

Social care and obesity



Foreword

The COVID-19 pandemic has thrown into sharp relief the urgent need for long-term reform and sustainable funding for adult social care. All areas of adult social care and its interdependence with health care, need to be considered in the round in a comprehensive action plan. One area which places high demands on social care and exerts significant pressures on costs and resources, is obesity; yet it is often overlooked. Focus to date has centred on obesity-related costs and pressures on the NHS, rather than on social care.

Obesity is one of the very serious public health challenges of our time. Adult obesity, and most worryingly, severe obesity, is rising, along with associated health and social care costs. Obesity is impacting people's lives now, across the generations, affecting our quality of life by increasing our risk of developing chronic illnesses, such as musculoskeletal conditions and type 2 diabetes; and exposing us to the physical and social difficulties that often result from the development of severe obesity. People living with obesity also suffer weight-related stigma and prejudice.

The costs associated with caring for and treating people with obesity-related, long-term health conditions are significant. Costs are likely to rise as levels of obesity increase and as the population ages, with people spending many more years in ill-health, often with multiple and complex needs. The social care requirements for people with severe obesity are costly and include housing adaptations, specialised equipment, and carer provision.

Particularly over the last decade, health inequalities have widened. This has been accompanied by wider inequalities in both child and adult obesity, with rates increasing most among those from more deprived and less educated backgrounds, and among different ethnic groups.

Effectively preventing and treating obesity will tackle health inequalities and has the potential to significantly improve quality of life and wellbeing, in addition to reducing health and social care costs. Social care has a pivotal role in boosting mental health as a means to support healthy weight management.

We call for the public health grant to be restored and placed on a long-term sustainable footing for the future, with the additional money to be used by local authorities to help prevention efforts and reduce the burden on the NHS and social care.

With adequate, sustainable funding, social care can:

- focus on prevention: work with partners to embed physical activity and healthy eating-support within existing social care pathways
- work collaboratively and move towards integration with the NHS
- use a whole systems approach to obesity
- contribute to key local authority policies that include tackling obesity
- develop bariatric policies and pathways, and provide adaptations and carer support
- raise awareness and provide specific training for social care staff
- invest in reablement
- use proven innovative models of social care.

By supporting healthy weight management through prevention, early intervention, and provision of appropriate social care, we can improve clients' health and wellbeing, pre-empt future health and social care issues, promote independence, and reduce the pressures on social care and the NHS.



Councillor Ian Hudspeth

Chairman, LGA Community Wellbeing Board

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Acknowledgements and thanks to everyone who took the time to discuss and provide information to help inform this report.

Your help was very much appreciated.

Shireen Mathrani for the LGA, August 2020

Introduction

The increasing costs, funding shortages and growing pressures on adult social care are well documented. People are living longer but their extra years of life are often not spent in good health. The demand for social care is growing, as people are living longer with multiple and complex needs.^[1]

The total budgeted spend for adult social care in England in 2019/20, was £16.79 billion. The Local Government Association (LGA) has previously estimated that there will be a funding gap of £806 million for adult social care in 2020/21, predicted to rise to £3.9 billion by 2024/25.^[1]

Three key factors that challenge adult social care have been highlighted by the King's Fund [2]: rising disability among those of working age; growing numbers of older people; and existing needs being unmet. The King's Fund also identifies underinvestment in preventive services that keep people independent and out of hospital, such as the number of people receiving Disabled Facilities Grants or reablement services.

In England in 2018,^[3] 19 per cent of men and 28 per cent of women aged 65 and over who took part in the Health Survey for England (HSE), had some unmet need for help with at least one Activity of Daily Living (ADL)¹. Meanwhile, 12 per cent of men and 15 per cent of women had unmet need for help with at least one Instrumental Activity of Daily Living (IADL)². Sixty-nine per cent of adults with at least one severe health-related

problem,³ had unmet needs with at least one ADL. Estimates from Age UK indicate that 1.4 million older people do not receive the help they need.^[4]

With this backdrop of a social care system that is already under great stress, obesity pressures on social care have a very significant impact. Focus to date has centred on obesity -related costs and pressures on the NHS, rather than social care; the implications for which are much less researched.

This report is a follow-up to 'Social Care and Obesity: a discussion paper', produced by the LGA in 2013. To inform this current report, discussions were held with a number of social care and health professionals from different local authorities, as listed below:

- a Housing Occupational Therapist (Housing OT)
- a Service Manager and a Team Manager for OTs and social workers
- a Service Manager for Direct Provision
- a Head of Operations for long-term conditions and musculoskeletal health
- two Directors of Adult Social Services
- a registered Manager of a council care home.

Case examples and aspects of the discussions are captured in the report below.

1 Activities of Daily Living (ADLs) are: Having a bath or shower; using the toilet; getting up and down stairs; getting around indoors; dressing or undressing; getting in and out of bed; washing face and hands; eating, including cutting up food; and taking medicine.

2 Instrumental Activities of Daily Living (IADLs) are: Doing routine housework or laundry; shopping for food; getting out of the house; and doing paperwork or paying bills.

3 Via the EQ-5D health status questionnaire which has five dimensions: mobility, self-care, usual activities, pain or discomfort, and anxiety or depression.

Obesity facts and figures

The results of the Health Survey for England 2018 [5] indicate that almost three out of 10 people are obese⁴ (66.9 per cent). Obesity prevalence continues to rise, particularly among women.



Public Health
England

Obesity among adults Health Survey for England 2018

Almost **3 out of 10 men** are obese (26.2%)



Almost **3 out of 10 women** are obese (29.2%)



Adult (aged 16+) obesity: BMI \geq 30kg/m²

Source: Public Health England (2020) Patterns and trends in adult obesity

⁴ Adults are classed as obese if their body mass index (BMI) is 30kg/m² or more.

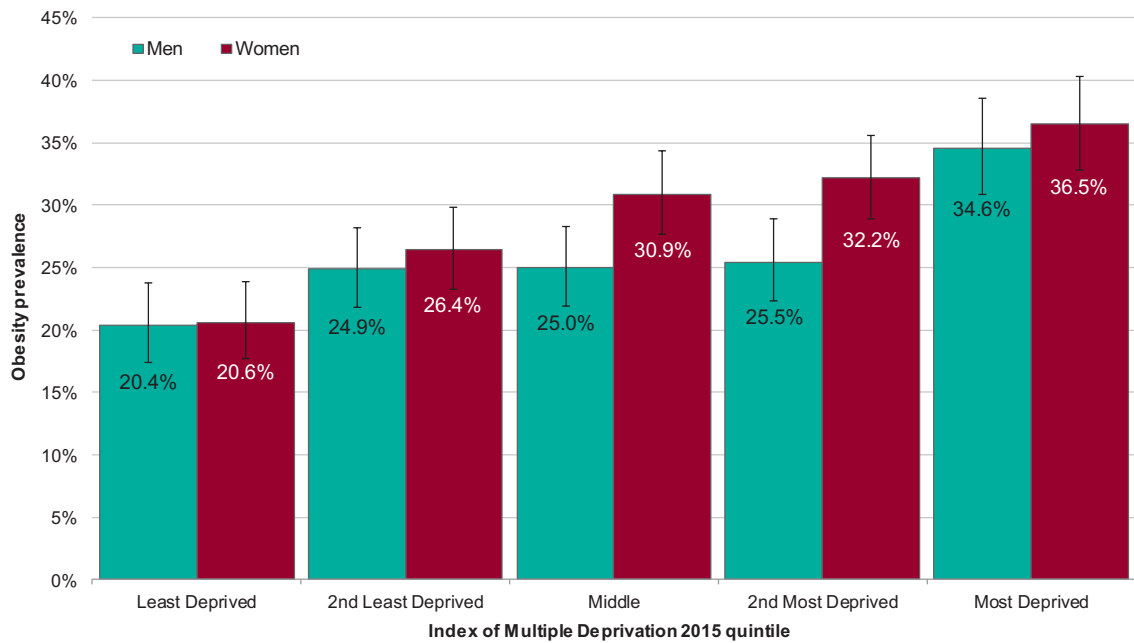
Women and men living in the most deprived areas are more likely to be obese than those living in the least deprived areas:



Public Health
England

Adult obesity prevalence by deprivation

Health Survey for England 2018



Obesity prevalence is age standardised

95% confidence intervals are shown
Adult (aged 16+) obesity: BMI \geq 30kg/m²

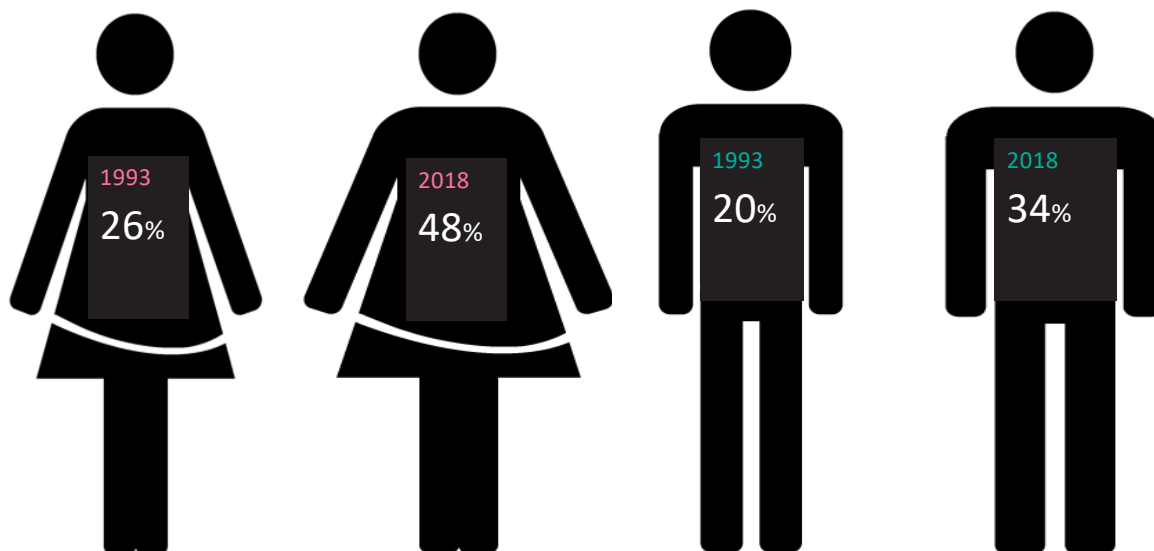
Source: Public Health England (2020) Patterns and trends in adult obesity

High waist circumference is an independent predictor of future obesity-related conditions, including type 2 diabetes, hypertension, and heart disease. The prevalence of very high waist circumference is much higher among women than men. Both sexes have seen a large increase since 1993.



Adult very high waist circumference

Health Survey for England 2018



Adults aged 16+
Very high waist circumference is taken to be greater than 102cm in men and greater than 88cm in women

Source: Public Health England (2020) Patterns and trends in adult obesity

Living with overweight or obesity is linked to a wide range of diseases including type 2 diabetes, hypertension, some cancers, heart disease, stroke, liver disease and musculoskeletal conditions. Obesity can also be associated with poor psychological and emotional health, and poor sleep.^[6]

Since 2007, there has been an upward trend in adult obesity and it has been rising faster than previously forecasted. If this rise continues, then between 26.6 per cent and 33.9 per cent of adults could be living with obesity by 2024, although rates could rise further as childhood obesity has not declined in recent years.^[7] Rates of obesity are higher in the learning disabled population than the general population. The subsequent risks to health are greater in individuals with a learning disability, who may already have underlying health conditions, yet the uptake of health surveillance is lower than the general population.

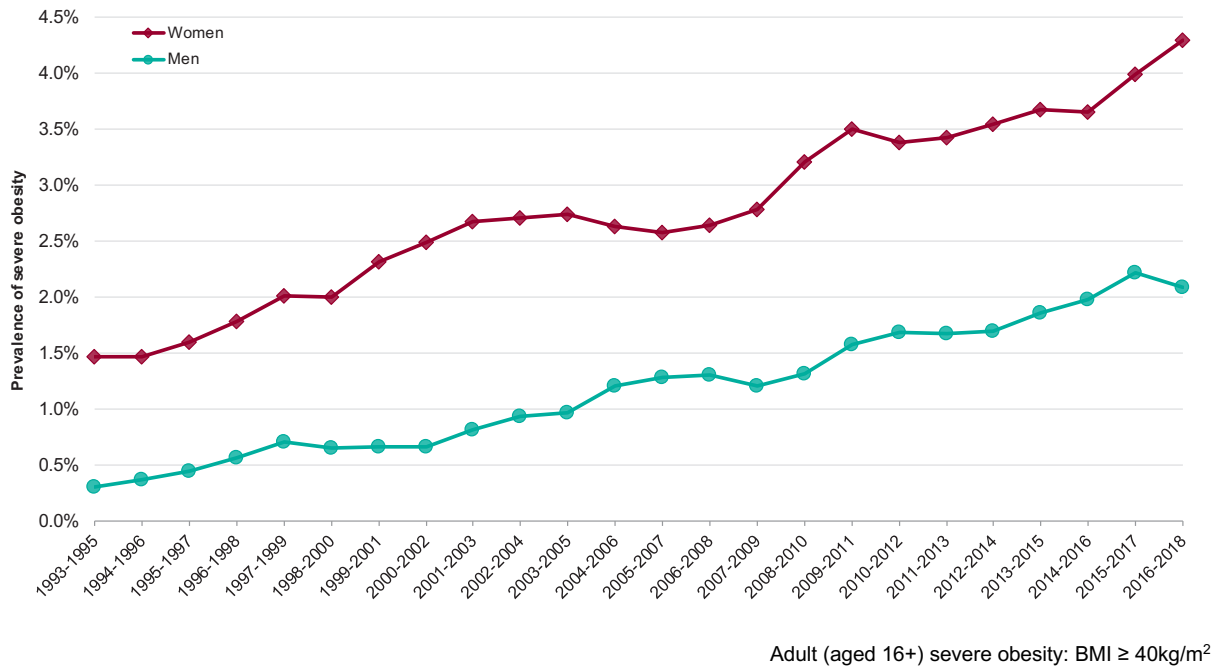
Severe obesity

The prevalence of severe obesity, defined as a body mass index (BMI)⁵ of 40kg/m² or more, has increased over the last three decades for both men and women. Overall, a very small proportion of the population are severely obese but the rise in prevalence has been substantial since 1993-1995; a seven-fold increase for men and a 2.9-fold increase for women. Severe obesity prevalence is much higher for women than men.



Trend in severe obesity among adults

Health Survey for England 1993 to 2018 (three-year average)



Source: Public Health England (2020) Patterns and trends in adult obesity

5 Body mass index or BMI is expressed as weight divided by height squared (kg/m²)

Obesity and health inequalities

Socioeconomic and health inequalities in the UK have increased since 1970. Particularly over the last decade, health inequalities have widened and life expectancy in England has stalled for the first time since at least 1900.^[8] This has been accompanied by wider inequalities in both child and adult obesity, with rates increasing most among those from more deprived backgrounds and among different ethnic groups. Education also plays a big part – both men and women with no qualifications have the highest rates of obesity.^[9]

People with obesity suffer weight-related stigma, which can damage their self-esteem and employment prospects and lead to mental ill health, such as anxiety and depression. People with severe obesity who are also disabled, may as a result suffer even worse social stigma, as the stigma associated with disability can be compounded by obesity.^[10]

Weight status is not a protected characteristic under the Equality Act 2010. However, people living with obesity may have legal recourse against discrimination (infrequently used) given that 'a person is considered to have a disability if he or she has a physical or mental impairment and it has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.'

^[11] A 2013 legal case in the UK showed that obesity discrimination could be considered disability discrimination.^[12]

Practitioners comment that by the nature of social care, all their clients are already struggling. Even so, they observe a strong link between more disadvantaged socioeconomic status and more severe obesity.

They observe high numbers of women, in their thirties and forties, asking for assistance. These are clients with obesity and mobility difficulties (frequently with a diagnosis of fibromyalgia, often accompanied by depression and anxiety).

Fibromyalgia is a long-term rheumatic disorder characterized by widespread pain and muscle tenderness. It is around seven times as common in women as in men. Fibromyalgia patients have a higher prevalence of obesity (40 per cent) and overweight (30 per cent) compared with healthy people. Furthermore, people with obesity have an increased higher risk of developing fibromyalgia, particularly if they are physically inactive.^[13] Excess weight among those with fibromyalgia leads to more pain and fatigue and lower quality of life, and physical activity and weight loss improve its symptoms.^[14]

Such clients become static, immobile and in pain; not wanting to move because of the pain. This means that practitioners often compensate for their loss of mobility with more equipment – which means the clients move about even less and their problems are compounded.

In general, practitioners feel that whatever the health condition (eg fibromyalgia, musculoskeletal conditions, type 2 diabetes) it is often directly or indirectly due to obesity. However, the issue is rarely broached, partly for fear of offence and partly because there is a lack of referral services for people living with severe obesity, as demonstrated below:

“I see many women like this: in their 30s-40s, obese, with fibromyalgia, who are fast becoming disabled. And I think ‘your career as an obese person has begun’.”

Housing OT

“There is a taboo/stigma around the issue of obesity. It’s never raised either by the professional or by the person themselves.”

Housing OT

“Gradually the term ‘bariatric’ is becoming more accepted, it is considered insensitive to say ‘obese’. But it means that when collecting data we are not encouraged to be explicit about obesity... we don’t capture data on size. Usually we would record the condition, eg diabetes, stroke, MSK, not mentioning obesity nor BMI even though that is often the underlying issue.”

Head of Operations

National costs: obesity pressures on social care

There is a lack of costing data regarding obesity pressures on social care. A recent statistical analysis using three years' of HSE data from adults aged 65 or over^[15] found that BMI is positively associated with a self-reported need for social care. This association exists even after sex, ethnicity, level of area deprivation, income level and limiting long-term illness have been adjusted for.

