Contents

4 Obesity

4.1 Introduction

Obesity is a term used to describe abnormal or excessive fat accumulation that may harm health. Obesity-related health conditions include type 2 diabetes, high blood pressure, heart disease, stroke, certain cancers, depression, anxiety, liver disease, reproductive complications and musculoskeletal conditions. [1] [2]

Body mass index (BMI) is the most commonly used method of approximating how much fat a person is storing on their body (Box 1).[1] BMI is a useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages (although it does not take account of body composition, such as muscle density, so can be misleading for some individuals).

Box 1: Definitions used in this section

Body mass index (BMI) – a measure of the extent to which a person's weight is healthy for their height. BMI is calculated by dividing body weight (kilograms) by height (metres) squared.

Overweight and obesity – the most common method of measuring obesity is using BMI. An adult BMI of between 25 and 29.9 is classified as overweight and a BMI of 30 or over is classified as obese (Table 1). [3]

Table 1: Body mass index (BMI) classifications

BMI range (kg/m²)	Description
≤18.5	Underweight
18.5–24.9	Healthy weight
25–29.9	Overweight
30–39.9	Obese
≥40	Very obese

Source: National Institute for Health and Care Excellence (NICE). [4]

There is evidence to suggest that people who are from Black, Asian and other minority ethnic backgrounds have a higher risk of obesity-related health harms (for example, type 2 diabetes) at lower BMI levels than the White population. [5] The National Institute for Health and Care Excellence (NICE) recommends that lower BMI thresholds are used to raise awareness of the risks of obesity and preventing type 2 diabetes in people from Black and Asian ethnic groups – specifically, using

[1] Other methods for determining how much body fat a person is carrying include skin fold thickness measures, waist circumference to hip measurement ratios and bioelectrical-impedance (a method of estimating how much water is in the body). However, the varied measurement techniques used, and the lack of routine availability of certain specialist equipment, mean these methods are not able to reflect population prevalence with accuracy.

23kg/m^2 to define 'increasing risk'/overweight (rather than 25kg/m^2 as in the general population) and 27.5kg/m^2 to define 'high risk'/obese (instead of 30kg/m^2). [6]

There has been significant growth in obesity prevalence in the developed world over the past 30–40 years, coinciding with a complex mix of rapid societal and technological change. [7] High BMI (overweight or obese) is now the second biggest contributor to disability-adjusted life years (DALYs)[2] in England. [8] Obesity is estimated to be responsible for more than 30,000 deaths each year nationally, and increases the risk of developing a wide range of non-communicable diseases. Obesity, and therefore the poor health associated with it, is largely preventable. [9]

People living in the most deprived circumstances and those from certain minority ethnic communities, as well as 'vulnerable' people (for example, adults with learning disability), are at increased risk of being obese. As such, obesity acts to perpetuate and increase social inequalities in health. [10] [11]

As well as affecting individual health and wellbeing, obesity puts pressure on the economy and public services. In England, it is estimated that the annual costs of obesity include: £27bn to the wider economy; £5.1bn to the NHS (including £13.3m spent on obesity medication); £352m in social care costs; and 16m days of sickness absence from work. [2]

4.2 Causes and risk factors

The fundamental cause of obesity is an imbalance between energy consumed and energy expended.

Obesity primarily arises from people living in an environment that affects group and individual behaviour in a way that encourages weight gain. Obesity is influenced by a wide range of complex factors and influences that can accumulate over a lifetime. Some people are affected by particular risk factors due to a genetic predisposition, but mostly obesity is driven by social and/or environmental circumstances. [12] A scientific enquiry into the complex interplay of the different factors contributing to obesity highlighted seven key variables that make up the 'obesity system' – these are described in Table 2. [7]

[2] DALYs are a way of measuring and comparing the health burden of different disease conditions and health states. One DALY represents one year of 'healthy life' lost due to a given disease or state of health.

Table 2: Causes of, and risk factors for, (adult) obesity

Risk factor	Details
Biology	• Age – the impact of small increases in energy intake accumulates over the life course. Obesity increases with age, with the highest rates of obesity in 45–74-year-olds. [13] • Ethnicity – the prevalence of obesity is higher in certain Black, Asian and Minority Ethnic (BAME) groups due to a combination of biological and wider societal influences. • An individual's biological composition, including genetic predisposition to obesity and level of primary appetite control • Ill health and impaired ability to engage in activities of daily living • Intergenerational effects • Being obese as a child
Food environment	• The 'food environment' describes the factors that influence individual and community food choices (see also the 'Food environment' section of the 'Society and environment' JSNA chapter).
Food consumption	• The amount of food consumed at a given sitting can be affected by several factors – these include portion size, rate of eating, palatability of food, and whether alcohol has been consumed. (Also see the 'Diet' section of the 'Lifestyle and behaviour' JSNA chapter.)
Societal influences	• Societal 'norms' and the way they are reflected by society (most frequently through the media) affect the social acceptance and importance of body image. • Perceived lack of time to be physically active
Individual psychology	• This includes low self-esteem, food indulgence and food literacy. It may be reflected in parenting behaviours and control over food.
Activity environment	• This refers to variables in the environment that facilitate or obstruct physical activity. Some examples include: the societal dominance of motorised forms of transport (instead of walking or cycling); the cost of accessing physical activity; and the dominance of sedentary employment. (See 'Places and spaces' and 'Transport and travel' sections of the 'Society and environment' JSNA chapter for more detail.)
Physical activity	• This is the main driver in energy expenditure systems, and includes domestic, recreational and professional activity. (See the 'Physical activity and inactivity' section of the 'Lifestyle and behaviour' JSNA chapter for further details).

Source: Government Office for Science. [7]

NICE highlights the following potential barriers to lifestyle change in relation to obesity management: [14]

- lack of knowledge about buying and cooking food, and how diet and exercise affect health

- the cost and availability of healthy foods, and opportunities for exercise
- safety concerns, for example about cycling
- lack of time
- personal tastes
- the views of family and community members
- low levels of fitness, or disabilities
- low self-esteem and lack of assertiveness.

4.3 Local data and unmet need

There is no single, 100% reliable source of local data on the underlying prevalence of adult obesity in Hackney and the City.

