Obesity care pathway

A successful tool to manage obesity in North East Lincolnshire, UK

Introduction

The increase in poor quality convenience foods, the prevalence of labour-saving technology, increased car use and more people doing sedentary jobs, means that UK residents weight and body mass index is increasing significantly. Obesity is a growing problem which is recognised as a lifestyle disease which is preventable. Britain has one of the highest rates for overweight children in Europe, with one in three adults predicted to be obese by 2012. This has enormous implications for both health service providers and individuals, as obesity is directly linked to serious health problems, increased mortality, premature deaths, long term capacity, reduced quality of life and increased expenditure to reduce obesity.

Within the UK, nearly 25 per cent of men and women are now obese. This is expected to increase to 60 per cent of the UK population by 2050, which needs to be reduced. At present 9,000 adults die an early death each year due to obesity-related illness. Being obese puts you at greater risk of getting high blood pressure, type 2 diabetes, heart disease, osteoarthritis, a stroke and some forms of cancer. The number of people who are obese continues to increase at an alarming rate, with almost half coming from disadvantaged or low-income communities.

Life expectancy within North East Lincolnshire is less than the national average with males (76) and females (80.8), men from deprived areas having around eight years shorter life expectancy than those in the least deprived areas (North East Lincolnshire Care Trust Plus, 2009a). Within North East Lincolnshire there are 38.4% of people living within the 20% most deprived areas of England, well above the national average

(North East Lincolnshire Care Trust Plus, 2007). Within North East Lincolnshire there is also an increase within early deaths from heart disease, stroke and cancer which is widening the health inequalities gap within the area (North East Lincolnshire Care Trust Plus, 2009b).

Deprivation has led to a cultural shift with poor lifestyle behaviour changes and higher than average obesity levels (obese adults, 26.8% and obese children, 11.3%) (Association of Public Health Observatories, 2009) within North East Lincolnshire. Within North East Lincolnshire there is an increase of children who are physically unactive with only 90.7% 5-16 years olds who spent at least 2 hours per week on high quality PE and school sport (Association of Public Health Observatories, 2009). The obesity prevalence across reception year pupils in North East Lincolnshire is extremely high across East Marsh (17.7%) in the worst deprived ward, obesity prevalence is average within Humberston and New Waltham ward with 11.3% which is the most affluent ward in North East Lincolnshire and a low prevalence in the Wolds ward 3.1% (North East Lincolnshire Care Trust Plus, 2010a).

North East Lincolnshire is the seventh highest PCT in England and Yorkshire and the Humber with adults who smoke (33.5%) (Association of Public Health Observatories, 2009). This is extremely alarming when considering the number of women smoking in pregnancy is 29.8% well above the national average of 14.7% (Association of Public Health Observatories, 2009). Within North East Lincolnshire there is a higher than average number of deaths from smoking 239.4 per 100,000 population aged 35+ (Association of Public Health Observatories, 2009).

In North East Lincolnshire, hospital stays for alcohol related harm and drug misuse is much higher than the England averages (North East Lincolnshire Care Trust Plus,

2009c). With 22.4% of adults binge drinking and 13% drug misusing (Association of Public Health Observatories, 2009).

Overweight and obesity should be treated like any other medical condition, and patients should have access to appropriate treatment and care. A sensitive, empathic, non-judgemental approach should underpin all obesity-related intervention. The advice provided within this pathway is intended to complement the National Institute for Health and Clinical Excellence (NICE) guidelines (North East Lincolnshire Care Trust Plus, 2010b), This pathway, while based on the best available evidence, recognises the need for further research in the primary care setting.

Weight-management strategies

Treating overweight and obesity is undertaken in a variety of settings. After initial assessment, healthcare professionals need to work with patients to try to understand the causes of their condition, teasing out their healthcare beliefs and understanding of their nutritional status.

Food is consumed not just for taste or nutritional value but also for its symbolic value. Often patients' deep-rooted misunderstandings about meals and exercise need unravelling. Translating technically complex nutritional issues into an everyday, easy-to-understand language for patients is an important issue.

