SPECIAL REPORT

Diabetes – Weight Management

Diabetes and Obesity

A Modern Problem; an Eternal Obstacle

Prevention More Cost Effective than Treatment

Stronger Together

Lipotrim

Reform to Rethink

Make What Works Work Well

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The Weight Management Programme
Managed by Healthcare Professionals

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GP or Pharmacy monitored
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Lipotrim Weight Loss Programmes have been extended to include pharmacies.

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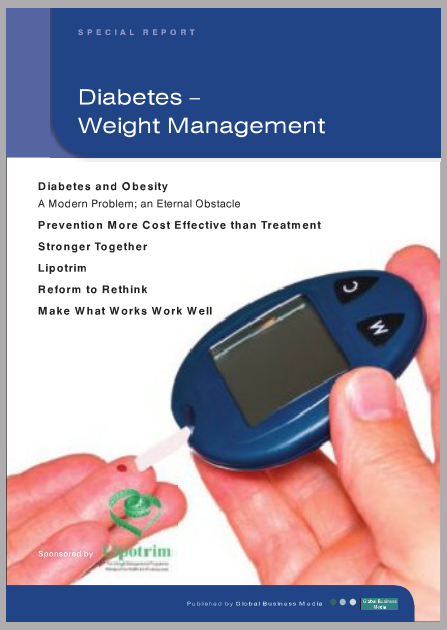

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Foreword

By 2008, figures released by the World Health Organisation showed that worldwide obesity had more than doubled since 1980 and that it had become the fifth leading risk factor for global deaths. No mean achievement for a condition that is, in most cases, quite avoidable. Of course, it isn't the obesity alone that kills; it's more the string of life threatening conditions that assault a body whose wellbeing and ability to fight off illness have been compromised by the strains caused from being overweight or obese. Not least among these conditions is diabetes (usually the Type 2 variety when the cause is excess weight) which, we should not forget, was a killer condition even a few decades ago.

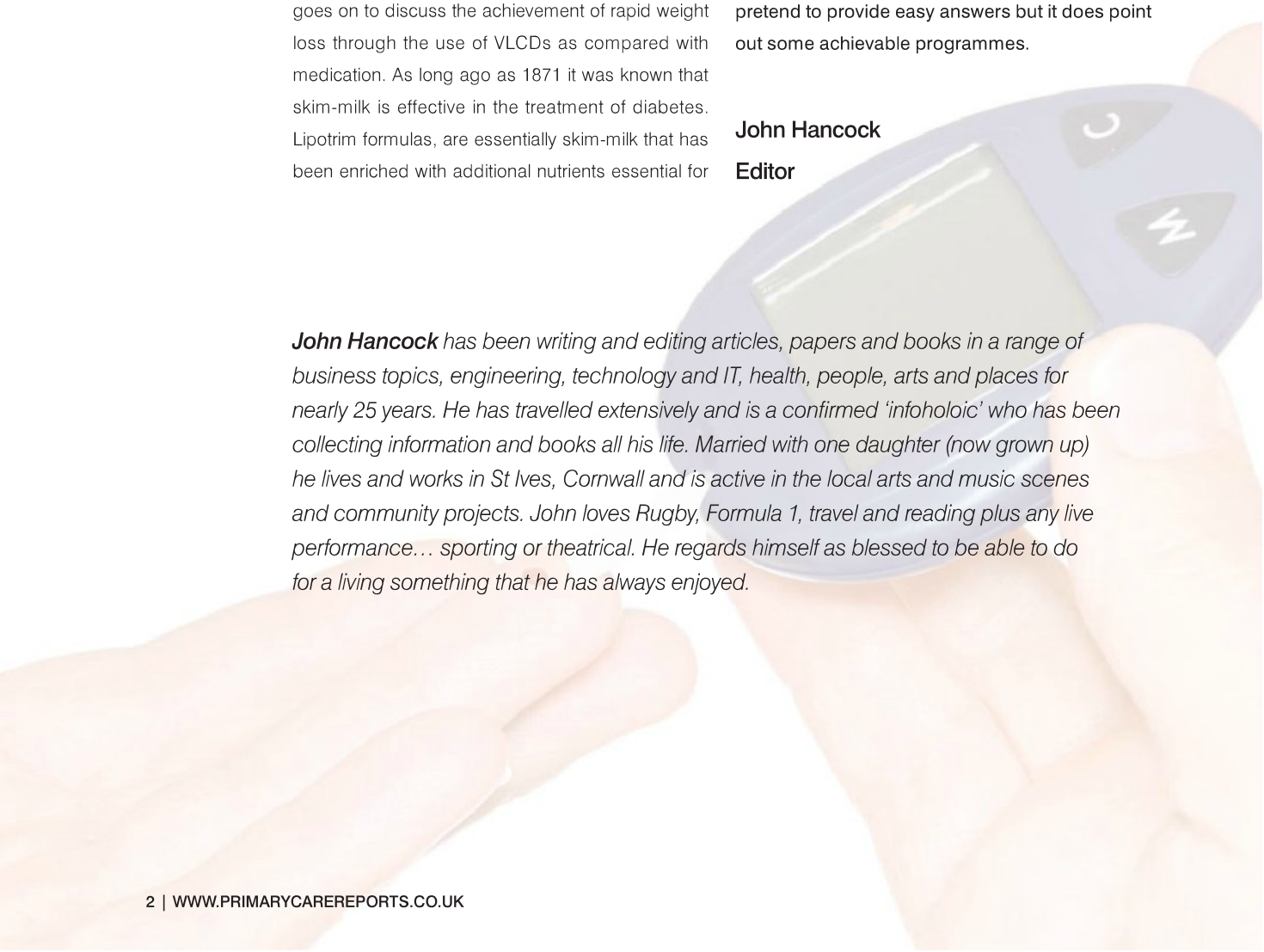
Overeating is now recognised as sharing the biological characteristics of addictions such as alcoholism. This Special Report opens with an article that stresses the importance of rapid weight loss in the treatment of patients with type 2 diabetes. It goes on to discuss the achievement of rapid weight loss through the use of VLCDs as compared with medication. As long ago as 1871 it was known that skim-milk is effective in the treatment of diabetes. Lipotrim formulas, are essentially skim-milk that has been enriched with additional nutrients essential for long term health. The article goes on to argue that this form of treatment should, at least, be offered to patients before resorting to drugs.

