SCOPE School

LONDON
14-15 JUNE 2016

FAKENHAM
WEIGHT MANAGEMENT SERVICES

HOW CAN PRIMARY CARE CONTRIBUTE?
INTEGRATING CARE & DEVELOPING PATIENT PATHWAYS

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Affiliations & COI

- NICE Obesity CRG and quality standards
- GP with interest in nutrition group
- Association for the study of Obesity (ASO) Eastern region representative
- Norfolk Obesity Network founder
- Consultancy; Janssen, Ethicon, Mundipharma, Orexigen, Oviva, Kastech
- Hospitality; LighterLife, Cambridgeweightplan, Nutricia
- Research funding; RCGP, Breast Cancer Campaign

How can primary care contribute?

Why integrate services? Horizontal and vertical integration.

How to develop a Patient pathway using Norfolk as an example?

Multidisciplinary working within a Tier 3 service

How can primary care contribute?

- Identifying people at risk from obesity related co-morbidities
- Weighting and measuring height and calculating BMI
- Discussing the result as appropriate; may include individual risk scores and personalised advice
- Asking the patient if they would like help
- Offering appropriate advice and referral
- Supporting weight loss attempts and weight maintenance
- Working closely with other services
- Supporting Public Health messages and interventions
- Encouraging CCGs to commission appropriate services
- Develop and disseminate local pathways for weight management

How can primary care contribute? Examples from Norfolk

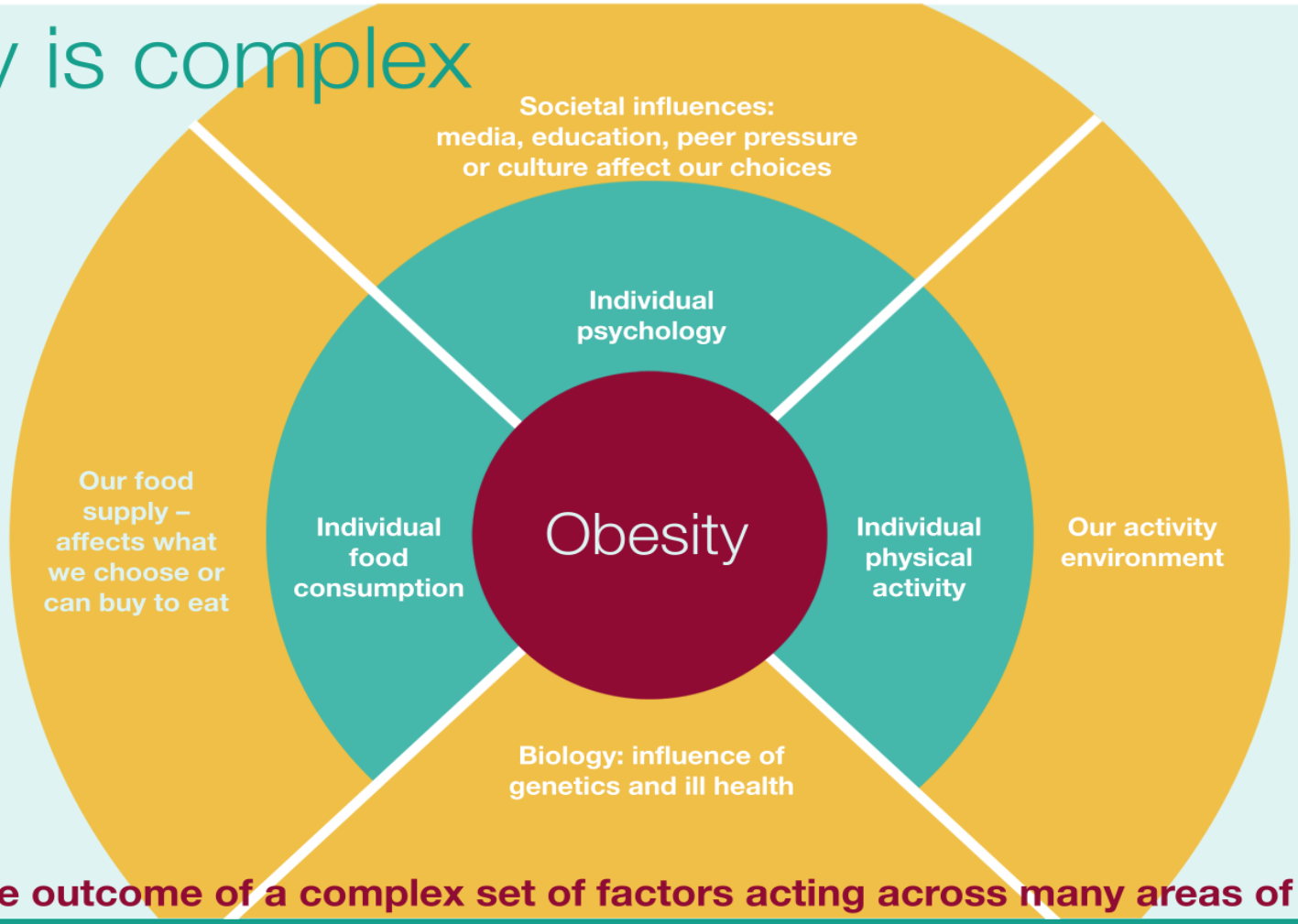
- County in East Anglia
- 860,000 population
- 110 GP practices
- 5 Clinical commissioning groups (CCGs) responsible for planning &buying healthcare services for their local area such as: hospital care, Community Health Care services for people living in Norfolk and Waveney area. They can buy services from any service provider that meets NHS Standards and cost and must gain assurance of the quality of the services being provided.
- 3 acute hospital trusts
- Public health managed within Norfolk County Council (with guidance from Public health England)

Why integrate?

