Brief Interventions for Weight Management in Primary Care

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2 Speakers and key:

The original video of this presentation can be found here.
The accompanying PDF for the PowerPoint presentation can be found here.
The accompanying Lancet article referenced in this transcript can be found here.

This is the accompanying transcript for the presentation made by Professor Susan Jebb (OBE) hosted by the Thames Valley Strategic Clinical Network and Senate. Speakers and persons involved are denoted as followed:

- **AC**: Dr Aarti Chapman, Associate Director of the Thames Valley Strategic Clinical Network and Senate.
- **SJ**: Professor Susan Jebb OBE, Professor of Diet and Population Health from the University of Oxford.
- **JC**: Mr James Carter, Senior Network Manager, Thames Valley Strategic Clinical Network and Senate.

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3 Transcription:

**Dr Aarti Chapman**: Hi, welcome to our webinar on brief interventions for weight loss. We’re delighted to have Susan Jebb, Professor of Diet and Population Health from the University of Oxford with us today.

Before we start, just a few housekeeping points:

Please do make sure the volume on your laptop or phone is turned as high as you need it. If you’re having problems with the connection, do give another browser a try, and just be a little bit patient, it will take a couple of minutes to connect and our experience shows it will take a few seconds to get going.

If you’re really stuck, send us an email at tvscnsenate@gmail.com and we’ll plan to get you online as soon as possible. We also have a recording of this session going on to our website, so we’ll absolutely make sure that you don’t miss out.
I'm Aarti Chapman, Associate Director of the Thames Valley Clinical Network and Clinical Senate, and as a clinical network we focus on NHS England clinical priority areas to bring about improvement in the quality and equity of care as well as outcomes for our local population. Slide 3 [slide reference in webinar video, not in PDF] gives you a sense of the geography that we cover.

Now Susan - Professor Susan Jebb - is a nutrition scientist working in primary care. Her research focuses on interventions to support people to change their diet and to improve their health. Susan was an advisor to the Department of Health on obesity and food policy for ten years and in 2008 was awarded an OBE for services to public health. We’re really pleased to have her here today to talk about her work on brief interventions for weight loss in primary care.

Just a couple more points that I want to make; we do encourage you write questions in the chat box during the webinar. We’ll collate these and then we’ll feed them to Susan at the end of the presentation.

A number of you will have heard Susan speak at the January conference; this webinar gives us a bit more time to go into more depth and also for Susan to talk about some work that is about to be published next week in The Lancet, so what we’re planning to do is to share these slides and the recording of this webinar after the publication next week. And we’ll make sure that all of you get access to that.

Thank you, over to you, Susan.

Professor Susan Jebb: Thank you very much, Aarti, and my thanks for you all for joining us today, and your interest in some of the work that we’re doing.

So I’ve been interested in obesity for a long time, and about three years ago moved to Oxford, really to try to work much more closely with primary care practitioners because I really believe there are huge benefits to be gained if we can deliver effective weight loss interventions at scale.

Two thirds of adults in the UK are clinically obese, many more are overweight, so I absolutely recognise that we need interventions which can be part of routine care, which are scalable and which are affordable. And it’s that sort of ethos and philosophy which underlies some of the research we’ve done.

I guess the first question is really to ask yourself is ‘Do you make brief interventions in your practice’? I’m quite sure that many of you do on a range of different topics, but the reality is that rather few people make brief interventions in relation to weight loss. And that’s despite the fact that this is an established part of clinical guidelines in many parts of the world.

But specifically here in the UK, NICE does recommend that health professionals should [sound cut out] the issue of weight loss and identify people who [video and sound cut out for a minute]

So the question we asked ourselves is: ‘Why is it that people are reluctant to make
brief interventions for weight loss? And part of that, I think, is that people worry that it may not be effective. What can I do which in a brief intervention, which is actually going to help people to manage their weight?

And that concern is not unjustified. When we did a review for NICE as part of their guidance on weight management services, what we did was to look at trials which had investigated the effectiveness of weight management interventions led by health professionals in primary care. And, unfortunately, I have to say that there was really no evidence from trials that these interventions were effective, and here [slide 3] you can see the meta-analysis of those studies.