Excess weight can also compromise most of the body's 'vital' organs including the heart, liver, kidneys, skin and even the brain. All of these conditions are treatable to some degree but any treatment is far less likely to be effective if the underlying cause, weight, remains unaddressed. It's not easy to address weight loss any more than it's easy to stop smoking, or drinking or taking 'recreational' drugs or any of the other harmful things that people do to themselves.

But there are better ways of tackling this particular problem today and this Report looks at them as well as the cost of excess weight to the individual and the healthcare system, the benefits that can be enjoyed with weight reduction and management, how the reformed UK health service can address the problem and what the future holds. It doesn't pretend to provide easy answers but it does point out some achievable programmes.

John Hancock

Editor



John Hancock *has been writing and editing articles, papers and books in a range of business topics, engineering, technology and IT, health, people, arts and places for nearly 25 years. He has travelled extensively and is a confirmed 'infoholoic' who has been collecting information and books all his life. Married with one daughter (now grown up) he lives and works in St Ives, Cornwall and is active in the local arts and music scenes and community projects. John loves Rugby, Formula 1, travel and reading plus any live performance… sporting or theatrical. He regards himself as blessed to be able to do for a living something that he has always enjoyed.*

Diabetes and Obesity

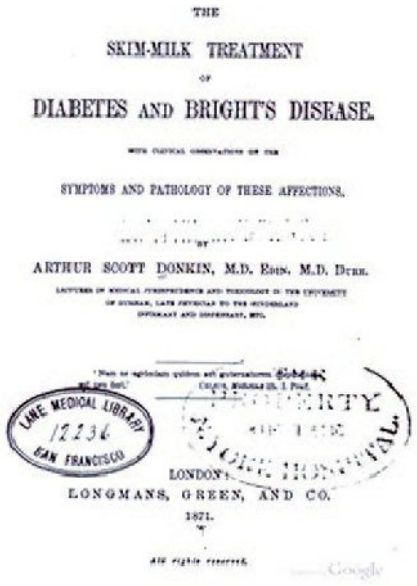
A Modern Problem; an Eternal Obstacle

Stephen Kreitzman Ph.D, R.Nutr. Valerie Beeson, Shawm Kreitzman,
Howard Foundation Research, Cambridge UK

From *The Skim-milk treatment of Diabetes and Bright's disease* by Dr Arthur Scott Donkin:

I shall now proceed to the consideration of the skim-milk *treatment, which I have already introduced into practice through the pages of the 'Lancet' by the contributions already referred to. This treatment, I may venture to state, is incomparably superior to that of Rollo in its most approved form inasmuch as I have found it after numerous trials to yield results far beyond my own expectations, formed at the time when it first occurred to me that it might act beneficially in diabetes.*