- Obesity is a complex problem; environmental, genetic, epigenetic, medical, behavioural, psychological, socio-economic, commercial, political
- Costs of medical and social care are huge and impact on both public services and employers
- There is a need to tackle both prevention and treatment of existing disease
- There are potential conflicts between providers of care in a market driven NHS (commercial vs NHS, primary vs secondary care, CCG vs Public health budgets)
- Food and drink manufacturers may have conflict between maximising profit vs producing ‘healthy consumables’
- A whole systems approach is needed

Public Health England

Obesity is complex



Obesity is the outcome of a complex set of factors acting across many areas of our lives

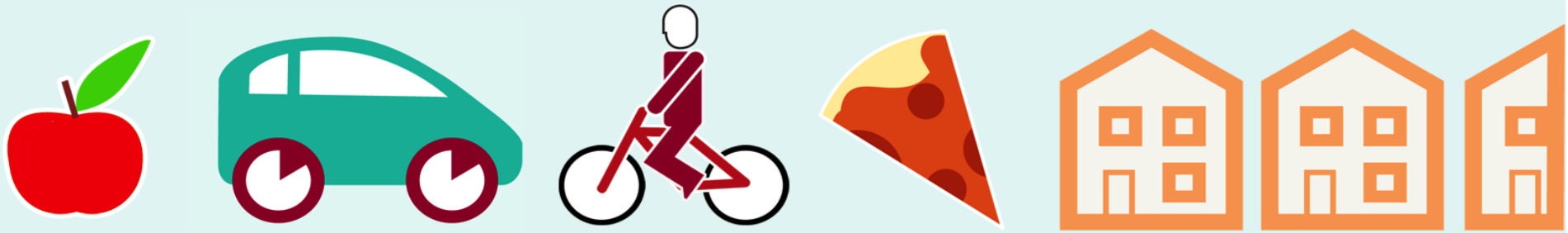
Public Health England

Whole system approach

Sustained changes to individual behaviours across the whole population will require:

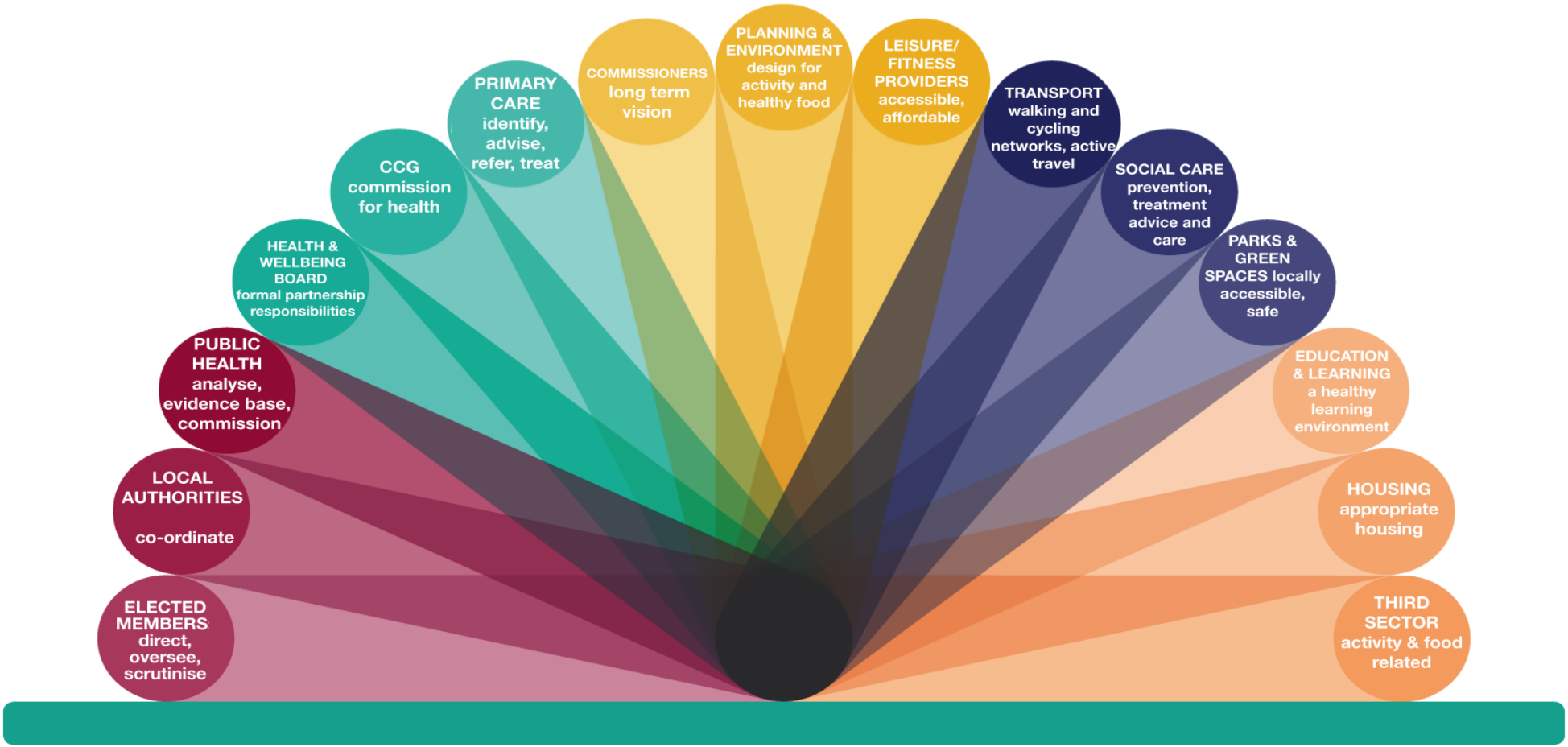
Multiple actions across all parts of the **system**