The most reliable source of recorded obesity prevalence is data from GP records – 88.7% of adult GP patients in Hackney and 87.4% in the City of London have a BMI measure recorded by their GP (Table 3). [15] These data are based on most recent recorded BMI, so are likely to be more reliable for those who visit their GP on a regular basis (such as those with long-term health problems) and those who have registered with a GP more recently. (For local data on GP consultation rates see the 'Use of services' section of this JSNA chapter.)

Table 3: Percentage and number of Hackney and the City residents with a GP-recorded BMI measure (age 18+, 2017)

Residents	Percentage with a BMI measure recorded	Number with a BMI recorded
City	87.4%	5,414
Hackney	88.7%	194,988

Source: Extracted from the local GP register by the Clinical Effectiveness Group (CEG), Blizard Institute, April 2017. Data cover residents of Hackney and the City registered with a GP in Hackney, the City of London, Tower Hamlets and Newham. [16]

The estimates of adult obesity reported in this section are based on data collected from a local sample of adult residents who participated in the national *Active Lives Survey*. [17] This survey is based on a very small sample of local residents (around 475 responses in Hackney and 249 in the City of London in 2016/17), is carried out by post and telephone, and relies on self-reported information on height and weight to derive estimates of local obesity prevalence. While some adjustments are made to the data to address these methodological weaknesses, these estimates should be treated with some caution.

4.3.1 Numbers affected – known to services

Table 4 shows that, among Hackney and the City adult residents with a BMI recorded, one in five is obese (20.2% in Hackney and 12.4% in the City), and just under half are either overweight or obese (47.8% in Hackney and 39.4% in the City). The numbers reported in Table 4 are likely to be an underestimate of the number of

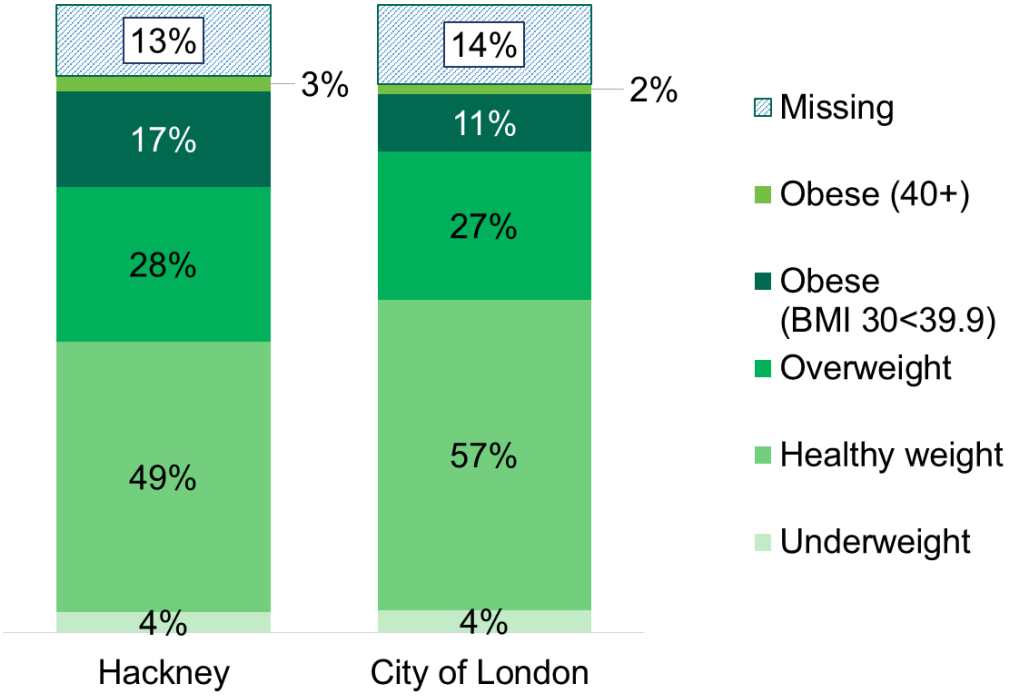
adults who are overweight or obese locally, as they exclude those with no BMI recorded by their GP.

Table 4: Number of Hackney and the City residents with GP-recorded overweight and obesity (age 18+, 2017)

Adult residents (18+)	% with a BMI measure recorded	Overweight (BMI 25<29.9)	Obese (BMI 30<40)	Very obese (BMI 40+)
City	87.4%	1,463	569	100
Hackney	88.7%	54,342	33,370	5,496
City and Hackney	88.6%	55,805	33,939	5,596

Source: Extracted from the local GP register by CEG, Blizard Institute, April 2017. Data cover residents of Hackney and the City registered with a GP in Hackney, the City of London, Tower Hamlets and Newham. [16]

Figure 1: Percentage of Hackney and the City residents by BMI category (age 18+, 2016/17)



Source: Extracted from the local GP register by CEG, Blizard Institute, April 2017. Data cover residents of Hackney and the City registered with a GP in Hackney, the City of London, Tower Hamlets and Newham. [16]
Note: Only includes GP patients with BMI recorded.

4.3.2 Numbers affected – estimates

In Hackney, 59% of adults are estimated to have a BMI in the 'overweight' or 'obese' range. For the City of London, 38% of residents are estimated to be either overweight or obese. [18]

Table 4 reports the number of overweight and obese adults that would be expected in Hackney and the City if these percentage prevalence estimates were applied to the projected local resident populations.

Figure 2: Estimated number of Hackney and the City residents who are overweight or obese (age 18+, 2016/17)

Source: PHE Fingertips. [18]

4.3.3 Unmet need

Due to the limitations in the available data on estimated prevalence (as described earlier), it is not possible to make a valid assessment of local unmet need in relation to obesity (that is, the gap between the number of adults known to their GP to be obese and the estimated population prevalence of obesity).

Most adults in Hackney and the City have a BMI recorded by their GP and these data suggest that at least 95,000 are at risk of overweight/obesity-related poor health locally – around 40,000 at high risk (BMI 30+).