NICE (2006) recommended multicomponent interventions with structured programmes run by multiprofessional teams delivered in a variety of settings, aimed at reducing calorie load and increasing physical activity (NICE, 2006). Targets should be agreed, taking into account patients' cultural and individual preferences and the general aim should be around a 600 kcal/day deficit, using the modified Harris-Benedict equation

(Barnett et al, 2009). This formula applies an activity rating factor to the basic metabolic rate calculation to determine daily energy expenditure requirements.

NICE recommended that physical activity is important to everyone; it is particularly beneficial in those who are overweight or obese and have co-morbidities (NICE 2006).

NICE (2006) recommended using diet and exercise interventions first-line as part of a multicomponent regimen. Diets should be nutritionally sound and not unnecessarily restrictive. Very low calorie diets are recommended only for obese people who have reached a plateau and should be carefully supervised and medically managed.

When adults do not reach their target weight loss or have reached a plateau on dietary, activity and behavioural change alone, pharmacotherapy may be included in the strategy (NICE, 2006).

It is crucial that health care professionals are encourage to use an evidence based approach to manage adult obesity which is the aim of this paper.

Aim

To develop an evidence-based adult obesity care pathway 8 collaboratively across the North East Lincolnshire Care Trust Plus and to ensure successful implementation of the pathway within the Trust. Consequently, to evaluate the effectiveness of implementing an adult obesity care pathway in primary care, using qualitative methodology.

Objectives

- To develop an evidence-based adult obesity care pathway based on the NICE obesity guidance, but incorporating local referral criteria and input.

- To successfully implement the adult obesity care pathway across all general practices within the sector.
- To evaluate the effectiveness of the adult obesity care pathway.

Methodology

An Obesity Strategy Group was set up to develop an evidence-based adult obesity care pathway based on the NICE guidance. The care pathway was widely consulted on through stakeholder engagement and partnership working. The pathway was launched at an official event open to the community, primary care staff and stakeholders across North East Lincolnshire.

Context

Upon the publication of 'Choosing Health', the second author Public Health Lead established a strategic and operational obesity group within North East Lincolnshire Care Trust Plus. All the stakeholders and partners and other relevant healthcare professionals were invited to attend several obesity strategy meetings. The current obesity services within the Care Trust Plus were mapped to identify the provision of services available for the management of overweight patients and obesity. The results were subsequently analysed and compared against the latest evidence-based guidance (NICE obesity guidance). A number of key problem areas were identified: service provision varied across the Trust and within general practice, services were often under resourced and over-referred (e.g. dietetics), not provided (e.g. weight management clinics), the management of patients were not systematic and structured (e.g. patients not provided with first line advice prior to drug treatment). GPs were referring many patients to have bariatric surgery inappropriately without following the obesity care pathway. This adult obesity care pathway was subsequently developed to translate the

NICE obesity guidance into a local protocol which could be implemented within primary care. A resource pack and electronic EMIS template for GP computer systems will be developed to support the pathway. Training events will be held to launch the pathway and provide training for practice nurses and healthcare assistants.

Results

- An adult obesity care pathway was successfully developed collaboratively across North East Lincolnshire Care Trust Plus. This pathway will be adapted by the Trust and be related to local referral criteria.
- Currently, the pathway has been successfully implemented as a trial within several practices. The Trust will not be funding any surgical intervention without strict adherence to the obesity care pathway. GP's, Practice Nurses and other health professionals are on board and are fully aware of the referral criteria for services.
- The effectiveness of the pathway will be evaluated by the Trust via semi-structured interviews with primary healthcare professionals (e.g. GPs, practice nurses, healthcare assistants). Initial feed back will be collected from practice nurses and healthcare assistants who will be implementing the pathway and considered the tools usefulness in managing obese patients and applying the NICE guidance to practice. GPs were less positive about using the pathway but considered it useful for practice nurses.
- The pathway is effective at translating evidence into a local protocol but is hindered by the patient e.g. their motivation and readiness to change.

Monitoring and evaluation

Evaluation of the pathway will be conducted in the coming few months. Implementation of the pathway will continue to be monitored by the primary care staff.

