Received: 30 June 2023 | Revised: 1 September 2023 | Accepted: 16 November 2023

DOI: 10.1111/cob.12629

ORIGINAL RESEARCH

Clinical OBESITY WILEY

A cross-sectional survey study exploring provision and delivery of expanded community tier 2 behavioural weight management services in England

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Funding information
National Institute for Health and Care Research (NIHR) Applied Research Collaboration (ARC) North East and North Cumbria, Grant/Award Number: NIHR200173

Summary

Guidelines recommend provision of local behavioural weight management (tier 2) programmes for adults living with overweight and obesity. Following the publication of the UK Government's publication 'Tackling Obesity: empowering adults and children to live healthier lives' in July 2021, Government invested around £30 million of additional funding to support the expansion of local authority commissioned tier 2 provision for adults living with excess weight. We conducted a cross-sectional survey study to scope the types of services available, to whom they were made available, and barriers and facilitators to service delivery. An e-survey was disseminated to local authority commissioned tier 2 service providers in England from September to October 2022. Through a combination of closed and open (qualitative) questions, the survey collected data on referral routes, participant eligibility criteria, service content and format, and challenges and enablers to service delivery. Quantitative data were analysed descriptively whilst thematic content analysis was applied to qualitative data. We received 52 responses (estimated response rate = 59%) representing all nine England regions and 89 unique local authorities. Most services were multi-component (84.3%), were 12 weeks duration (78.0%), were group-based (90.0%), were primarily delivered in-person (86.0%), and were free to participants (90.2%). Five responses indicated provision of support for other health and wellbeing issues, for example, mental health, assistance with debt. To improve future WMS service commissioning and delivery, WMS providers need to be allowed adequate time and resource to properly prepare for service delivery. Referral systems and criteria should be made clear and straightforward to both referrers and service users, and strategies to manage surplus referrals should be explored.

KEYWORDS
obesity, service delivery, weight management services

What is already known about this subject?

- UK guidelines recommend provision of local behavioural weight management (tier 2) services for adults living with overweight or obesity.
- In 2021/22, the UK government announced an investment of £100 million to support children, adults and families to achieve and maintain a healthier weight. This included around £30 million additional funding to support the expansion of local authority-commissioned, community-based tier 2 provision in England via the 2021/22 adult weight management services grant.
- This funding was provided to local authorities during the COVID-19 response and local authorities were required to commission and deliver services at pace and scale. The adult weight management services grant was not renewed for the following financial year because funding was reprioritized to support the UK Government's living with COVID-19 strategy.

What this study adds?

- This scoping study provides insight into the types of services available, to whom they were made available, and barriers and facilitators to service delivery from service provider perspectives in the context of the new grant.
- Whilst tier 2 services were similar in terms of their duration, format and mode of delivery, there was variation in participant eligibility criteria and programme content between and within services. Several programmes provided support for other health and wellbeing issues such as debt assistance, mental health and smoking cessation.
- To improve future WMS commissioning and delivery, WMS providers need to be allowed adequate time and resource to properly prepare for service delivery. Referral systems and criteria should be made clear and straightforward to both referrers and service users. Strategies to manage surplus referrals should be explored to reduce the likelihood that participants disengage with the service and lose motivation whilst waiting for vacancies.

1 | BACKGROUND AND CONTEXT

Obesity remains a significant public health issue in England; on average around one in five adults are classified as having obesity, although in the most deprived areas of the country this is closer to one in three adults.[1] System-wide, cross-sector action is needed to address obesity, and this includes supporting the local delivery of evidence-based, effective and sustainable weight management services (WMS), as recommended by the National Institute for Health and Care Excellence (NICE).[2] In the United Kingdom (UK), obesity management is conceptualized as a tiered model: tier 1 involves universal preventative action, tier 2 services are behavioural weight management programmes, tier 3 services are clinician-led, specialist services and tier 4 services involve bariatric surgery for those living with severe obesity. Tier 2 services are considered the first line treatment for those living with excess weight; the recommended body mass index (BMI) referral criteria is BMI ≥30 kg/m^2, and where there is capacity, adults with a BMI ≥25 should also be able to access services[2] although eligibility criteria depends on the need of the local population. They are generally delivered in community settings and promote weight loss by providing participants with basic skills and knowledge on healthy eating, physical activity and/or behavioural change.[2] There is robust evidence showing that these programmes are effective at producing clinically significant weight loss that is sustained up to 12 months in both trial and everyday settings.[3]