I’m sure some individual practitioners are doing some fantastic work, but overall it’s really difficult for us, at present, to recommend that interventions of this kind are a good way forward.

In contrast, as part of the same review, we looked at the evidence of effectiveness of some of the community weight loss groups, things like Weight Watchers or Slimming World. And what we found, as you see here [slide 4], that these interventions clearly show that they are able to help people achieve clinically significant weight loss, and more weight loss than the comparator group at one year. And remember that one year will usually be many months after the programme has ended. So what we’re seeing here is good evidence of sustained weight loss right out to one year.

So we have started to focus on whether we can develop partnerships between primary care and some of these providers, to allow health professionals to make brief interventions and to refer people to what we know is an effective source of support for weight loss.

I’m going to tell you about two trials that we’ve recently completed. The first is the WRAP trial (Weight Loss Referrals for Adults in Primary Care) [slide 5]. This recruited over 1200 patients in 23 practices, and what we were interested in here was to compare a very, very brief intervention, whereby patients were seen on a single occasion and given a booklet with self-help information for weight loss, compared to referral to a commercial provider, in this case Weight Watchers, either for the standard NHS twelve week programme, or we were interested in whether extended treatment would bring additional benefits. Would that be more clinically effective, and crucially, would it be worth the extra cost of an extended intervention?

Obesity’s a chronic, relapsing condition and I think many health professionals for many years have been concerned that twelve weeks perhaps isn’t sufficient to really deliver adequate intensity of programme.

What we see here [slide 6] is results after one year. So, the first thing to notice is that all three groups lost weight, even the group who had only received a self-help booklet: were more than three kilos lighter, almost four kilos lighter, at one year. Now of course this wasn’t absolutely everybody who was overweight, these were people who had essentially accepted the offer of support: they wanted help to lose weight.

But this should really encourage us that in those groups of patients who are seeking support to lose weight, even just a very brief intervention and a simple booklet
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appears to help people to lose weight.

But, importantly, referring to one of the community providers was associated with significantly greater weight loss. Both groups lost weight, and perhaps as you might expect, the group who were able to access this service for a whole year lost significantly more weight: seven kilograms at one year.

Now, the thing that many people are, of course, concerned about is not what somebody weighs, but it’s about their health. The reason we worry about weight is because we know as health professionals that it’s an extraordinarily strong risk factor for other diseases, particularly cardiovascular risk. And what you see here [slide 7] is the results of the change in somebody’s cardiovascular risk factors over that first year.

What I want to really highlight is the improvements there were in the diabetes markers. So what we see here is highly significant reductions, particularly in fasting glucose and HbA1c. These were not people with diabetes-some people had diabetes-but they were not recruited on that basis. This was a group of people were overweight and who we thought would benefit from an intervention.

So this is the kind of improvement in HbA1c which we typically see in some of the more intensive diabetes prevention programmes. But the key question is ‘What happens later?’ One of the reasons that people tell me that they are perhaps a little bit reluctant to offer people support to lose weight is the fear that they’ll put it back on again later. And indeed, that is true to some extent. Weight regain is very common, and this study was no different than any other.

So here [slide 8] you see the data at two years. So during that second year of follow up, nobody had had any intervention or contact with health professionals at all. It was simply looking at what was the lasting effect of what had happened much earlier on. What you see is that all three groups remained below their baseline weight right out to two years. But the effect of the treatments persisted, so the group who had had the extended referrals for one year remained significantly lighter than those who either had the brief intervention or just a short referral to the community programme.

Now, as I said earlier, weight regain is common and I think we have to be honest with ourselves and indeed with our patients, but I also want to give you a real note of optimism and of hope. This is the data from the diabetes prevention programme [slide 9] in the US, and a very, very big study which we know was associated with real improvements in health. What you see here is the group who had a much more intensive lifestyle intervention also regained weight. In fact, they regained weight at a very similar rate to that we saw in our trial.