4.4 Inequalities

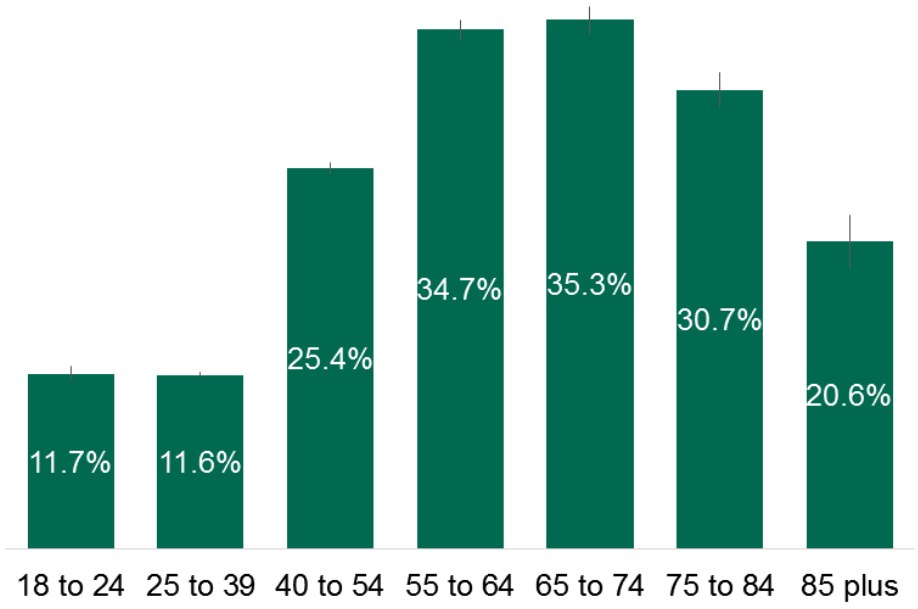
The main source of data on inequalities in local obesity prevalence is GP records. These data have been combined for Hackney and the City of London below.

London is reported as having the greatest inequalities in obesity prevalence, on a number of different dimensions. [11]

4.4.1 Age

Locally, among those with a BMI recorded by their GP, prevalence of adult obesity increases with age up to 74 years (
Figure 3). Nationally, the rate of obesity also increases with age, with the highest proportion observed in the 55–74 age group. [10]

Figure 3: Percentage of Hackney and the City residents who are recorded as obese (BMI 30+) by their GP, by age group (age 18+, 2017)



Source: Extracted from the local GP register by CEG, Blizard Institute, April 2017. Data cover residents of Hackney and the City registered with a GP in Hackney, the City of London, Tower Hamlets and Newham. [16]
Note: Only includes GP patients with BMI recorded.

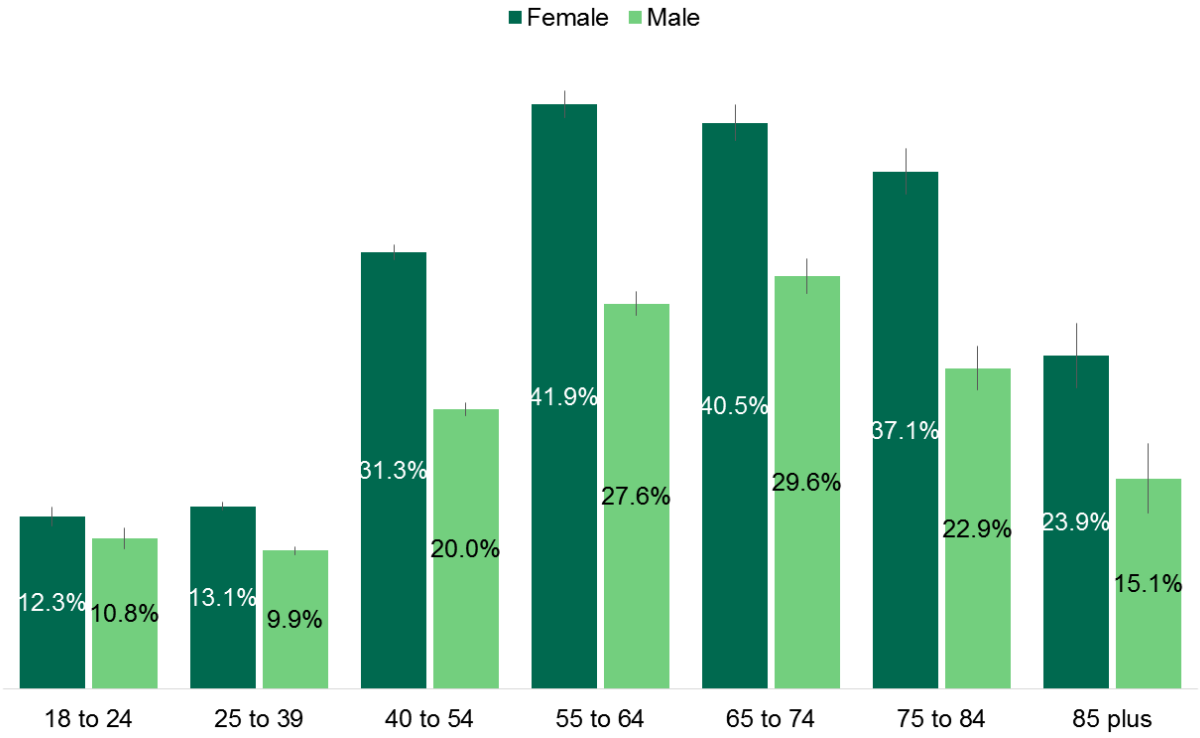
4.4.2 Gender

Figure 4 shows that GP-recorded obesity is significantly higher among women than men across every age group in Hackney and the City. The majority of both females (91.4%) and males (85.7%) have a BMI recorded by their local GP, but the 18–24 age group shows differences by gender (74.2% of females and 59.2% of males have a BMI recorded).

Locally observed gender differences in GP-recorded obesity prevalence are likely to be reflective of a recording bias (males are less likely to visit their GP and therefore less likely to have a recent BMI measure). Nationally reported survey data (*Health Survey for England*) show that males are significantly more likely to be overweight or obese across all age groups; however, females have a slightly higher average BMI score overall. [13]

Overall, locally, 22.7% of women are recorded by their GP to be obese (BMI 30+) and 3.8% as very obese (BMI 40+) – compared with 16.4% and 1.7% of men, respectively.

