NHS Greater Glasgow & Clyde

NHS BOARD MEETING

Director of Public Health **27 June 2017** **Paper No: 17/32**

ADULT WEIGHT MANAGEMENT SERVICES

Recommendation:-

The NHS Board is asked to:

- Note progress in embedding the community weight management service into the Glasgow and Clyde Weight Management Service and establishment of multiple referral pathways.
- Support further optimisation of specialist weight management service by providing intensive interventions for complex patient groups in conjunction with lifestyle intervention delivery through the community service.
- Receive a further report on the expansion of surgical intervention for suitable patients in line with National guidance and best practice in due course.

Purpose of Paper:-

The paper provides an update on the strategic development of adult weight management services previously outlined to the Board in 2016 with a particular focus on the new Community Weight Management Service.

Key Issues to be considered:-

- The Community Weight Management Service has now been fully operational for 8 months with referrals from acute services; primary are and self referral for prioritised patient groups established.
- Due to the innovative nature of the arrangements with a commercial weight management provider, regular updates will be provided to GGC NHS Board.
- Organisational change and service redesign are underway to provide intensive interventions including surgical intervention, for suitable patients through NHSGGC specialist weight management services.

Any Patient Safety /Patient Experience Issues:-

Improved patient experience through service redesign and expansion of community services is emerging.

Any Financial Implications from this Paper:-

The substantial re-framing of specialist weight management services has enabled resources to be allocated to the redesign of bariatric services, work is ongoing to enable the service to be delivered in line with the current evidence base. The Community Weight Management Service is funded from National non recurring 'Prevention bundle' funding.

Any Staffing Implications from this Paper:-

The service redesign programme requires Organisational Change with Staff Partnership involvement secured. Staffing implications have now been scoped.

Any Equality Implications from this Paper:-

An EQIA of the Community Weight Management Service was previously completed and uptake and access by protected groups will continue to be monitored with actions planned to improve uptake. A further EQIA of specialist services will be undertaken as part of the redesign programme.

Any Health Inequalities Implications from this Paper:-

The Community Weight Management Service will be free at the point of service for all clinically eligible patients. Local and flexible service provision will improve service access for patients. Promotional activity is being undertaken with practices serving the most deprived communities. The experience of patient's with protected characteristics will be closely monitored to identify areas for improvement.

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:-

Considerations regarding demand exceeding supply will be controlled by ongoing management of eligibility criteria / thresholds for service.

Non recurring funding risk is principally managed through time limited contracting processes.

Highlight the Corporate Plan priorities to which your paper relates:-

Prevention and Early Intervention

Author – Anna Baxendale
Tel No – 0141 201 4989
Date – 16/0517

ADULT WEIGHT MANAGEMENT SERVICES

1. Introduction

The Board previously received a number of papers outlining the issues associated with the Public Health priority to address of Obesity. These papers have previously described:

- *the nature of the challenge* within the GGC population; over half of adults are overweight and/or obese; obesity increases with age; women tend to be more obese and whilst obesity levels are in generally higher in the most deprived communities, the differences are levelling out due to increasing levels of obesity in the least deprived areas.
- *the health implications;* recent research has identified being overweight or obese is the single biggest risk factor for cancer after smoking, in Scotland, and is linked to 13 types of cancer, including the most common, breast and bowel (Cancer Research UK, 2016)
- *the health service implications* of obesity; average life expectancy can be reduced by 2 – 10 years across BMI range of 30 - 50 kg/m (National Obesity Observatory 2010) and Average health care costs for people with a BMI of 40 are estimated to be at least twice those of people within a normal weight range and obesity is associated with the 3 of the five common reasons for GP visits. (Obesity in Scotland, SPICe 2015)
- *the evidence* for effective obesity intervention in adults; including commercial weight management interventions and Bariatric Surgical intervention (SIGN 115[i]; NICE CG43[ii] & CG189[iii]). Additional studies have demonstrated improved access and further weight loss outcomes associated with commercial interventions. (Jepp 2007)
- *the strategic direction* for NHSGGC weight management services; expansion of community based weight management services in conjunction with a commercial provider; optimisation of specialist weight management services to provide intensive interventions for complex patient groups and expansion of surgical intervention as a treatment option for suitable patients in line with National Planning Forum guidance to increase interventions to 108 cases.
- *The financial investment* in obesity services to be maintained at current levels with service change to be achieved as cost neutral (approx £1.2m). Additional national non-recurring investment secured for Community Weight Management services (£250k) with services commissioned on a 'pay on use' basis.