When a patient, in whom the more distressing symptoms are fully developed, is placed under the skim-milk treatment, it is truly surprising to witness the almost magical rapidity *with which they are subdued, twenty-four hours being generally sufficient for the production of a marked improvement, and seldom more than from two to six days being required to procure complete relief from suffering.*


THE
SKIM-MILK TREATMENT
OF
DIABETES AND BRIGHT'S DISEASE.
SYMPTOMS AND PATHOLOGY OF THESE AFFECTIONS.
ARTHUR SCOTT DONKIN, M.D. Edin. M.D. Durh.
LONDON:
LONGMANS, GREEN, AND CO.
1871.
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WITH THE rapidly expanding problem of overweight and obesity, diabetes is now seriously undermining the nation's health. The excellent book quoted above could easily have been written today; it is relevant and its findings are urgently needed – now more than ever. It was, however, published in 1871. Struggling with a severe crisis of type 2 diabetes, modern UK medicine seems to have missed compelling evidence from the 19th Century.

At least three decades of published experience with modern very low calorie diets has produced (in addition to rapid weight loss) a rapid remission of type 2 diabetes. Although this approach was apparently understood nearly a century and a half ago, it is still not often encouraged as an option in modern medicine. The consequences of diabetes are serious, and the current state of treatment is woefully inadequate for many reasons. All options need to be considered.

New NHS research has revealed the shocking toll of preventable deaths caused by just one medical condition. Diabetes – in which the body fails to control blood sugar levels safely – is causing 24,000 needless deaths a year in England alone.

It's not just the old and middle-aged who are at risk. Young women with diabetes are 6 to 9 times more likely to die than their age group overall. And many more young people who don't die will develop life threatening diseases later due to failure to manage their blood sugar.

Badly controlled diabetes can lead to kidney disease, heart conditions, or blindness. It's also the cause of 5,000 amputations a year, mainly of legs or feet. With around 3 million diagnosed sufferers known to the health service, diabetes is said to be costing the NHS £9 billion a year, about a tenth of the total health budget.

BBC – BBC Radio 4 Programmes – File on 4, Diabetes Tue 21 Feb 2012 20.00 BBC Radio 4

Weight Management services can bring real benefits to diabetes patients. A recent report from NHS Research reveals that one in every 25 prescription items is now written for diabetes, accounting for about £9 Billion, about 10% of the entire health budget.
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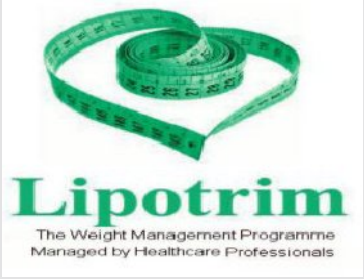

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Pharmacists need to be recognised and commended for the success they are experiencing with type 2 diabetics in conjunction with their local GPs.

The Case for VLCDs over Medication

There have been countless published articles in the scientific literature reporting the remission of diabetes with VLCDs, the most recent being a study at Newcastle University by Professor Roy Taylor. The findings from the published results[3] have been reported worldwide in hundreds of print and broadcast media outlets.

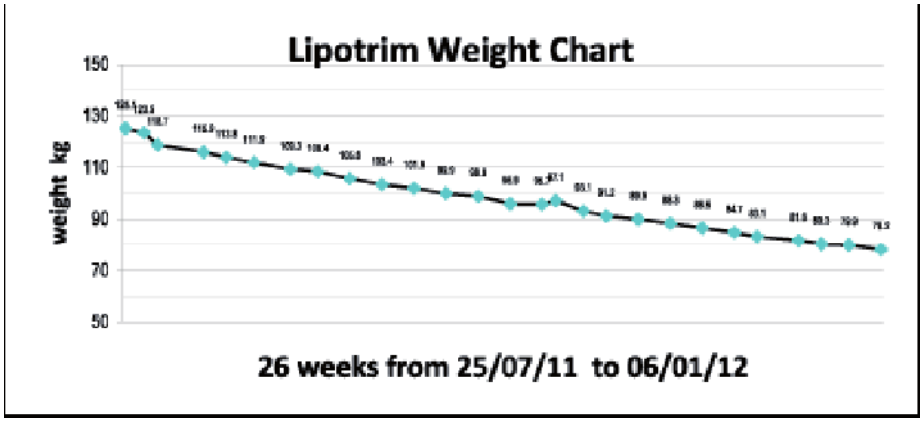
Richard Paisey, head of the diabetes clinic at Torbay Hospital, was a pioneer in the UK, recognising the potential of VLCD to put type 2 diabetes into remission. Although experience with VLCD had been published many times by investigators using various formulations popular in other countries, the study he enabled with Lipotrim more than 15 years ago was the first in the UK.[1] The Torbay Hospital group recognised the immediate value of the weight losses with diabetic patients as well as the necessity of quickly stopping medication. The results, published after one year, should have led to considerable medical interest. Curiously, more attention was given to the significantly less successful (and costly) efforts of a secondary group, handled by two dedicated hospital dieticians specialising in diabetes.

