EDUCATION & LEADERSHIP FELLOWSHIPS
2008:
OBESITY

OXFORDSHIRE PRIMARY CARE TRUST &
THE LEYS HEALTH CENTRE
Leadership Fellow Post: Obesity
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During this Leadership Fellow (Senior Registrar) post I was interested to work in the field of obesity with the PCT. I worked on a new MDT community service for obese patients with a BMI of >40. Although these patients according to NICE (1) should proceed to surgery the local Lavender statements allowed patients with a BMI>50 to be eligible for that bariatric service. There was no community service that included components recommended by NICE for example health trainer, dietician and psychology input. The report outlines my contribution and development of the service.

As part of this post I also worked in a lower socioeconomic non training practice with a high prevalence of obesity and diabetes. As part of this I passed the Warwick Certificate in Diabetes and Warwick insulin initiation course. In a practice with a mainly younger population I was able to develop my skills further in paediatrics and Women’s health. This allowed me to develop my interest further in these fields as I have detailed below.

The Obesity project: MDT service for patient with BMI>40

Context

The way we live in modern society means that it is harder to be a healthy weight. We are less active and do not eat as healthily as we used to, meaning that rates of obesity in adults and children are higher than ever before. Being overweight or obese can have a severe impact on an individual’s physical health. They both are associated with an increased risk of type 2 diabetes, cancer, and heart and liver disease, among other illnesses. These illnesses put pressure on families, the NHS and society more broadly and, without action, the cost to society is forecast to reach £50 billion per year by 2050. (1)

Nationally

The Health Survey for England: forecasting obesity report highlights the trend towards an increase in the prevalence of overweight and obesity. In 2002 the proportion of men and women in the survey who were classified as either overweight or obese was 65.4% and 56.5% respectively. In 1980 just over 8% of women and 6% of men were estimated to be obese. In comparison, by 2002 the estimated percentage of males who were obese was 22.1% and the estimated percentage of females was 22.8%. (2)

Nearly one in four people in the UK are obese. Being obese reduces life expectancy by an average of 9 years. (3)

National guidelines in the form of NICE & SIGN suggest that:

NICE recommends that ‘multicomponent interventions are the treatment of choice’ and these include dietary advice, physical activity and behavioural modification techniques tailored to the individual to manage obesity. (1)
SIGN recommends ‘multicomponent interventions should include physical activity, dietary change and behavioural components (grade A evidence) (4)

The Department of health ‘Healthy weight, Healthy lives: a cross-government strategy for England’ launched in 2008 aimed to support people to maintain a healthy weight. One aim was to ‘support the commissioning of more weight management services by providing extra funding for this over the next three years’ for the obesity group of patients. (5)

Locally

In Oxfordshire the estimated number of obese patients with a BMI > 30 is 114,000 (23%). The estimate for patients with BMI >40 which is extrapolated data from 10 sample practices is 13,000.

Obesity was identified as a key area for action within the Director of Public Health annual report 2005 – 2007 (6). It continues to be on the most recent annual report agenda.

Within Oxfordshire the prevalence of obesity is currently estimated at 24% of the population, with estimated forecasts of an increase to 45% by 2026 if no action is taken. Many initiatives are active across Oxfordshire to help prevent and treat obesity. These include slimming & exercise on referral programmes which are available to a wide group of patients including those with BMI >30 (6).

In addition to these services Oxfordshire purchases bariatric services from Luton and Dunstable Hospital. Obesity surgery is currently a low priority within Oxfordshire and only patients with BMI >50 are accepted for consideration of bariatric surgery.

Strategic Health Authority – Road Map – 2008

In Oct/Nov 2008 the SHA produced a market roadmap for the PCT and Obesity treatment was identified as a priority area. The roadmap identifies the market scope as

• Non surgical intervention, rehabilitation and maintenance steps.
• Focus on obese patients not those considered for bariatric surgery.
• For the Tier 2 services patients require in depth 1:1 support: psychotherapy, dietary, exercise.

Impact will be on current obesity related conditions – which with increasing numbers of obesity will add to the health burden year on year (7).

Impact

The aims of this project are:

• to provide greater choice and increased accessibility of appropriate treatment services for obese patients (BMI>40)
• improve health outcomes in obese patients
• reduce the health burden of obesity

The target group for the purposes of this project are those with BMI>40. There is no specific guidance other that bariatric referral for this group

In the planning phase my role was to appraise options of how this service could be provided. As research for this I visited all existing service providers of weight management in Oxfordshire and the main provider of bariatric services in Luton. National obesity leads were contacted as well as other PCTs who had been successful in implementing a service. Attending conferences allowed
me to meet national leads including the National Obesity Conference (London, 2008) to learn from best practice.

