**Principles of improving healthcare for people who are overweight**

Overweight is an important and complex phenomenon, which requires an intelligent and integrated approach by all people working within the health service, and within other parts of civil society, to effectively address it, and minimise the negative impact of overweight on individuals.

In Ireland in 2019, it is evident and agreed that levels of co ordination and understanding between different health service providers will benefit from a more integrated approach towards service delivery.

Further, it is also known that unacceptable inequalities in service provision based on geography, and on socioeconomic differences, remain throughout Irish Society. Inequalities are relevant to the experience of people who are suffering due to overweight, and these inequalities require to be addressed.

This Principles Section addresses aspects of improving medical care for people who are overweight. People attending for medical care, and clinical staff in the Health Service, can expect the weight of individuals will be checked routinely as part of medical care. Individuals who are overweight will be consistently and professionally advised on helpful and relevant strategies, to assist in maintaining a healthier weight.

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| **Principle** |  | **What this means** |  | **How this may be achieved** |  | **Patient outcome** |
| **Primary Care plays a key role** |  | Primary Care at its best helps a person to remain healthy and well in his/her community and is able to address most of the individual’s health and well-being issues. Home, school, community services and environment (built and regulatory) are all important in preventing and managing overweight.  *On the emergence of overweight, the support of family, friends and agencies in his/her community are important for the individual****.*** |  | Families and households need to be aware and constructively alert to the emergence of overweight.  *Services in Primary Care need to be relevant, understandable, effective, accessible, responsive and properly resourced by either the State or health insurers, to address overweight systematically.* |  | Effective Primary Care can sometimes prevent and minimise the extent of progressive weight gain, and prevent or reduce the need for overweight individuals requiring care in hospitals for   * Acute infections * Acute medical / surgical problems * Chronic disease or multiple chronic diseases * Flare up of a chronic disease * Mental health issues |
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| **GP led Primary Care** |  | People know their GP and the GP knows them personally, and coordinates their care when required. GPs often know the individual’s family history. Each individual / child has an ongoing relationship with a registered, personal, indemnified GP, trained to provide prompt first contact, continuous and comprehensive care.  *All people (or carers in the instance of children) attending general practice will be advised in a timely and professional manner regarding their weight or the weight of the child.* |  | The GP leads trained staff in the practice, who collectively take responsibility for the ongoing care of individuals. Other members of the Primary Care team, and relevant community agencies, are also available when required, and the GP will organize and co-ordinate their input.  *Individuals attending GPs can expect to have their weight checked - quickly, reliably and professionally, being advised if it is becomeing excessive, and assisted in addressing overweight as it arises.* |  | Individuals who are overweight will be invited and assisted in devising a family or household centered management plan, using available community services, with referral to tertiary care when BMI exceeds 40 (or 35 in instances of important comorbidities / complications), and / or PAEDS Equivalent from ICGP HSE Algorithm.  *Maintaining a healthy weight, and overweight, will both be systematically addresses as a core part of chronic disease prevention and management, in GP led primary care.* |
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| **Comprehensive care** |  | When the individual, or his/her carer, is not able to do so, the GP team will take responsibility for ensuring that the individual’s health care needs are met in accordance with the individual’s preferences in his/her community as far as possible. |  | The GP team arranges appropriate care and supports for the individual/family, or his/her carer, with other qualified professionals and appropriate resources. |  | This includes care for all stages of life relating to maintaining a healthy weight, including evidence based prevention, earlier diagnosis, acute care, and ongoing medical care for multimorbidities. |
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| **Co-ordinated care** |  | Each individual has his/her own secure, electronic, up to date health record, eventually accessible on his/her personal computer or smart device.  *Given the emerging importance of overweight, serial measurements of weight and BMI will be reflected reliably and prominently in medical records and in clinical correspondence (eg referrals / discharges).* |  | The GP has access to comprehensive electronic medical records and these, with the consent of the individual, are shared with, and updated by other health professionals.  *The universal introduction of electronic medical records throughout the remainder of the Health System is a strategic priority, which will benefit the management of overweight, and all other medical conditions.* |  | Care is coordinated and integrated across the complex healthcare system, and in the individual’s community. The patient’s pathway through the healthcare is both efficient and effective, and the patient is fully informed at all times during their journey.  *In the intermediate / longer term, the individual who is overweight and their professional carers will develop a consistent, evolving and shared understanding regarding the ongoing management plan for the individuals weight, with clear care pathways and clinical objectives through Primary, Secondary and TertiaryCare.* |