Of the VLCD group, eight out of the 15 diabetic subjects sustained more than 10 kg weight losses at 3 years. Even after 5 years and some weight regain by the VLCD subjects, at least 1 subject had maintained more than 10 kg weight loss and had sustained remission of diabetes for 5 years.[2]

In contrast, none of the dieticians' group ever experienced a complete remission of their diabetes. In fact, medication had been increased at the time of the 5 year data. All of the VLCD patients had significant time without medication. These results emphasise the need for rapid weight loss for control of diabetes. Slow weight loss (the dietician group showed almost no weight loss before 1 year) does not produce the same results for diabetes.

Pharmacists need to be recognised and commended for the success they are experiencing with type 2 diabetics in conjunction with their local GPs. While the customary medical experience is commonly a continuous escalation of drugs with all-too-often dire medical consequences, the pharmacy programmes using Lipotrim require cessation of all diabetic medication prior to dieting since the blood sugars normalise in just a few days. Many dieters never need to go back on their medication even if there is some weight regain. Too many GPs unfortunately are not informed about the value of rapid weight loss, and are unable to consider altering their medication prescription for the patient. Such patients are not permitted to use the Lipotrim VLCD as a precaution against the drugs causing a hypoglycaemic episode after the sugars normalise from the weight loss.

As an example of the success that can be achieved by a diabetic patient, consider the Case Study of patient W. A.; a 58 year old male, Initial weight 125.1kg. He was diagnosed as diabetic 1 year ago and was on 1000 mg metformin twice a day.



Continuous weight loss progression is typical of a compliant Lipotrim dieter. W A's diabetes continues in remission. The metformin, stopped prior to initiating the diet, is no longer required. This patient had a heart bypass several years ago. Medication for high blood pressure has been greatly reduced as a result of the weight loss. His GP is very impressed.

Benefits of Rapid Weight Loss

Very low calorie diets and bariatric surgery are demonstrably the most effective weight loss methods for diabetic patients. Ultimately, it is the loss of the excess weight that will lead to the long term improvement in insulin sensitivity and blood sugar control. However, the specific rapid weight loss by VLCD or surgery share a common feature

which augments the benefit: in both cases, there is an immediate substantial reduction in the oral consumption of either carbohydrates or substances that can be readily converted to carbohydrates. As a result, the metabolic response is rapid. Circulating glucose and mobilised glycogen stores are rapidly consumed and are generally depleted within about 3-4 days, resulting in normal glucose levels. It should be stressed again that this reduction is so dramatic, it is crucial to stop the administration of oral hypoglycaemic agents prior to the start of a VLCD programme.

Weight loss, regardless of how it is achieved, will sometimes put the diabetes into long term remission, but rapid weight loss confers better long term glycaemic control than the same loss achieved more slowly. The combined effect of the rapid initial normalization of blood sugars and the subsequent loss of excess body weight yields impressive clinical results. Blood sugar levels and HbA1c levels become normal and there is improvement in insulin sensitivity. With reasonable long term weight management these parameters remain normal.

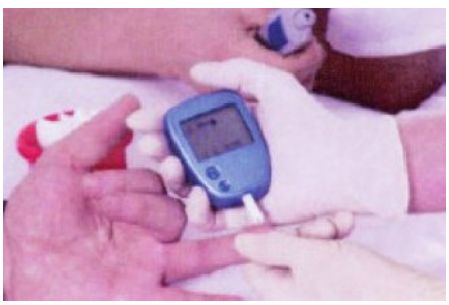
Very low calorie diets are considerably more effective than standard calorie restricted diets (for weight loss as well as for blood sugar control) as evidenced in the Paisey trial. In the first instance, the calorie gap (the difference between calories consumed and the calories utilised) is very much larger. It is this gap that requires calories to be mobilised from the body's energy stores and since fat is so calorie rich, it takes a wide gap to use up the 7700 calories per kg needed for weight loss. A small gap takes so long to deplete even a single kilogram of fat that discouragement frequently sets in long before substantial fat is lost. It is also frequently not understood that a calorie restriction – in order to promote weight loss – must be from the level of calorie expenditure, not intake. Reducing intake by, say, 500 calories when traditional consumption is already 1000 or more calories in excess, will not cause a loss of weight. It may slow weight gain, but it will not cause fat loss Another reason for the superiority of VLCD formula diets relates to the recognition that for many seriously overweight people, food is in fact a substance of abuse.