Changes to the food, physical activity and social environments



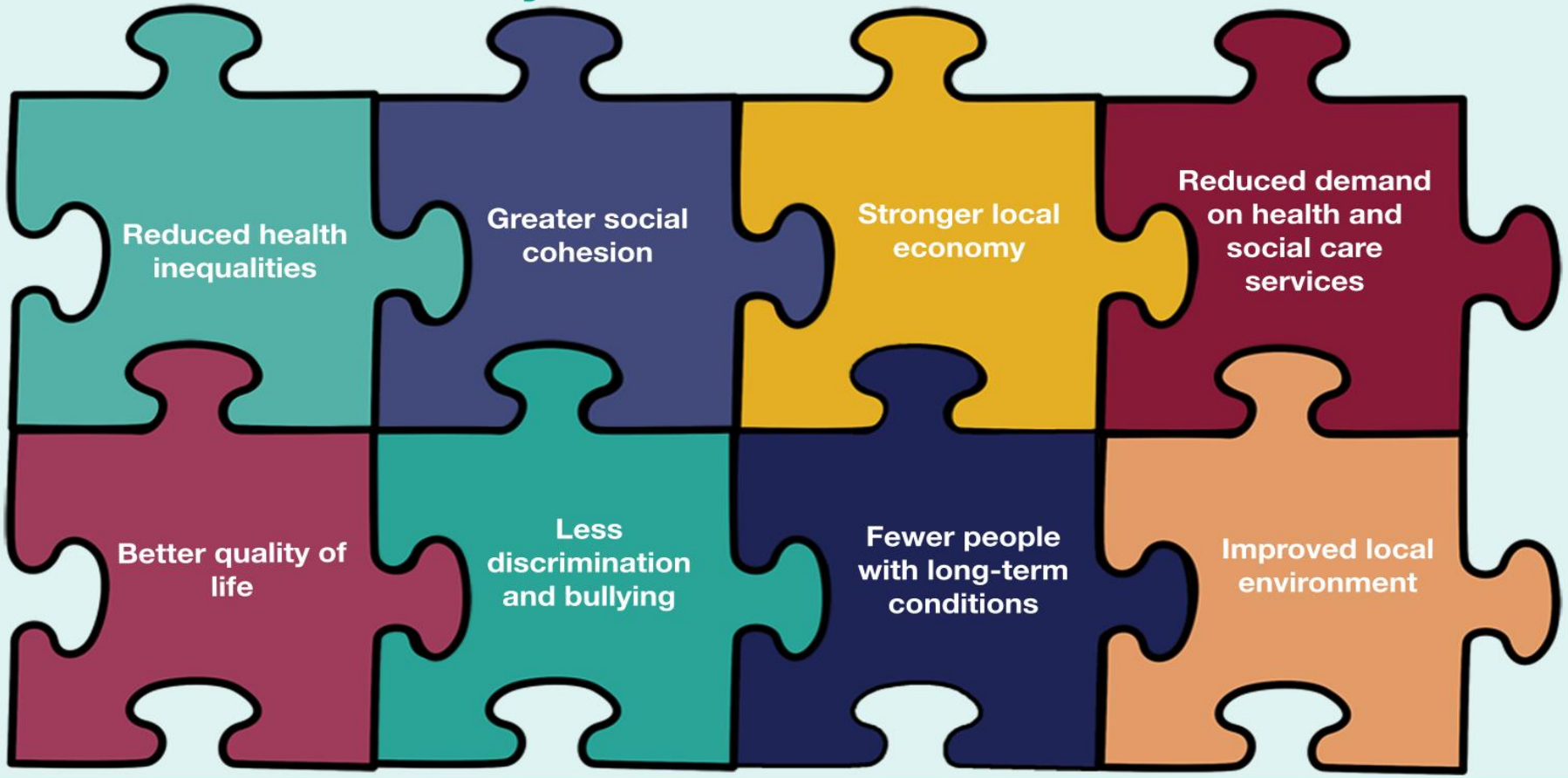
Public Health England

Partnership: the key to success



Public Health England

Action on obesity can lead to:



The disproportionate economic burden associated with severe and complicated obesity: a systematic review

E. Grieve, E. Fenwick, H-C. Yang and M. Lean. Obesity reviews 2013

Class 3 or 4 obesity BMI >40 kg/m2 is the fastest growing category of obesity and adds an additional economic burden.

BMI > 30 kg/m2 resource use per capita is estimated to be a 1/3rd higher compared to those of normal weight

Pharmacy costs for diabetes and CVD medications are up to 27% greater in the obese population