This paper provides a further update to the April 2016 Board paper with a focus on the implementation of the Community Weight Management Service.

2. NHSGGC Position

2.1 Glasgow and Clyde Weight Management Service (GCWMS)

The Glasgow and Clyde Weight Management Service incorporates both the Specialist Weight Management Service and the Community Weight Management service (provided in conjunction with Weight Watchers. Access to GCWMS is based on clinical need, defined through an initial range of conditions / co-morbidities associated with weight loss related health gain. (Appendix 1).

Developments

The Community Weight Management service was initiated in secondary care in August 2015. Key clinical areas where reduction in weight will provide most health benefit for patients were

targeted including; liver, lipid, dermatology, cardiac rehab, cardiology, diabetes, hypertension and respiratory clinics.

Through close working with the Local Medical Committee (LMC), primary care referrals to the CWMS were enabled on 27 July 16 and have now been running for 8 months. At the same time referral criteria for the Specialist Weight Management Service were revised to ensure the more intensive service was seeing those patients with higher level of need or complexity.

A self referral pathway for patients with Diabetes; Stroke and CHD was approved by the LMC was rolled out across the 6 HSCPs by December 2016 and active promotion of self referral for the general public; NHS staff and health professionals who work with patient groups that are eligible for self referral is ongoing. Additional promotion has been undertaken with practices working in the most deprived communities.

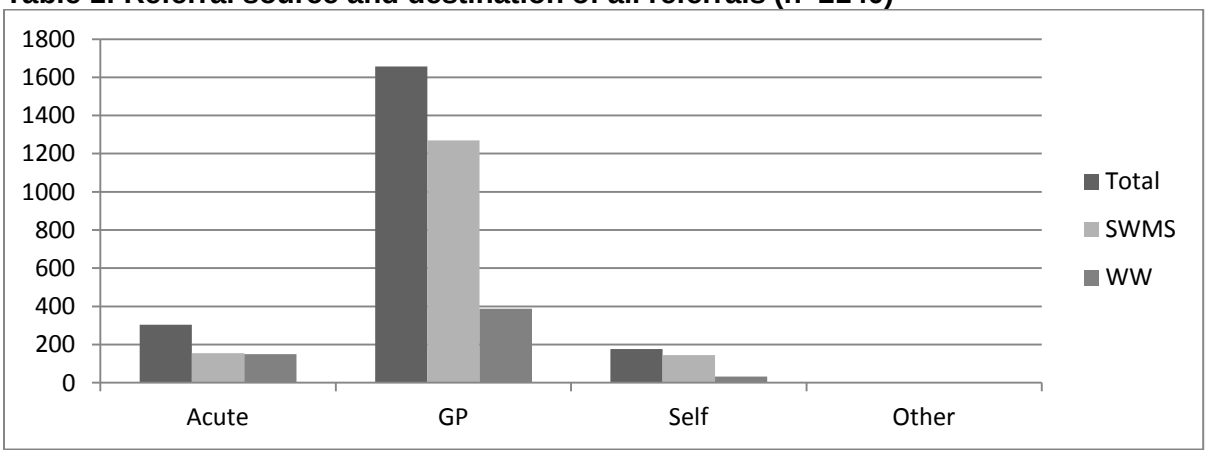
Source and destination of current referrals

In the 6 months between August 2016 and January 2017a total of 2140 referrals have been made to GCWMS this is comparable to pervious referral rates prior to the introduction of the community service.

The majority (77%) of these referrals were made by GPs; acute referrals account for 14% and self referral accounts for 9% of all referrals. Self referrals have been steadily increasing with 68 self referrals received in January.

It was anticipated prior to the redesign, that a quarter of referrals would be triaged to the community service in reality this is approximately 1/3 of monthly referrals.

Table 1: Referral source and destination of all referrals (n=2140)



2.2 Community Weight Management Service (CMWS)

Initial Outcomes

Between August 2016 and January 2017, 484 participants had been referred into the CWMS approx 1/5th (20.7%) did not attend service and a further 79 (16.3%) participants dropped out. However of those engaged with the service 204 (42.1%) are currently live, and over 1/5th of participants (101) have completed their 1st set of 12 vouchers.

Comparator data from Jebb 2007[iv] would suggest that 45% of patients initiating the programme lapsed compared with 16% locally and 55% of patients went on to complete the programme compared with 20.9% locally with a further 42.1% remaining live in the programme. There is no comparable data for those referred who DNA.

