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Key Performance Indicators: Tier 2 Weight Management Services for Adults

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Introduction

This document provides an example of the Key Performance Indicators (KPIs) which could be incorporated into a specification for a tier 2 adult weight management service. The KPIs proposed in this document are intended to be used in conjunction with a service commissioned and delivered in line with the Public Health England (PHE) Guide to Delivering and Commissioning Tier 2 Adult Weight Management Services. It is envisaged that commissioners and providers can utilise this guide to develop tier 2 adult services, which co-exist with other services in a local obesity care pathway.

This KPI set has been developed to support the delivery of adult weight management services through the collection of robust data, which contributes to the evidence base on the impact, including long term effectiveness, of such services.

It is intended that the proposed KPIs may evolve as the evidence base develops. Commissioners and service providers are therefore encouraged to publish details of their local practice and outcomes data, as appropriate, to help inform any future development of these KPIs.

It is recognised that some of these suggested KPIs, such as KPIs 9 and 10, relating to participant weight loss at the end of the active intervention and the provision of weight measures at 6 and 12 months post active intervention respectively, may be stretching. KPIs should be determined based on local needs, and should reflect how the service is commissioned, for example, if certain population groups are targeted. Local consideration should always be given when applying the proposed KPIs, which are intended to be used to assess the whole commissioned service.

This document has been developed in consultation with weight management service providers and commissioners following consideration of real world service data and published research data.

This document builds upon and supercedes the KPIs outlined in the Department of Health Developing a Specification for Lifestyle Weight Management Services: Best Practice Guidance for Tier 2 Services document.[1]

Definitions

Referred but not enrolled: service provider received the referral but individual did not wish to enrol on the service or did not meet the eligibility criteria

Enrolled: individual has been referred or self-referred to the service and has been booked onto the service by the provider

Participant: individual who attended at least one session

Completer: individual who attended at least 75% of all sessions

Active Intervention: the pre-defined weight management service, that doesn't include follow up

Follow up: the period after the active intervention

[1] Department of Health (2013) Developing a Specification for Lifestyle Weight Management Services: Best Practice Guidance for Tier 2 Services. Available at: https://www.gov.uk/government/publications/best-practice-guidance-for-weight-management-services

Table 1: Summary of Key Performance Indicators

	Key Performance Indicator
1.	100% of participants enrolled in the service meet, as a baseline, the eligibility criteria as defined in the PHE Guide to Delivering and Commissioning Tier 2 Adult Weight Management Services.
2.	60% of participants complete the active intervention.
3.	100% of commissioned services are developed using specialists, as defined in the PHE Guide to Delivering and Commissioning Tier 2 Adult Weight Management Services.
4.	100% of staff receive training specific to the proposed service.
5.	XX% of individuals enrolled in the service are from identified high risk groups (please insert locally defined figures for: low income, Black and Minority Ethnic communities, individuals with disabilities, individuals with mental health conditions).
6.	100% of participant data is recorded, analysed and reported in line with the minimum dataset outlined in the PHE Guide to Delivering and Commissioning Tier 2 Adult Weight Management Services.
7.	i) 100% of enrolled participants are invited to provide feedback at the end of the active intervention. The tool used should be locally agreed, and could for example be the NHS family and friends test or equivalent. Additional (optional) indicator: ii) At least XX% of enrolled participants provide feedback (please insert locally defined figures).
8.	75% of participants will have lost weight at the end of the active intervention.
9.	i) 30% of all participants will lose a minimum of 5% of their (baseline) initial body weight, at the end of the active intervention. Additional (optional) indicator: ii) 50% of completers will lose a minimum of 5% of their (baseline) initial body weight, at the end of the active

		intervention.
10.	i) ii)	35% of completers provide a weight measure at 6 months. 20% of completers provide a weight measure at 12 months.
11.	XX% of completers at 12 months have a body weight that is lower than their (baseline) initial body weight (please insert locally defined figure).	

