very brief description of the local process of commissioning
- Very brief description of the process of procurement
- The PCT and/or LA directorates involved in the local commissioning process
- Prior knowledge of the provider
- Ease of the commissioning process
- Challenges, lessons learnt and what went well
- Evaluation or planned evaluation of WMPs delivered

8. (If not mentioned so far) Have you considered commissioning services from a 3rd sector organisation?
   Yes/No

   Is there any guidance you can offer such organisations to help facilitate engagement with the commissioning process

9. Additional information

   Are there any documents or reports that you may share with me to supplement the information provided in this interview?

10. External sources of information

    Please tell how useful you have found any freely accessible information about WMPs.

11. Is there anything else you would like to share about any of the topics covered today?

Thank you for your participation in this study. We will feedback a summary of this interview to you. If you have any comments at any time please contact LTPHN Office at 020 7972 8287 or email Fiona.sim@lshtm.ac.uk
Appendix 3 - Summary Guidance for PCT Commissioners wishing to develop a fair local market of WMP providers, including SSPs

1. Publicise a readily accessible source of tendering information – eg a website and/or local newspaper
2. Consider establishing transparently and maintaining a database of providers who wish to be informed of upcoming tenders for particular services
3. Develop tender documentation informed by provider intelligence from more than a single source
4. Ensure that tender documentation is as jargon-free as possible – and provide a glossary to explain unavoidable jargon/health and social care system acronyms
5. Ensure a named individual is responsible and accessible for responding to providers’ enquiries about a tender
6. Ensure sufficient time for providers to respond to tenders
7. Ensure sufficient notice to attend information briefings
8. Provide information other than via face to face briefings so that an organisation unable to attend can still respond adequately to the tender
9. Consider sponsoring a local independent ‘umbrella’ organisation to act as intermediary/mentor for 3rd sector or other small scale providers
10. Consider investing in provider development to build tendering competencies, in the context of achieving WCC
11. Ensure WCC competencies in all PCT staff responsible for commissioning
12. Ensure that all PCT staff responsible for procurement are competent or appropriately supported to carry out this responsibility
13. If encouraging providers to collaborate on bids, bear in mind that there may be a lower limit to the size of a viable contract for any individual provider, even as a member of a syndicate [ie if you spread the tender funding too thinly, it may cease to be viable]
14. Ensure that PQPs do not inadvertently discriminate against small scale (or any) potential providers – eg permit respondents to explain on the response pro forma why a particular question is not applicable to them if they cannot answer it
15. Provide constructive feedback to unsuccessful tendering organisations on request, regardless at what stage in the process they failed; and consider that successful tenderers also appreciate feedback
Appendix 4 - Number of WMPs currently commissioned (Spring 2010)

<table>
<thead>
<tr>
<th>PCT</th>
<th>No. of WMPs for Adults</th>
<th>No. of WMPs for Adults provided by SSPs</th>
<th>No. of WMPs for Children</th>
<th>No. of WMPs for Children provided by SSPs</th>
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<tbody>
<tr>
<td>Barking &amp; Dagenham</td>
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<td>City and Hackney</td>
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<td>9</td>
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<td>Tower Hamlets</td>
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<td><strong>17</strong></td>
<td><strong>65</strong></td>
<td><strong>17</strong></td>
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WCC Competencies are summarised as follows\textsuperscript{12}:

1. Are recognised as the local leader of the NHS
2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
3. Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health
4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation
5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements
6. Prioritise investment according to local needs, service requirements and the values of the NHS
7. Effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes
8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
9. Secure procurement skills that ensure robust and viable contracts
10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes
11. Make sound financial investments to ensure sustainable development and value for money

World Class Commissioning and Weight Management Programmes:

Although we did not seek explicitly to assess PCTs against WCC competencies, we have been asked to comment on the observed level of achievement of these competencies and present our observations in this appendix:

1. \textbf{Are recognised as the local leader of the NHS} - WMP commissioning is largely undertaken with PCT leadership, though in some instances the local authority or GP practices were leading the process. The WCC competency assumes that the commissioning process should be NHS-led, but leadership from other sources may be appropriate for services such as WMP, as long as the lead commissioner has access to sound advice regarding the needs of the local population, evidence of effectiveness of diverse models of intervention and local priorities for health improvement. Our study did not extend to exploration of any of these commissioning factors beyond the PCT interviewees

2. \textbf{Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities} – we found limited evidence of collaborative working, with neighbouring PCTs or with the coterminous local authority. Since most London directors of public

\textsuperscript{12} World class commissioning competencies: good practice guidance, Commissioning Team, DH, Dec 2007 [www.dh.gov.uk/worldclasscommissioning ]
health have joint PCT:LB appointments and WMP are mainly commissioned by public health personnel, it seems a reasonable expectation that collaboration between PCT and LB would be the norm in commissioning WMPs, but this does not appear to be the case: we have therefore selected examples that were identified as good practice.

3. **Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health** – there appears to be variable engagement with public and users around WMPs. Clearly, for well established clinical services, this should be fully embedded by now, but for WMP services, which are a relatively recent innovation for the NHS, it may be a little early in the commissioning of these services for a meaningful dialogue to have been established. We cite in the main body of the report as an example of good practice, links with Public and Patient involvement at strategic level. This was found only in one PCT.

4. **Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation** – this competency is not always relevant to the provision of WMPs, which are frequently not clinician-led or dependent. There is a need for continuous and meaningful engagement with service providers, which, as has been shown by national research with larger providers and our research with small scale providers, not always to be the case. This is described further in the body of the report.