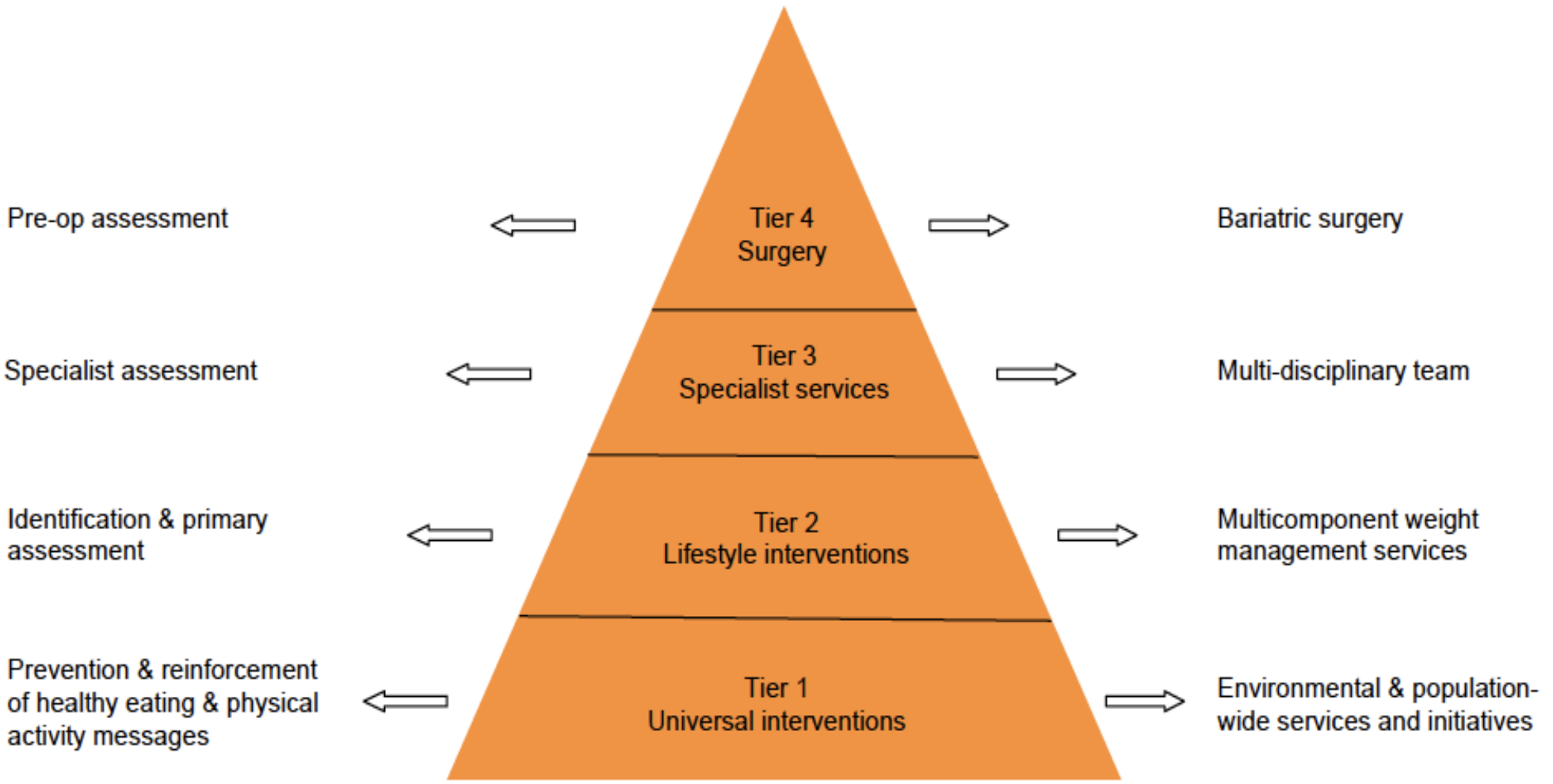
Costs of absenteeism and workers claims 1.7-8.0 higher for those with BMI > 40 kg/m2

Tsai et al report that the total healthcare costs of severe obesity account for 35% of the total obesity costs although only 15% of obese population have severe obesity.

Horizontal and Vertical Integration

- At every level collaboration between multiple stakeholders is required
- Prevention and treatment of people with Obesity both require a range of services to suit differing populations
- Children require specialist services but ideally should link with adult services or family services so that the whole family unit can be helped
- Multi-component interventions are more successful (dietary advice plus physical activity intervention NICE CG 189)
- People with co-morbidities and complex obesity require medical input into the multidisciplinary team (Tier 3 services)
- Medical specialist services need clear links with bariatric surgery services (Tier4) and community services (Tier 2)
- Health and social care need to work together

Tiers of Obesity services DoH 2013



Tier 1 Public health initiatives

Commissioned by Public health (now hosted within local government not NHS

National initiatives Public Health England;

- Change4Life http://www.nhs.uk/change4life/Pages/change-for-life.aspx
- Sugar Swaps App
- Social marketing
- Promoting best practice

Local initiatives;

- Town planning/ Active transport/Licensing of food outlets
- Programmes within schools
- Website providing information www.*norfolkslivingwell*.org.uk/

Public Health England

Opportunities to influence action

Health and wellbeing boards setting strategic direction and decision making

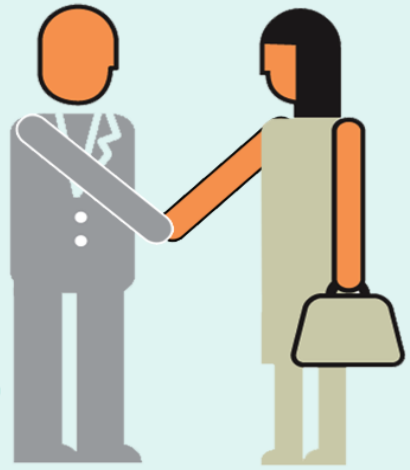
Local transport planning cycle and walking networks, new roads, access to public transport on new developments, street lighting for safer streets

Enforcing planning guidance for new developments and fast food outlets. Walkability scores for new developments

Community infrastructure levy money derived from new development schemes to put something back into community infrastructure

Ofsted inspections school meal standards and how pupil sport premium is spent

New universal school meals for all pupils in reception, year 1 and year 2



Tier 2 services (multi-component NICE CG189 & PH 53)