Figure 4: Percentage of Hackney and the City residents who are recorded as obese (BMI 30+) by their GP, by age group and gender (age 18+, 2017)



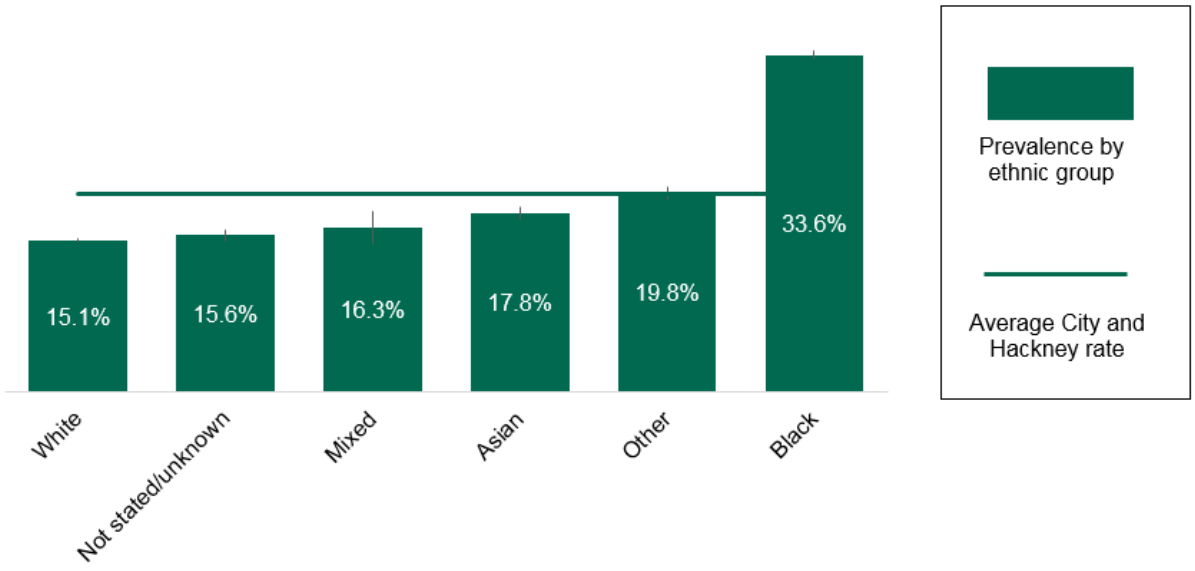
Source: Extracted from the local GP register by CEG, Blizard Institute, April 2017. Data cover residents of Hackney and the City registered with a GP in Hackney, the City of London, Tower Hamlets and Newham. [16]
Note: Only includes GP patients with BMI recorded.

4.4.3 Ethnicity

Please note that 'standard' (whole population) BMI thresholds have been used in the analysis below, which is likely to underestimate the risk of obesity-related poor health in BAME groups.

Among adults, obesity is more prevalent among adults of Black ethnicity than other groups in Hackney and the City (Figure 5). This finding is also reflected in national data. [19] [20] In particular, Black females in Hackney are twice as likely as males to be recorded as obese by their GP.

Figure 5: Percentage of Hackney and the City residents who are recorded as obese (BMI 30+) by their GP, by broad ethnic group (age 18+, 2017)



Source: Extracted from the local GP register by CEG, Blizard Institute, April 2017. Data cover residents of Hackney and the City registered with a GP in Hackney, the City of London, Tower Hamlets and Newham. [16]
Note: Only includes GP patients with BMI recorded.

4.4.4 Sexuality

There is insufficient information on obesity by sexual identity and orientation to draw local inference.

4.4.5 Disability

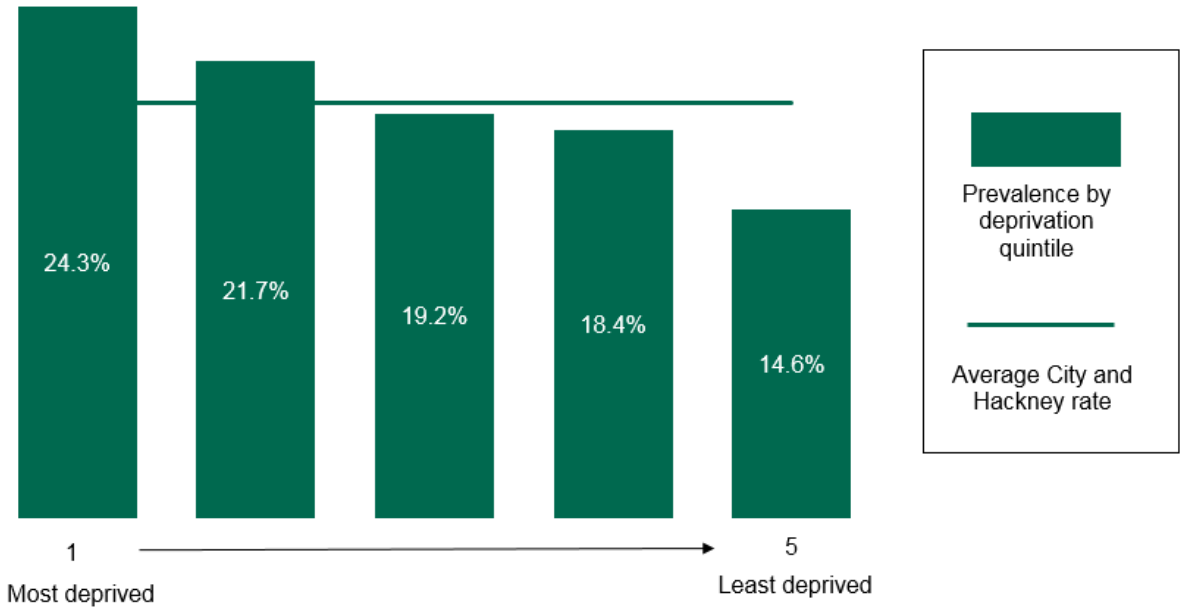
Evidence from the 'Lifestyle and behaviour' chapter of the JSNA suggests that adults with a disability are more exposed to lifestyle risk factors for developing obesity. For example, they are less likely to take part in regular physical activity and may also face difficulties in achieving a healthy diet. [21]

Almost one third (32%) of local adults identified with learning disability by their GP have a recorded BMI that classifies them as 'obese'. [22] This is significantly above the level recorded for other patients.