Recommendations

- Providing training and launch events were crucial for successful implementation. All general practices that attended the training events implemented the pathway. Those that did not implement the pathway will need to be approached and an education session will be offered to them.
- Re-visit and re-evaluate
- The Local Service Agreement with the Trust highlighted obesity as one of the three criteria. This seems to have led to increased levels of implementation. A whole practice approach led to higher levels of implementation, e.g. the practice manager, practice nurses, GPs, all needed to support implementation of the pathway. Targeting all professionals together (e.g. presenting at individual practice meetings) or separately (e.g. nurse forum, practice managers meetings) would increase implementation and effectiveness. Electronic component of the pathway increased implementation levels as it acted as a prompt during consultations. A pathway supported by an electronic template is therefore a valuable addition.

Acknowledgements

Thank you to all our colleagues from Public Health and the Specialist Health Promotion Service.

Dan Pyrah Programme Manager - Health in the Workplace

Jenny Fox Programme Coordinator - Food & Nutrition

Lauren Jackson Healthy Weight Partnership Coordinator

Lee Marriott Public Health Intelligence Analyst

Greg Gilbert Tobacco Control Co-ordinator

Conflict of Interest

The authors declare that there is no competing financial interests in relation to the work described.

References

Association of Public Health Observatories (2009) Health Profile 2009 North East Lincolnshire This is a Spearhead area. Association of Public Health Observatories. www.healthprofiles.info

National Institute for Health and Clinical Excellence (2006) Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE www.nice.org.uk/guidance/CG43

North East Lincolnshire Care Trust Plus (2007) Deprivation. Communities and Local Government 2007.

North East Lincolnshire Care Trust Plus (2009a) Joint Strategic Needs Assessment for North East Lincolnshire. North East Lincolnshire Care Trust Plus.

North East Lincolnshire Care Trust Plus (2009b) Obesity (Adults)- modelling versus recorded prevalence. North East Lincolnshire Care Trust Plus.

North East Lincolnshire Care Trust Plus (2009c) Drinking Behaviour. North East Lincolnshire Care Trust Plus.

North East Lincolnshire Care Trust Plus (2010a) % of children with height and weight measured who are obese (reception year). North East Lincolnshire Care Trust Plus.

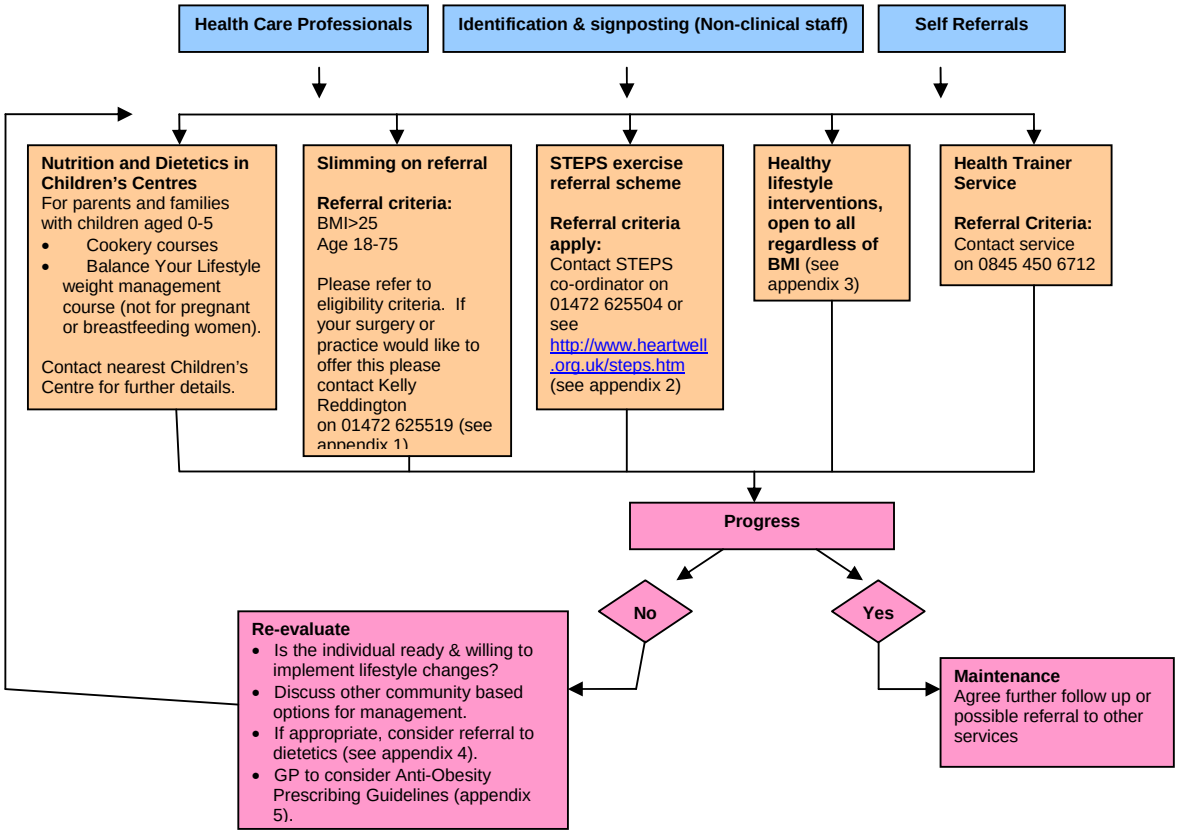
North East Lincolnshire Care Trust Plus (2010b) Adult obesity pathway. North East Lincolnshire Care Trust Plus.