Table 2: Key Performance Indicators and supporting narrative

	Key Performance Indicator	Supporting narrative
1.	100% of participants enrolled in the service meet, as a baseline, the eligibility criteria as defined in the PHE Guide to Delivering and Commissioning Tier 2 Adult Weight Management Services [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/623091/Tier2_adult_weight_management_services__guide.pdf].	Evidence based practice, outlined in National Institute for Health and Care Excellence (NICE) guidance[2], on measuring overweight and obesity should be used. Body Mass Index (BMI) should be measured, and in addition measuring waist circumference in individuals with a BMI less than 35 kg/m^2 should be considered. Eligibility criteria is defined as: Adults with a BMI ≥30 kg/m^2. Where there is capacity: • Adults with a BMI ≥25 kg/m^2 should be able to access the service. • Adults with a BMI ≥23 kg/m^2 of black-African, African-Caribbean and Asian family origin should be able to access the service, as individuals from these groups are at an increased risk of conditions such as type 2 diabetes at a lower BMI. • Consider lower eligibility criteria for individuals with other health conditions, such as comorbidities, including type 2 diabetes. There should be no upper BMI or upper age limit for individuals accessing the service, however for patients with severe or complex obesity, consider referral to a tier 3 specialist weight management service if one is available. Services should not exclude, and should make reasonable adjustments for individuals with physical and learning disabilities and individuals with mental ill health.

[2] National Institute for Health and Care Excellence (2014) Clinical Guideline 189: Obesity: identification, assessment and management. Available at: https://www.nice.org.uk/guidance/cg189

2.	60% of participants complete the active intervention.	Completion is measured as attendance of at least 75% of all sessions during the active intervention. It is recommended that commissioners or service providers do not stipulate that specific sessions must be attended to allow for periods of sickness, holidays, clashes with commitments etc. to occur at any point during the active intervention.
3.	100% of commissioned services are developed using specialists, as defined in the PHE Guide to Delivering and Commissioning Tier 2 Adult Weight Management Services [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/623091/Tier2_adult_weight_management_services__guide.pdf].	Specialists may include some of the following experts as defined in the PHE Guide to Delivering and Commissioning Tier 2 Adult Weight Management Services; a registered nutritionist, dietitian, behaviour change expert, and physical activity specialist.
4.	100% of staff receive training specific to the proposed service.	It is important to consider the training needs of individual staff relating to their level of involvement and interaction with participants, and to ensure staff members receive training appropriate to their role in the service. For example, staff responsible for booking participants onto the service will have different training needs to staff facilitating the service. If using nutrition professionals, it is important to ensure that they are appropriately trained and can select and apply appropriate communication methods to explain reliable evidence-based healthy eating guidelines. The UK Register of Dietitians and Voluntary Register of Nutritionists can be found through the British Dietetic Association (https://www.bda.uk.com/) and the Association for Nutrition (http://www.associationfornutrition.org/) respectively, which can help when deciding

		which professionals deliver this component of the service. The Association for Nutrition additionally provides a competence framework for the wider workforce[3]. If delivering physical activity, ensure that the facilitators are appropriately trained and tailor the type, duration, intensity and format of activity to the population needs.
5.	XX% of individuals enrolled in the service are from identified high risk groups (please insert locally defined figures for: low income, BME communities, individuals with disabilities, individuals with mental health conditions).	This KPI is for local determination. In order to facilitate the referral of individuals from identified high risk groups, commissioners should support service providers to actively engage and promote awareness of tier 2 weight management services locally with all health and social care professionals. Commissioners should support service providers to raise awareness of tier 2 weight management services among the local target population, as outlined in the PHE Guide to Delivering and Commissioning Tier 2 Adult Weight Management Services [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/623091/Tier2_adult_weight_management_services__guide.pdf] Both commissioners and providers should consider undertaking Equality Impact Assessments to ensure that the needs of protected characteristics are considered. In addition local areas should consider undertaking health equity audits of service provision to identify areas in which services may not be equitable. To ensure high risk individuals are accessing the service, commissioners and service providers should aim to ensure that the proportion of participants attending their service align with the local population prevalence indicators derived from the PHE fingertips tool [https://fingertips.phe.org.uk/]. Examples may include: Asian or Asian British ethnic group: % of population (from crisis care profile)