As BMI rises, the need for social care also rises and cost pressures increase. A 1 kg/m² increase in BMI is associated with a 5 per cent rise in the odds of need for help with social care. The authors calculate (using the average cost of a care worker of £24/hour [2014 prices]), that the yearly cost of council funded community-based social care for an individual with severe obesity and a BMI of 40, would be £1086, nearly double the cost for a person with a BMI of 23, which is in the healthy range.

This equates to an annual excess social care cost for a typical council⁶ of £423,000 [2014 prices]. Note that due to limitations of the HSE data, this work relates only to those aged 65 or over and not living in care homes. Therefore, the true cost of the effect of BMI on the need for social care is likely to be higher.

Two recent research studies from Kent University outline the implications of the rise in adult obesity in England for long-term care, whether this is formal social care or informal, unpaid care. The first analysis^[16] used data from adults aged 65 and over from the English Longitudinal Study of Ageing (ELSA).

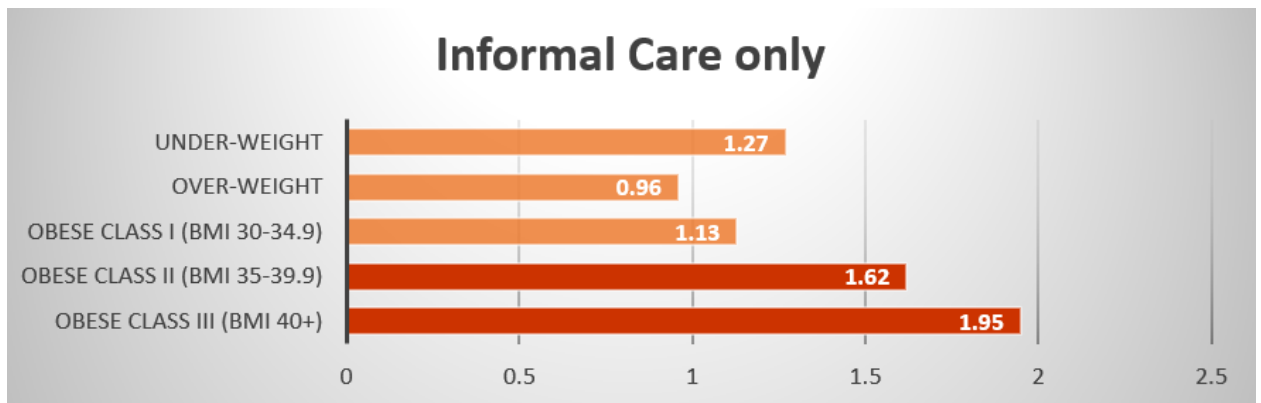
It estimated that people with obesity (BMI of 30+) would be 25 per cent more likely to be using some form of long-term care – almost entirely informal care – in two years time, than those with a BMI in the healthy range.

This effect was seen even after controlling for sociodemographic characteristics and a range of health conditions associated with obesity. Using the national figure of £55b for the approximate total value of informal care to society in England^[17], the study found that the overall value of informal care related to obesity was around £3.9b per year and calculated that that this was increasing by £200m per year due to the rise in adult obesity.

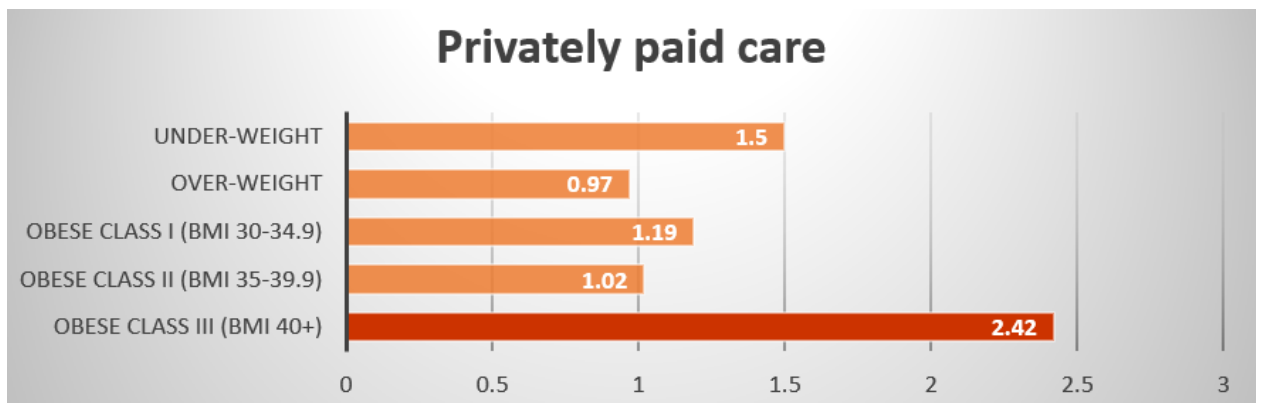
The second study^[18] examined the effect of different degrees of obesity. Apart from the high risk of ill-health and long-term conditions, people who are living with severe obesity have mobility and self-care difficulties due to their body weight, size and shape. When obesity data was split into three categories (BMI 30-34.9/ BMI 35-39.9/ BMI 40+) it was found that severe obesity has a statistically significant effect on the use of long-term care, whether informal care, privately paid home care or formal home care. These findings show the pressures which social care is under, as a result of severe obesity.

⁶ Example calculation for an average lower tier local authority with a population of 30,000 adults aged 65 and over and a severe obesity prevalence of 2.9 per cent.

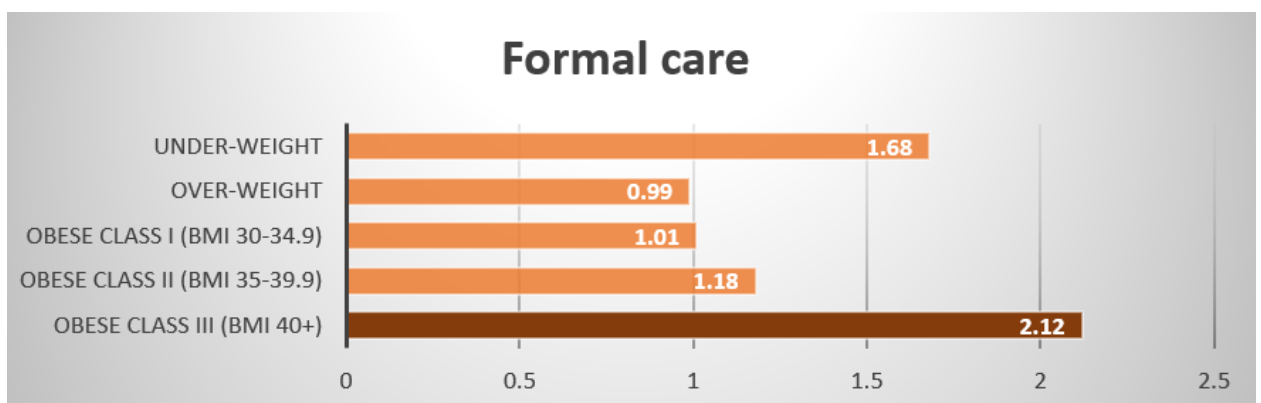
Effect of BMI category on the use of different types of care^[19]



Adults aged 65 and over with a BMI of 40+ are nearly twice as likely⁷ to use informal care than a person with a BMI in the healthy range.



Adults aged 65 and over with a BMI of 40+ are nearly two and a half times as likely⁸ to use privately paid home care than a person with a BMI in the healthy range.



Adults aged 65 and over with a BMI of 40+ are over twice as likely⁹ to use formal home care than a person with a BMI in the healthy range.

Source: PSSRU, University of Kent (2019) The Hidden Costs of Obesity: Implications for Long-Term Care. www.pssru.ac.uk/blog/the-hidden-costs-of-obesity-implications-for-long-term-care/

Long-term health conditions (LTCs) have a huge impact on the NHS and social care. Obesity is

⁷ Relative Risk Ratio of 1.95. Significant at 1 per cent level, i.e. 99 per cent confident that the results are not due to chance.

⁸ Relative Risk Ratio of 2.42. Significant at 5 per cent level, i.e. 95 per cent confident that the results are not due to chance.

⁹ Relative Risk Ratio of 2.12. Significant at 10 per cent level, i.e. 90 per cent confident that the results are not due to chance.

Obesity and long-term conditions: pressures on social care

associated with a number of these conditions which place a significant burden on the social care system, including MSK conditions, type 2 diabetes, mental health problems, cardiovascular disease, some cancers, and respiratory disease.^[6]

Treating and dealing with these conditions is extremely costly for the health and social care system as a whole. More than 15 million people in England live with a long-term condition, and the number is rising as the population ages. Furthermore, the number of people living with more than one LTC is rising. It was estimated that 2.9 million people had two or more long-term health conditions in 2018. People with LTCs are the biggest users of healthcare services, with 70 per cent of acute and primary care spending in England in 2015, spent on treatment and care for long-term conditions.^[20]

In 2018, 54 per cent of adults aged 65 and over who had a limiting longstanding illness¹⁰ needed help with at least one ADL¹, and there is evidence of substantial unmet need. 46 per cent of adults with limiting longstanding illness had some unmet need for help with ADLs, and 26 per cent aged 65 and over with IADLs².^[3]

“Patients with long-term conditions such as diabetes and MSK have complex co-morbidities, immobility, often they are obese and have a reduced quality of life. Obesity is a rising challenge with hidden costs and lack of data. We’ve seen a huge rise in specialist wheelchair requests; this is definitely driven by obesity, the burden of care, and pressures on services. Costs have increased and are getting worse as a result.”