- Commercial group providers e.g. weight watchers/slimming world
- NHS groups; Dietitian led ‘Reshape Rotherham’
- Health trainers (group or individual appointments)
- Physical activity services ‘ActiveNorfolk’ plus Health Trainers
- Individual dietitian appointments (may be local BMI criteria)
- Local initiatives e.g. GP practice based programmes

There are many other services available which may help individuals to lose weight

- On-line services
- Specialist groups ‘Man v Fat’
- Other commercial providers e.g. LighterLife/Cambridgeweightplan

Tier 3 services

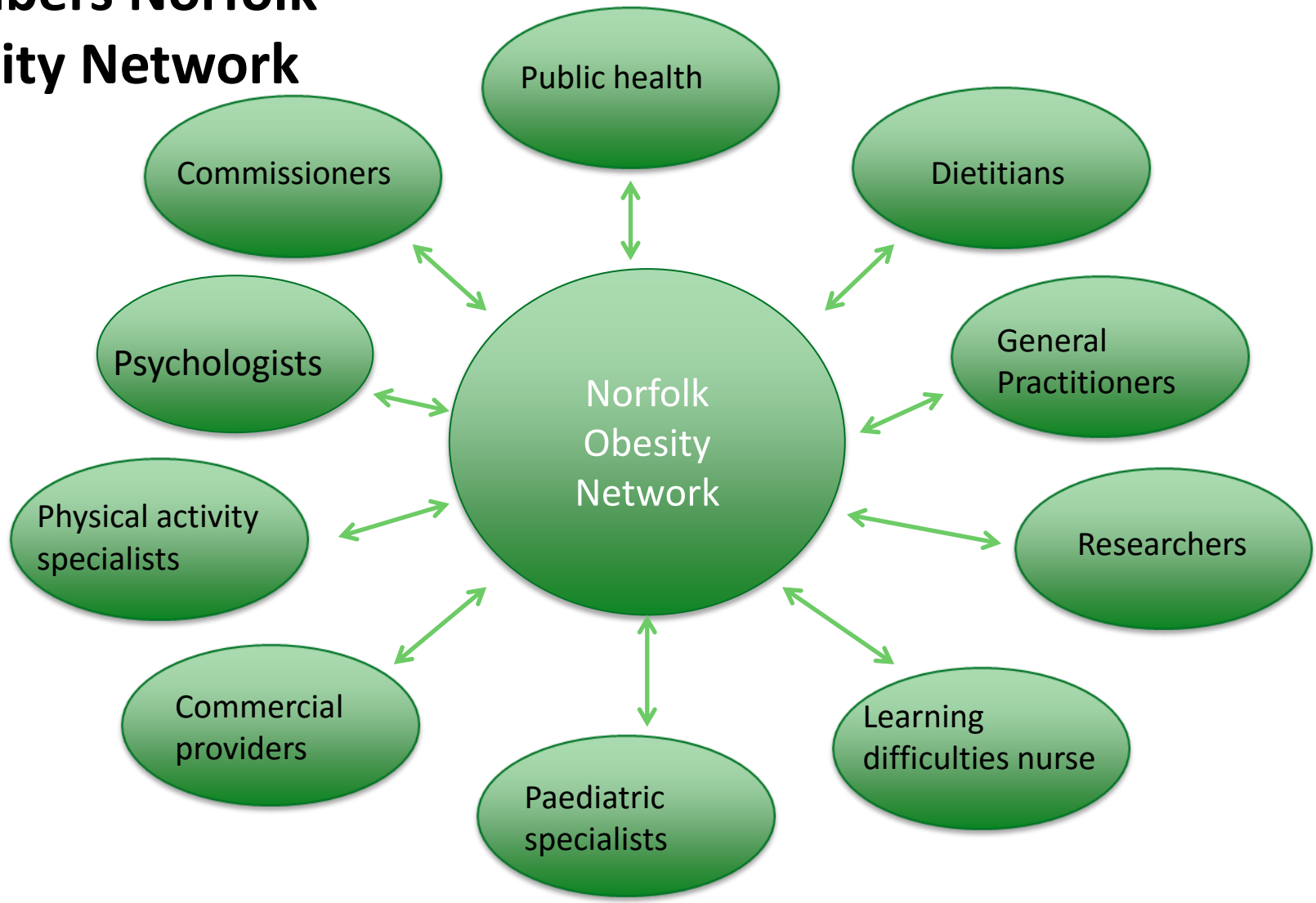
Multidisciplinary team should include;

- Specialist doctor/bariatric physician (usually endocrinologist/GPwSI/metabolic medicine specialist)
- Dietitian
- Physiotherapist or medical exercise specialist
- Psychologist/psychiatrist/mental health nurse/eating disorders specialist
- Obesity specialist nurse
- Dedicated administrator
- *Bariatric surgeon (if co-located with surgical unit)*
- *Health trainer*
- *Occupational therapist*
- *Public health link worker*

Norfolk Obesity Network

- Started in 2011 by a GP, Endocrinologist, &Public health consultant
- Unfunded
- Free to join
- Local meetings across the county ; well attended wide range of people
- Clinical network but involving commissioners
- Primary and secondary care
- NHS and commercial providers
- Responsive to local need (service changes/safety alerts)
- Developing Norfolk Obesity pathway and clinical protocols
- Joint meetings with Active Norfolk/Association for the Study of Obesity/local hospital Norfolk and Norwich University trust/Institute of Food Research Norwich