[Slide 10] Despite that weight regain, there was a significant and sustained reduction in diabetes incidence. So although in the diabetes prevention programme, people’s weight had returned to baseline after four or five years, out at ten years, the reduction in diabetes is about 30%. So weight reduction is important, and of course, long term weight loss maintenance is absolutely what we’re all aiming for, but we should not be deterred from making that initial intervention by the fear of subsequent weight regain, because there are sustained improvements in health despite weight
So going back to our WRAP trial now, what we tried to do is to estimate what would be the improvements to the healthcare system. What would be the benefits of these interventions? And so we did some long term health modelling using a model from the UK health forum, which has been widely used by government to estimate the long term benefits of treatment. What you see here is that the intervention, even just a referral for three months, is associated with significant improvements in QALYs and of course, perhaps not surprisingly, you get greater improvements with the longer term intervention.

If we now look at the costs of this, then what you see here is the absolute costs of the intervention per kilo of weight loss. So yes, a three month intervention costs less than a twelve month intervention, and if we look at the costs per kilo, the costs are slightly greater at two years because people have regained some weight. But the costs per patient are relatively modest compared to many of the other interventions we may be making, and that really is illustrated very clearly in the bottom panel on this slide, where we've looked at the cost per QALY.

What you see here is when you do this modelling over twenty five years, that reduction in weight is sufficient to, we expect, to prevent many cases of diabetes, coronary heart disease, and so forth, such that actually, a twelve week referral, the standard NHS offer, appears to be cost saving when we model it over twenty five years. A longer programme is a little bit more expensive, and comes out at about £2400 per QALY, but that of course is still a very, very cost effective intervention if we compare that to the standard NICE threshold of about £20,000 per QALY.

So the take home message from this is that longer programmes are definitely better. They cost a little bit more, but we anticipate that these will still be very cost effective. But at the minimum, it would make absolute sense to be using these twelve week referral programmes because in the medium term it is actually going to be cost saving.

Now what I've talked to you about so far is an intervention which was offered to people who had essentially asked for support to lose weight. We recruited them by mailing everybody on the practice list who was recorded to have a body mass index rating of twenty eight, and about 10% of people responded. So they were the people effectively who were open to the offer of support, but a key question, I think, for primary care is ‘what about all the rest of the people?’ Many people who are overweight who might benefit from weight loss, but who frankly aren’t really expressing any interest in managing their weight at the present time. Is there anything we can do to help there?

This is what leads me to our BWeL trial: Brief Interventions for Weight Loss [slide 13]. This was an opportunistic intervention. What we did was to train GPs to make a very brief, 30 second intervention in everybody who came to their routine clinics who had a BMI greater than 30. And this was essentially a 30 second intervention offered at the end of a routine consultation, an intervention in that ‘while you’re here’ moment; ‘while you’re here, can you make a brief intervention for weight loss’.
The aim of doing this was to really create momentary intervention, who weren't really thinking about weight, but the doctor raises the issue, and then we can capitalise on the moment by offering them support, and we hope that by referring them to a programme, we can create lasting motivation to lose weight. That was the theory; how did it work out?

[Slide 14] Well, one of the issues that doctors tell us, which deters them perhaps from making brief interventions for weight loss is a worry that patients may not appreciate being offered advice about their weight. We tend to think of it as a very personal issue, perhaps a rather sensitive issue, but this trial should give you real reassurance that brief interventions, conducted of course in a sensitive and supportive manner, are actually rated as extremely appropriate, and indeed helpful, by patients.

So this graphic shows the ratings of appropriateness by people who are asked immediately after the consultation 'how appropriate was it for your doctor to talk to you about your weight today?', and you can see overwhelmingly in the green bars that people thought it was appropriate, or very appropriate for the doctor to intervene.

I should perhaps explain that this was a trial, so there are two groups; one who on the left that was offered advice to lose weight, the doctor simply said 'it would be good for your health if you lost some weight', and the one on the right, support where the doctor raised the issue of weight, and offered people a referral to a weight management programme.

[Slide 15] Here we see a similar chart looking at helpfulness, how helpful was it for your doctor to raise the issue. And again, overwhelmingly, people thought it was helpful. Indeed, only 1 in 500 people thought it was not appropriate and helpful for their doctor to raise the issue of weight loss, and that should provide huge reassurance to practitioners.