Provision of tier 2 WMS is based on local needs and priorities but is not statutory. Following a significant reorganisation of NHS structure in 2013, the responsibility for public health including the commissioning of tier 2 WMS moved to local government in England.[4] In some cases, tier 2 services are in-house, that is, both they are both commissioned and provided by the local authority. In 2015, a national service mapping exercise found that 61% of local authorities reported providing or commissioning a tier 2 service, although provision varied geographically within and between England regions.[5] Two-thirds of services were multi-component, and most were delivered over 12 weeks in group sessions. More detailed information on service content was not reported. Most respondents reported a minimum eligibility criterion of BMI > 30 followed by BMI > 25 and the most popular referral routes were through GPs, practice nurses and/or other health care professionals (HCPs) and self-referral. For most services, the average costs to participants were <£100.[5]

Since this mapping work was conducted, there have been significant changes to tier 2 service funding and provision. In 2020, new evidence on the association between obesity and poor COVID-19 outcomes emerged, and in July 2020 the Government published 'Tackling Obesity: empowering adults and children to live healthier lives'.[6] As part of this, the UK government announced a £100 million investment for an enhanced service for weight management to support children, adults and families to achieve and maintain a

healthier weight. This included over £70 million investment into WMS including a new NHS digital weight management programme, expansion of the Diabetes Prevention Programme, and expansion of the existing local authority Tier 2 WMS offer through the 2021/22 adult WMS grant.[7] Historically, funding for local authority WMS has come from a central public health grant, which can be spent at the discretion of the local authority to best meet the needs of their local population; however, this new grant was ring-fenced specifically for introducing new or expanding existing tier 2 WMS provision. Local authorities who accepted the new adult WMS grant were able to access funding from March 2021 until the end of the UK financial year in April 2022. Any underspend was accessible until December 2022. GP practices that signed up to the weight management enhanced service were entitled to a payment per referral to eligible services including the local authority offer.[7] The tier 2 services were required to reflect NICE guidelines, namely: be multi-component programmes that addressed dietary intake, physical activity, and behaviour change with the primary aim of promoting health behaviour change for weight loss. Whilst provision for specific population groups was not required, Public Health England (disbanded and responsibilities for diet and healthy weight transferred to the Office for Health Improvement and Disparities (OHID) from October 2021) encouraged services to prioritize higher risk groups including men, people living in deprived areas, people from Black, Asian and Minority Ethnic groups, people living with serious mental illness and people living with physical and/or learning disabilities. As a condition of the grant, all commissioned service providers were required to collect and submit data, including participant characteristics and weight outcomes for all participants and their progress, to OHID's Minimum Data Set.[8] Data on the content and nature of the services were not collected through the minimum data set.

The adult WMS grant was available for the 2021/22 financial year, meaning services needed to be commissioned, set up and delivered at pace. At the same time, public health teams were also under pressure to coordinate intensive COVID-19 responses, which involved significant mobilisation and reconfiguration of public health resource and services, whilst some had decommissioned their WMS years ago and were, therefore, starting from scratch. Given significant changes to tier 2 service provision and the unique context in which services were delivered, this scoping study aimed to characterize the local authority commissioned tier 2 adult WMS available in England, ascertain to whom they were made available, and to understand the barriers and facilitators to service delivery from the perspective of the WMS providers in the context of the newly implemented enhanced service for weight management. This research is important to understand how the new grant was used, and how future WMS commissioning and delivery can be improved. Importantly, after commencement of this study, public health teams within local authorities were notified that this new adult WMS grant was not going to be renewed for the financial year 2022/23, because funding was reprioritized to fund the UK government's Living with COVID-19 Strategy.

2 | METHODS

2.1 | Survey development and content

An e-survey was developed and hosted on Qualtrics (Data S1). Survey development was informed by previous work in this area, and meetings with academics in the field and key stakeholders within the OHID 'Diet, Obesity and Healthy Behaviours' directorate. The survey was piloted with various key stakeholders such as Public Health and Social Care leads and experts in obesity and WMS who were not included in the final survey sample. Several public advisors also reviewed the survey and provided feedback on its acceptability, usability and comprehensibility. Survey items covered several broad themes including details of the commissioning local authority and the name of the service (voluntary), referral route(s), marketing/advertising strategies, target group and participant eligibility criteria, aim of service and a description of what was offered, mode and format of delivery, costs to participants, and challenges and enablers to service delivery. For open-ended qualitative questions, participants were able to provide a written response or a verbal response via embedded voice note software,[9] which automatically generated a transcription. To encourage response rate and as gratitude for completing the survey, a donation of £3 per response was made by the research team on participants' behalf to a charitable organisation who fight against hunger and the cost-of-living crisis in the UK.