Overeating Akin to Alcoholism

While not every person who consumes beer or wine becomes an alcoholic, clearly some do; currently alcohol addiction is correctly recognised as a serious problem. In a similar way, many people are able to eat (and at times overeat) without becoming overweight or obese. As with alcoholism, food abuse (by a significant percentage of the overweight population) is now recognised as sharing the biological characteristics of other addictions. We have to assume that it is as difficult for many obese people to reduce their dietary excesses as it is for alcoholics to stop drinking.

No one would expect an alcoholic to simply cut down to a unit or two of alcohol a day. To deal with addictive behaviour it is generally understood that the individual must first discontinue the substance of abuse. This means that, for a large segment of the overweight and obese population, it is futile to expect them to sustain a dietary regime that essentially amounts to the food-addict's equivalent of 1 or 2 alcohol units a day. They need to stop the substance of abuse - completely. The dilemma, however, is that while total abstinence from alcohol, tobacco or drugs is possible (and desirable), this is not true with food. The total absence of food necessarily leads to nutritional deficiencies that will, of course, become fatal in a very short time. Providing the essential nutrients however (in a properly formulated enteral feed) solves this problem. It permits the total cessation of traditional foods while providing essential nutrition with absolutely minimal calories and the result is weight loss and – perhaps more importantly – a disruption of the addictive process. While, occasionally, there still can be recidivism, an effective follow-on maintenance programme keeps this to a minimum.

A study extolling the role of weight loss for treatment of diabetes was published in the *Journal of Endocrinology and Metabolism* in 2004 by Cummings et al *"Gastric Bypass for Obesity: Mechanisms of Weight Loss and Diabetes Remission"*. In support of their efforts to promote the use of surgical techniques, the authors claimed that no more than 5-10% of body weight can be lost through dieting, exercise or the few available anti-obesity medications. They further write – correctly – that:



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As with alcoholism, food abuse (by a significant percentage of the overweight population) is now recognised as sharing the biological characteristics of other addictions.

"Importantly, even mild weight loss confers disproportionate health benefits, in terms of ameliorating obesity-related co-morbidities. Nevertheless more substantial and durable weight reduction would improve these ailments more effectively"

…and then not correctly that:

"At present, bariatric surgery is the most effective method to achieve major weight loss. The best operations reduce body weight by 35-40%."

This is quite a dramatic claim, but as discussed above, surgery is not the only effective means of achieving large amounts of weight loss when it is necessary.

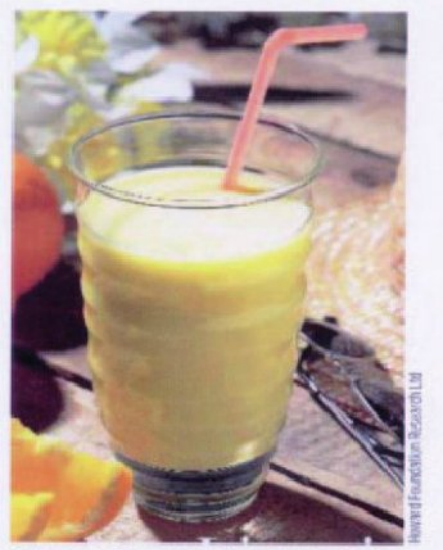
The Lipotrim Alternative

Lipotrim is an alternative to bariatric surgery, but without the problematic aspects of bariatric surgery: high morbidity and mortality risk; prohibitively high cost, possible post-operative addiction transfer and – in consideration of the large numbers of severely overweight people with or without diabetes – extremely limited availability.

Detailed records have been kept of the weight loss results of every individual who has dieted with Lipotrim, either at a UK GP practice, hospital clinic or pharmacy for the past 26 years. The current availability of computer software to replace paper records has made auditing of these records far more practical. Using audit data (accumulated from UK pharmacies) it was a simple matter to identify cases of successful weight losses in excess of 35%. There are many very high-weight patients being treated at pharmacy. A recent audit of patients attending a single pharmacy (Prestwich pharmacy in Manchester) had 270 successful patients with initial BMIs in excess of 40. There are currently over 2000 pharmacies running the service in the UK.