[Slide 16] So what happened when you have made this intervention in people who had come to the surgery for something completely different weren't thinking about weight loss? What happened when the doctor said ‘Can I refer you to one of the community weight loss groups?’ Well, the answer is that three quarters of people said ‘Yes doctor, I’d like to do that’. Now, that’s a fantastic result, much better than we expected, but we are realists. [Slide 17] And of course, they didn’t actually all turn up!

But nonetheless, a surprisingly large number of people did. And of those who accepted the referral, more than half attended the programme, and most of them completed the course. So for a completely unselected, totally opportunistic intervention, we were quite encouraged at the uptake of this programme. [Slide 18]

But of course the crunch is: what happened to their weight? So this was a simple twelve week programme, and what you see here in the top panel is that at three months, people had lost weight. Interestingly, both groups, the control group who were simply advised to lose weight had lost one and three quarter kilos, the group where we had offered a referral to a community programme had lost significantly more weight. In fact, they had lost about three kilos after three months.
The programme ended at that point, but we followed them up again at twelve months, again looking at the benefits beyond programme end. And really encouragingly, you can see that that benefit persists. Both groups remain below baseline, and the intervention group who were offered a chance to attend a weight loss programme had done significantly better; they were one and a half kilos lighter than people who were left to their own devices.

[Slide 19] Why was that? Well, as we said earlier, a large proportion of people went to the programme, and those people who did attend did very well indeed and they got benefits very like those I showed you for people who attended in the WRAP trial. But secondly, even people who didn’t attend were more likely to take effective action, and this slide shows the answer to a question we asked people at twelve months, about what they had done to manage their weight. And we graded these in an \textit{a priori} way into effective and probably rather less effective action, and what you can see here is that in the group who were offered a referral to a programme, we stimulated about four times as many people to take effective action to lose weight.

And it may well be that the intervention from the health professional prompted those people who perhaps might have done something about their weight over the following year to actually do something rather more effective. The net effect was that a year later, they were significantly lighter than they would have been if no intervention had been made.

[Slide 20] So, this is an interesting trial because it’s the first time we’ve tried to make opportunistic interventions in everybody who walked through the door who had a BMI <30. And so what we can now do is to model what would be effect on the UK population if everybody was to do that all of the time, and this is model change in the proportion of people in the country with a BMI more than 30, if a GP made this kind of brief intervention, with this effectiveness, just once a year for each eligible patient.

What you can see is that by 2035, we would have halved the prevalence of obesity. That is a dramatic result. What it shows is that these brief interventions not only help individuals, who reduce their risk of disease, but actually they would have huge gains to society, reducing the headline prevalence of obesity.

[Slide 21] So in summary, I guess what I want to convey to you, particularly from these two trials but really from everything we’ve learned about weight management in primary care is that a brief opportunistic intervention from a doctor to encourage weight loss is acceptable to patients, they welcome it, and they find it helpful, and interventions made in a supportive manner are really to be encouraged.

One of the benefits of advice from a doctor to lose weight is that it seems to increase the number of people who are taking effective action about fourfold. That said, we know that it is more effective rather than leaving people to their own devices, if we offer them a referral to one of the group programmes.

We’ve shown that referral to the standard NHS twelve week group is actually expected to be cost saving over twenty five years relative to just advice to lose weight. But let’s not lose sight of the fact that longer support over a whole year significantly increases weight loss and brings greater health benefits. Yes, it is more expensive, but in comparison to many, many other things we do, it is still very cost
effective.

And the final things are that weight regain is common, but that does not invalidate the benefits of the initial losses and should not put us off making these interventions. The final issue is that size really matters; and I say that in the context of needing to scale up.

We are doing some work on weight management, but we’re not doing it enough, we’re not offering enough people support to lose weight. Not just those who ask for it, but actually we should also be reaching out and offering support to far more people, and I just remind you of that key fact that I showed earlier, which is that a brief intervention, even if it results in just one and a half kilos of weight loss at one year, if we deliver that once a year to all eligible people visiting their GP, we could halve the prevalence of obesity by 2035.

Thank you.