(Head of Operations)

Sleep apnoea

Obesity-related respiratory issues such as restricted respiration, effects on diaphragm and lung function are a huge and growing challenge for the NHS and social care. Obstructive sleep apnoea (OSA) is a condition affecting many people with obesity. There is a two-way association between obesity and OSA: obesity increases the risk for OSA and OSA predisposes to weight gain and obesity.^[21]

¹⁰ Longstanding illness is defined as ‘any physical or mental health condition or illness lasting or expected to last 12 months or more’. A longstanding illness is defined as ‘limiting’ if the participant reports that it reduces their ability to carry out day-to-day activities.

Sleep apnoea equipment costs £5000 per kit: practitioners say clients often do not remember the instructions they were given in hospital on how to use the kit at home. These kits are also noisy and cumbersome. The person's partner may complain about the noise and its effect on their own sleep – they really need their own bedroom but often a request for rehousing to provide an additional bedroom (leading to under-occupation) is not approved.

Thus, very costly kit often remains unused and the respiratory health of the person continues to deteriorate. “These costs are just merged in with other costs as data is not collected on body size nor is there a requirement to account separately for obesity-related costs”. (Head of Operations)

Musculoskeletal conditions (MSK)

MSK conditions affect the bones, joints, muscles and spine and are a public health concern worldwide. They are the greatest cause of disability in the UK, accounting for 22 per cent of the total burden of ill health^[22]. In 2018/19, 16.9 per cent of adults reported a long-term MSK problem, ranging from 9.7 per cent to 25.4 per cent among local authorities in England.^[23]

People with an MSK condition are likely to be living with a number of long-term conditions. Around 80 per cent of people with osteoarthritis have at least one other long-term condition such as hypertension or cardiovascular disease, due to common risk factors such as obesity and because the prevalence of these conditions rise with age.^[23]

The costs to health and social care are high; treating the two most common forms of arthritis alone (osteoarthritis and rheumatoid arthritis) was estimated to cost the economy £10.2 billion in direct costs to the NHS and wider healthcare system in 2017^[22].

These costs are predicted to rise as the population ages and spends more years living in ill health, while the prevalence of risk factors such as obesity continue to rise.^[24]

51.5 per cent of local authority expenditure on adult social care in 2018-19 was on people aged 65 and over, of which a substantial number would have an MSK condition. An indication of this is that 66.1 per cent of the social care expenditure on this age group is for physical support.^[25]

40 per cent of those entitled to Attendance Allowance and around 30 per cent of those receiving Personal Independence Payments (PIP) in the UK in 2018, had an MSK condition as their primary disability.^[22]

There are considerable health inequalities in the prevalence of long-term MSK conditions. Women are affected disproportionately; 19 per cent of women as opposed to 14.6 per cent of men. These problems rise with age, with 23.4 per cent of people aged 55-64 reporting a long term MSK problem, rising to 44.1 per cent of those aged 85 and older.

The most deprived areas have a higher prevalence than the least deprived (17 per cent compared to 15 per cent). Prevalence also varies by ethnicity, with the highest prevalence (20.8 per cent) in the Irish group, compared to the lowest prevalence (6.5 per cent) in the Chinese ethnic group.^[23]

Obesity and MSK conditions

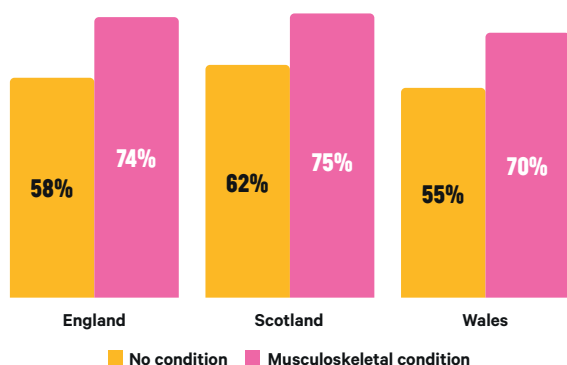
Obesity is a risk factor for a number of MSK conditions, such as osteoarthritis, rheumatoid arthritis, gout and back pain, and can make the effects worse. It directly damages weight-bearing joints such as knees and hips due to the abnormally heavy loads put upon them.

The average BMI of knee replacement patients in the UK was in the obese category (31), while the average BMI for hip replacement patients was in the overweight category (28) in 2017.

The risk of developing osteoarthritis throughout life increases with rising BMI. People who are overweight or obese are 2.5-4.6 times more likely to develop knee osteoarthritis (knee OA) than those with a healthy BMI; and 1.5-2 times more likely to have back pain rising to four times more likely in those with severe obesity.^[22]

Practitioners confirm that the number of people with health and disability issues due to body shape, size and weight is rising. Some of the problems seen include joint damage, mobility deterioration, knee OA, fibromyalgia and a range of MSK issues.

7 in 10 people who report living with a long-term MSK condition are overweight or obese.



Source: Versus Arthritis (2019) The State of Musculoskeletal Health 2019

It is often a vicious circle; the person with obesity feels MSK pain when moving so they become more immobile and put on more weight, so it becomes even more difficult to move about.

The client may then apply for a Disabled Facilities Grant (DFG)¹¹; for example, to get the ceiling reinforced to install hoists. If this is approved, the client has to be placed elsewhere while the building work is carried out. The whole process requires an immense amount of coordination and involvement of different services; and the costs are considerable.

11 A Disabled Facilities Grant (DFG) is a means-tested grant from local councils (up to a maximum of £30,000 per individual in England) to enable a disabled person to make necessary adaptations to their home. For example, to widen doors, install ramps, or improve access to rooms and facilities – eg using stairlifts to access a downstairs bathroom. There are eligibility criteria; however, means-testing is not usually an issue for bariatric clients, as they have often been unable to work for many years. The local council would fully fund the adaptations in these situations. If the work starts before council approval is given, no grant may be payable. However, there can be a very long waiting time to get a decision.

12 ESCAPE-pain for knee pain is one of seven separate interventions found to be cost-effective. [24]

“There is a very high prevalence of obesity in patients with OA Knee, more so than with hip osteoarthritis (OA Hip). Such people are more prone to pain and immobility. There is a definite drive nationally for conservative management (avoidance of surgery) of MSK conditions where obesity is a factor.

This is not just about rationing – such patients are a general anaesthetic risk so surgeons are less willing to operate. Patients with obesity are encouraged to enrol in a formal exercise programme, such as the national ‘Escape Pain’ programme¹². Sometimes, the outcome is so successful that they don’t need surgery at all.”

Head of Operations

Diabetes

Type 2 diabetes prevalence is on the rise globally and is a major cause of premature mortality. It causes around 22,000 early deaths annually in England, usually due to complications such as cardiovascular disease (CVD). Five million people in England are at high risk of developing type 2 diabetes and around 3.8 million people already have the condition, with about 200,000 new diagnoses annually.^[26]

The estimated prevalence of all diabetes, both diagnosed and undiagnosed, is 8.5 per cent for those aged 16 and over in England, ranging from 6.7 per cent to 11.5 per cent among local authorities in England.^[27]

Among those with type 2 diabetes, 3.9 per cent are under 40 years, 43.1 per cent are aged 40-64 and 38.4 per cent are aged 65-79. 14.6 per cent are aged 80 or above. 44.1 per cent are female and 55.9 per cent are male.^[27] Substantial health inequalities can be seen in type 2 diabetes prevalence. It is 68 per cent more common among those in the most deprived quintile¹³ compared with those in the least deprived quintile in England.^[28]

20.7 per cent of people with type 2 diabetes in England are of minority ethnic origin.^[27] People of a South Asian background in the UK are six times more likely to develop type 2 diabetes than the white population, and those of an African or African-Caribbean background are three times more likely.^[26] Those with a minority ethnic origin have a very noticeable earlier onset (around 10-12 years earlier) of type 2 diabetes, and a significant proportion of cases are diagnosed before the age of 40 years.^[29]

Disabled adults are at high risk of obesity, and thus type 2 diabetes. In 2017/18, 70.6 per cent of disabled adults were overweight or obese, compared with 60.1 per cent of the non-disabled population and 62 per cent of people in England as a whole.^[23] Those with a learning disability in particular, tend to have higher rates of obesity; as high as 50 per cent in adults with learning disabilities.^[30] Therefore, they may be at greater risk of developing type 2 diabetes.^[31]

Obesity and type 2 diabetes

Type 2 diabetes is associated with lifestyle risk factors of which the main modifiable risk factor is obesity. The increasing prevalence of obesity is a major driver behind the rise in type 2 diabetes, which accounts for 90 per cent of all diabetes cases in the UK.^[26]

If current trends continue, one in three people in England will be obese by 2034 and one in 10 will develop type 2 diabetes.^[32]

90 per cent of adults with type 2 diabetes are overweight or obese. There is a seven times greater risk of diabetes in people with obesity compared to those of a healthy weight, and a three times greater risk for overweight people. People with severe obesity and a BMI of 40+ are at even greater risk than those with obesity and a BMI from 30 to 39.9.^[33]

Research findings indicate that almost 75 per cent of those with type 2 diabetes have at least one other comorbidity at the time of their diagnosis and 44 per cent have at least two.