2.2 | Survey distribution

An e-survey was disseminated to all local authority tier 2 adult WMS providers in England who were commissioned between 2021 and 2022 and funded by the new 'adult weight management services' grant. The approach used to disseminate the survey was informed by discussions with OHID who agreed to support dissemination. This approach was taken to effectively target respondents, leverage existing communication channels and maximize response rate. The OHID national team forwarded an invite email (highlighting that they were sending the survey on behalf of independent researchers), information sheet and link to the e-survey to the OHID regional 'healthy weight and physical activity leads', who in turn, cascaded it to local authority healthy weight leads and commissioners within their patch. The local authority healthy weight leads and commissioners then distributed the survey to the adult WMS providers they commissioned to complete the survey. In the case where a tier 2 service was an in-house service, that is, both commissioned and provided by the local authority, the survey was completed by the appropriate person within the local authority. Service providers were asked to complete a separate survey for each unique programme they offered. They were also able to select multiple local authorities in the instance where they had been commissioned by more than one. The survey was live from 12 September 2022 to 14 October 2022. Two reminder emails were sent (2 weeks apart) to OHID regional leads and service providers via the OHID national team.

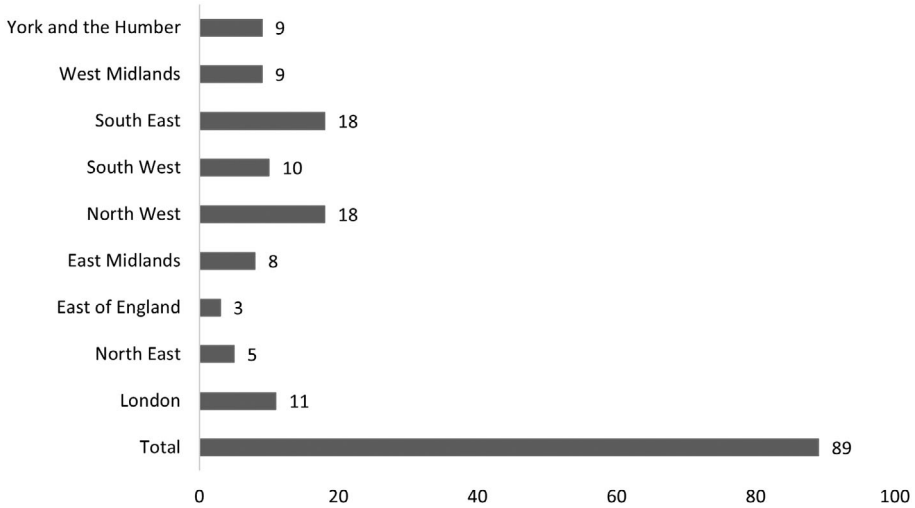

FIGURE 1 Number of local authorities within each England region represented by survey data.

2.3 | Ethics

Ethical approval was granted by Newcastle University Faculty of Medical Sciences Research Ethics Committee (Ref: 2401). Before participating in the study, all survey respondents provided their informed consent.

2.4 | Data cleaning and analysis

Where survey data were ambiguous, they were corroborated with information published on service provider websites or clarified through direct communication with the service provider. Quantitative survey data were analysed in Microsoft Excel using descriptive statistics. To provide a crude estimate of response rate, we used data from OHID's minimum data set to which all tier 2 providers in the country were required to submit data. Based on this, there were a total of 152 service providers in England at the time of survey completion.[8] The 152 providers were used as an estimate of the denominator for the response rate. Qualitative data were entered into matrix display tables, which allows for easy viewing and detailed analysis.[10] Findings were grouped and summarized and themes and sub-themes identified. Content analysis[11] was applied to the sub-themes to identify patterns and trends. We reported tallies to indicate how many times a response was attributed to a sub-theme. This does not mean that those who do not report information relating to an identified theme, do not/have not carried out a process or have experienced an issue relating to a theme, but that it was not explicitly reported in the survey.

3 | RESULTS

We received a total of 52 responses. All nine England regions and 89 unique local authorities were represented in survey data. The estimated response rate was 59%. Figure 1 shows the number of local authorities within each region represented by the survey data. Five responses did not indicate the commissioning local authority and one commercial service provider reported being commissioned in over 100 local authorities, but these were not all reported. In total, there were 42 unique providing organisations and 37 unique WMS.

3.1 | Types of services ($n = 52$)

A total of 49 (94.2%) responses indicated the service was currently being delivered, whilst three indicated the service was no longer being delivered by 14 October 2022. Most providers were in-house local authority providers ($n = 22$; 42.3%) followed by voluntary, community, social enterprise (VCSE) ($n = 13$; 25.0%) and commercial organisations ($n = 11$; 21.2%). Other providers were a combination of these or NHS programmes.