* Miss Phillipa Hobson and Professor Abdallah Mangoud

Word count 1,826

Figure 1

Obesity Care Pathway - Management of Adult Obesity



When to initiate a discussion about weight (* refer to NICE CG 43)

- If the adult expresses concerns about their weight
- If the individual had weight-related co-morbidities
- If the individual is visibly overweight

The opportunity to raise the issue of weight may arise at health checks, or at regular clinic appointments such as asthma check-ups

Full Assessment

Stress that obesity is a clinical term with health implications, rather than a question of how a person looks.
Assess lifestyle, co-morbidities and willingness to change. Consider the following:

- The adults views of the diagnosis, and why they have gained weight.
- Current lifestyle – diet and activity levels – and their beliefs about eating, activity and weight.
- Be aware that people from some ethnic and socioeconomic backgrounds may be at greater risk from obesity and may have different attitudes and beliefs about weight management.
- Family history of overweight/obesity & co-morbidities.
- Environmental, social & family factors that may influence weight status and success of intervention
- Find our what they have already tried and what they have learned from this.
- Readiness to make changes and confidence in making changes.

Measuring progress

The priority in weight management is to reduce risk factors for the patient, rather than to return them to a healthy weight range. For some individuals, a weight loss of as little as 3.0-5.5kg (7-12lb) can achieve health benefits. Clinically significant changes result from a loss of 5-10% body weight. Use the following to help individuals set realistic goals for themselves:

- BMI between 25 to 30 with no associated co-morbidities and not from a high-risk ethnic group → Aim to prevent further weight gain.
- BMI 30+ or 28+ with associated co-morbidities and/or from a high-risk ethnic group → Aim to lose 5-10% body weight over 3-6 months or to at least prevent further weight gain.

Maintaining weight loss

Maintenance of changes in eating and physical activity, and maintenance of weight loss, is a major challenge. Individuals are prone to relapse and for many, maintaining their weight requires a lifetime of support and increased effort. Setting goals to help maintain changes should be encouraged along with finding acceptable methods of ongoing monitoring.

Communication between professionals

- Where a referral is made, results will be fed back directly to the referring GP.
- Referring GP will be informed of non-attendance.

Patient Criteria for Slimming on Referral

At least 18 years old.

BMI of at least 26 kg/m2.

Must not have attended a slimming group within the last 6 months.

Pregnant or breastfeeding women should seek the advice of their Midwife or Health Visitor regarding weight management.

If the patient is under the supervision of a Dietitian for any reason, then they should discuss Slimming on Referral with them first.

No continuation vouchers provided i.e. only 1 set of vouchers per person.