The comorbidities with the highest prevalence are hypertension, depression, CHD (coronary heart disease), asthma, CKD (chronic kidney disease), underactive thyroid, and COPD (chronic obstructive pulmonary disease). There is a higher burden of comorbidity among people from the most deprived compared to the least deprived areas, particularly regarding depression, CHD, asthma and COPD.^[34]

The social care costs of type 2 diabetes were estimated in 2013 using different data sources. Over 70,000 people with diabetes (both type 1 and 2) were estimated to have incurred local authorities direct social care costs of £1.4 billion; £1.26 billion of which was for type 2 diabetes alone.¹⁴ By 2030, 130,000 people in council care are estimated to be affected by diabetes at an associated social care cost of £2.25 billion for those with type 2 diabetes.^[35]

As the pressures on adult social care from the rising prevalence of type 2 diabetes and obesity increase, the pressures on care homes also rise and are not keeping up with the trend. Research on the management of diabetes in care homes indicated that around 25 per cent of residents have a diagnosis of diabetes. Most of these clients will be overweight or obese.

13 The most deprived quintile refers to the most deprived 20 per cent of areas while the least deprived quintile refers to the least deprived 20 per cent of areas.

14 90 per cent of the total costs are retained to reflect type 2 diabetes alone. [36]

An assessment found that 60 per cent of care homes with diabetic residents did not provide any training, and 77 per cent of care homes did not screen residents for diabetes on admission. These limitations led to frequent hospital admissions for such patients, with repercussions for the individual's health and further costs to the NHS and social care. Furthermore, 62 per cent of local authorities had not made an assessment of the needs of older people with diabetes in their area.^[35]

A care home providing training on diabetes

Care staff have often not had the chance to undergo diabetes education. They may not feel they have the necessary skills or knowledge to care for residents with diabetes. Local diabetes specialist nurses and primary care teams have been working together with the care home staff to educate them on diabetes care. Importantly, this has included ensuring residents with diabetes undertake some physical activity, reduce weight and improve their diet. The participants can also complete a certificate in diabetes care and one of them is now the link worker for diabetes.^[35]

Disordered eating

Binge-eating disorder (BED) and night-eating syndrome (NES) are two forms of disordered eating associated with overweight and obesity. While these disorders also occur in those without obesity, they seem to be associated with weight gain over time and higher risk of diabetes and other metabolic dysfunction. BED and NES are also associated with higher risk of psychopathology, including mood, anxiety, and sleep problems, than those of similar weight status without disordered eating. It is essential that greater collaboration and understanding is needed between obesity treatment and eating disorders sectors, from NHS and social care services through to public health policy.

Severe obesity: bariatric or ‘plus size’¹⁵ pressures on social care

As a direct effect of body weight, size and shape, severe obesity can lead to mobility difficulties, physical disability and an impaired ability for self-care. All these factors put pressure on social care.

It is necessary to work with colleagues in other services, such as those working in the area of discharge from hospital.

Increasing demand for specialist bariatric equipment

“We are observing an increase in special purchase beds and the need for specialist equipment for those needing bariatric care at home or in a care home.”

Director of Adult Social Services

Practitioners explained the importance of taking a multidisciplinary approach and that supplying special equipment in isolation can worsen the client’s health, compounding immobility and pain.

A bariatric equipment audit at one council was undertaken using data from 2010/11, 2011/12 and 2012/13. There was a 13 per cent increase in the total amount of non-bariatric equipment issued over those three years, compared with a 10 per cent increase in the total amount of bariatric equipment. However, when it came to costs there was a nine per cent increase in net spend on non-bariatric equipment from 2010- 2013 compared to a 47 per cent increase in bariatric equipment spend.

Bariatric equipment spend accounted for 18 per cent of the total spend in 2010/11 and this rose to 31 per cent in 2012/13. Bariatric equipment items are considerably more expensive than their non-bariatric equivalents as they have bigger and stronger specifications. See the following examples (2014 prices):

Equipment	Non-bariatric cost per item	Bariatric cost per item
Perching Stool	£17.80	£70.00
Walking Frame	£12.90	£58.16
Riser Recliner Chair	£265.00	£800.00
Commode	£19.50	£78.35
Toilet seat and frame	£18.55	£80.64
Mattress	£69.00	£475.00

¹⁵ There is no standard definition for ‘bariatric’ or ‘plus size’ in a care context. Training materials from a commercial bariatric equipment provider use the following criteria: BMI of 40+; or BMI of 30+ with comorbidities; or bodyweight greater than 136 kg (over 20 stone). They caution that BMI alone is not sufficient to assess bariatric needs; the person’s shape and weight distribution are important considerations when reviewing handling, space and equipment for plus size people. Bariatric facilities include larger, reinforced beds, commodes and baths, and mechanical lifts and hoists.

Equipment for disabled people is already at a premium as it is specialised and for a niche market. Bariatric equipment is even more expensive. For example, there is only one suitable stairlift for bariatric use up to 30 stone (190kg), which is imported from the USA and costs from £2400-£6000 depending on the type of staircase. A bariatric bed can cost £3000-£5000, ten times as much as a standard bed.

Toileting is often an issue for bariatric clients due to their girth and weight. A bariatric toilet can cost over £1500. The other option is to send in carers several times a day to tend to the client's toilet needs, at £17.50 per hour, but this is not cost-effective.

Many disabled people need bathroom modifications. However, for bariatric clients these are very costly because the shower tray of a standard level-access shower is too small. A full wet room needs to be installed, so the price rises and the council may not give approval. Such a scenario is common and eventually may lead to a health crisis, fall or injury, requiring a move to hospital or a care home. Commonly, the person then soon loses what independence they had and unfortunately becomes institutionalised.

“The UK is behind other countries such as the USA and Australia in the field of bariatric design. Minimum standards in UK Building Regulations are incompatible with bariatric needs, so expensive adaptations are often needed.”

Housing OT

Case example: bariatric adaptations

The client

A middle-aged man with type 2 diabetes and cellulitis who weighed around 25 stone (160 kg) in 2015 is almost 40 stone (250 kg) by 2018. He has previously been admitted to hospital for sepsis. He is able to walk only a short distance before he needs to rest due to leg and back pain and breathlessness. He experiences depression and anxiety, sometimes severely.

Housing

The client lives in social housing in a one-bedroom flat. He sleeps on the sofa in the living room and does not use the bedroom. The base of the sofa needs to be directly on the floor for stability to take his weight. He has declined the option of a bariatric bed. He has problems accessing and using the toilet in his home.

Contact with services

The client accesses statutory services for his mental health needs and ongoing support. He needs carers to help him manage day to day tasks at home. He is not in employment and is in receipt of various benefits. He can no longer drive, as he is no longer able to manoeuvre the car. He used to go out often, so he is now becoming more isolated. He has been referred to a disabled driving centre. He is provided transport to health/ psychology appointments weekly, has his medication delivered by the pharmacy and has home podiatry visits. He uses the internet to order food and other shopping.

Bariatric adaptations

The client had Disabled Facilities Grants approved for necessary adaptations. In 2015, the client had a level access shower installed so he could wash independently. He stands to shower but is only comfortable to do this for a few minutes. He sits on a specialist shower seat (maximum load 40 stone) as necessary, to rest.

In 2018, as his weight was nearing the safe working load of the shower tray (which became too small) and seat, his bathroom required another redesign and modifications. A full wet room was needed to give him access and manage the water spray and overflow. The adapted bathroom has tiled walls and a floor with a central gully, a specialist bariatric shower chair and a specialist bariatric automatic toilet. The costs of these adaptations (in terms of equipment costs alone) are as follows:

2015: £3,475.00

2018: £4,345.00

Overall total of both Disabled Facilities Grants = £7,820.00

The specialist toilet alone cost £1,550.00 which is around five times more than a standard toilet.

Need to provide specific training on bariatric care

Due to the increase in numbers of clients with severe obesity, council social care departments are finding they need to provide specific training. One local authority ran a 'Plus Size Study Day', for social care and community health staff. The agenda included:

- implications of severe obesity
- difficulties for the client in managing their health and care needs
- the complex psychology of obesity
- the role of motivational interviewing
- housing issues
- moving and handling
- the need for a holistic approach to the clients' wishes and needs.

Bariatric training is now incorporated into annual training skills courses and updates.