AC: Thank you, Susan. That was an absolutely wonderful presentation, and also incredibly informative. And we know why this is all so important; we know that excess weight accounts for 44% of diabetes cases in the UK, 23% of heart disease, and up to 41% of cancer; some cancers are caused by the extra weight.

So we’re going to open up for questions that have been coming through in the course of this presentation, but can we start by just asking you to describe again what you think about the value of weight loss even if it is for a short period of time, because that seems to be quite an important aspect.

SJ: This is a key issue; so many people say to me ‘oh, but we just put weight on again afterwards’. I think there are a few things to remember. Firstly, that weight regain is common, let’s be honest about that. But in any trial, what we see is a proportion of people do extraordinarily well and keep the weight off very long term; that would never happen if they didn’t lose weight in the first place. So, the average weight change conceals a lot of variability; some people actually are extremely successful.

Secondly, that weight regain is probably a bit slower than many people imagine, there’s a sense that twelve weeks to lose weight, and you put it all back on again twelve weeks later. And our data, and the wider literature, shows that that is not the case; weight regain is slower than that. It appears, probably, it take four to five years to regain all the weight that’s been lost. And the fact is that the health risks of obesity relate partly to how much excess weight you’ve got, but also to how long you have carried that excess weight.

So even having a short period where you are below where you might otherwise have been, actually brings lasting health benefits, and if we think about it in those sorts of terms, I think it’s more understandable why actually surprisingly small weight losses bring pretty remarkable health benefits.
An analogy that some of my public health colleagues use, is the way in tobacco control we think about ‘pack years’: how many years have you smoked and how much of it you have smoked, and of course your health risks are related to the number of pack years. In a way, weight is perhaps a little bit similar to that. So, weight regain is common, not as fast as people expect, and there are still lasting benefits. And some people will succeed in losing weight and keeping it off.

**AC:** And some of that, some of the clinical and health benefits of that, communication of that from clinicians to the patients would give them significant motivation to keep trying.

**SJ:** Absolutely, and people really do need that support longer term, because when you’re losing weight, everyone’s saying ‘oh that’s fantastic, you’re losing weight’ but actually when you’re the same weight as you were a month ago, as health professionals we know that’s a good result!

But nobody’s going to give you much positive feedback as you’re walking down the street. So that’s the time for health professionals to come in, remind people of how much weight they’ve lost, and how fantastic it is that now they’re keeping it off.

I think the other point is that one of the reasons why people regain weight is because the world we live in makes it very hard for all of us to manage our weight, and as we scale up our wider public health action to prevent obesity, that will disproportionately benefit people who have lost weight, because they’re the ones who we know are very susceptible to weight gain, and so they will derive greater benefit. So, you know, prevention and treatment are not poles apart, and all of our preventative efforts will absolutely bolster up the longer term success of obesity treatment.

**AC:** Thank you, thank you. Can you tell us what you think about low carb diets for weight management?

**SJ:** So, I have spent many years, when I previously worked in Cambridge, looking at different macronutrient compositions of diets, and I have to say my conclusion is that, and again reading the wider literature, diet composition doesn’t really make that much odds. Some people lose weight well on low fat; some people lose weight on low carbohydrates, some people on high protein. The composition of the diet doesn’t really matter; to lose weight you’ve got to cut calories, and you can take calories out from carbohydrate, take them out from fat, you need to cut calories.

The issue is what’s going to be sustainable for you and some people find low carbohydrate diets a really sort of simple prescription, relatively easy, just to take the bread or the pasta or the rice off your plate, and of course, if you’re saying low carb diets, you’re also asking people to cut out biscuits, cakes, confectionary, chocolate. That’s a pretty good way to lose weight! So if people want to lose weight with low
carb diets, fine by me. The important thing is to lose weight and to find something that you can stick to.

420 **AC:** Thank you-

**SJ:** -perhaps…I think for patients with diabetes, I think there’s emerging evidence that there may have some additional benefits, not absolutely proven, but clearly there’s less insulin demand, but that’s an area I think of pretty active research. But if you’ve got patients with diabetes, then there may be additional reasons to perhaps, say, encourage them to at least lower their carbohydrate intake.

430 **AC:** Thank you. Shall we see some questions that are coming in?