The service will be subjected to long term evaluation and an evaluation framework has been developed. To date weight loss has also been very encouraging with 78% of completers at 12 weeks achieving ≥5kg weight loss and attendance at 10/12 Weight Watcher sessions and therefore met the requirements for a second set of vouchers. Of those successfully completing (12 sessions with ≥5kg) the mean weight loss was 7.94kg. This would indicate favourable results when percentage weight loss is calculated suggesting better outcomes than previously identified with in the literature; Jebb reported 54% of completers lost >5% of body weight with a median of 5.2kg.

A small number of participants have now gone on to a 3rd set of sessions with an individual weight loss of more than 15kg. At this early stage weight loss in the heaviest patients is positive with 1/3 of participants who lost >5kgs having a BMI >40 being successful with a commercial service.

Whilst a greater percentage of women are being referred into the programme, 36% of referrals are for men and nearly 1/3 of all male participants are successful in completing the programme both of which are higher than other NHS / Weight Watcher referral schemes.

Full evaluation will be undertaken to enable comparative analysis with other weight management programmes.

Attendance Issues

A key driver for the community service was to provide greater flexibility in service provision. Early analysis indicates that 65% were attending in the evening or at the weekend, with only 35% attending on weekdays.

Work is underway to fully understand reasons for DNA or lapsed attendance but initial feedback suggests low levels of personal motivation (one person who was followed up said it was the GP who wanted them to lose weight) as well as group related issues.

A numbers of measures are available to support vulnerable patients or groups with protected characteristics attend the community programme including interpreters; tailored materials such as alternative formats; free attendance for carers or family members however numbers remain limited to date and further promotion in relation to relevance and accessibility of service are required with referrers and communities.

2.3 Specialist Weight Management Service (SWMS)

A redesign programme has been initiated by the North Sector to enable an increase in bariatric surgical interventions, provide a greater focus on patients with higher BMIs and more complex co morbidities to facilitate resource shift within existing services.

A number of workstreams, operating in line with NHSGGC Organisational Change Policy have now concluded. Implementation plans are currently being finalised which include the adoption of a new generic screening and assessment process; provision of increasingly intensive

interventions for patients having successfully completed an initial lifestyle stage and the introduction of new pre and post surgical intervention pathways within the redesigned specialist service. Arrangements for the management and transition of patients from the current programme into new arrangements have been agreed with full transition to the new programme completing in 2018. Pathways for new patients were live from 1st April 2017.

Engagement with the Diabetic MCN clinicians has been progressed and further clinical engagement across primary care and the acute division is planned to ensure patients most suitable for surgical intervention are identified and appropriately managed in line with the revised surgical criteria.

Extensive capacity planning and redesign work to extend bariatric surgical provision has also been completed. This reflects a dramatic shift in surgical practice in the last 5 years and required the service model outlined in 2014 to be revised.

Across the UK the move away from Gastric Band (LGB) to Gastric Sleeve (LSG) procedures resulted in a decrease from 85% to just 20% of all bariatric surgery in 2014[v]. Evidence supports LSG surgery as an extremely safe and effective procedure with sustained efficacy in terms of weight loss, co morbidity resolution and low rates of surgical re-intervention. Almost all of NHSGGC patients now are opting for LSG procedures (>90%) as the preferred intervention.

Lap gastric by-pass surgery is not currently offered in NHSGGC but this procedure is available across the rest of the UK and is now being requested by individual patients. The future service needs to establish capacity to deliver gastric by-pass surgery in addition to LSG and LGB procedures.

Bariatric surgery will be provided as a single, integrated service across NHSGGC. Service management and clinical governance arrangements will be hosted by the North sector with trained surgeons in both north and south sectors contributing to the service. There is now an expectation that the implementation of changes to enhance the surgical service will progress imminently.

3. Diabetes

The biggest challenge going forward is to increase the level of referral of patients with Diabetes and co-existent obesity. In the 6 months from August 16 to Jan 17, just over 500 individuals with Type 1 and Type 2 diabetes were referred, 23.6% of total referrals. This is an increase of 5% from previous arrangements and given similar referral numbers overall does suggest a small change in referral practice.

To give context, 54,515 patients in NHS GG&C have type 2 diabetes and 53.1% of them have a BMI ≥30kg/m^2 (making them eligible for referral). At ~1000 referrals/ year we are currently seeing just 3% of the eligible type 2 diabetes population.

An interactive, multidisciplinary e-module to support motivational behaviour change and referral of patients with Diabetes for weight management in primary care is currently being trialled across NHSGGC. The Small Talk Big Difference project has been developed in conjunction with Diabetes MCN; Diabetes UK; University of Glasgow and pharmaceutical industry colleagues will conclude summer 2017 with rollout from late 2017.