“There has to be a change in cultural norms regarding the subject of obesity. There is a bit of a taboo about bringing up the subject of the client’s weight. But if you ignore the underlying condition (i.e. obesity) and concentrate on the secondary conditions like MSK, diabetes, respiratory problems, sleep apnoea, this can compound the issues and make the person’s situation worse.”

Service Manager – Direct Provision

Commercial bariatric equipment providers offer training and consulting, such as a clinical consulting programme and a 5-day CPD accredited cascade training course to ‘work in partnership to embed cultural change in patient handling’. Carers gain the skills to enable them to coach others in their own organisation. The training emphasises that the principles of good care are the same for plus size people as for any other group: “Overweight, obese and morbidly obese people have a right to safe, dignified care, and caregivers have a right to a safe working environment”.

Unmet needs and client hardship

Practitioners comment that for all clients there are already long waits for social care help across the board, and that for many of these people obesity will be an issue. Practitioners such as Housing OTs assess a person’s suitability for a DFG and design the environment for their needs and the needs of family members, who are also often living with obesity. Their aim is to keep people in their own home and as independent as possible. It can be particularly challenging to meet the needs of people with severe obesity and their families.

Such clients usually have limited income, live in social housing and are not able to work due to ill-health and disability. They may need one more bedroom (to house their bariatric equipment) than what would normally be allocated for the numbers in the household.

“But space costs money...they become liable for the bedroom tax¹⁶, due to under-occupation, and affordability drops.”

Housing OT

They could receive housing benefit/universal credit to help with housing costs but not to cover the cost of an extra room if they were to be rehoused. Commonly, such clients are unable to afford the extra rent, so they remain in unsuitable housing (with limited adaptation using a DFG), and eventually have an acute crisis. This then leads to hospitalisation, further problems with health and independence, and extra pressures on social care later on.

“Difficulty in meeting needs at home [for people with severe obesity] is becoming a deciding factor in whether or not care home admission is needed.”

Director of Adult Social Services

Lack of suitable care home places

Suitable and affordable care homes for clients with severe obesity are not easy to find. The care home sector is under great pressure. In 2019, 75 per cent of councils (a rise from 66 per cent in 2018) reported that providers in their area had closed, ceased trading, or handed back contracts in the last six months.^[37]

Bariatric care in a care home requires special equipment, spacious rooms, wide access and support from two or more bariatric-trained¹⁷ staff members for personal care. People living with severe obesity often have great difficulty obtaining a placement in a suitable and local care home.

122 care homes in the UK are listed as accepting clients who require bariatric care, out of a total of 17,783 care homes (0.69 per cent)

41 of the above offer residential care only and **81** offer a care home with nursing

Source: www.carehome.co.uk; accessed 15/03/20

One practitioner had worked to fulfil the needs of six different individuals with obesity over the last two years; increasingly, repeat admissions to care homes were needed for them. These were younger individuals (in their 50s and 60s) so it was not appropriate to look for a long-term care home admission.

“The objective is to work cross-agency, with the care home and with the housing team, to rehouse the person on a permanent basis in a suitable property.”

Team Manager

“As a consequence of the need for specialist equipment we are needing to purchase extra large care home rooms and in some instances two adjacent rooms so that one room can be used just for the bed and equipment.”

Director of Adult Social Services

¹⁶ ‘Bedroom tax’ is a measure introduced in the Welfare Reform Act 2012, by which the amount of housing benefit/universal credit housing element paid to a claimant is reduced if the property they are renting is judged to have more bedrooms than necessary, i.e. if it is deemed ‘under-occupied’.

¹⁷ Care homes that do not have specific bariatric policies and procedures, and do not provide specialist training or supervision, are at risk of health and safety issues and subsequent legal action and penalties.

Case example: placement in a care home

A council care home enabled a placement for a resident with bariatric needs, ensuring her needs could be met, but at a capacity cost.

The elderly client with severe obesity had been in a nursing home but did not need that level of care. She was unable to find a place at other care homes.

“Due to her size, she would be viewed as a difficult case – and more expensive for the care home. Where there’s no care home provision, such cases end up in the nursing sector, even though nursing care may not be needed.

We were creative, we want people to have a nice place to live. Our philosophy is to look after the needs of the person and try to make them more independent. We should try to accommodate people and their needs”. (Service Manager- Direct Provision)

The care home was able to allocate two adjoining rooms to the client to accommodate her and the specialist equipment needed. A few rooms at the home were interconnecting, so the only adaptation needed was to remove the connecting door. The staff put a sitting area at one end and put the bed in the middle facing into the room so the staff can move around the client easily. She has a profiling bed that can carry up to 35 stone (220kg), (all the care home beds are of this specification), and a mobile hoist (also up to 35 stone/220 kg), recently purchased as the care home was looking to the future – there are a number of larger residents. The resident seems happily settled and the placement is permanent. This is now her home.

However, this outcome was achieved at a capacity cost: one less client can be accommodated at the home and potential lost revenue to the council is over £36,400/year for the second room, had it been taken by a self-funding client. Note that this is a council-provided care home, of which there only a few hundred remaining nationally.

“We are not there to make a profit, we are there to best meet the needs of the resident. It’s her home, her needs are what’s important” (Care Home Manager). Meeting this client’s needs appropriately saved nursing home costs for the NHS despite increasing the costs to social care.

There are indications that a growing number of care homes in the UK are building specialist bariatric rooms with the necessary equipment and built to a larger scale than standard. Unsurprisingly there are higher costs attached; depending on the equipment provided, costs for a fully equipped bariatric room can be over £20,000.^[38]

Additional care costs will mean such facilities are out of reach for many people with severe obesity. Martin Green, Chief Executive of Care England, recently warned of a two-tier system developing among care homes. Despite care homes closing “there is a huge amount of external investment ready to go into this sector... all based on high-end, high-quality, self-funding clients. The challenge is to make sure social care is available to everybody”.^[39]

Severe obesity is a hidden problem

Many people with obesity, due to lack of mobility and other long-term conditions such as lymphedema and knee OA, are unable to leave their house to access support; nor do they wish to due to the stigma they feel. Yet, if they were able to begin to lose weight and be more active it would help with their condition, weight loss and pain management.

“People living with severe obesity are often hidden in their houses, trapped. It’s tragic. They can be hidden for years until they come to sight due to a health crisis and have to be rushed to hospital. By then it’s often too late. The largest person I ever dealt with weighed 50 stone (over 300 kg). She had remained hidden for years. Eventually she had a health crisis and had to be extricated by the Fire Service in a bariatric rescue. This was very undignified as they had to take out the windows to get her out of the house. Sadly, she died in hospital.”

Housing OT

Bariatric rescues by the Fire Service are an indicator of the extent to which people living with severe obesity are trapped in their homes, in distressing situations, and the related pressures on the emergency services, social care and health. Fire Rescue Services in England attended 5076 bariatric person-assistance incidents between 2012/13 and 2018/19.^[40]

The number of incidents almost tripled from 429 in 2012/13 to 1209 in 2018/19. The most common reason for the rescue was to assist the ambulance where the patient had fallen, followed by rescue of people stuck in some way; for example, in the bathroom or upstairs due to equipment failure (such as hoists, stair lifts, and electric riser chairs).

Sometimes the rescue involved removing equipment such as stairlifts and tracks, or a window, so the casualty could be moved to an ambulance. The weights of the casualties ranged from 16 to 65 stone, (100 – 400 kg) with the majority being around 25 – 35 stone (160 – 225 kg).

Lack of data

“We have to think about body size in housing adaptations. But we don’t have to record it in any statistics... specific conditions are not recorded, they would be under a more general heading, eg neurological conditions, cognitive impairment, long term conditions... grants for housing adaptations are not available by condition so we are not required to record in this way.”

Housing OT

Despite the lack of data, practitioners are aware of growing numbers of clients with bariatric needs, which are challenging to meet. These professionals commented that extreme obesity, such as a body weight of 40 stone or more (250 kg), was still unusual but the trend of clients weighing 20-30 stone (125- 200 kg), was increasing. Frequently, these clients also suffer from long-term conditions, leading to further social care issues and problems with functioning.

“Figures aren’t much collected so it’s difficult to say. But looking back over my career I saw one plus size person in 20 years and now I’ve seen ten in ten years. So it’s an important area to highlight, it consumes resources and time. It’s important for all professionals to work together to try every effort to support people at home. We need to get it right for the person; we have to be motivated to work together.”

Team Manager

Lack of access to suitable community rehabilitation

Lack of access to suitable community rehabilitation is a key concern among practitioners.

“A person with obesity could be just managing at home. They could have a fall, go to hospital. Once they leave hospital – they need the right equipment, and the space, in the first few weeks to try and regain functionality. This is often not available.

The person could be many months working with therapists getting them moving again. Many agencies are involved and the client may never regain the functioning they had before they fell.”

Team Manager

Case example: a fall at home

The client

Mrs X is sixty-five years old, plus size, with type 2 diabetes, cellulitis, reduced vision, COPD¹⁸, anxiety and depression. Mrs X owns a small property where she lives alone. As there are steps into the property she is not able to go out. She is able to walk very short distances so is managing at home with some support from her children who do not live locally.