**James Carter:** Yeah, we’ve got just a couple more questions and then I’m just waiting on our team to pull out all the questions from the actual session in and of itself. We’ve got one more from our preliminary questions that would be helpful as well.

**AC:** Yes, so just going back to…is there any thought about the sort of intervention that you’d need in a different healthcare setting such as an outpatient clinic, or a practice nurse?

**SJ:** Well one of the interesting things I think was because that the trials we’ve done so far which have both involved referring to an external provider, actually could be used not just in primary care but of course could be used in secondary care as well, they could be used in outpatients, they could be used in health check type settings.

They’re very, very broadly applicable. I think the point is that people need to raise intervention in an appropriate and sensitive manner, and we’re working with PHE and the Royal College of GPs to try to develop training materials to give people support to do that. And then you can refer to any effective intervention.

We happen to have used the community weight loss groups in these trials, but the point is that as long as we know the intervention is effective, you can signpost people in to that. And so, for some groups of patients, it may be that other interventions are a more appropriate route. But the beauty of this is it’s about raising the issue, and signposting people to where they can get support, and that makes very efficient use of health professionals’ time, because it uses their generic skills in their communication relationship with the patient, raising the issue, motivating them to
take some action, and identifying effective action, but then uses more specialist services to actually deliver the intervention.

JC: We have actually pulled out the questions from the session, so if I can just grab that now…

AC: While that’s going on, Susan can you talk us a little bit more about the barrier that people feel in raising the issue about weight loss with their patients, how your work has shown that that’s important or not?

SJ: You know, as I said earlier, I think that weight is a personal issue, it’s a very sensitive issue. We know that people who are overweight are the subject of huge prejudice and discrimination and it’s not surprising that they feel sensitive about their weight, because society has really kind of created that culture. However, doctors and other health professionals are talking to patients with whom they have an established relationship, and we think it’s a different issue. And our experience has been that patients welcome this support, particularly when it’s done in a genuinely preventative fashion.

I think one of the temptations is that as health professionals we wait for what we think of as a teachable moment, a new diagnosis of diabetes. Actually, that may be quite a tricky time, because what patients tell us is that they feel a little bit blamed if we start talking about weight at that point. Whereas if you actually do it in a truly opportunistic way, it’s absolutely clear that you’re saying ‘look, I know that this is a risk factor and I want to help you to manage this risk factor before it really starts to create problems’, so we think that sometimes may actually be better than others, and we’re working hard to understand more about that so we can really optimise that intervention.

AC: That’s really interesting, yes. Okay, so now we’ve got some questions that have come up from the audience here, that are on the WebEx.

Question: What did the WRAP 12 week weight loss programme involve?

SJ: Okay, Katy, so what did the WRAP twelve week weight loss programme involve? It’s quite simply a referral to a Weight Watchers programme in this instance, but the sort of standard NHS referral scheme.
Question: What kind of training did you make available for GPs (and PNs) for the BWeL Trial?

SJ: What we did, we had an online video which basically explained the importance of weight loss; a talking head, ‘this is why it really matters’, and then we had a whole series of little roleplay videos where we had real GPs talking to actor patients and role modelling how the conversation might go.

We’ve recently been working with Public Health England who are developing a training guide resource which should be available very shortly. We’re also working with Cancer Research UK, they’re doing something similar, and the RCGP. There are a number of initiatives to make this training more widely available, and we’re hoping, now we’ve finished our trials, to actually go back and look again at our videos and perhaps enhance them.

Question: Has the BWeL trial been published?

SJ: Yes, the BWeL trial has been published. It was in The Lancet in October last year, it’s an Open Access publication and I’m sure the team here can make that available to people if you’re interested [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)31893-1/fulltext].

The WRAP Trial will be published in The Lancet next week, and again will be available on Open Access.

Question: How could/did dietitians contribute to the programmes? Training? Or did they run the programmes?

SJ: So as I’ve explained, in this instance dietitians weren’t involved in the programme. We organised it like that because we know the dietetic work force isn’t of sufficient scale to be able to deliver these kinds of programmes when we’re doing them in routine practice. One of the projects we’re beginning to think of now is how we can develop other programmes, perhaps for people who require slightly more individualised care, which may benefit more from the more specialist input that trained dietitians could offer.