3.2 | Participant eligibility criteria

Forty-nine (of $n = 51$ responses; 94.2%) responses indicated that people identifying as any sex were eligible to participate in the programme; two (3.9%) responses indicated that the service was for men only. Most responses ($n = 46/50$; 92.0%) indicated a minimum age criteria of 18 years; the oldest minimum age was 35 years. Most ($n = 35/50$; 70.0%) did not have a maximum age criteria, of the 15 (30.0%) that did, the maximum age ranged from 60 to 70 years, with 65 years being the most common ($n = 10$; 20.0%). The minimum BMI criteria ranged from 20 to 35; the most common minimum BMI criteria was ≥25 ($n = 17/48$; 35.4%) followed by BMI ≥28 ($n = 11/48$; 22.9%) and BMI ≥30 ($n = 10/48$; 20.8%). Twenty-three responses (of $n = 48$ responses; 47.9%) indicated there was an upper BMI limit and this was most commonly BMI < 40 ($n = 20$; 41.7% of total).

3.3 | Referral route and methods of advertising ($n = 52$)

All responses indicated that services had at least two routes of referral. Most accepted referrals from GPs ($n = 49$; 94.2%); self-referral ($n = 46$; 88.5%) and nurses and other HCPs ($n = 48$; 92.3%). Of the three responses indicating that GP referrals were not accepted, two selected 'Other' referral routes but did not provide additional detail, and the other accepted self-referral and referrals from non-HCPs. Additional routes of referral were NHS health checks ($n = 31$; 59.6%), non-HCPs ($n = 28$; 53.8%), and 'Other' routes ($n = 19$; 36.5%) including through secondary care, sports clubs, VCSE groups and social care. The most common methods of advertising and marketing the services were publishing on websites ($n = 49$; 94.2%), social media ($n = 45$; 86.5%), and in community bulletins ($n = 52$; 61.5%). Other approaches included displaying flyers ($n = 25$; 48.1%) (e.g., in GP surgeries, leisure centres, local businesses and community and VCSE hubs), delivering presentation/talks ($n = 29$; 55.8%; e.g., to HCPs, commissioning and care system boards, primary care, community groups and secondary care), advertising in newspapers ($n = 11$; 21.2%), mail drops ($n = 9$; 17.3%) and radio advertising ($n = 7$; 13.5%).

3.4 | Programme target group and content ($n = 51$)

Most services were universal, that is, able to be accessed by everyone meeting the eligibility criteria ($n = 37$; 72.5%). Fourteen programmes (27.5%) catered to specific groups: three (5.9%) responses indicated offering a programme specifically designed for men, six (11.8%) for people from Black, Asian and Minoritised Ethnic groups, seven (13.7%) for people living with physical or learning disabilities, six (11.8%) for people living in areas of high socioeconomic deprivation, four (7.8%) for people living with a mental illness, and one (2.0%) for people aged 35–65 years (this same provider was also piloting a programme for men aged 18–35 years).

Most responses ($n = 43$; 84.3%) indicated that services incorporated dietary intake, physical activity and behavioural change components. Free text and/or voice note responses provided additional detail about the offer (Table 1). Responses indicated that 'weekly session' format was common and weight-loss a main desired outcome. Although within the 'programme elements', weight maintenance/management was not highly reported, it may have been implied that it would be a core integral element. Examples of dietary support were provision of recipes, nutrition education and advice, for example, calorie counting, food groups and healthy swaps. Examples of physical activity included exercise sessions integrated into the in-person session (e.g., gym based, group walks, taster sessions, adapted exercise, e.g., chair based exercise class) and encouragement of physical activity outside of the in-person sessions. Some services also reported offering participants a range of different physical activities. Examples of behavioural change included goal setting and weighing (monitoring). Five reported that participation in football was a central feature of the programme. Five services reported also offering support for other issues, for example, alcohol, smoking, sleep, mental wellbeing, debt/housing, whilst four mentioned community activities, for example, group walks, sports taster sessions and gardening.

TABLE 1 The main aims and activities of the services.

Theme	Sub-themes (count)
Programme length and format	Set programme length (11)
	Weekly sessions (28)
	One-to-one consultation (3)
	Face-to-face sessions (3)
	Tailored activity/advice (individuals/community groups/those with additional needs/men etc.) (10)
	Choice/flexible approach (5)
Programme elements	Support/advice (10)
	Healthy eating/nutrition/diet advice/education (16)
	Healthy lifestyle support/education (9)
	Behaviour change advice (12)
	Weight maintenance/management (4)
	Access to physical activity classes/health walks (30)
	Free exercise classes (3)
	Goal setting (3)
Desired outcomes	Gain confidence (2)
	Weight-loss (24)
Additional Support	Exit classes/support (2)

3.5 | Programme delivery mode ($n = 50$), format ($n = 50$) and costs to participants ($n = 51$)