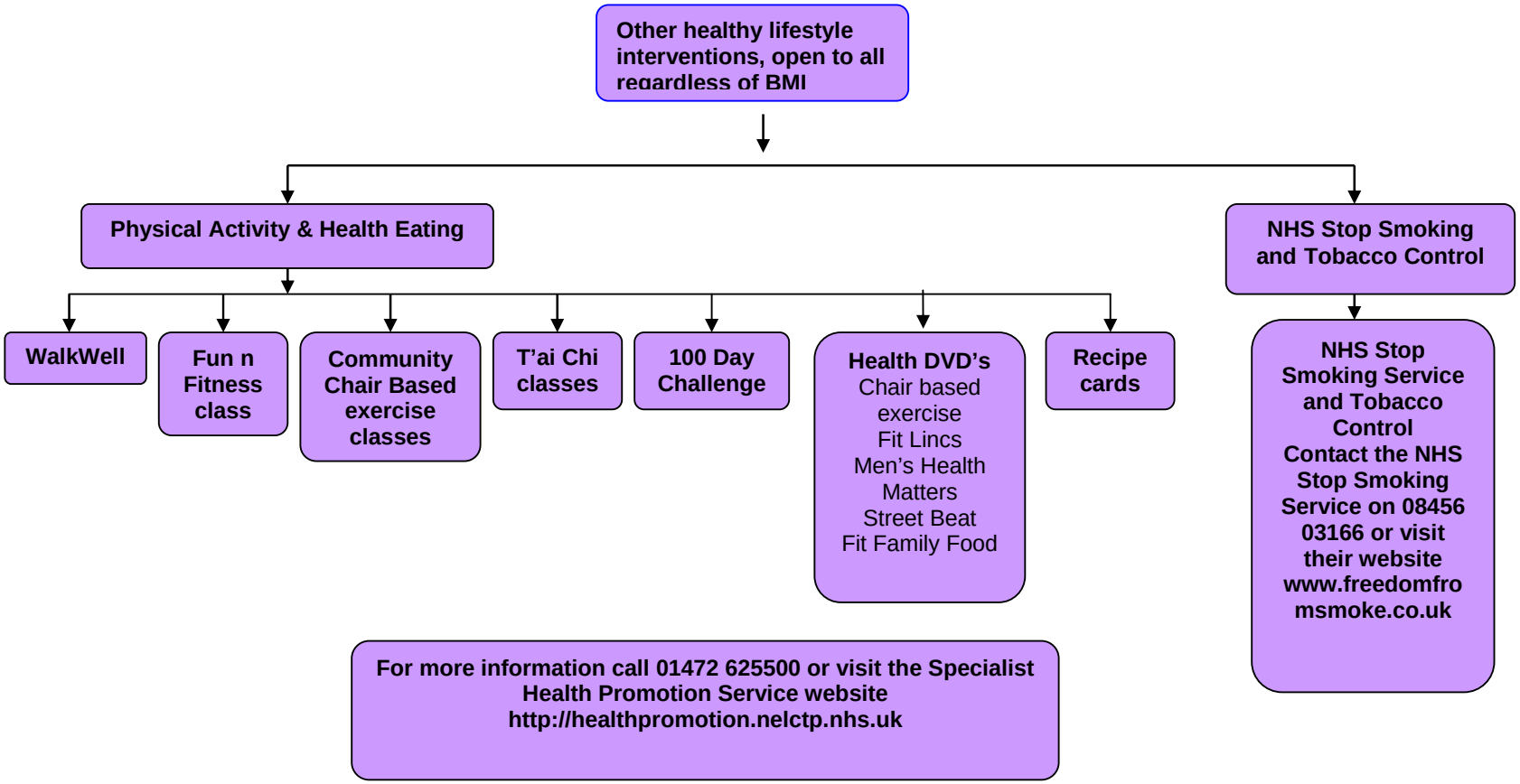
STEPS

Patient ***can*** be Referred	Patient ***cannot*** be Referred
All referrals must be aged 16+ and fulfil at least one of the following criteria: ▪Considered inactive ▪Are not moderately active for a total of thirty minutes more than twice a week **Exhibit at least one of the following risk factors for coronary heart disease:-** ▪Obesity/Overweight (BMI 25+) ▪Hypertension (140/90 to 179/109mmHg) (ACSM, 1995) ▪High cholesterol levels (consistently above 5.2 total cholesterol) ▪Family history of heart disease ▪Smoking ▪Controlled diabetes ✓ Post Cardiac Rehabilitation Phase 3 ✓ Controlled Asthma ✓ Suffer from mild to moderate rheumatoid arthritis or osteoarthritis ✓ Suffer from mild to moderate depression, stress or anxiety	***X*** Previously completed the STEPS programme ***X*** Unstable Angina ***X*** High hypertension (over 179mmHg /109mmHg) or uncontrolled hypertension ***X*** Unstable diabetes ***X*** Unstable COPD ***X*** Unstable Heart Failure ***X*** Severe asthma ***X*** Chronic muscle, joint or bone conditions that greatly impede mobility or require physiotherapist treatment ***X*** Unstable severe mental health state ***X*** Patients who in the Healthcare Professionals opinion are not medically fit to undertake an exercise programme