Four recent cases will be presented here. It has to be emphasised that these people, although at higher BMI than many of the people treated in pharmacy, were participating in the routine Lipotrim weight loss service in pharmacy and the total cost to each was £36 per week. These four patients did not happen to suffer from diabetes, although many of the people being treated by the pharmacies did present with type 2 diabetes and achieved rapid remission. As has already been recognised however, this magnitude of weight loss is not necessary for rapid remission of the diabetes. Most type 2 diabetics show normal blood sugars within the first week of dieting. The selection of these examples is simply evidence to contrast the achievements of VLCD use with the weight losses achieved by surgery.

The four women whose initial weight ranged from 14 stone 10 pounds (93.5 kg) to 20 stone 9 pounds (131 kg) collectively lost 25 stone 12 pounds (164.1 kg).



An orange flavoured drink is one of the Lipotrim weight management products

BMI at the start averaged 43 and ranged from 35 to 49. Following weight loss their average BMI was 27 and ranged from 23 to 31.

The percentage of initial weight lost ranged from 35 to 39%.

Weight changes for the 4 cases are displayed in Figures 1-4 opposite.

Sadly, any evidence – no matter how compelling – is of no use if it is ignored. As noted above, Dr. Arthur Scott Donkin was aware of the benefits of a low calorie diet to diabetes patients as long ago as 1871.

As he noted then:

"…I have found it after numerous trials to yield results far beyond my own expectations, formed at the time when it first occurred to me that it might act beneficially in diabetes.

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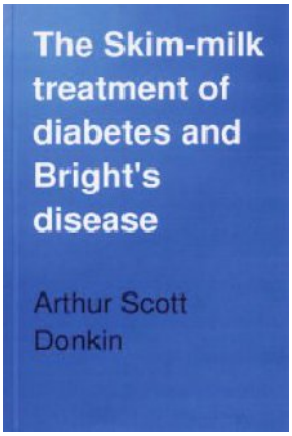