The emergency and its initial outcome

Following a fall, Mrs X requires two ambulance crews to lift and support her to be admitted to hospital with a chest infection and possible fracture. This admission is prolonged and she requires intensive care treatment.

Four weeks later, Mrs X is medically ready to be discharged, but is unable to get out of bed without the support of a hoist and three people. She requires rehabilitation to be able to regain her balance, to be able to sit and then stand with the goal of walking again.

Delayed discharge

Mrs X is not able to access rehabilitation as resources are limited to enable a plus size person to undertake rehab. She needs to remain on the ward to progress her rehab before the community health rehab unit will be able to create a support plan with her.

Mrs X remains in hospital for a further two months. Working with the physiotherapist, progress is limited and it takes several people to transfer, support and reassure Mrs X. Treatment sessions are often completed in her bed space and are resource limited as this is an acute hospital setting.

Review by multidisciplinary team

At review with the medical team, therapists, community rehab team and social care, it is agreed that Mrs X is not going to benefit from rehab and that it may not be possible

18 COPD: Chronic Obstructive Pulmonary Disease.

for her to stand and walk again. Mrs X is low in mood and the mental health team review how they are able to support her with her increasing depression and anxiety.

The occupational therapists assess that Mrs X cannot return to her home as there is not sufficient space for the equipment she requires, care cannot be provided in this space and she will not be able to access her home safely. There are several risks facing Mrs X in her home.

Rehousing

Mrs X decides to consider rehousing and all agree that in order to plan and be safely discharged, she should move to a nursing home temporarily.

Temporary move to a nursing home

It takes a further month to source a nursing home that can offer Mrs X the space and level of care she requires. The nursing home develops a plan, and risk assessments are completed that include a fire safety check and exit plan before the move can be organised.

Mrs X moves to the home and with family and council housing support, considers properties that will be able to meet her needs, including adaptations that may be required.

A suitable property

It takes a further six months to sell and find a suitable property. The property is in a supported living unit and care is available on site. The council complete a Care Act assessment and include an occupational therapist so the equipment and adaptations required can be provided.

Outcome

Mrs X moves into her new home just over a year after falling in her home. It is now possible to make an assessment for a powered wheelchair as she is in a property where she will be able to use it. She is settled in her home.

Her environment, equipment and level of care are key to ensuring that she remains in control of her health and that her needs

are met. It has taken an extended time to be able to meet Mrs X's needs. All services have had to work in partnership to be able to achieve these outcomes.

Conclusion

During this time Mrs X has required extensive input from:

- the ambulance service
- acute health services, including intensive care
- physiotherapy
- occupational therapy
- psychology
- mental health services
- community health services (including GP support)
- district nursing services
- rehabilitation therapists
- council housing teams and access to a Disabled Facilities Grant
- equipment and wheelchair services
- a social worker
- community occupational therapists
- a nursing home and related staff
- a care agency
- an advocate and housing support worker to support with finances and benefits.

“It is a struggle to facilitate discharge of plus size patients. Though the actual numbers of people with severe obesity are few, individual cases have a huge impact on every service that they come into contact with. There are increasing pressures of time, costs, and resources.”

Service Manager

Why is tackling obesity important to social care?

Costs associated with treating long-term conditions, including diabetes, are significant and likely to increase as levels of population obesity rise and as the population ages, with many more years spent in ill-health.

Obesity has a negative impact on long-term health conditions and people's ability to live independently. Social care requirements for people living with severe obesity are costly and include housing adaptations and carer provision. Tackling obesity through prevention, early intervention and provision of appropriate social care will improve clients' health and wellbeing, pre-empt future health and social care issues, promote independence and reduce the pressures on social care and the NHS.

Obesity damages the employability and productivity of local communities and leads to increased benefit costs and demand for social care.^[41] Tackling obesity will help reduce these demands and narrow health inequalities.

Work to tackle obesity pressures in social care is in line with the Adult Social Care Outcomes Framework, Domain 1: Enhancing quality of life for people with care and support needs, and Domain 2: Delaying and reducing the need for care and support.^[42]

Such work also supports progress towards outcomes identified in the Public Health Outcomes Framework including Domain C: Health improvement and Domain E: Health care and premature mortality.^[43]

What can social care do to tackle obesity?

Focus on prevention: work with partners to embed physical activity and healthy eating support within existing social care pathways

“Prevention is what’s needed – people not getting so big in the first place.”

Housing OT

Obesity-related, long-term problems like MSK conditions and type 2 diabetes all improve with taking up a healthy lifestyle, even when older, and physical activity and healthy eating have a protective effect into old age.^[44] Any physical activity helps MSK symptoms and reduces later uptake of care.

People who are physically active are 38 per cent less likely to be using any care two years later, with the strongest effect for formal care use. Those who are active are 36 per cent less likely to use informal care, 27 per cent less likely to use privately purchased or informal care, and 64 per cent less likely to use formal care, so promoting physical activity is a potentially cost-effective intervention to tackle rising social care costs due to obesity.^[16]

“Just the cost of bariatric chairs and beds vs. the standard cost makes the point...but of course the interventions need to be much earlier than at the point of the person needing such care.”

Director of Adult Social Services

Nationally, the Government’s 2019 Prevention Green Paper ‘Advancing our health: prevention in the 2020s’^[45], the NHS Long Term Plan 2019^[46] and the Government 2018 policy paper ‘Prevention is better than cure’^[47] all emphasise the key role prevention plays in tackling major health challenges such as obesity.

The LGA has called for more funding. The public health grant provided to local authorities has reduced by over £700 million from 2015/16 to 2019/20. The LGA is pressing for it to increase to at least £3.9 billion by 2024/25 so it matches the growth in overall NHS funding which is part of the NHS Long-Term Plan.^[48]

Work collaboratively and move towards integration

The NHS Five Year Forward View from 2014^[49], Next steps on the NHS Five Year Forward View in 2017^[50] and the 2019 NHS Long Term Plan^[46] put forward a vision of integration between the NHS and social care, to meet the needs of our changing population. The aim is for the whole of England to be covered by Integrated Care Systems (ICSs) by April 2021.

These local partnerships – Integrated Care Systems (ICSs), Integrated Care Partnerships (ICPs), Accountable Care Organisations (ACOs), along with the voluntary sector, local communities and businesses need to work together to tackle obesity in the local area.^[41]

Working with an integrated approach, including joint health and social care budgets, will help to reduce some of the pressures on social care.

“The move towards integrated care is welcome but it requires good integrated working with partners. This is not easy, it requires influencing and persuading and depends on good relationships with individuals. Organisational systems are not set up to do this easily. Joint budgeting requires good work together, not just trying to save costs to your own budget.”

Head of Operations

A significant proportion of people accessing council care will have diabetes and at least one other condition or care need, requiring an integrated, client-centred approach, with tailored care packages^[35] and interventions targeting both physical and mental health. Mental health issues among people with diabetes are of growing concern.^[34]

“We can’t work in isolation, we need to work together. We have to anyway because of limited resources to enable appropriate support and care for plus size clients, and to achieve good outcomes while considering the needs of the whole person.”

Service Manager

Crisis response falls team (CRFT): joint work reducing admissions and repeat falls

The CRFT consists of specialist ambulance crews, two bariatric ambulances with specialist lifting equipment and a social care support team.

Description

Fall-related calls make up about 20 per cent of all calls received by the East Midlands Ambulance Service (EMAS); approximately 90,000 calls per year. Reducing demand on hospitals and the potential negative outcomes associated with hospital admission are important priorities.

The Northamptonshire area (population 700,000) developed the Crisis Response Falls Team (CRFT). The ambulance crews include seven staff made up of paramedics and emergency care assistants who are trained in enhanced diagnosis and lifting techniques related to falls. The CRFT social care support team is provided by Northamptonshire County Council, under a contract with a social care provider.

The social care team works with people who have fallen, who are referred by the CRFT ambulance crews, other clinicians or the council. They assess people in their own home, identifying risk factors for repeat falls, removing trip hazards and installing aids to help reduce that risk. They also attend A&E to assess patients and facilitate discharge, undertake home visits and support/refer patients afterwards, thereby avoiding unnecessary admissions.

Rationale

Falls are already the main cause of mortality due to injury in people over 75 and as the population ages, falls will make up a higher proportion of emergency calls. In addition to this, with the rising numbers and levels of obesity in the UK, bariatric patients often require mechanical lifting equipment to help them when they fall,

resulting in treatment delays and adding further pressure to the services involved.

The CRFT crews, therefore, use two bariatric ambulances and specialist lifting equipment, rather than standard ambulances, to ensure people of any size who fall can be helped.

Outcomes and savings

Of 1300 referrals to the CRFT in Northamptonshire in 2012, 1050 admissions were avoided. This was due to faster access to specialist lifting equipment, enhanced diagnosis to avoid conveyance to A&E, and the support offered by the CRFT social care support team to facilitate discharge from A&E. This had a net saving of £640,000 (£91,000 per 100,000 population).