4.4.6 Socio-economic disadvantage

Figure 6 shows a positive association between GP-recorded obesity and local area deprivation, reflecting national trends. [13] Average prevalence of GP-recorded obesity (among those with a BMI measure) is highest among adults living in the most deprived areas of Hackney and the City, and lowest in the least deprived areas.

Figure 6: Percentage of Hackney and the City residents who are recorded as obese (BMI 30+) by their GP, by deprivation quintile (age 18+, 2017)



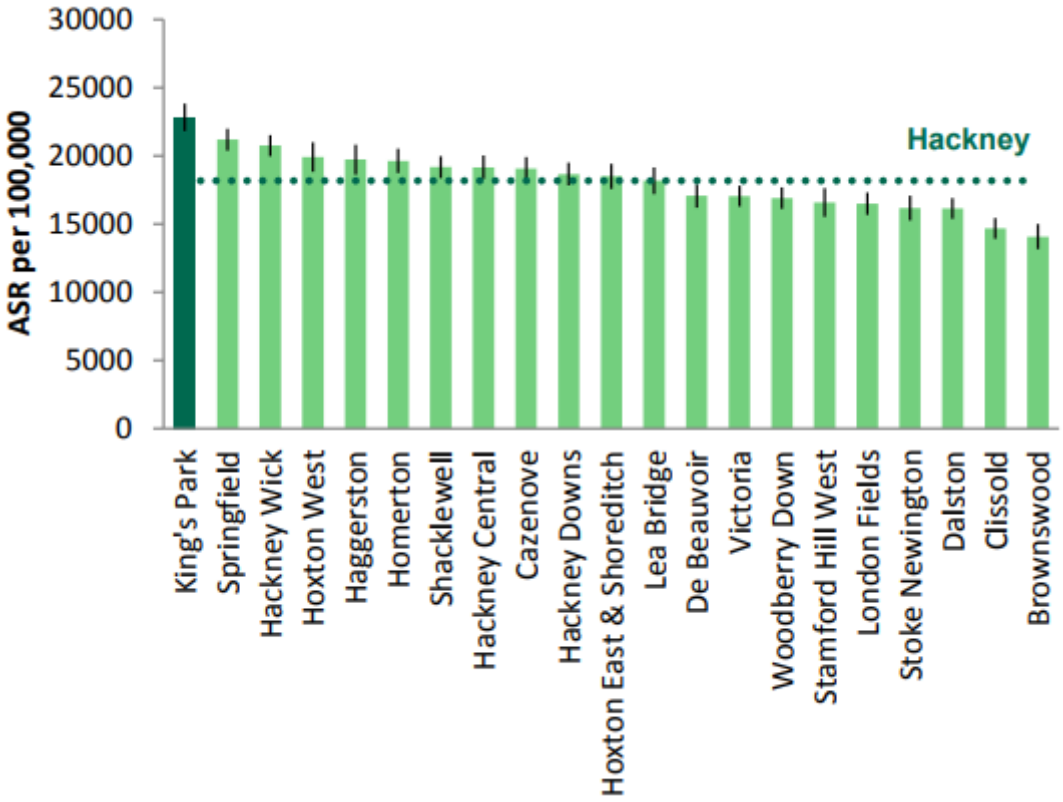
Source: Extracted from the local GP register by CEG, Blizard Institute, April 2017. Data cover residents of Hackney and the City registered with a GP in Hackney, the City of London, Tower Hamlets and Newham. [16]
Note: Deprivation is defined using the Index of Multiple Deprivation 2015 (IMD). IMD is a measure of relative deprivation for small areas that combines 37 separate indicators, each reflecting a different aspect of deprivation. Deprivation groupings are reported from 1 (most deprived) to 5 (least deprived).
Note: Only includes GP patients with BMI recorded.

4.4.7 Location within Hackney and the City

The Hackney health and wellbeing ward profiles describe a range of population health indicators for each ward in the borough. Based on data from 2015, the highest GP-recorded prevalence of obesity is shown to be in King's Park ward (in the south east of Hackney), and the lowest obesity prevalence in Brownswood ward (in the north west) – see Figure 7.

Equivalent ward level data are not yet available for the City of London.

Figure 7: Age-standardised rate of GP-recorded obesity, by Hackney ward (all ages, 2015)



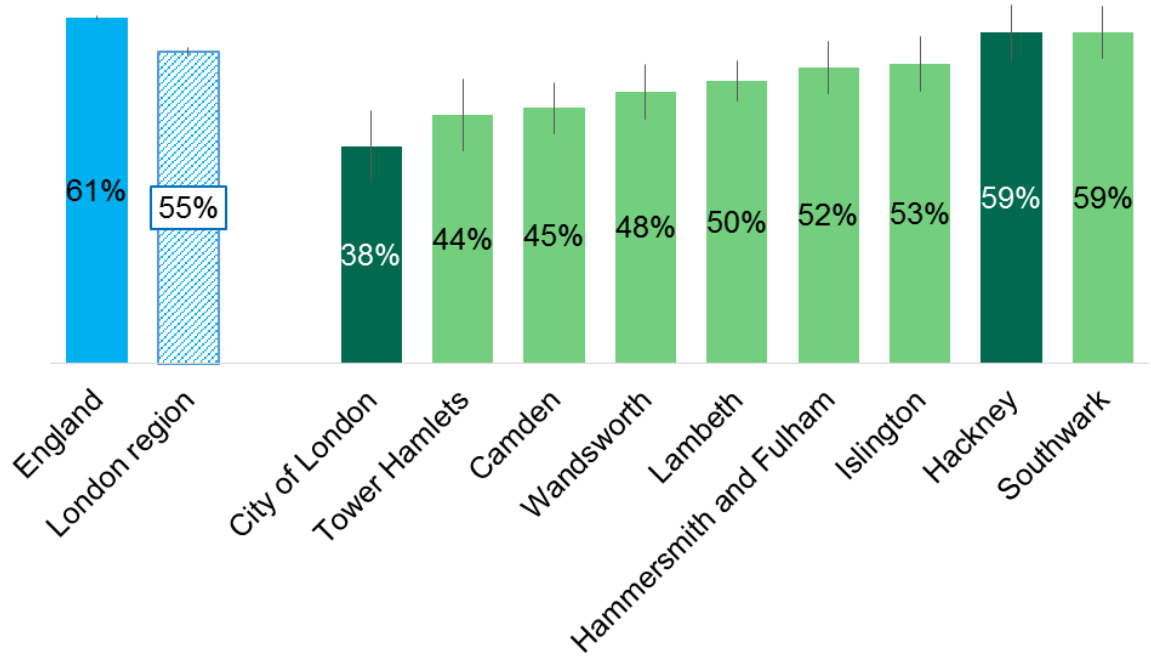
Source: London Borough of Hackney. [23]