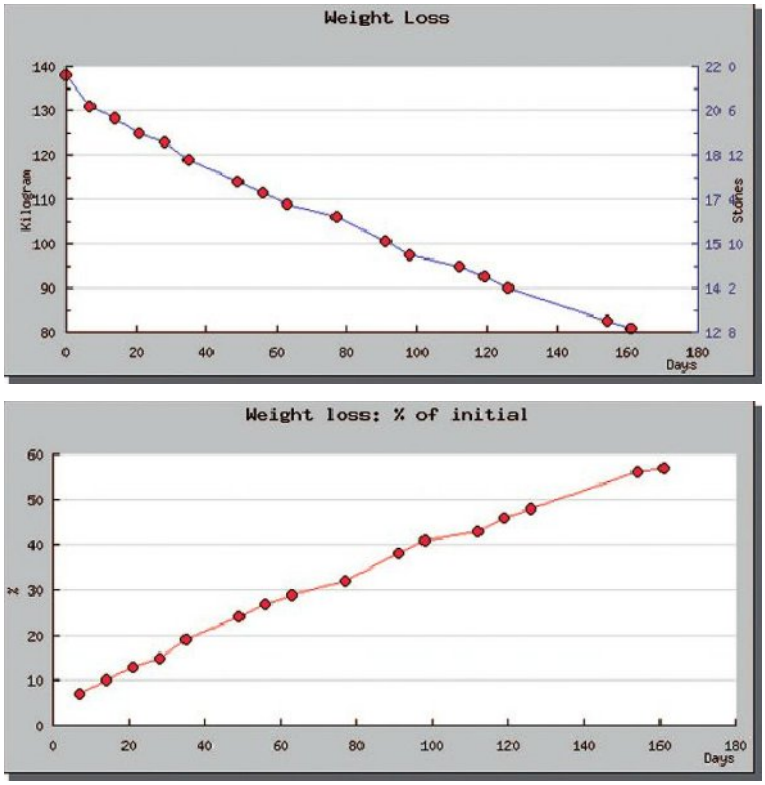

FIG 1 – SUCCESSIVE WEIGHT DETERMINATIONS AND PERCENTAGE OF INITIAL WEIGHT LOST – PATIENT 1643-305 FEMALE

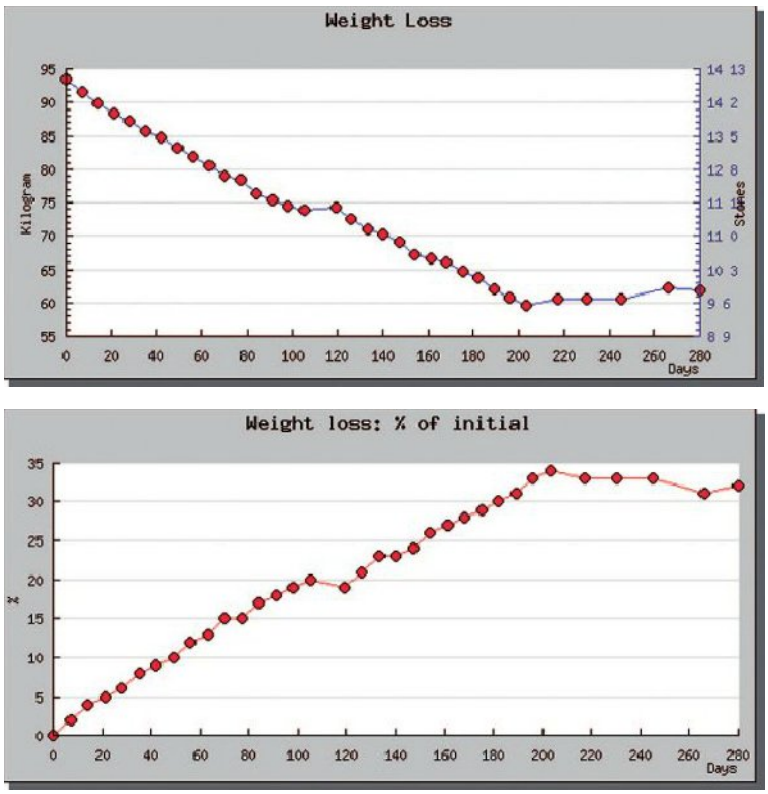

FIG 2 – SUCCESSIVE WEIGHT DETERMINATIONS AND PERCENTAGE OF INITIAL WEIGHT LOST – PATIENT 2251-356 FEMALE

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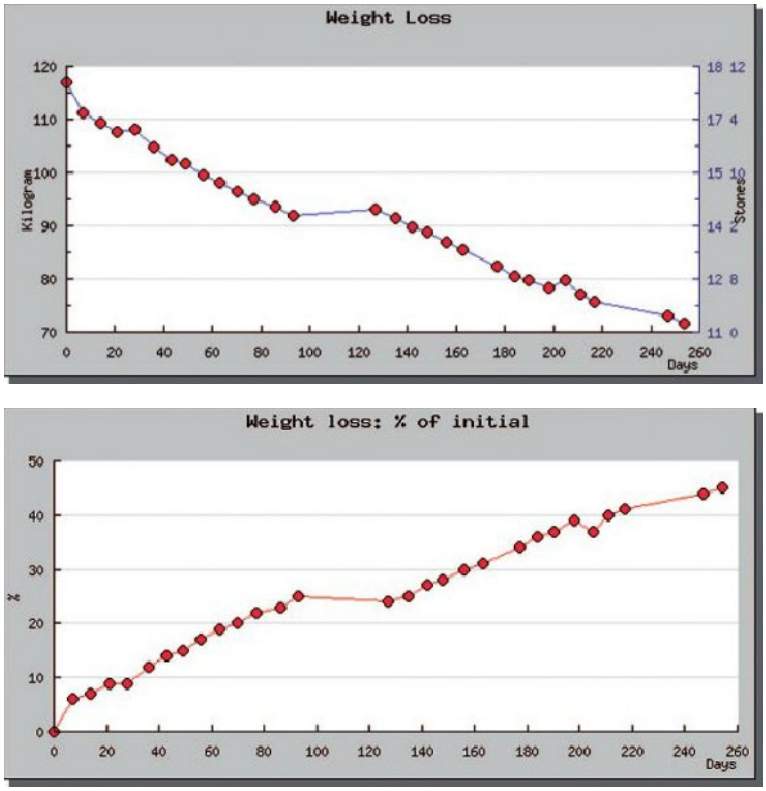