5. **Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements** – as described in the report, we identified several examples of PCTs responding rapidly to local and national policy drivers to commission WMP, rather than first undertaking comprehensive needs assessment. Many PCTs are now reviewing their commissioning decisions regarding WMPs, in which some have explicitly decided to shift to a needs-based approach. We found that drivers for this activity included financial constraints, and a high staff turnover where rationale for previous decision making was not clear to the person now in post. Many PCT leads expressed knowledge gaps in conducting a robust needs assessment and we found little evidence of shared learning across PCTs in this regard. Some PCT leads looked to the RPHG to provide guidance and methodology for this activity.

6. **Prioritise investment according to local needs, service requirements and the values of the NHS** – it appears that local commissioning decisions have been based on a variety of principles, including availability of affordable (or ‘free’, where funded from external sources such as the Big Lottery) WMPs, the desire to establish a mixed economy of WMP providers and an understanding of local needs; priorities were influenced by local and national policy drivers. As in no. 5 above, there is scope for review of earlier commissioning decisions that could lead to the appropriate prioritisation of investment.

7. **Effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes** – the extent to which the local market has been stimulated is very variable. Some PCTs have prioritised this aspect of commissioning and, in particular, made efforts to engage the third sector as providers of WMPs, while others have intentionally confined commissioning to the local PCT ‘provider arm’, effectively stifling any broadening of the provider market.

8. **Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration** – we identified
little evidence of this competency being met. Whilst many PCTs specify compliance with the national evaluation framework, for example, there was little evidence of incentives or sanctions for compliance or non-compliance, and few PCTs seeking innovation or quality improvement: however, once again, this may be related to the relative newness of WMP provision and the practicalities of establishing a stable service may have taken precedence over seeking innovation or improved quality. A few PCTs had engaged with local universities to provide a resource for evaluation through student projects.

9. **Secure procurement skills that ensure robust and viable contracts** – as indicated in the report, we found a very mixed picture here. Some PCTs have a joined up approach to commissioning WMPs, with teamwork between public health, commissioning and finance/procurement expertise, while others left WMP commissioning to an often poorly prepared member of the public health team. Although WMPs are a very small part of overall commissioning by the PCT, the risks exposed by the latter model need rapidly to be recognised and rectified.

10. **Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes** – this is not an area we emphasised with PCT interviewees and so our observations may be unrepresentative. However, we gained an overall impression that there has been, as yet, little partnership work with providers to ensure compliance or quality improvement and monitoring systems are simple, limited to ensuring basic provision of service. As the commissioning process matures, it is reasonable to expect that these aspects will become standard: our discussions with providers suggest that they are seeking this type of engagement with commissioners.

11. **Make sound financial investments to ensure sustainable development and value for money** – until recently, some WMPs have been ‘free’ to PCTs, as a consequence of external sources of funding, but as these sources cease, particularly at the same time as the NHS is seeing real reductions in funding, PCTs will have to make careful investment and disinvestment decisions. The report refers to examples of risky investment decisions made by ill-prepared PCT staff, which will be even more essential to avoid in times of financial stringency.
Appendix 6 - Weight Management Programmes – London evaluation, 2010 –
Key Personnel

Steering Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
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<tr>
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</tr>
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</tr>
<tr>
<td>Jan Hickman</td>
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</tr>
<tr>
<td>Patrick Tobi</td>
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</tr>
<tr>
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<td><a href="mailto:tlobstein@iaso.org">tlobstein@iaso.org</a></td>
</tr>
<tr>
<td>Fiona Sim</td>
<td>Co-ordinator, London Teaching Public Health Network, LSHTM</td>
<td><a href="mailto:fiona.sim@lshtm.ac.uk">fiona.sim@lshtm.ac.uk</a></td>
</tr>
<tr>
<td>Lorraine Williams</td>
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<td><a href="mailto:lorraine.williams@lshtm.ac.uk">lorraine.williams@lshtm.ac.uk</a></td>
</tr>
<tr>
<td>Raheelah Ahmad</td>
<td>Research associate, London Teaching Public Health Network, LSHTM</td>
<td><a href="mailto:raheelah.ahmad@lshtm.ac.uk">raheelah.ahmad@lshtm.ac.uk</a></td>
</tr>
<tr>
<td>Lisa Vaughan (to March 2010)</td>
<td>Food and obesity programme manager, Regional Public Health Group, London</td>
<td><a href="mailto:Lisa.Vaughan@dh.gsi.gov.uk">Lisa.Vaughan@dh.gsi.gov.uk</a></td>
</tr>
<tr>
<td>Mark Browne</td>
<td>Regional Public Health Group London</td>
<td><a href="mailto:Mark.Browne@dh.gsi.gov.uk">Mark.Browne@dh.gsi.gov.uk</a></td>
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<tr>
<td>Gill Moffett</td>
<td>Regional Public Health Group London</td>
<td><a href="mailto:Gill.Moffett@dh.gsi.gov.uk">Gill.Moffett@dh.gsi.gov.uk</a></td>
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Core Team

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<th>Name</th>
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<tr>
<td>Fiona Sim</td>
<td>Project lead</td>
<td></td>
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<tr>
<td>Raheelah Ahmad</td>
<td>Researcher</td>
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<tr>
<td>David Taylor</td>
<td>Database designer</td>
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<tr>
<td>Lorraine Williams</td>
<td>Researcher (to March 2010)</td>
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<tr>
<td>Marlene Costa</td>
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<tr>
<td>Pamela Harling</td>
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Interviewers

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