[3] The Association for Nutrition competence framework for the wider workforce can be accessed at: http://www.associationfornutrition.org/Default.aspx?tabid=300

		Black or Black British ethnic group: % of population (from crisis care profile) Long term health problem or disability: % of population (Mental Health Joint Strategic Needs Assessment) Percentage people living in 20% most deprived areas in England (from Public Health Outcomes Framework)
6.	100% of participant data is recorded, analysed and reported in line with the minimum dataset outlined in the PHE Guide to Delivering and Commissioning Tier 2 Adult Weight Management Services [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/623091/Tier2_adult_weight_management_services__guide.pdf]. This includes: collecting and reporting participant demographics, and participant anthropometrics and well-being outcomes pre, post intervention and at 6 and 12 months follow up.	This KPI aims to ensure all required data fields in the minimum dataset are completed for all participants. Providers should make every effort to provide data within each required field. If participants data is not captured or missing, for example, for those who do not attend or disengage from the service, this KPI will be achieved, as long as it is reported as such.
7.	i) 100% of enrolled participants are invited to provide feedback at the end of the active	Commissioners and service providers should consider and explore a range of communication methods to engage with participants in order to collect feedback and these should be tailored to participant preferences, as groups may prefer different contact methods. It may therefore be helpful to consider a range of contact methods

	intervention. The tool used should be locally agreed, and could for example be the NHS family and friends test or equivalent. Additional (optional) indicator: ii) At least XX% of enrolled participants provide feedback (please insert locally defined figures)	such as: print, phone calls, email, text messages or use of social media networks. Commissioners should work with providers to ensure that the feedback collected is considered and acted upon in order to improve the service. Commissioners are encouraged to work with service providers to set a KPI (7ii) related to the percentage of enrolled participants who provide feedback. It is recommended that local consideration is given when applying this KPI as this may be considered a stretching KPI for services depending upon target population groups.
8.	75% of participants will have lost weight at the end of the active intervention	Last observation carried forward (LOCF) analysis should be applied to all participant measures at the end of the active intervention, including participants who do not complete the service by measure of the definition provided[4]. LOCF imputes the last weight achieved. Whilst this may be the baseline for those participants who only attend one session (which results in no weight loss) it is important that these participants are included as their attendance has had an economic impact on the service. LOCF analysis enables demonstration of the full impact of the service on weight loss achieved by participants i.e. including those who do not complete the service by measure of the definition provided, but achieve weight loss. This is particularly beneficial where services record measurements regularly throughout the intervention, as this will help demonstrate the impact for those who do not complete the service by measure of the definition provided, but still achieve

[4] Attendance of at least 75% of all sessions.

		weight loss. Anthropometric data collected during the active intervention including measures of weight should be measured and recorded by the service provider. The use of self-reported data is not recommended during the active intervention.
9.	i) 30% of all participants will lose a minimum of 5% of their (baseline) initial body weight, at the end of the active intervention. Additional (optional) indicator: ii) 50% of completers will lose a minimum of 5% of their (baseline) initial body weight, at the end of the active intervention.	Last observation carried forward (LOCF) analysis should be applied to all participant measures at the end of the active intervention, including participants who do not complete the service by measure of the definition provided[1]. LOCF imputes the last weight achieved. Whilst this may be the baseline for those participants who only attend one session (which results in no weight loss) it is important that these participants are included as their attendance has had an economic impact on the service. LOCF analysis enables demonstration of the full impact of the service on weight loss achieved by participants i.e. including those who do not complete the service by measure of the definition provided, but achieve weight loss. This is particularly beneficial where services record measurements regularly throughout the intervention, as this will help demonstrate the impact for those who may attend some, but not all of the service, but still achieve weight loss. Anthropometric data collected during the active intervention including measures of weight should be measured and recorded by the service provider. The use of self-reported data is not recommended during the active intervention. Commissioners are encouraged to include an additional indicator (9ii) related to the percentage of completers who lose a minimum of 5% of their (baseline) initial body weight at the end of the active intervention.