Members Norfolk Obesity Network



Clinical achievements

- **Developed Norfolk Obesity pathway 2011**
- **Support for practitioners**
- **Developed shared care protocols for management of severe & complex obesity between community based Tier 3 and expert endocrinology at Norfolk & Norwich NHS hospital trust**
- **Developed protocols for LELD use**
- **Education meetings on wide range of topics (eating disorders/physical activity/update from conferences/national level speakers to meet local needs)**
- **Shared meetings with ActiveNorfolk at physical activity forum**
- **Shared meetings with Eastern region ASO**
- **Dissemination of local resources**
- **Link with researchers at University of East Anglia and Institute of Food research Norwich**
- **Case discussions leading to safety alert about lack of provision of post bariatric surgery follow-up care**
- **Winner ASO best practice award 2015**

Example of action

- Discussion of 2 cases at NON meeting who had been lost to follow-up after discharge from bariatric unit
- Common themes of miscoding and loss to follow up, with serious consequences for the patients
- At discussion it was agreed to write to all Norfolk CCGs with safety alert, enclosing the RCGP Top ten tips on post-bariatric care for GPS advice, and referencing the RCGP post-bariatric care audit template.
- This was published in the GP practice bulletin circulated to all Norfolk GPS
- The referrals from GPs to Tier 3 services for post-bariatric care appropriately increased

Safety alert on post-bariatric surgery care: advice for practices

- The safety alert can be viewed on North Norfolk CCG's website.
- RCGP 10 top tips for post-bariatric care available from RCGP website or

  Ten Top Tips for the management of patients post-bariatric surgery in primary care Helen Mary Parretti, Carly Anna Hughes, Mary O'Kane, Sean Woodcock, Rachel Gillian Pryke BJO 2015 vol 1 2 68-73

  http://www.britishjournalofobesity.co.uk/journal/2015-1-2-68

  A follow-up letter for patients outlining their own responsibilities after surgery which can be adapted is also on the website. Links to resources for practice staff have been placed on Knowledge Anglia website for continual reference (Norfolk CCGs only) .
- Norwich CCG have recommended running the RCGP post-bariatric care audit and may incorporate incentives via the safe prescribing scheme
- North Norfolk CCG have agreed to commission post bariatric care using a shared care model.
- NON will look at designing a teaching package for GPs on post-bariatric care
- Post-bariatric care will be discussed at the next NON meeting to include recent article;

  Guidelines for the follow-up of patients undergoing bariatric surgery

  O'Kane M, Parretti H ,Hughes CA, Sharma M, Woodcock S, Puplampa T, Blakemore A, Clare K, MacMillan I, Joyce J, Sethi S, Barth J

  Clinical Obesity June 2016 Vol 6 Issue 3 210-224

  http://onlinelibrary.wiley.com/doi/10.1111/cob.12145/abstract

Patient pathway North Norfolk CCG

Primary care

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Weight and calculate BMI

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If BMI > 30 kg/m2 offer tailored advice and refer to Tier 2 service (multi-component)

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Tier 2 intervention : if BMI > 50 kg/m2 refer to Tier 3 service

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Tier 3 service : if BMI >35kg/m2 with co-morbidities or BMI > 30 kg/m2 with recent onset T2D

Multi-component multidisciplinary intervention as per NICE CG 189

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Tier 4 service: bariatric surgery

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Tier 3 service

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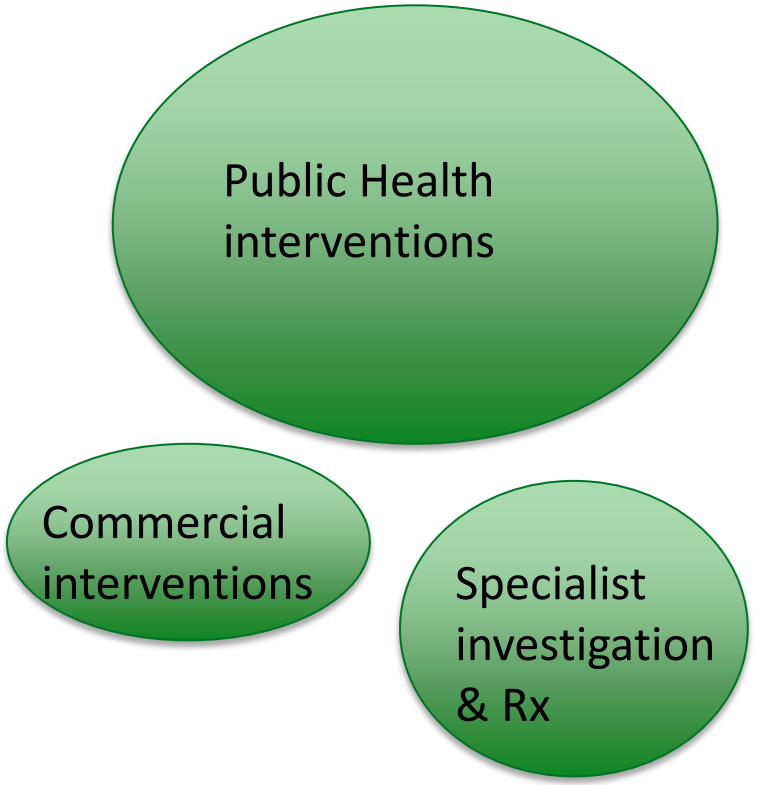
Primary care: shared care follow-up after discharge from bariatric unit



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NHS North Norfolk Clinical Commissioning Group

Multi-component Multidisciplinary team ASO Best Practice Award 2015

FAKENHAM WEIGHT MANAGEMENT SERVICES

Fakenham Weight Management Service (FWMS)

- Dedicated administrator
- GP with specialist training (SCOPE certification)
- Obesity specialist nurses (OSNs)
- Dietician
- Weight management advisor (trained HCA)
- Psychological therapist
- Health trainer
- Exercise professional
- Clinical core group :endocrinologist, clinical psychologist, Public health, patient participant representatives x2, PPG representative and CCG representative