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| **Accessible care** |  | * **General practice**   Enhanced access to care is available through systems such as appointments, expanded hours, out of hours co-operatives and responsive electronic communications between individuals, their GP, practice staff, other primary care professionals and hospitals/other care providers involved in the patient’s care.   * **Access to diagnostics**   The GP arranges diagnostic tests for the patient in a timely fashion. Diagnostic reports are issued promptly and, where necessary, arrangements for urgent access and immediate reporting are available.   * **Access to hospital specialists**   If progressive overweight, that cannot be managed in the community, becomes evident, the individual attends a secondary or tertiary hospital if the specialist is located there. Arrangements to attend hospital or specialist care are made by the GP on behalf of the individual. The reason for the referral and type and urgency of specialist input is clearly communicated at point of referral. Integrated referral and care protocols/ standards are in place between the hospital and GPs to make the process efficient, and effective for the individual.  **In the management of progressive overweight, all citizens likely to benefit from bariatric surgery will have timely and equitable access to relevant surgery, based on adult BMI of >40, or in instances of multimorbidity or complex medical history, of BMI >35.** |  | Where appropriate, GPs and hospital specialists work together for the benefit of people, at the community level.  Appropriate evidence based community services are available to individuals and households where progressive overweight is apparent, in an efficient and equitable manner. These will include input from relevant allied health care professionals in the delivery of local community programs, operating at the level of local communities / small populations.  Given the importance of socioeconomic deprivation in the genesis of population overweight, use of deprivation weightings in the delivery of primary care will be implemented.  Nationally agreed referral criteria are agreed, periodically reviewed and utilised in the establishment of clinical pathways, within Hospital Groups, and nationally. These will be used to provide standards, to ensure accountable and equitable service delivery nationally.  It is the responsibility of individual services in communities (GP and Primary Care) and CHOs to assist in addressing BMI below surgical thresholds.  It is the responsibility of Hospital Groups, and regional and national surgical services to provide timely and appropriate surgery. |  | When the individual attends hospital they are seen by a specialist, who will endeavor to improve and assist their management of overweight in a timely manner. They are discharged home at the earliest opportunity, and their GP is informed about the services and care provided, and appropriate continuing after care. Where a discharge plan needs to be put in place requiring the input of a number of healthcare professionals, this is organised and delivered by the GP and members of the individual’s Primary Care Team.  If the patient requires rehabilitation, recuperation or long-term care, it is arranged for the individual in facilities as close as possible to the individual’s home, as soon as acute hospital care is no longer required. Ongoing care is provided by the GP.    Where individuals are terminally ill they receive the highest standard of care and comfort in their own home as far as possible, or very close to home. The hospice, GP and other healthcare professionals will liaise to achieve this outcome for the individual, his/her carer and his/her family.  People with mild / moderate overweight will have this addressed mainly in primary care. People with progressive overweight, exceeding the surgical thresholds, will have this addressed on designated surgical services, in a timely manner.  People (adults and younger individuals) with a BMI of > 40, or in instances of significant co morbidities >35, will be referred to regional integrated hospital teams, which will include the necessary medical, surgical and paediatric expertise to deliver essential surgical treatment. |
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| **Quality and safety** |  | GPs and their practice teams have an essential role in monitoring the health and wellbeing of their practice population and their local community.  Primary Care Teams working with larger populations, in collaboration with GPs provide an extended level of community based care.  Specialists have an essential role in delivering essential, timely and specialised services to all individuals who will substantially benefit from specialised care, in a timely and equitable manner. |  | GP Teams and Primary Care teams will work effectively to prevent and/or initially address the issue of progressive overweight in both individuals, practice populations and communities.  Where overweight is progressive, prompt, appropriate and justified referrals will be undertaken for individuals, based on defined and effective care pathways, to appropriate specialist services, triggered by agreed thresholds, based on BMI, the presence of comorbidities, and in the case of paediatric care, on BMI Z Scores.  All GPs have an electronic register of patients, which is pro-actively used for alerts, recalls and the monitoring of progressive overweight. It is an important safety net in circumstances where the patients have difficulty looking after their health.  *Waiting times (from Hospital Groups and nationally) for Bariatric Surgery will be monitored and communicated, and both NTPF and Cross Border Directive referral resources will be considered, as necessary, to ensure timely and equitable service is delivered to people who require it.* |  | Healthcare is facilitated by information technology, health information exchange and other means, such as, disease registers to ensure that individuals obtain safe necessary care when and where they need it, and in an appropriate, timely and equitable manner.  General Practice Teams will be supported to code for overweight, and for high risk overweight (BMI of 30 and 40 respectively or 35 with co morbidities and Paediatric Equivalents), in the electronic medical record.  All individuals who are overweight will be able to easily avail of earliest identification of their overweight, of timely and appropriate community based intervention, and of specialist intervention (presently taken to mean close management of comorbidities and bariatric surgery), all of these services being delivered on an evidence based and equitable manner, and made available in a manner which addresses the impact of the Inverse Care Law on individuals who endure personal and social backgrounds characterised by deprivation. |