			It is recommended that local consideration is given when applying this KPI as this may be considered a stretching KPI for services depending upon target population groups.
10.	i) ii)	35% of completers provide a weight measure at 6 months 20% of completers provide a weight measure at 12 months	Ideally, anthropometric data including measures of weight should be measured and recorded by the service provider, to eliminate the risk of recall bias. However, given the challenges around collecting follow up data; participant self-reported measures of weight are acceptable. Where self-reported data is used, it should be recorded on the minimum dataset as such. Data to support the long-term impact of weight management services is limited and can be difficult to obtain. Therefore, commissioners should consider prioritising the collation of this data when setting out to procure services and work with service providers and other local partners to help achieve this KPI. Service providers are advised to inform participants at the start of the programme that follow up data will be required, and to stress that this data is an important measure of the maintenance of behaviours learnt on the programme. It is therefore important to return for measurements even in the case of weight regain. Service providers should consider ways of maintaining engagement with individuals after they have completed the service to ensure that their progress continues to be monitored. Service providers may wish to explore a range of communication methods to maintain contact with participants and these should be tailored to participant preferences, as groups may prefer different contact methods. It may therefore be helpful to consider a range of contact methods such as: print, phone calls, email, text messages or use of social media networks. Whilst this KPI has been set for completers to give a fair reflection of the service, this data should be contextualised with the completion KPI (2). Data from participants

		who have not met the completion criteria should still be collected and recorded where possible. It is recommended that local consideration is given when applying this KPI as this may be considered a stretching KPI depending upon target population groups. This KPI reflects what an established service can achieve and commissioners and service providers are encouraged to publish details of their local practice and outcomes data, as appropriate, to help inform the development and monitoring, in particular, of this KPI.
11.	XX% of completers at 12 months have a body weight that is lower than their (baseline) initial body weight (please insert locally defined figure).	Commissioners and service providers are strongly encouraged to work together to develop a local metric for this KPI. Given the chronic and relapsing nature of obesity, it is recommended that services are commissioned and delivered to support long term maintenance of weight loss. Therefore, when setting this KPI, it is important to consider that the majority of completers at 12 months should have a body weight that is lower than their (baseline) initial body weight, if the service is clinically and cost effective. Data from completers, who attend follow-up, whist valuable, provides a biased picture of weight loss. To deal with this, baseline observation carried forward (BOCF) analysis should be applied for any participants who do not return for follow up. BOCF imputes that anyone who did not attend follow up weighed the same at follow up as at baseline i.e. no weight lost. Women who become pregnant during the follow-up period should be excluded from this KPI. Data to support the long-term impact of weight management services is limited and can be difficult to obtain, however evidencing a sustained downward trend in body

		weight is one important measure of the success of services. Therefore, service providers are advised to inform participants at the start of the programme that follow up data will be required, and to stress that this data is an important measure of the maintenance of behaviours learnt on the programme, therefore it is important to return for measurements even in the case of weight regain. Service providers should consider ways of maintaining engagement with individuals after they have completed the service to ensure that their progress continues to be monitored. Service providers may wish to explore a range of communication methods to maintain contact with participants and these should be tailored to participant preferences, as groups may prefer different contact methods. It may therefore be helpful to consider a range of contact methods such as: print, phone calls, email, text messages or use of social media networks. It is recommended that local consideration is given when applying this KPI so a suitable metric is agreed and takes into account the target population groups.

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