Training

- Basic nutritional core knowledge
- Basic knowledge on lifestyle interventions
- Motivational Interviewing
- Specialist skills e.g. managing eating disorders
- Appropriate Medical training for their role;
- Screening for OSA/mental health problems etc
- Understanding of T2DM
- When to refer to the bariatric physician
- Data collection training
- IT skills (Prohealth programme/Oviva App)
- Research training
- Group Intervention training

Methods

Clinical protocol based on **NICE CG 189**

- **Close collaboration and shared protocols with local endocrinology and bariatric surgery centres**.
- **Links with PH and Tier 2 services via Norfolk Obesity Network**
- **Patient participants on Clinical Core group**

Inclusion criteria; Age 18-75 years, BMI≥40kg/m2, or BMI ≥ 30 kgm2 with obesity related co-morbidities, or waist circumference >102cm in men, or >88 cm in women

Exclusion criteria; pregnancy, active eating disorder, poor motivation (pre-contemplative stage)

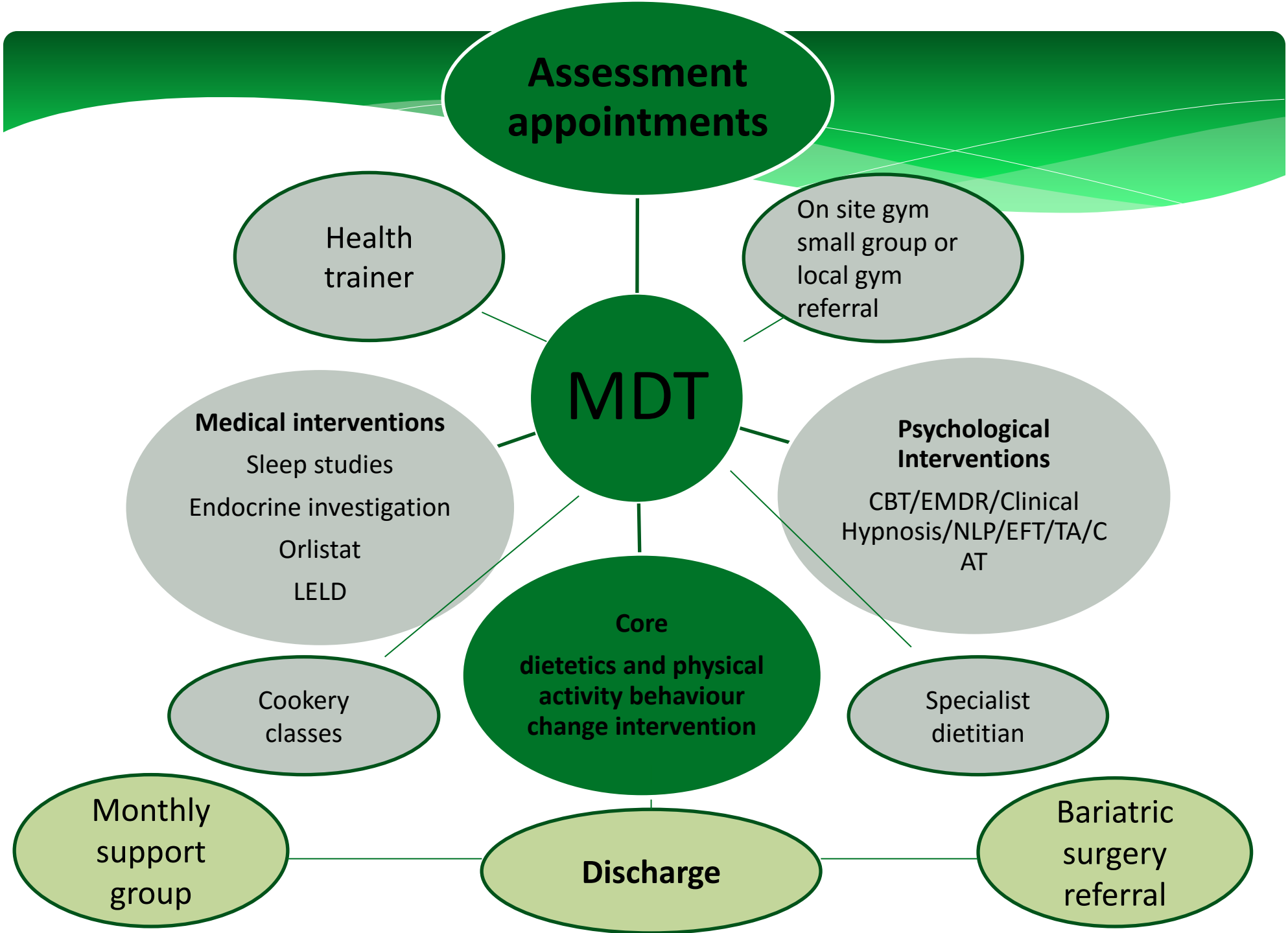
Commissioned by North Norfolk Clinical Commissioning Group

Methods

- **Initial medical assessment;** Discussion on the health risks of obesity and the benefits of losing weight. Review of dietary diary. Target weight set.
- **Individual education and behaviour change programme**; at least monthly appointments delivered by the OSN/weight management advisors
- **Individual FWMS workbook**
- **Each patient was discussed at the weekly MDT after second visit** and referrals were made as appropriate to psychological therapist/exercise small group sessions on site/exercise on referral/dietician /health trainer to support motivation/cookery classes
- **Complex medical patients all seen by a doctor** (>90%)
- **Bespoke software** (Kastech ProHealth)

