

“OBESITY AND TYPE 2 DIABETES – RAISING THE ISSUE OF WEIGHT MANAGEMENT IN PRIMARY CARE”

This is the executive summary of the joint working agreement between Merck Sharp and Dohme Limited (MSD), Astra Zeneca (AZ), University of Glasgow and NHS Greater Glasgow & Clyde (NHS GG&C). This agreement lasts from November 2015 to May 2018

Summary:

This project will develop a primary care educational package in order to generate a greater number of referrals of patients with type 2 diabetes and obesity from primary care, who are ready and willing to consider weight management, to NHS weight management services. The education will consist of an online learning module covering the benefits of weight loss in diabetes, the effectiveness of weight management services, communication skills training for raising the issue, the safe management of diabetes during weight loss and details of local services and a complementary face to face training course. An implementation toolkit will be developed for use in each practice. The project will be fully evaluated with a cluster randomised trial focusing on patient outcomes. The project consists of a feasibility pilot, a full evaluation and, if successful, full rollout across NHS GG&C.

Background:

Scottish Intercollegiate Guideline Network (SIGN) guidance recommends that “obese adults with type 2 diabetes should be offered individualised interventions to encourage weight loss (including lifestyle, pharmacological or surgical interventions) in order to improve metabolic control”. In NHS GG&C there are currently 44870 patients with type 2 diabetes (data from Scottish Diabetes Surgery 2013) yet only 658 patients with type 2 diabetes were referred to Glasgow and Clyde Weight Management service in the year 2008-9. Of those, only 378 attended at least 1 session and we know that less than half of these will have lost at least 5kg.

There are a numbers of barriers to appropriate treatment (medications and referral to weight management services) of patients with co-existent obesity and type 2 diabetes including patient’s lack of knowledge of the benefits of and support available for weight loss, Lack of knowledge by clinicians, lack of confidence by clinicians and negative opinions by clinicians

Overall project aim:

To ensure that patients who are overweight or obese and have type 2 diabetes are identified, receive personalised diabetes care, have the issue of weight raised and explained in a non-judgemental manner by staff in primary care, and are referred on to weight management services ensuring equity of access across NHS Greater Glasgow and Clyde.

Specific aims:

1. To improve GP/ primary care staff knowledge of the evidence base for the management of diabetes when there is co-existing obesity and local care pathways
2. To increase GP/ primary care staff knowledge of and confidence in their role in raising the issue of weight management
3. To improve primary care referral rates of appropriate patients who are overweight or obese and have type 2 diabetes, and are “ready to change” to NHS funded weight management services
4. To improve patient uptake of and attendance at NHS funded weight management services

Objectives:

1. To develop a training package for primary care staff covering the evidence behind weight management, referral to local services, management of diabetes in obesity and raising the issue with patients
2. To develop materials for use during consultations with patients to aid raising the issue of weight and weight management goal setting
3. To develop patient information about the benefits of and possible methods for weight loss

Proposed intervention:

1. Online training for primary care staff covering:
 - Links between obesity and T2DM and benefits of weight loss
 - Treatment of diabetes in obesity
 - Local services and referral pathways
 - Specific training in raising the issue

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- Overview of weight management components/ evidence base
- The role of the referrer

2. A written tool for consultations to support raising the issue and goal setting – linked to chronic disease management templates already used.

3. An information leaflet for patients covering reasons why weight loss is important in diabetes, methods of weight loss, local services and what to do next. It will have a pocket at the back for a copy of the goal setting sheet and local service documents to be stored.

Pilot (Feasibility):

Pilot of 10 practices (5 current high referrers, 5 current low referrers). The training would be offered as planned and resource delivered to practices. After a 2 month period a process evaluation would be conducted covering:

- Confidence mapping pre and post intervention
- Clinician usage and feedback from online learning platform
- Clinician attendance and feedback (pre-post questionnaire) from training event and also at end of pilot – covering the training itself and confidence in raising the issue
- Feedback will be given to practices on their pre- and post-intervention referral rates
- Numbers of resources used (collection and count of remaining resources)
- Change in referral rate (from routine data)

Pilot success will be defined by delivery of an accessible online learning platform and face to face learning. The components of the intervention may be modified in view of feedback from participants.

Full evaluation:

The project will be evaluated via a pragmatic 3 arm cluster randomised trial at the level of GP practice (sample size based on data from pilot study). This will be real life so the opportunity to use the education and tools will be given, but practices cannot be made to attend or use the materials.

The three groups will be:

1. Online learning, consultation tool, patient materials and experiential training
2. Online learning, consultation tool, patient materials
3. Usual care

Success criteria will be:

1. Primary care staff survey results showing increased confidence in raising the issue of weight management during annual diabetes reviews
2. Increased appropriate referral rates defined by primary care referral: patient uptake ratios

Outcome measures:

Using routine referral data which is collected electronically by NHS GG&C already. Intervention practices versus control practices:

- Referral rates
- Uptake of services by patients
- Completion by patients
- Weight loss by patients (both in services and all patients with diabetes from annual weight data)
- LES template completion
- Diabetes medication at referral

A subgroup of practices (approx. 10) will undergo confidence mapping to assess the final version of the online learning package.

Legacy planning:

Subject to NHSGGC review it is hoped that the proposed project will be adopted into mainstay healthcare provision by weight management services and health improvement +/- some industry support of refresher training. The steering group may wish to publish a project review to share and communicate learning both within the board and across other territorial boards within NHS Scotland & other parts of the UK where appropriate.

- After the pilot and initial roll-out (cluster randomised), if the intervention has been shown to be of benefit then it will be rolled out to all practices across NHS Greater Glasgow & Clyde. After this the project will be considered complete.
- If the project is successful and wider rollout beyond NHS GG&C is considered then this will be a new joint working project. Current industry partners would be invited to participate from the outset of any new project.

Benefits to the Patient:

The aim is to create a safe, effective and person centered intervention for patients with T2DM requiring weight management. Key to this will be the early identification of key issues relating to patients T2DM & weight early in the care journey and non-judgmental, caring and appropriate consultations with referral options made available to all eligible patients. A better understanding of the link between weight management and T2DM will hopefully raise patient engagement and self-management.

Benefits to the Partner Organisations:

For the institution: The development of a package offering training and materials to improve and standardize raising the issue of weight loss in patients with diabetes. It is hoped this will lead to an increase in appropriate patient referrals by primary care and an increased uptake of services by patients to create improved pathway flow. Also anticipated is increasingly 'personalised' treatment of diabetes for obese patients within the parameters of the current evidence based guidelines improving quality and reducing clinical variation.

For the industry partners: Supporting NHSGGC & other NHS stakeholders so that the appropriate patients with T2DM receive the appropriate treatment at the appropriate time reflective of local & national guidelines. A secondary benefit is being able to demonstrate that MSD & AZ are trusted partners in optimising and enhancing diabetes care through deployment of resources to support and facilitate higher quality care for all appropriate patients. The ability to apply shared skill, expertise and resources to further enhance patient outcomes and service performance will prove the suitability as a partner organization to the NHS.