4.5 Comparison with other areas and over time

Estimates from the *Active Lives Survey* (see Section 4.3) suggest that the level of adult overweight and obesity in Hackney is among the highest of its statistical peers, and similar to the London and England averages (see Figure 8). The City of London has among the lowest estimated levels of adult overweight/obesity of this comparator group.

While the focus of this chapter is on adults, it is worth noting the high prevalence of child obesity locally, as this is a strong predictor of adult obesity. Hackney and the City school children in Year 6 (ages 10–11) have the eighth highest rates of obesity (out of 32) in London, with local rates (26.6%) significantly higher than the London average (23.6%). [24] A more detailed analysis of child obesity is available in the 'Children and young people' JSNA chapter. [25]

Figure 8: Estimated percentage of the adult population who have a BMI above 25kg/m² (age 18+ 2016/17)



Source: PHE Fingertips. [18]

4.6 Evidence and good practice

4.6.1 Prevention

There is no one 'solution' to preventing obesity; the role of various drivers and interventions interact in a complex way at both a population and an individual level. [7] Preventing and tackling obesity effectively therefore requires the development of a sustained 'whole system' approach – addressing individual, environmental and societal influences – and requires the participation of a broad partnership of stakeholders. *Table 5* outlines the key areas of intervention identified in a 2007 report by the Government Office for Science Foresight Programme. [7]

For more detail on physical activity and dietary interventions that contribute to obesity prevention, please refer to the 'Lifestyle and behaviour' JSNA chapter. Interventions and programmes devised to increase active travel (such as walking and cycling), design local spaces to encourage physical activity and create a more positive food environment are outlined in the 'Society and environment' JSNA chapter.

Table 5: A summary of key target interventions to tackle obesity

Target variable or interconnection	Additional intervention point
Directly reduce the level of 'lock-in' to accumulate and preserve energy	• Increase satiety[3] degree of primary appetite control • Minimise generational effects by optimising maternal body composition and improving the quality and quantity of breastfeeding
Increase physical activity levels	• Enhance the walkability of the living environment • Reduce the dominance of sedentary employment • Mitigate the dominance of sedentary employment • Mitigate the dominance of motorised transport • Improve access to opportunities for physical activity
Reduce the force of dietary habits	• Decrease portion size
Reduce the level of psychological ambivalence	• Reduce the level of perceived information inconsistency around health messages • Improve public understanding of the value of food by incorporating the 'health value' as a clear factor
Additional leverage points	• Education • Change people's potential to graze (snack and eat on the move) • Increase purchasing power • Decrease stress levels

Source: Government Office for Science. [7]

Recommendations for obesity prevention are also set out in guidance from the National Institute for Health and Care Excellence (NICE), framed around the key audiences expected to be engaging with the guidance, including: [26] [27]

- the general public
- local communities
- the NHS
- local authorities and partners in the community
- early years settings
- schools
- workplaces
- self-help, commercial and community programmes
- businesses and social enterprises.

A summary of NICE guidance themes in relation to obesity prevention is provided in Box 2 and
Box 3 below.

[3] Satiety refers to the feeling or sensations of being satisfied having eaten the 'right' amount of food (not too much, not too little).

Box 2: Summary of obesity prevention themes from 'Preventing excess weight gain' (NICE guidance)

- Encourage people to follow current recommendations on physical activity and achieving a healthy diet.[4]
- Encourage good sleep practices, ensuring people are aware of age-specific recommendations on duration of sleep required across the life course.
- Reduce alcohol consumption in adults.
- Encourage methods of self-monitoring to help people understand their body weight and/or factors related to weight (such as physical activity levels or calorie intake).
- Provide sources of accurate information to people who may have concerns about their diet (or that of their friends/family), activity levels or body weight.
- Clearly communicate the benefits of maintaining a healthy body weight, improving physical activity levels and adopting positive dietary habits.
- Tailor messages for specific groups, ensuring all messages are clear, consistent, specific and non-judgemental.
- Adopt an integrated and strategic local approach to obesity.

Source: National Institute for Health and Care Excellence (NICE). [27]

Box 3: Summary of obesity prevention themes from 'Obesity: working with local communities' (NICE guidance)

- Develop a sustainable and community-wide approach to obesity, with clear and visible senior leadership, to ensure high-level commitment to long-term integrated action to prevent obesity.
- A champion's network should be established, with local individuals and organisations that have a particular interest or role in preventing obesity.
- Frontline staff should have dedicated time to deliver specific projects or interventions as part of the obesity prevention agenda.
- Public health teams can facilitate regular opportunities for partners working in related fields (such as transport, leisure, employment and regeneration services) to meet and share learning.
- Local people, groups, businesses and organisations should be involved in deciding what action to take on obesity.
- Commissioners should understand the demographics of their area, and consider local insight on the motivations and characteristics of subgroups.
- Ensure a coordinated local approach to obesity prevention and joined-up services to support effective delivery.
- Local communication leads should ensure obesity prevention messages are easily recognisable to residents.
- Value for money assessments of local action taken to tackle obesity should be a part of every project and initiative.
- Use examples of good practice of obesity prevention from local authorities and the NHS to encourage positive practices for staff and the public.
- Training should be available for local partners, to increase their knowledge of integrated approaches to obesity prevention. Public health teams can facilitate the fostering of a 'learning culture' by supporting the monitoring and evaluation of innovative interventions.