The majority of diabetic patients seeking weight management support currently receive care from the Specialist Weight Management service; however the direction of travel will be for most patients with Diabetes to be referred to the Community Weight Management Service in the first instance.

4. Next Steps

Referral pathways for suitable patient groups to receive lifestyle intervention in the community will be finalised.

Specialist Weight Management redesign work will be finalised and additional bariatric patients identified in line with new assessment arrangements and clinical pathways.

Referral criteria will continue to be monitored and implications identified in conjunction with the LMC. A downward revision of the BMI threshold to BMI $\geq$40 for patients with no co morbidities will be implemented following clinical engagement. This aligns the threshold with the established clinical definition for morbid obesity.

Referral pathways from wider AHPs are in development with Dietetics; Physiotherapists; Podiatry and Rehab and Enablement Service teams.

Further promotion of the self referral pathways will be undertaken including the targeting of eligible NHS staff.

5. Recommendations

The Board of NHSGGC is asked to:

- Note progress in embedding the community weight management service into the Glasgow and Clyde Weight Management Service and establishment of multiple referral pathways.
- Support further optimisation of specialist weight management service by providing intensive interventions for complex patient groups in conjunction with lifestyle intervention delivery through the community service.
- Receive a further report on the expansion of surgical intervention for suitable patients in line with National guidance and best practice in due course.

APPENDIX 1

Glasgow and Clyde Weight Management Service –Patient Destination (April 17)

Community Weight Management Service

BMI	Co-morbidity
≥25 – <30	-Type 2 Diabetes
≥25 – <45	-Impaired Fasting Glucose -Impaired Glucose tolerance -High risk of developing Type 2 Diabetes (WHO criteria 42-47mmol/mol)
≥30 (≥27.5*) – <45	-Existing CVD -NAFLD (no Fibrosis and no cirrhosis) -Psoriasis -Dyslipidaemia (high TG ≥3.0mmol/L) -Hypertension -Mobility Issues -Weight loss required prior to surgery
≥40 - <45	No co morbidity required

Specialist Weight Management Service

BMI	Co-morbidity
≥30 (≥27.5*)	-Type 1 diabetes -Type 2 diabetes -Sleep Apnoea -NAFLD with Fibrosis and/or cirrhosis -Severe Psoriasis -Renal CKD4+
≥45	-No co morbidity required (and all weight related co morbidities eg impaired fasting glucose)
≥180kg	-No co morbidity required (and all weight related co morbidities eg impaired fasting glucose)

What do the different services in the GCWMS offer to patients?

Community Weight Management (in partnership with Weight Watchers)

- Patients will be given twelve weeks full free membership to Weight Watchers
- Patients will follow a programme combining healthy eating, physical activity and behaviour change techniques
- Patients who successfully attend and lose 5kg will be considered for a further twelve week block.

- When referring a patient ensure the patient has the GGC Weight management service leaflet.
- The Weight management leaflet contains the **opt in** telephone number: **0141 211 3379** (available Mon-Fri, 8:00am -4:00pm)
- General enquires about the service should be made to by phone to: **0141 211 3379** or by email to: WeightManagement.HealthRecords@ggc.scot.nhs.uk

Specialist Glasgow and Clyde Weight Management Service

- Following an initial assessment, individuals will participate in a lifestyle intervention programme delivered in a group setting
- The service will help
  - change eating behaviours and improve physical activity levels
  - set realistic weight loss goals to improve health and give tools needed to maintain weight loss over time
- Specialised liquid diets, medication and surgery will be considered as appropriate
- Additional input from specialist physiotherapy and clinical psychology with be offered where required

[i] SIGN 115 (2010), Management of Obesity, A National Clinical Guideline. Healthcare Improvement Scotland: http://www.sign.ac.uk/pdf/sign115.pdf
[ii] NICE CG43 (2006) Obesity prevention – clinical guideline: https://www.nice.org.uk/guidance/CG43
[iii] NICE CG189 (2014) Obesity: identification, assessment and management: https://www.nice.org.uk/guidance/cg189?UNLID=458097808201633175647

[iv] Weight change of participants in the WeightWatchers GP Referral Scheme; Louise M. Aston, Mark D. Chatfield and Susan A. Jebb, November 2007, MRC Human Nutrition Research

[v] Trends in Bariatric Surgery: Procedure Selection, Revisional Surgeries, and Readmissions: Abraham A, Ikramuddin S, Jahansouz C, Arafat F, Hevelone N, Leslie D.. *Obesity Surgery 2016 26. 1371-1377*