In-person was the most reported primary mode of delivery ($n = 43$; 86.0%), followed by telephone calls ($n = 15$; 30.0%) and video calls ($n = 15$; 30.0%). Telephone ($n = 18$; 36.0%), text message ($n = 16$; 32.0%) and email ($n = 15$; 30.0%) were the most reported supplementary modes of delivery. Most programmes were primarily group-based ($n = 45$; 90.0%) and 11 (22.0%) were delivered on a group and individual basis equally. Only two (4.0%) programmes were delivered primarily on an individual basis. The duration of the programmes ranged between 8 and 52 weeks, with most being delivered for 12 weeks ($n = 39$; 78.0%). After completion of the programme, most programmes offered continued access to some aspects of the service ($n = 28$; 56.0%), whilst 16 (32.0%) provided full access. Four (8.0%) provided no further access after programme completion. Most programmes incurred no cost to participants ($n = 46$; 90.2%). Of the five that reported participant costs, these ranged between £5 and £25 and included refundable sign-up costs contingent on attendance, optional gym user key and course costs with exemption for participants with a low income.

TABLE 2 Future commissioning of the service beyond the current contract period.

Theme	Sub-themes (count)
Recommissioning of service post-contract	Dependent on local authority/ commissioners/if re-bid/re-tender (8)
	Evaluation/review being/will be undertaken (7)
	Same/adapted service will be recommissioned (13)
	No funding/funding cuts likely/ no longer commissioned (7)
	Some years left on contract (3)
	Waiting for further information (4)

3.6 | Future commissioning ($n = 48$)

Most responses indicated uncertainty as to whether their service would be recommissioned beyond the current contract period ($n = 33$; 68.8%). Whilst three responses to open-ended questions indicated that this was because they still had some years remaining on the current contract, most indicated this was because of uncertainty around funding and plans of commissioners to re-tender (Table 2). Some reported they were being commissioned to deliver the same or an adapted version of the current service ($n = 13$; 27.1%), whilst two (4.2%) indicated they were not going to be recommissioned.

3.7 | Barriers and facilitators to service delivery

The following section highlights some of the main barriers and facilitators reported by respondents (Table 3) and are supported by anonymized quotes.

3.7.1 | Referrals to programmes

Many respondents reported receiving a high volume of referrals that are not always appropriate:

> *The programme has had a huge number of referrals in a very short time that it has been running. Quite a few of those referrals that were made by other health professionals were not appropriate as the person was not in the right stage of change and quite often unaware of what the programme entailed (ID2).*

Conversely, some programmes found engagement with primary care for referrals was initially problematic, however, concerted efforts to engage with GP practices was found to be beneficial:

> *Initially referrals from primary care were not forthcoming and thus we focussed on engaging and building relationships with the local GP surgeries, practice managers and GPs to boost our referral numbers (ID45).*

Also, it was found that referrals did not always lead to service users taking up a place or remaining on the programme once started and service-users not remaining with or completing the programme was an issue for many programmes:

> *Large number of referrals, but service user uptake is a lot less and then we lose some from booking to attending the first session (ID3).*

However, it was reported that there were no apparent differences in the success of service-users losing weight based on whether they had self-referred to the programme or were referred by someone else:

> *We've had good results from people actually losing weight, and we've had a good response to people, self-referring into the system, and also health professionals referring into the system as well (ID24).*

> *Data analysis from the past year suggests that our weight loss results are above the national average and that there was no major difference in weight loss outcomes between a GP referral or a self-referral (ID45).*

3.7.2 | Meeting the needs of clients/groups

Universal programmes were described as not being suitable for all service users, those with additional or cultural needs were not always able to be catered for:

> *There is not one service that can meet the requirements of all, and it can be very challenging to meet the variety of unique requirements for more specialised groups - for example, those with English not as a first language in a community face to face group (ID43).*

> *We have people being referred that have complex issues with food or that have mild moderate anxiety and depression and support for MH is not provided in this programme (ID6).*

Accessibility to programmes/venues was also a concern:

> *It is important to know client's needs before the course starts so that the programme can be adapted to make it accessible for those who attend e.g. one course had wheelchair users on it, another course had people who required signing, some clients were literate, and some were not (ID27).*

The importance of working with communities and groups was highlighted as key for delivering appropriate services:

TABLE 3 Barriers and facilitators related to service delivery from service provider perspectives.