Source: National Institute for Health and Care Excellence (NICE). [26]

[4] See the 'Diet' and 'Physical activity' sections of the 'Lifestyle and behaviour' JSNA chapter.

NICE also recommends that health and care staff should use very brief interventions (30 seconds to a couple of minutes) to motivate people to change behaviours that may damage their health. [28] This is often referred to as 'making every contact count' (MECC) and is an important component of a whole system approach to tackling obesity. MECC is about utilising the opportunities that frontline health and care staff have in their day-to-day interactions with the public to initiate positive conversations about health and wellbeing. It involves skilling up staff in behaviour-change techniques so that they are able to identify opportunities to start these conversations, provide very brief advice, and signpost people to further information and support as needed. A recent consensus statement (signed by Public Health England, NHS England, the Local Government Association, Health Education England, NICE, and others) underlined cross-sector support for all health and care organisations to adopt the MECC approach. [28] [29]

4.6.2 Identification and early intervention

As described in Section 4.6.1, MECC involves training frontline staff to have opportunistic conversations about people's health and wellbeing and, where appropriate, signpost them to local support services. This approach can therefore support early intervention by making sure that people at risk of obesity-related harm receive timely and consistent advice and information.

Specific opportunities to help with the systematic identification and early intervention of obesity in primary care are highlighted by NICE – for example, when someone registers with a GP, has a consultation for a related condition (such as type 2 diabetes) or during other routine health checks. It is recommended that clinical judgement is exercised to decide when to measure a person's height and weight. [4]

A BMI measure of 30+ is recommended to identify obesity in adults. However, for people with a BMI below 35kg/m², waist circumference measures should also be considered. As described in the introduction, people from certain BAME groups are at a greater risk of obesity-related health harms at lower BMI thresholds, and these lower thresholds should be routinely applied in local settings. [5] [4] Also as discussed in the introduction, caution should be used in the interpretation of BMI in people with high muscle density, for whom this is a less reliable measure of excess adiposity (stored fat). [4]

NICE recommends that professionals give adults information about their BMI classification in a clinical setting, and that they are also provided with information on the impact of obesity on the risk of developing other long-term health conditions. [4]

For people identified as overweight or obese, NICE recommends structured, multicomponent weight management programmes – addressing dietary intake, physical activity levels and behaviour change. Although the referral criteria for a multicomponent weight management service can vary locally, it should be available to adults with a BMI over 30 kg/m^2, or lower for those from BAME groups or with other risk factors (including comorbidities such as type 2 diabetes). Where there is capacity, access for adults who are overweight should not be restricted and there should be no upper BMI or upper age limit for the service. [4]

Public Health England (PHE) also endorses the provision of evidence-based, multicomponent lifestyle weight management services, recommending that these are tailored to the needs of the local population. [30] Effective community engagement is recommended to ensure that these needs are fully understood.

4.6.3 Treatment, care and support

NICE clinical guidance recommends that decisions about treatment for obesity take into account a person's preferences and social circumstances, outcomes of previous treatments, level of risk (based on BMI and, where appropriate, waist circumference), plus presence of comorbidities. [31]

Table 6: Tiers of health care service support

Level of support	Service
1	Universal services, such as health promotion or primary care
2	Multicomponent lifestyle intervention
3	Specialist weight management services
4	Bariatric surgery

Much of the guidance for lifestyle weight management services, described in Section 4.6.2, is also relevant to the treatment of obesity for the majority of people affected. For obese patients with complex needs, NICE recommends that the following factors are considered in designing an appropriate programme of treatment: [31]

- the underlying causes of overweight and obesity
- presence of complex disease states and/or needs that cannot be managed adequately in either primary or secondary care
- success or failure of previous 'conventional' treatment in primary or secondary care
- drug therapy for a person with a BMI more than 50 kg/m^2
- whether or not specialist interventions (such as a very low calorie diet for extended periods) are needed/appropriate
- eligibility/suitability of the patient for bariatric surgery (see below).

Bariatric surgery is a procedure to enable weight loss that NICE recommends as a treatment option for people with severe obesity, provided they meet certain criteria. [31] Bariatric surgery is available for people who are very obese with complex needs, when all appropriate non-surgical measures have been tried but have failed to achieve or maintain adequate, clinically beneficial weight loss.

NICE recommends that the choice of surgical intervention should be made jointly by the patient and the clinician, with clear information presented about the potential benefits and associated risks, as well as the longer-term implications of surgery. [4] Priority bariatric assessments are recommended to expedite referrals for people with a BMI ≥35 and diagnosed with type 2 diabetes in the last 10 years. NICE also emphasises the importance of regular, specialist post-operative monitoring within the bariatric service for a minimum of two years. [31]

4.7 Services and support available locally

4.7.1 Prevention

The ‘Society and environment’ and ‘Lifestyle and behaviour’ chapters of the JSNA describe how Hackney Council and the City of London Corporation are working to change the local environment to promote positive dietary behaviours and physical activity (key factors in preventing obesity). This includes interventions to make healthier eating easier (such as limiting the spread of fast food takeaways through town planning restrictions), and to facilitate active travel (through changes to street infrastructure to promote walking and cycling). This approach recognises the role of wider influences on individual behaviours within the local obesity system.

In Hackney, the Obesity Strategic Partnership (OSP) was established in 2016 to formulate and lead a whole system approach to tackling obesity in the local area. The Hackney OSP is chaired by the chief executive of Hackney Council, and brings together strategic partners who play a role in influencing the local obesity system. It is a cross-cutting partnership, whose current membership includes leaders from transport, planning, regeneration, communications, housing, public realm, parks and leisure, children and adult social care, public health, education, and the NHS.