So, the answer is that the programmes I’ve been talking about, dietitians weren’t directly involved although of course dietitians work with some of the commercial providers to refine their programmes. But it’s definitely something we want to look to do.

Question: Can you explain broadly about the methodology which was used to model
the number of people with a BMI>30 by 2035 if this intervention is used?

SJ: Okay, so this is, if you like, a fairly standard long-term health economic model. So the models are basically built on data from observational prospective cohort studies. So they know that people with a BMI of 30 have a chance of having diabetes or heart disease or whatever the other outcome is, and a BMI of 35 they have this and at 40 they have that. So what we then do is run the model; it’s called a microsimulation, it envisages there are hundreds of thousands of people with this particular BMI profile who lose this particular amount of weight, and then in this instance, because we’d only followed them for two years, what we did is to make a fairly conservative assumption that those rates of weight regain actually continued.

We assumed people carried on putting weight back on, so that by five years they were back to their baseline, and so we then just modelled what the anticipated benefit of that period of reduced weight would have on the long-term health risks. So there’s much more detail both in the WRAP/BWeL paper and we’re currently working on a much more detailed economic modelling paper.

JC: Good. We’ve got some more questions as well, so if I can open up another document…questions two, I hope. Okay.

Question: Do you have a sense of how many GP practices are undertaking these simple brief interventions, and are there any moves to get this into GP training? It is simple, cheap and effective.

SJ: So, I don’t have a sense of how many GP practices are doing it. In the BWeL trial, we had something like 130 GPs involved, they were from practices which were research active because it was a trial, but they were not selected as having a particular interest in weight management, so they were relatively naïve to doing this.

One of the things that we were pleased by is that many doctors did report that as a result of the trial, they had carried on making these brief interventions subsequently. And it seems that having trained people, then the trial almost sort of forced people to put these into practice and have a go at doing this for a while, and when they’d done that, they started to get positive feedback from patients, and then it was much easier for them to continue.

What we really need to do now is to have a much, much bigger programme of implementation, indeed one of the things we’ve been talking to colleagues in the regional networks, is thinking about how we could start to implement this in much more routine care.

JC: Thanks.
**Question:** Does it matter if the brief intervention is from a GP or practice nurse?

SJ: In our trial it was a GP, I cannot see any reason why it would be different if it was a practice nurse, but I can’t absolutely give you the answer that it’s the same. But I’m sure similar principles would apply.

JC: And across AHPs as well?

SJ: I would have thought so. I think, you know, what matters is you’ve got a credible and authoritative person delivering the message, who the patient understands how, has a vested interest in improving their health. So I think it uses those generic skills that good health professionals have in terms of communicating, motivating and engaging patients, and I don’t think that’s limited to GPs.

JC: Brilliant.

**Question:** We are trying to do this locally, encouraging all Health Professionals to make it their business and use brief intervention and refer to services but how will it be encouraged locally?

SJ: Well, firstly, fantastic that you’re encouraging it locally, and you know sometimes these things are best when they’re built bottom up. Every area, every region wants to make an impact in relation to obesity because we know it has the potential to really make a huge difference to the NHS system, really.

We’ve got to start preventing disease before it occurs, and treating obesity is a great way to prevent disease, so I think that the more people who start doing it, and who evaluate what they’re doing, just collecting basic data, other areas will really start to sit up and take notice. So we of course are talking to NHS England and Public Health England and trying to encourage it from the top, but absolutely please continue to encourage it bottom up.

JC: And…sorry, this is James, you probably can’t see me on the camera, that’s fine; I don’t want to scare anyone off! We would also know, certainly at an NHS England more local and a CCG level, that there are, in sustainability and transformation plans (STPs), prevention appears in all STPs. Part of that focus is very much around how can improvements be made across the system so, that again, that sort of shows there are not only the local and the national, but also there are regional commitments which I think there can be better or greater influence into those, into that agenda.
**Question**: Do you have any trials showing weight loss figures with standalone weight loss interventions compared to the interventions used alongside activity/exercise programmes?