Barriers		Facilitators	
Theme	Sub-themes and (count)	Theme	Sub-themes (count)
Types of referrals	High demand/number of referrals (12)	Pre-delivery processes	Building in development time/ having enough time for delivery (3)
	Inappropriate referrals/participants not knowing what they have been referred to/not ready to make lifestyle change (9)		Easy referral process from a range of sources (12)
Meeting needs of clients/groups	Engagement/meeting needs of target groups (10)	Collaboration and partnerships	Multi-partnership approach/ working/building (15)
	Programme not suitable for/not able to be adapted for specific groups/those with additional needs (8)		Good working relationship with providers/partners (12)
	Loss of participants after booking/early drop out/inconsistent attendance (7)		Engagement/working with communities (7)
	Participants achieving weight-loss goals (8)	Types of programmes/activities	Providing choice of programmes (2)
Programme requirements/ restrictions	Prescriptive methods/programme content (3)		Face-to-face sessions/One-to-one support (3)
	Finding/securing appropriate/accessible venues (5)		Peer/group support/activities (5)
	Necessary COVID restrictions/adaptations to online delivery (8)		Offering range of physical activity sessions/activities (10)
	Post-COVID adaptations/confidence building to resume group sessions (4)		Range of accessible venues/dates/ times (3)
	System operating process/procurement/data management systems (2)		Exit classes with ongoing support (5)
Capacity and resources	Staff capacity (7)	Positive outcomes	Good programme outcomes/ successful weight-loss figures (12)
	Time pressures (5)		Participants demonstrating lifestyle changes (3)
	Lack of resources (3)	Quality of service	High quality/experienced/ professional staff/services (8)
	Costs/funding (4)		Use of recognized/trusted commercial programmes (2)
			Flexible practices/ability to tailor programme to specific/targeted groups (8)

> *Completing insights work with targeted groups also works well to tailor the content to the audience (ID8).*

> *Partnership work with key and trusted members of the community was paramount to the success of the programme (ID11).*

Having a programme that is flexible, holistic and offering a range of options was described as being of benefit for clients:

> *Lots of venues locally, on different days and different times. Very well known, people usually know what to expect. Run by peer leaders, which many people relate positively to (ID12).*

> *A blend of teaching facts of benefits with practical applications of how to make those changes has been most impactful. Making sessions highly interactive (ID17).*

The use of commercial programmes that were well-known was reported as a positive:

> *Using commercial providers of weight management programmes works well as they are recognised by people, and they are effective (ID1).*

Several respondents highlighted that outcomes such as improved health behaviours and weight-loss were achieved within their programme:

> *Members are motivated to be healthier and lose weight, and once engaged have demonstrated a diverse range of significant behaviour change. focussing on healthier lifestyles (ID17).*

However, it was recognized that having a free universal service, rather than prioritising services for those most in need, may lead to health inequalities:

> *Weight management [is] too broad as a free service, so unable to devote resources to supporting those who need it most (inequality gaps) (ID46).*

3.7.3 | Programme implementation

Having enough resources, time and dealing with implementation processes was a challenge for some:

> *Due to the covid pandemic many staff members left the leisure industry, which has led to a resource shortage (ID21).*

> *Insufficient time in pilot to set up governance procedures/standard operating procedures (ID19).*

Furthermore, data collection could be excessive and did not always capture the desired outcomes:

> *Excessive Data requirement - this can be a balance between getting information commissioners would like to know about participants, vs [sic] asking too many questions that become barriers to participation and take the focus away from support and weight management (ID43).*

Costs and funding were a barrier for some. Some respondents indicated that their funding was not sustainable/being sustained, which caused uncertainty in the future of the programme. Those with targeted services reported higher costs:

> *Cost of setting up the programme- it costs more than a universal programme such as Weight Watchers and Slimming World (ID26).*

However, despite these challenges, it was evident that having a strong workforce to deliver the intervention and working in partnerships with other bodies was an asset for programme implementation:

> *High quality instructors and programme, good relationship with council/public health team (ID4).*

> *Multi-partnership approach without a doubt. It's understanding and accepting you do not have all the experience and tools for every specialised area. Acknowledging that as a team with your own strengths and passions around the table can make the programme go from strength to strength (ID10).*

Also contributing to successful implementation was partnership working with other external professionals/agencies:

> *Instructors are highly skilled and specialists in the area. Providing links to wider health services so they have the tools to support weight loss in their areas (ID46).*

4 | DISCUSSION

This scoping study aimed to describe various local authority commissioned tier 2 adult weight management offers in England and explore barriers and facilitators to service delivery from service provider perspectives. In our sample, services were predominately group-based, multi-component programmes that were delivered in-person over 12 weeks. The most popular referral routes were through GPs, nurses and other HCPs, and self-referral. Whilst these findings are similar to those reported in previous mapping work and evaluations of tier 2 services,[5,12] we identified a few key differences. One of note was cost to participants; previous work reported costs to participants were on average £50–100[5,12,13]; however, virtually all WMS in the current study were free and this was likely because the services were fully funded by the 2021/22 adult WMS grant. Previous research has identified that financial costs associated with WMS are prohibitive to participation,[14–16] especially in those with relative socioeconomic disadvantage.[15,17] UK-based research found that free WMS were better attended and more acceptable than self-funded services.[18] Evaluating the effect of free WMS on participant uptake and outcomes across the socioeconomic spectrum is an important area of further research. Another key difference was the lower BMI eligibility criteria observed in the current study (most services BMI > 25) compared to previous work (most services BMI > 30).[5] This may be due to enhanced capacity within services afforded by the 2021/22 adult WMS grant which eliminated the need to prioritize enrolment of those with higher BMI. Other factors such as local population obesity rates and awareness of the service through advertising may have also contributed to this difference. Research has shown that lower baseline BMI predicts adherence to behavioural weight management interventions,[19] and that higher baseline BMI is a predictor of programme attrition, non-adherence and less weight loss.[20] Earlier intervention in people with lower BMI (i.e., BMI > 25) may be more effective and cost-effective than waiting until participants are at greater risk (BMI > 30); further research is needed to determine this.