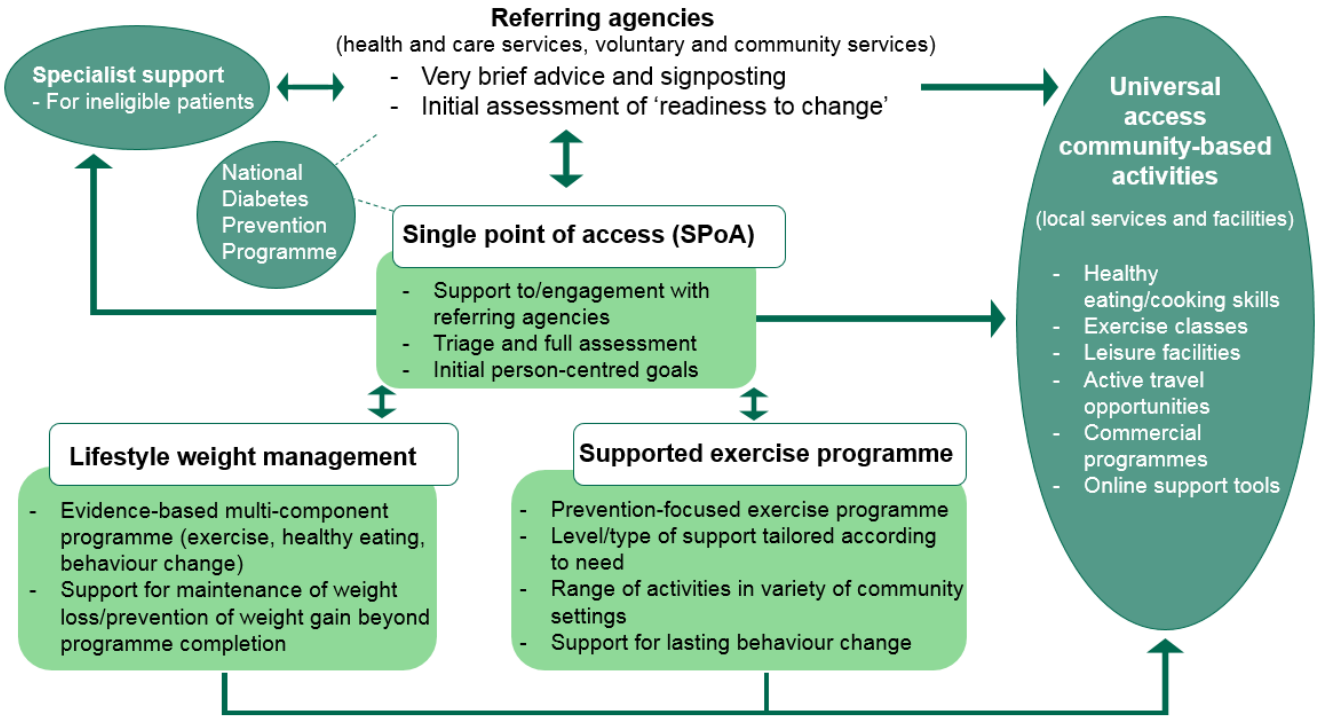
Hackney and the City support a range of individual and group-based interventions for adults relating to improving diet and increasing physical activity – such as community kitchens/cook-and-eat classes, a low-cost healthy recipe pack scheme, exercise classes (including for beginners, older people and families), cycle training and walking groups. These operate in community halls, leisure centres and other spaces, with many seeking to target groups at highest risk of obesity. More detail on these services and interventions is provided in the ‘Lifestyle and behaviour’ JSNA chapter.

4.7.2 Identification and early intervention

Referral-based services relevant to the identification and early intervention of obesity are in place in both Hackney and the City. This includes an integrated weight management and exercise on referral programme commissioned by each local authority (see ‘Lifestyle and behaviour’ JSNA chapter for details).

The Hackney weight management and physical activity ‘pathway’ is outlined in Figure 9 below; a similar pathway operates in the City.

Figure 9: Local weight management and physical activity pathway



Source: City and Hackney Public Health Team.

Council-commissioned adult weight management and exercise on referral services also adopt MECC principles by working with referrers (primarily health and care professionals) to better equip them to: raise the issues of weight and physical inactivity in a respectful and non-stigmatising way; provide very brief advice; and signpost or make effective referrals to appropriate local services.

Local delivery of the NHS Health Check programme also provides a vehicle for identifying overweight and obesity in adults aged 40 to 74, and providing advice and support to help prevent associated health problems (for example, through referral to local lifestyle services). There have been significant improvements in the performance of the local NHS Health Check programme in recent years. In the five years to 2017/18, 60.2% of people eligible for an NHS Health Check in Hackney had received one, which is significantly above the London average (49.3%). For the City of London, 56.5% of eligible people had received an NHS Health Check over this period. [32]

4.7.3 Treatment, care and support

City and Hackney Clinical Commissioning Group (CCG) commissions Homerton Hospital to provide a community-based nutrition and dietetic service for adults and older people in accordance with clinical criteria, focusing on those patients with associated physical and psychological needs. The service is accessed via referral by health or social care staff. The service provides dietetic assessment, diagnosis and treatment interventions for adults whose obesity-related needs exceed the referral criteria for local lifestyle weight management services.

There is currently no specialist multidisciplinary weight management service for people with complex needs in the City and Hackney. This gap has been identified locally and a review of the complex obesity pathway is underway to better understand local needs and inform service planning.

Bariatric surgery is also provided by Homerton Hospital, with commissioning responsibility recently transferring from NHS England to the CCG. Around 50 patients per year from Hackney and the City undergo bariatric surgery at the Homerton. Patients who are assessed as eligible for bariatric surgery (based on clinical and psychological criteria), have made unsuccessful attempts to lose weight using other methods, and who choose to go ahead with the procedure, are set a 5% weight loss target within 3-6 months prior to surgery.

4.8 Service gaps and opportunities

A gap has been identified in the obesity pathway for patients with complex needs who need a specialist multi-disciplinary service. The new Hackney and the City integrated commissioning programme provides an exciting opportunity for partners to work together to address this issue, and work has already begun to find a solution.

Integrated commissioning is also throwing up many other opportunities for much closer working between partners to improve the health of local people, with a renewed focus on prevention and supporting people to look after their own health. A key priority of the new system is to develop a comprehensive programme to embed MECC principles in all service delivery. This will play a major role in obesity prevention, identification and early intervention.

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