It was also my role to engage with GPs and practice staff about what was already being provided and what was felt to be necessary. I engaged with them through email, face to face and PBC meetings. A questionnaire was provided to all practices to assess services. This was presented and used in the project planning meeting and documents. The results are attached in appendix 1.

This information led to a project outline which was circulated for opinions. I discussed this with each lead in each consortia. A service specification was then developed. This was presented at the PEC meeting for approval prior to the tendering process. An advert was written by a team member and was put out for the tender. There were numerous responses to this when were put through the process and interviews were conducted. At the present moment a provider has been elected and will set up this service in Oxfordshire once the contract is finalised and signed.

**Outcome**

As of March 2010 there has been a service commissioned which is at the contract stage. This means that the service initially structured with my work has now been commissioned by the PCT.

**Learning**

As part of the learning I was able to appreciate the commissioning cycle. From assessing local needs, service provision locally to procurement and service design.

The service specification was a particular learning point. This was written and submitted to the Executive committee. The whole process from understanding terminology & research to writing the service specification were a challenge.

Working across the PCT, GPs and providers has provided me with project management and service implementation skills. This will once the service is implemented lead to improvement of patient outcomes.

I have had first hand experience on how to make a difference to patient health needs on a large scale. I was able to work with GPs, providers and the PCT to develop this service. This background and experience will allow me to confidently approach similar projects in the future.

**Recommendations**

This role allows joint working between PCTs/ SHA/ DH and GPs. The process of commissioning and implementing change is required by GPs to provide improved health outcomes for patients. This all comes down to our ‘Duties of a Doctor’ - Provide a good standard of practice and care (8). Primary care needs GP leaders. Providing this leadership experience it encourages joint working and produces GP leaders.
Additional experience as a Senior GP registrar

During this time the project had been only part of my experience. My additional achievements have included:

**Leadership training**
- Training
  - Lead or be led
  - World Class Commissioning
  - Social Marketing
- Working with the practice on idea of becoming a training practice
  - Expectations of trainee, trainer and practice
  - Advantages and disadvantages
  - Involvement of registrar in practice meetings and development
- Involvement in practice change & meetings

**Special Interest: Diabetes Care**
- Certificate in Diabetes Care Warwick University – September 08 – March 09
  - Complete care of diabetic patients
  - Formal Assessments required to obtain Pass – Case Studies, Audits & Project.
- Warwick accredited Insulin Conversion course
  - Supervised insulin conversion
  - Medication & insulin titration
  - Warwick accredited nurse observed my clinic twice a month – to provide formal assessment of competence to pass course
- Independently set up and run in house diabetes clinic twice a month
- 15 Insulin conversions for practice patients – usually sent to hospital for this - ongoing.
- Audits of diabetes care
- Practice protocols – Microalbuminuria testing, Management Hba1c.

**Additional achievements**
- DRCOG – October 2008 – passed
- Attendance and involvement at PEC & PBC meetings

**Personal experience**
Overall this was an amazing opportunity to develop leadership skills that are a foundation for my future career. Looking back whilst writing this report has allowed me to reflect and realise that in this post I have achieved a great deal. It has been a wonderful opportunity and would thoroughly recommend this post to all who want to develop leadership attributes!
Appendix 1

Local Survey Results- Oxfordshire October 2008

A local survey of primary care services was conducted in October and based on replies from 22 practices –
41% of practices are already running a weight management clinic in house
63% welcomed the introduction of an MDT service
70% felt it would be successful.
53% felt this should be offered in the PBC area

These replies may not represent the actual activity within Oxfordshire. They are likely to represent the more active practices.
Do practices within Oxfordshire run Weight Management Clinics?

41% Yes

59% No

Preferred Location For MDT Clinics

53% Community Hospital

28% Hospital

13% PBC area

6% Other
References

(1) **NICE** Clinical Guideline CG34 Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. December 2006
(Accessed 9th March, 2010)

(2) **Forecasting Obesity** to 2010
Paola Zaninotto, Heather Wardle, Emmanuel Stamatakis, Jennifer Mindell and Jenny Head. Prepared for the Department of Health
(Accessed 8th March 2010)

(3) Foresight, Tackling Obesities: Future Choices, October 2007,
www.foresight.gov.uk/OurWork/ActiveProjects/Obesity/Obesity.asp.
(Accessed October. 2008)

(4) **SIGN** Obesity in Scotland: integrating prevention with weight management. Update of the Scottish Intercollegiate Guidelines Network No. 8, October 2008


(Accessed 16th March, 2010)

(7) South Central NHS: Obesity Roadmap – 2008 – Oxfordshire PCT

(8) GMC – Duties of a Doctor
http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp
(Accessed 16th March, 2010)