Participants were offered;

- **Orlistat, low energy liquid diets, or bariatric surgery** if clinically appropriate (NICE CG 189)
- **Specialist dietary advice if needed**
- **Screening for co-morbidities** (OSA/endocrine disease/T2D/AF)
- **Medical referrals for sleep studies or specialist endocrine** investigation were done by the bariatric physician as required
- **Medications were reviewed** by the bariatric physician, and recommended changes were sent to participants own GP
- **On-site gym** with individual or small group sessions
- **Exercise on referral** scheme at local Gyms
- **Cookery classes**


Assessment appointments
Health trainer
On site gym small group or local gym referral
MDT
Medical interventions
Sleep studies
Endocrine investigation
Orlistat
LELD
Psychological Interventions
CBT/EMDR/Clinical Hypnosis/NLP/EFT/TA/CAT
Core
dietetics and physical activity behaviour change intervention
Cookery classes
Specialist dietitian
Monthly support group
Discharge
Bariatric surgery referral

Additional resources

- **Patient run Facebook group**
- **Long term weight maintenance support group monthly**
- **Specialist booklets**
- **Dietary coaching via Oviva App**
- **Additional exercise classes via ActiveNorfolk ‘Fun’n’Fit**
- **Group education session on Bariatric surgery**
- **Group sessions on emotional eating, carbohydrate cravings, food scripting, weight maintenance**
- **Relaxation CD** (produced in-house)
- **Library of books, DVDs**
- **Loan of pedometers and resistance bands**

FWMS results

- >650 patients over 3 years
- >30% pre-existing T2D
- Evaluated using National Obesity Observatory Standard Evaluation Framework (NOO SEF)
- Published Clinical Obesity Oct 2014
- http://onlinelibrary.wiley.com/doi/10.1111/cob.12066/full
- high patient satisfaction

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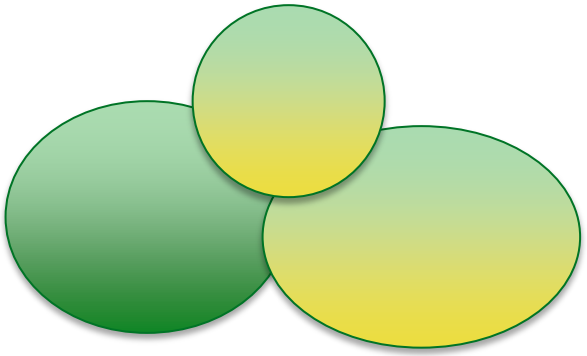
WEIGHT MANAGEMENT SERVICES



Evaluation of Outcomes was based on the NOO SEF

Data collection: 0m, 3 m, 6 m,9m, 12m, 18m and 2 years

- Baseline socioeconomic data
- Height
- Weight
- BMI
- Waist circumference
- Dietary intake; 2 Item food frequency questionnaire (Wardle et al)
- Physical activity levels; General Practice Physical Activity Questionnaire (GPPAQ)
- Quality of life data EQ 5D
- HBA1c in diabetics
- Blood Pressure

Results; Completers

- Baseline mean weight was 124.4 kg mean body mass index was 44.1 kg/m2.
- 72% of completers achieved 5% weight loss at 12 months
- 27% of completers lost more than 10% of initial bodyweight at 12 months.
- The mean weight loss was 10.2 kg among the participants who completed the 12-month programme.
- At 18 months the mean weight loss was 9.6kg, and at 2 years 5.9kg

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Results; Completers

Significant improvements were detected in completers at 12 months in;

- Fruit and vegetable intake p=<0.001
- Activity level p=<0.001
- Quality of life p=<0.001
- HBA1c; initial mean 57.8 (SD 15.3), final mean 53.7 (SD 24.1) mmol/mol p=0.006
- Blood pressure; systolic drop 10 mmHg, diastolic drop 5mmHg
- The dropout rate was 14.3% at 6 months and 45.1% at 1 year
- DNA rate 4% August 2014
- Results for all with weight recorded and BOCF are available

Key learning points

Obesity is complex and requires a multicomponent, multidisciplinary approach with integrated care

Establishing a local obesity network has proved fruitful in Norfolk

Integrated care and clear pathways will improve the patient journey and outcomes

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WEIGHT MANAGEMENT SERVICES

Education Resources

World Obesity SCOPE e-learning SCOPE (Specialist certificate of obesity professional education).

http://www.worldobesity.org/scope/

SCOPE e –learning course is a course of over 20 bite – sized modules that provides an internationally recognised certificate in obesity management (CPD and CME points for professional development). Endorsed by the NHS.

RCGP e-learning

The nutrition and obesity section has excellent e-learning modules (RCGP and RCN members free) aimed at professionals working within primary care (SCOPE accredited).
http://elearning.rcgp.org.uk/

RCGP Ten top tips; Raising the topic of weight, post-bariatric surgery care & audit

NICE e-learning : http://www.nice.org.uk

College of Contemporary Health Postgraduate Certificate in Obesity Care

http://contemporaryhealth.co.uk

Obesity learning centre www.obesitylearningcentre.org.uk

National Obesity Observatory http://www.noo.org.uk/

ASO UK Congress on Obesity 2016 (UKCO 2016)

Nottingham University - Sutton Bonington Campus, September 19-20th, 2016.

The focus of the ASO UK Congress on Obesity 2016 (UKCO 2016) is to consider opportunities to improve for joined-up thinking and action on the prevention and management of people who are overweight or obese

In addition to international external speakers, UKCO 2016 will also showcase the latest research from delegates via two streams: basic science, and clinical and behavioural science.

http://www.aso.org.uk/events/ukco/registration/