**SJ**: So we have done a systematic review which looked at behavioural weight management programmes, and within that which was based on the work we did for NICE as part of their adult weight management guidance, and what we showed in that is that interventions which involve diet and exercise together are significantly better than diet alone, so every reason to encourage more physical activity as well as dieting. But the weight loss groups actually do do that to some extent, we might like them to do more, but certainly they all are encouraging people to be more active, some of them encourage the use of pedometers and things like that.

**Question**: This is really powerful and persuasive. Simple intervention having colossal effect on prevalence of the high BMI population. Why are the government/NHS not putting this at the top of the incentive agenda for us GPs? It stands head and shoulders above some of the QOF intervention that we are asked of us.

**SJ**: [laughs] Oh, well, I ask myself this all the time! Truth is, of course, there are a huge number of priorities and as ever, I think, that in a very pressurised system, people are very focused in on managing today’s problems and it’s really hard to actually say what we also need to be doing is thinking about tomorrow’s problems, and treating obesity is actually about preventing disease down the line.

You know, the figures that I showed you, in the first year it costs to treat obesity, you don’t make savings in the first year; the savings come down the line and whilst we all want to take that longer term perspective, when you’re under as much pressure as the NHS is right now, I think it’s tough. Of course I think that’s what we should be doing, of course I think we should, but I do understand how tough it is.

And I think there is still also this issue of some prejudice against treating conditions like obesity relative to some other diseases, so there is somehow a sense that people should just get on and do it for themselves, and I think one of the important things about this data is it really drives home that a little bit of support from a health professional makes a huge difference to people’s own efforts. Doctors can’t lose weight for their patients, but a bit of support from a health professional makes a huge difference, and I think understanding that partnership also matters, because just thinking that people should just go off and sort it out for themselves I think is not the
most effective thing to do and in the end is...support works! Funnily enough, support works! [laughs]

JC: Quite. And this is the final question, Susan.

Question: Are you planning any similar research in BIs for children?

SJ: Oh, absolutely, well, we would love to do this and indeed if I had, you know, more people and more time and more funding, we would be doing it right now. We need to put in some grant applications to allow us to start planning to do this work in children.

The reality is that raising the issue, just that first part, raising the issue about excess weight in children is probably much more sensitive than raising with adults. Most adults know they’re overweight, and so the doctor raising it isn’t really new news, they’re just delighted that the doctor is now going to help. I think that we, there is good evidence that most parents really are unaware that their child is overweight, or perhaps even obese, and so raising the issue is much more sensitive, but we really need to do some very formative research to find effective and appropriate and genuinely helpful ways to intervene.

The other challenge with children is that, unlike adults, where we have good evidence that weight loss groups are effective, actually for children there is much less evidence of effective interventions, so children who are referred to very specialist hospital services, you know, some of those have had some good results, but we don’t yet have a widely available, if you like, off the shelf intervention that children who are overweight could be referred to, which we’re confident is effective. So I think we need to have more research to help doctors to raise the issue, but we also need to give doctors and families some clear advice about what would be a helpful thing to do.

JC: Fantastic.

AC: Thank you very much, Susan, that’s been an absolutely inspiring as well as evidence-based talk, and certainly from the questions that have been coming through, we’ve got a very engaged and interested audience wanting to know more and participate in this agenda. So we’ve given you here our contact details [slide number], and we’d like to suggest that everyone on this webinar today, do get in touch with us, give us your ideas about how you and we collectively might be able to get some real traction on this, on obesity in our local patches.

You have the details for how to contact us, and we’d be really, really interested in hearing from you. As Susan mentioned at the start her presentation, there’s a Lancet paper coming out next week and we will certainly send the link to that to everyone
who’s signed up for the webinar. If you have other contacts who you think would like to be hearing more about this directly, do send us their contact details and we’ll add them to our database.

From our side we’re very excited to be working with Susan locally and starting to put together a programme within the network workplan to, and the STP workplans locally, to make this a reality. Thank you.

SJ: Thank you very much, it’s a real treat to come and talk to you and everybody on the call who’s engaged so enthusiastically. Thank you very much.

JC: Thanks.

AC: Thank you.

[End of webinar]