Moreover, the conveyance rate to hospital for people who fall attended by the CRFT is around 40 per cent compared to 65 per cent for a standard ambulance. The number of fall-related calls in Northamptonshire has stabilised at around 10,500 per year, in contrast to previous annual rises, and the risk of repeat falls has reduced.

Costs

The net savings of £640,000 take into account the additional staff required, training and cost of the contract with the social care provider. The non-recurrent costs (two bariatric ambulances with additional equipment) are equivalent to less than six months' savings.

Quality improvement

All patients who fall benefit, but particularly those who would otherwise have to wait for a bariatric vehicle. The CRFT can safely lift and move patients who have fallen, who might otherwise be left on the floor until more specialised equipment is found. This helps to stop their injuries worsening and prevents further injuries, distress and indignity resulting from being left immobile on the floor.

Patients who can avoid going to hospital with the help of the social care team are at lower risk of healthcare-acquired infection. In an evaluation, the social support offered by the service was seen as a particular benefit to patients.

Lessons learnt

The initiative depends on a good working relationship between all stakeholders; the use of bariatric ambulances and equipment; and the participation of a social care team provider.

It involves joint training of paramedics and social care staff, providing each sector with a unique insight into the other's role. It is a significant and positive achievement from multiple organisations working well across health and social care.

Quality and Productivity NICE case study (2016) ^[51]

Use a whole systems approach to obesity and healthy weight

Obesity is a complex and dynamic problem with long-term implications. To support action on reducing obesity, local authorities and their departments, such as social care, should utilise systems thinking. A collaborative whole systems approach (WSA) is more likely to succeed than single, separate interventions.

A 'Health in all Policies' (HiAP)^[52] approach provides a useful framework for whole systems working. It enables tackling obesity to be embedded in work across the council and all partners including the NHS, local businesses, communities and the voluntary sector.^[41]

What is a whole systems approach?

“A local whole systems approach responds to complexity through an ongoing, dynamic and flexible way of working. It enables local stakeholders, including communities, to come together, share an understanding of the reality of the challenge, consider how the local system is operating and where there are the greatest opportunities for change.

Stakeholders agree actions and decide as a network how to work together in an integrated way to bring about sustainable, long term systems change”.

Integrating a WSA into the council has many benefits:

- Supports the council’s key priorities – tackling obesity can improve workforce health, contribute to a stronger local economy, and reduce social care costs.
- Develops a coordinated set of approaches – recognises that tackling a single cause of obesity in isolation is less effective than a coordinated range of activities over the short, medium and long term.
- Ensures partners across the system work together – moves from silo working in departments to an approach engaging a wider range of stakeholders, focused around agreed goals.
- Maximises all the assets in the local system, including community resources – bringing in valuable insights and creating additional resource.
- Reflects the local leadership role of local authorities – working with and through an extensive range of stakeholders, including communities.
- Develops transferable workforce skills and capacity, relating to system thinking – relevant to many different complex issues.^[53]

‘Making obesity everybody’s business’
(LGA, Nov 2018)

Public Health England (PHE) and Leeds Beckett University, with the support of the Association of Directors of Public Health (ADPH) and the LGA, worked with 11 local authorities from 2015-2019 to produce a ‘whole systems approach to obesity’ practical guide and the following resources for local authorities:

- Whole systems approach to obesity: A guide to support local approaches to promoting a healthy weight. PHE, 2019
- Health matters: whole systems approach to obesity. PHE, 2019
- Health matters: Short version: whole systems approach to obesity. PHE, 2019
- What Good Healthy Weight For All Ages Looks Like. PHE, 2019

Contribute to key council policies that include tackling obesity

For example, the Joint Strategic Needs Assessment (JSNA) should include detailed information on obesity to provide adequate data as a basis for service provision and action. It feeds into the Health and Wellbeing Strategy that sets out joint action on health and wellbeing, including obesity.

The Adult Services Plan should detail the links between obesity and demand for adult social care services, particularly relating to its impact on long-term health conditions and independent living. The Housing Strategy should reflect demands for housing type and adaptations related to obesity. The Obesity/Healthy Weight Strategy should be collaborative and engage key stakeholders while demonstrating a clear approach to physical activity and healthy eating throughout the life course.^[54]

Develop bariatric policies and pathways and provide adaptations and carer support

This would ensure consistent, person-centred care for clients living with severe obesity. An example policy can be seen here^[55]. Multiagency, collaborative policies and bariatric care pathways are needed as the care of people with bariatric needs is complex and involves a number of agencies.

The aim should be to provide seamless, respectful care and a less daunting experience for both client and care giver. This can help people with severe obesity to improve their quality of life and avert the need for emergency service intervention (as a result of falls, for example).^[56]

Provide specific training and awareness raising for social care staff

The training of practitioners in 'Making every contact count (MECC)'^[57] will help to alleviate stigma and improve clients' physical and mental health. Practitioners learn how to undertake brief interventions and how to raise issues sensitively and in a non-judgemental way.

Specialised training for social care staff in bariatric care and appropriate use of bariatric equipment is also needed.

It is also important for social care staff to be trained and made aware of key prevention programmes for their clients, such as Healthier You: the NHS Diabetes Prevention Programme (DPP)¹⁹, which can be accessed via primary care.

Practitioners should familiarise themselves with their local obesity care pathway (via their council public health team or clinical commissioning group), so they are aware of local weight management services available and the referral criteria and process.^[58]

Invest in reablement

'The LGA, along with other national health and care partners, advocate for preventative, person-centred integrated care, with investment in community provision that maximises people's independence and wellbeing, and the resilience of communities.

This means investing in services such as reablement, which helps people regain their independence after time in hospital and helps reduce the likelihood of returning to hospital.^[48]

Reablement services are invaluable for people with severe obesity and any accompanying long-term conditions such as diabetes or MSK problems. There is strong evidence that investing in such services is effective, with 75 per cent of people shown to improve their independence as a result of reablement.^[59]

In 2018-19 in England, just 2.8 per cent of people aged 65 and over were offered reablement services following discharge from hospital and numbers vary greatly from one council to another: ranging from 0.4 per cent to 13 per cent across local authorities.^[60]

The Institute for Public Care (IPC) proposes that that at least 70 per cent of people assessed as having care needs should have an enablement-based service.^[61]

19 The NHS DPP is part of the stronger national focus on improving diabetes prevention in the NHS Five Year Forward View. It provides evidence-based behavioural interventions on a large scale for those identified as being at high risk of developing type 2 diabetes.

Use proven innovative models of social care

These can provide excellent outcomes for clients with obesity. For example, Shared Lives services²⁰ are an effective alternative to a care home.

Shared Lives Lancashire: an innovative model of care

This service was judged as outstanding in all categories by the CQC in 2019.

Shared Lives Lancashire provides long term placements, short breaks, respite care, day care and emergency care for adults with a range of needs, within carers' own homes. The CQC Inspection Report (2019)^[62] included the following:

'People's needs were met through robust assessments and support planning. We saw outstanding examples of when the service had worked with other healthcare professionals to achieve positive outcomes for people and to improve their quality of life. The service had supported carers to secure a grant to make their homes accessible. This supported the delivery of high-quality care and independence for people.

We saw outstanding examples of when people had been supported to maintain a healthy and balanced diet and how this had significantly improved their lives. For example, one person used to be in constant pain and had health problems related to being significantly overweight. The carer encouraged and supported them with their diet and exercise and three years later they had lost seven and a half stone (48kg).

This person had not taken a tablet for pain in over 12 months, no longer required the use of a leg brace, worked as a volunteer and undertook many activities within the community. This had a significant, positive impact on the person whose confidence had grown immensely.

People spoke extremely positively about the impact the carers and service had on their lives. One person told us, "I have lost a lot of weight through healthy eating." And another person told us, "I do my exercises daily to keep fit."

People with complex health needs received care and support that was positive and consistent and improved their quality of life. For those people with protected characteristics as defined in the Equality Act, we saw excellent examples of how the service, staff and carers were proactive in how they supported them.

Staff and carers had excellent knowledge and skills and the training made available to them ensured people's needs were extremely well met.'

²⁰ Shared Lives services recruit, train and support self-employed 'shared lives carers' who offer accommodation and support arrangements for vulnerable adults, including those with disabilities, within their own family homes in the community.

Conclusion

The adult social care system is already under great stress and suffering a huge funding gap. The rise in obesity is putting increasing pressure on social care costs. There are links between obesity and social care need: both through the association between obesity and the development of long-term conditions, and the physical and social difficulties that often result from the development of severe obesity.

As the prevalence of obesity – especially severe obesity – along with associated long-term conditions such as diabetes and MSK conditions, increases in the population, health and social care costs rise.

There is no systematic collection, publication or analysis of national and local level data on the links between obesity and social care need, leading to big gaps in data and challenges in prevention work, service planning and prediction of future needs. This situation could be improved by appropriate data collection, sharing, and linkage, to ensure that services are tailored to population need.

Effectively preventing and treating obesity will tackle health inequalities and has the potential to significantly improve quality of life and wellbeing in addition to reducing health and social care costs. As outlined, social care services should address both prevention of obesity and care of people with obesity in order to reduce this burden on individuals and society.

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