Concurrent with previous work[5,12] and as anticipated given the specifications of the adult WMS grant, we observed that most services were multi-component, that is, they provided support for healthy eating, physical activity, and behaviour change. Yet, services varied in their approach to providing healthy eating and physical

activity support. We also found that even within a service, participants were offered variety and choice, for example, types of exercise and physical activity. This is a promising finding given that being offered a greater range of activities was identified as an area of improvement by tier 2 participants in a previous evaluation.[12] In addition to diet and physical activity, some programmes reported providing support for mental health. Whilst there is evidence that behavioural weight loss interventions can improve some psychological outcomes[21,22] research on the effectiveness of psychological support embedded WMS is sparse.[23] Provision and conceptualisation of psychological support within tier 2 services is poor despite it being identified as a need by service commissioners, providers and users.[23,24] Several services also provided support for other health and wellbeing related issues, for example, smoking, debt assistance, whilst some reported signposting to other support services. Whilst support for mental health and wider determinants of health are not traditionally considered to be within the remit of WMS, this approach represents a more holistic and person-centred model of health that acknowledges psychosocial factors as a cause and consequence of obesity. Further research is needed to understand the impact of these holistic programmes on weight and broader wellbeing outcomes.

We identified that most services in our sample were provided 'in-house', that is, the local authority was both the service commissioner and provider. There have been suggestions that in the instance where a service is underperforming, this model of service delivery may cause issues due to financial and political pressures and potential conflict between provider and commissioner leadership.[25] In contrast, our study found that an in-house service model could facilitate successful service delivery as local authorities, equipped with local knowledge, are able to harness local resources, infrastructure, and partnerships with external organisations. Indeed, partnership working and local collaboration drawing on combined expertise, strengths and resource was a commonly cited facilitator to service delivery among survey respondents. For these reasons, an in-house model may have supported faster service set-up and delivery than external organisations in the time-pressured context.

In previous literature a lack of funding has been cited as a barrier to WMS provision.[5,25,26] Given the instatement of the adult WMS grant for the 2021/22 financial year, this was not cited as an explicit barrier to delivering the current service over the contracted period. However, this funding was not renewed for the following financial year. Time-limited funding places pressure on public health and WMS professionals and resources and can perpetuate an ineffective cycle of service commissioning and decommissioning.[25] Our data also suggest that increased funding alone is not sufficient to achieve successful service delivery. Participants reported that insufficient time and resource (e.g., staff), overwhelming numbers of referrals (perhaps due to incentivisation for referral, number of people living with obesity, successful advertisement of services) and inappropriate referrals and referral systems were barriers to service delivery. Services may have received inappropriate referrals as the variety of WMS offers could be confusing to referrers. In addition to local authority provision, a new NHS digital programme and the national Diabetes Prevention Programme were also available at the time, each with varying participant eligibility criteria, and with some participants being eligible for all services. Also, whilst overwhelming numbers of referrals were reported by service providers in the current study, this may not have been the case for all services, and it is likely that some experienced poor referral rates. Overly, prescriptive programmes that were difficult to adapt, especially for people in higher risk groups including those with cultural needs, were another barrier to effective service provision. Only a small proportion of services in this study specifically targeted higher risk groups. However, it should be noted that this contrasts to data collected by OHID from all Tier 2 WMS, which indicated that around 60% of services funded were deemed targeted.[27] One survey respondent reported that the costs to deliver targeted services are greater than those for universal services. People in higher risk groups may also have complex or particular needs which require more experienced staff and service adaptation.

A previous evaluation of tier 2 services in Northern England found that only 12% of respondents (members of the public) were aware of the WMS; the authors recommended that the services should also be publicized more widely to the public to gain greater population reach.[12] They also identified a lack of awareness of the service among GPs,[12] which potentially may relate to the difficulty in understanding the various WMS offers and participant eligibility criteria. In the current study, most responses indicated that services were advertised to the public via several approaches, mainly through publication on websites, social media, community bulletins and through flyers displayed in GP surgeries, leisure centres, local businesses and/or community and VCSE hubs. We also found that over half of responses indicated that the service was promoted to GPs, HCPs, commissioning boards and/or community groups. Reports of concerted efforts to raise awareness of services among the public and HCPs are promising; quantifying awareness was beyond the scope of this study and is a recommended area of future research.