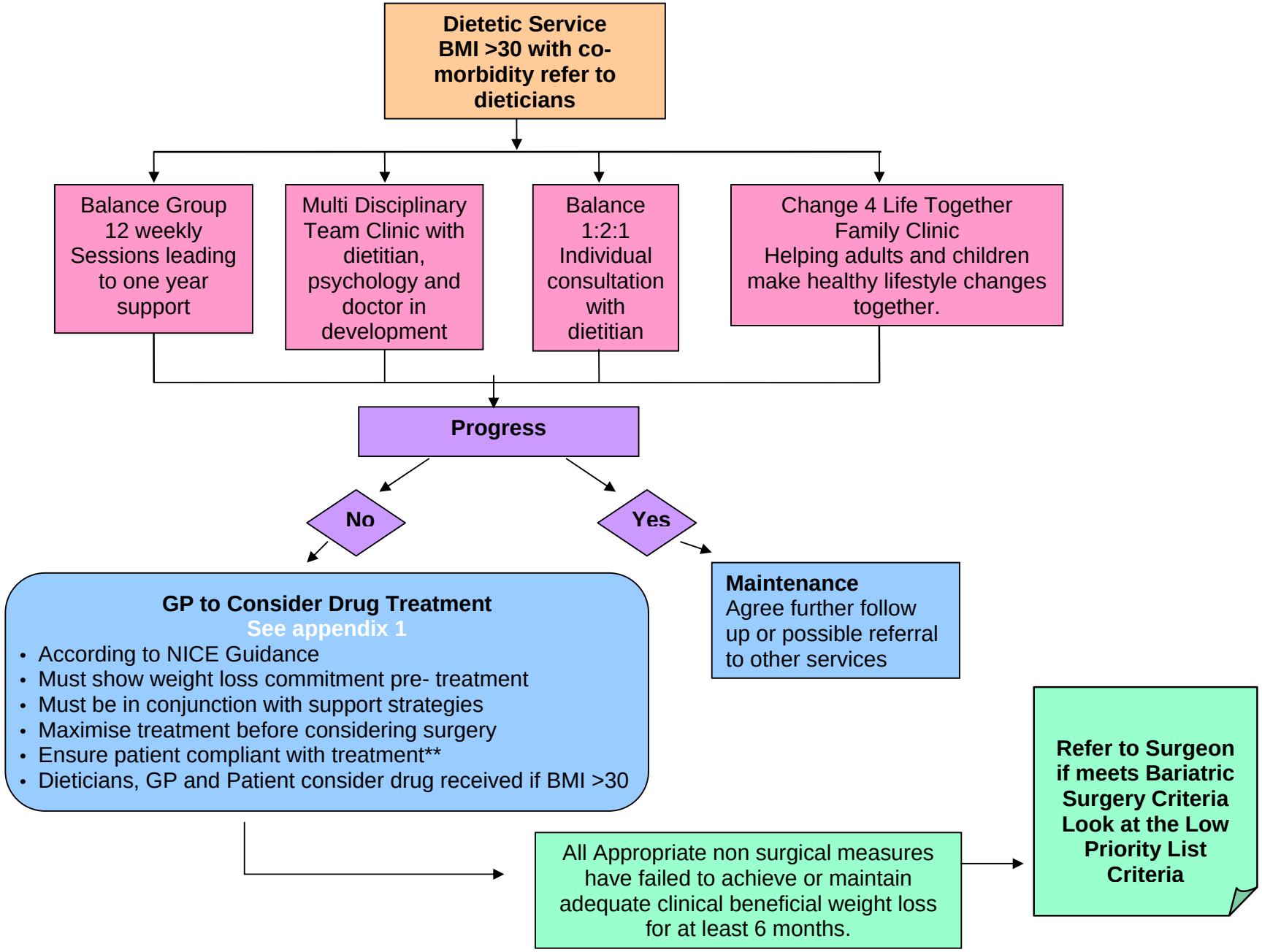
STEPS REFERRAL FORM MUST BE COMPLETED

STEPS…to a more active life
Specialist Health Promotion Service
NELPCT
1 Prince Albert Gardens
Grimsby
North East Lincolnshire
DN31 3HT
01472 625500

