

How should we deliver obesity services?



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Obesity is one of the Cinderella services. We all know that it is a major problem and yet no-one wants to take responsibility for providing the service. Obesity has been a growing problem for the past decades. Latest figures suggest that 25% of the population are obese and that the direct costs of obesity and its comorbidities are in the order of £6 billion per year (Health and Social Care Information Centre, 2014). This cost is huge but it has developed because we have ignored obesity as a medical problem and waited until the obesity-related comorbidities, which we are willing to class as “real diseases,” have developed. There are now so many obese individuals that the NHS cannot manage, and a two-pronged approach is needed, consisting of patient care for the obese at the same time as an imaginative and comprehensive public health strategy using public transport and food policies.

Current situation

The provision of weight management and obesity services over the past decades has been sparsely scattered across the country, delivered mainly by enthusiasts and, in many places, as short-term projects. Following the enactment of the Health and Social Care Act (HSCA) in 2012, obesity has been carved up into four tiers of care.

Tier 1 consists of primary care provision of obesity prevention, with basic interventions provided by GPs, health visitors, school nurses and leisure services. Tier 2 consists of community-based obesity services led by dietitians and exercise therapists. Tier 3 weight management services consist of multidisciplinary groups, including a medical clinician who could be a specialist GP or a hospital physician. Tier 4 consists of hospital-based specialist care, which is largely obesity surgery but in many institutions includes specialist medical services.

This appears to be a coordinated service but it

is fragmented by multiple responsibilities. Tiers 1 and 2 are commissioned by Local Authorities, as the HSCA placed public health responsibility with them. Tier 3, where it exists, is an orphan service inconsistently commissioned by either Local Authorities or Clinical Commissioning Groups (CCGs). Tier 4 is commissioned by the Specialist Commissioning arm of NHS England. This system clearly has not been working, as NHS England demands the use of Tier 3 services to manage patients prior to surgery and Tiers 3 and 4 are often not co-located. Therefore, in 2014 Public Health England and NHS England published a document called *Joined Up Clinical Pathways for Obesity*, which proposed that Tier 3 services should be commissioned by CCGs (NHS England and Public Health England Working Group, 2014).

All change in April 2016

In 2015, NHS England made the decision to devolve Tier 4 services comprising obesity surgery and the required 2-year period of post-surgical follow-up to the CCGs (*Figure 1*). This has a considerable advantage, in that the separation of Tiers 3 and 4 was largely arbitrary and it is more logical to commission the entire service as a coherent pathway. However, there are a considerable number of challenges to local commissioning. Firstly, CCGs are not universally aware of their new responsibility; secondly, obesity may not be a major priority; and, thirdly, in order to commission obesity surgery safely, CCGs will need to join up into clusters to be able to have sufficient volume. Together, these factors will threaten quality and safety. Over the past years, the central commissioning of obesity surgery by NHS England was starting to bring a uniformity to Tier 3 and Tier 4 services, but these clinical standards will not be binding on CCGs when they commission services. NHS England will retreat and only retain a small interest in obesity

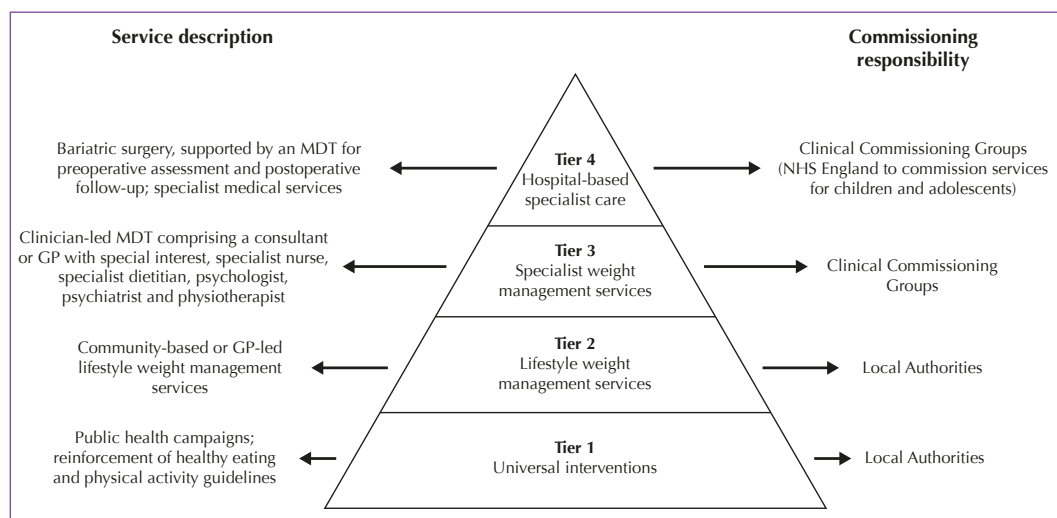


Figure 1. UK obesity care pathway and commissioning responsibilities from April 2016. MDT=multidisciplinary team.

by commissioning obesity surgery for children and adolescents.

What issues need to be addressed?

Several recent reports have highlighted the “diagnostic inertia” of primary care in relation to obesity. This failure is a multifaceted problem and includes factors such as blame, derogation of responsibility and feelings of therapeutic helplessness. However, these issues have existed for alcohol and tobacco and have been overcome. Recognising the presence of overweight and obesity by all healthcare practitioners is an important first step.

The issue of therapeutic helplessness needs to be addressed by changing targets to improving health rather than weight loss. The narrative needs to change from weight to blood pressure, glucose tolerance, physical fitness, etc. First-line therapies should be initiated through gyms/exercise classes, slimming clubs and community dietetic services. Many primary care physicians may feel uncomfortable making these recommendations even though, as individuals, they are regarded by patients as the best source of information regarding weight and nutrition, despite the lamentable efforts made by medical schools to teach students about obesity.

The next step is to develop pathways so that both Local Authorities and CCGs can plan how to deliver these services.

Conclusion

At present, neither primary care nor CCGs are prepared for managing obesity in many parts of

the country, and this will result in a return to the “postcode lottery” of service provision. Interested clinicians will need to lobby their respective CCGs in order to raise obesity in the list of priorities. Failure to do this will only haunt us in the future. The cost of treating the medical complications of obesity has risen ten-fold between 1998 and 2007 and is now estimated at £6 billion per year. It has the potential to bankrupt the NHS.

There are lots of mixed messages regarding obesity concerning exercise, healthy eating and failure of treatments, all of which sow the seeds of confusion in patients and healthcare professionals alike. Moreover, the CEO of the NHS, Simon Stevens, has made it clear that he favours prevention over treatment. Therefore, we need to develop a joined-up service for obesity that provides a healthy environment at one end but then connects gyms, weight loss groups, community cooking lessons, etc., and which has pathways connecting primary and secondary healthcare with access to highly specialised obesity services, including obesity surgery. Secondly, we need to have protocols that help decide who would benefit most from medical intervention so that our resources are best used.

We all need to collaborate to design those local pathways, and we need to negotiate with our CCGs on how to implement and deliver them. Be imaginative! ■

Health and Social Care Information Centre (2014) *Statistics on Obesity, Physical Activity and Diet: England 2014*. HSCIC, Leeds. Available at: <http://bit.ly/Z02odv> (accessed 20.11.15)

NHS England and Public Health England Working Group (2014) *Joined up Clinical Pathways for Obesity: Report of the Working Group*. NHS England, London. Available at: <http://bit.ly/RNNm7S> (accessed 20.11.15)

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