4.1 | Recommendations for policy and practice

1. In addition to (recurring) funding, policy makers should grant service commissioners and providers adequate time and resource for service delivery. This could be used by service providers to engage in activities to benefit service delivery, for example, cultivate partnerships with other organisations, conduct insight work with service participants, adapt services to meet needs of different groups, recruit or train staff.
2. Referral systems should be straightforward, and referral criteria and description of the service should be made clear to GPs and other referrers. A distinction between the various WMS offers i.e. local authority services vs. NHS digital service, and their respective eligibility criteria and pathways should be made clear. This may be achieved through concerted engagement efforts between providers and these groups. Participants should also be provided with basic information about what the service involves at the point of referral.

3. Strategies to manage surplus referrals should be explored to reduce the likelihood that participants disengage with the service and lose motivation whilst waiting for vacancies.

4.2 | Strengths and limitations

This study provided novel insight into England-wide local authority provision and delivery of tier 2 WMS following a significant government-funded investment. The survey was well-informed through consultation with a range of academic, practitioner and policy stakeholders. The use of open-ended qualitative questions allowed us to explore service providers experiences of service delivery. The use of Voice Note software[9] elicited richer data than what is typically captured in text. Whilst our (estimated) response rate was modest and may have been affected by the news that the adult WMS grant was not going to be renewed, it is similar to that achieved in previous WMS mapping exercises conducted in the UK[25,26] and we had good geographical representation across England. The true coverage is likely to be higher as five responses did not indicate the commissioning local authority and one commercial provider reported being commissioned in over 100 local authorities, but these were not all reported individually. Additionally, because of the way the survey was disseminated, that is, through public health teams in local authorities, in-house local authority providers are highly represented in the sample. Therefore, the data, particularly the barriers and facilitators to service delivery, may be more specific to these services. Another limitation was that survey participants could not indicate BMI cut-offs for specific groups, for example, specific BMI eligibility criteria for participants from Black, Asian and Minority Ethnic groups. Additionally, the highest BMI that could be selected for maximum BMI criteria was BMI 40, although from website searches, we know that some services in our sample did accept referrals for people with a BMI > 40.

5 | CONCLUSIONS

The new adult WMS grant was used to fund tier 2 services that were similar in terms of their duration, format and mode of delivery, but programme eligibility criteria and content varied between and within services. Several programmes provided support for wider health and wellbeing issues such as debt assistance, mental health and smoking cessation. To enhance future commissioning and delivery of local authority Tier 2 WMS, WMS providers need adequate time to conduct preparatory work to promote successful service delivery. Referral systems and criteria should be designed so they are clear and straightforward to both referrers and service users, and should include strategies for managing surplus referrals.

AUTHOR CONTRIBUTIONS

Mackenzie Fong and Charlotte Rothwell designed the study and developed the survey. Mackenzie Fong and Lorraine McSweeney analysed the data. Mackenzie Fong drafted the article. Lorraine McSweeney, Charlotte Rothwell, Claire Mathews, Scott Lloyd and Ashley Adamson reviewed the article.

ACKNOWLEDGEMENTS

This study is funded by the National Institute for Health and Care Research (NIHR) Applied Research Collaboration (ARC) North East and North Cumbria (NIHR200173), National Priority programme for Prevention and Behavioural Risk Factors. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care. We gratefully acknowledge the support of Margie van Dijk and Elizabeth Atherton at the OHID obesity team who reviewed and helped to disseminate the survey. Thanks are also due to Cheryl Cavanagh, Penny Withers, Sarah Williamson, Celine Chauvin, Dai Richards and Elizabeth Toyne at OHID for lending their expertize and reviewing the manuscript. We also extend gratitude to our public advisors, Bethan Macdonald (Consultant in Public Health NIHR Applied Research Collaboration Public Health and Social Care lead) and the Healthy Weight Leads in the North East region who piloted, reviewed and commented on the survey. We also acknowledge the ongoing support of the wider National Enhanced Service Incentive Evaluation (NESIE) project team lead by NIHR Applied Research Collaboration Oxford and Thames Valley.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Fong M, McSweeney L, Adamson A, Mathews C, Lloyd S, Rothwell C. A cross-sectional survey study exploring provision and delivery of expanded community tier 2 behavioural weight management services in England. *Clinical Obesity*. 2023;e12629. doi:10.1111/cob.12629