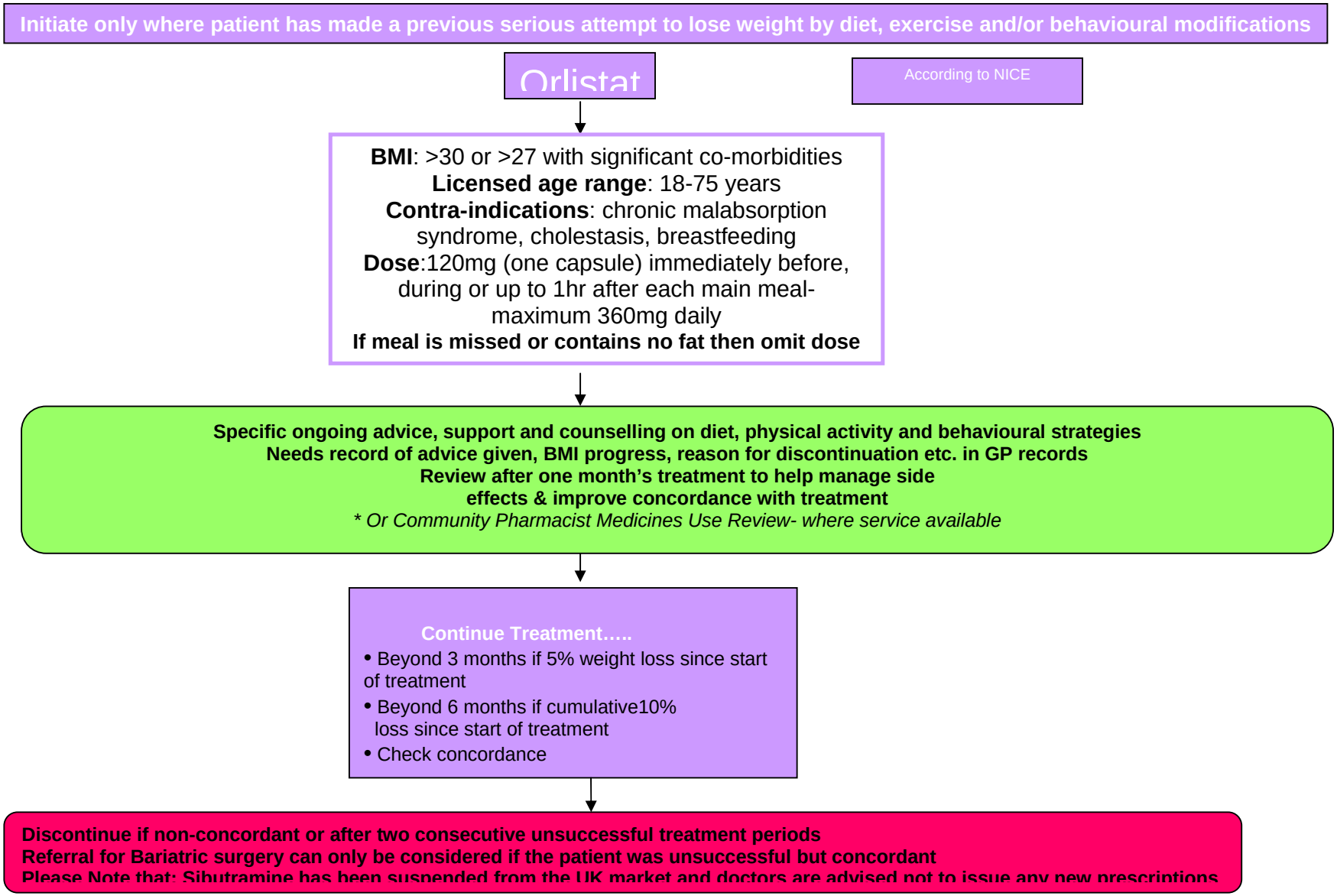
1 **Healthy lifestyle interventions**



Dietetic Service referral



Anti-Obesity Prescribing Guidelines



1

1