FIG 3 – SUCCESSIVE WEIGHT DETERMINATIONS AND PERCENTAGE OF INITIAL WEIGHT LOST – PATIENT 2196--892 FEMALE

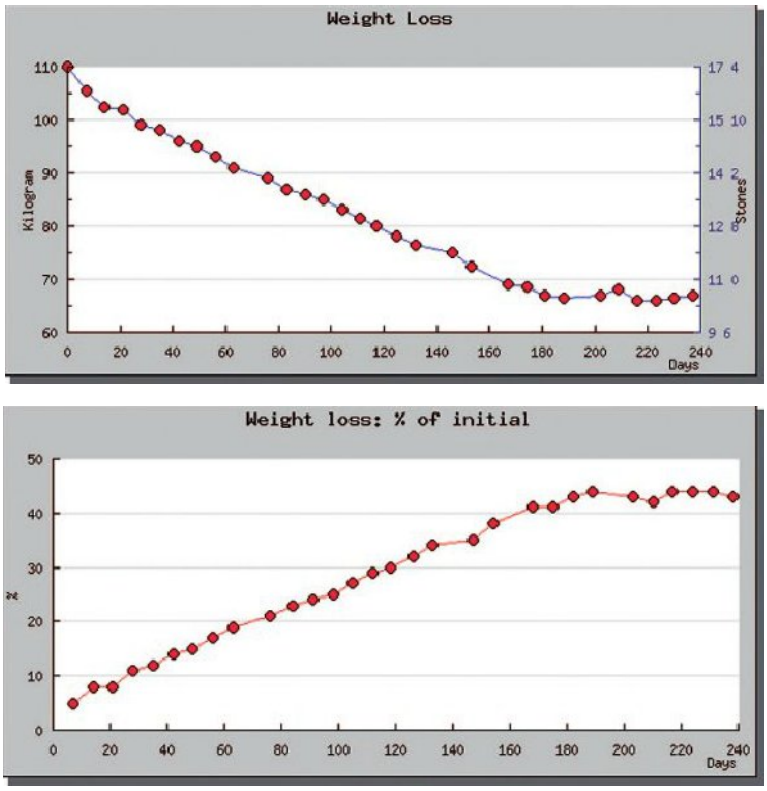

FIG 4 – SUCCESSIVE WEIGHT DETERMINATIONS AND PERCENTAGE OF INITIAL WEIGHT LOST – PATIENT 1643--1588 FEMALE

generally sufficient for the production of a marked improvement, and seldom more than two to six days being required to procure complete relief from suffering…"

"The Skim-milk treatment of Diabetes and Bright's disease", by Dr Arthur Scott Donkin

This text is now freely available online, thanks to the valuable efforts of popular Search Engines to bring important texts into the public realm once more.

No Excuse for the Current Level of Type 2 Diabetes

The facts are quite clear: there are effective treatments for type 2 diabetes, and these should at least be offered before patients are subjected to drugs and possibly a very bleak future. Skim milk will work as Donkin showed, but current nutritional science recognises that there are additional nutrients required for long term health and safety. Lipotrim formulas are essentially skim milk that has been so enriched. At present there are more than 2000 UK pharmacies offering the Lipotrim programme and it is available to any GP (as it has been since 1987). There is no excuse for the condition reported by the File on 4 programme. While every diabetic patient may not be able to defeat the addictive lure of a subsequent return to food abuse, many can. And if the time away from the diabetic condition allows for dealing with other medical problems and an improved quality of life, it must be worth giving the patients a chance.

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Prevention More Cost Effective than Treatment

John Hancock

For diabetes and related conditions the Healthcare system could save money by doing more but earlier

"Diabetes leads to heart disease, stroke, amputations, kidney failure and blindness and causes more deaths than breast and prostate cancer combined."

Prevalence and Impact

When the Quality and Outcomes Framework (QOF) was introduced in 2004, it provided a financial incentive for general practices to deliver high-quality healthcare. Although participation is voluntary, most general practices have chosen to work in the framework and to complete statistical returns that, among other things, count the number of people with diabetes in their care; from this, diabetes prevalence figures for the UK are now available. These figures are published annually and, when applied to current populations, the number of people with diabetes can be calculated. For the year 2011, measured in October 2011, some 2.9 million people in the UK were known to be diabetic.

Prevalence of Diabetes in the UK[1]

Country	Prevalence	No of people
England	5.5 per cent	2,455,937
Northern Ireland	3.8 per cent	72,693
Scotland	4.3 per cent	223,494
Wales	5.0 per cent	160,533
UK total	5.3 per cent*	2,912,657*

Source: Diabetes UK from QOF returns except… extrapolated by author*

The impact of this on the UK healthcare system is significant not only because of the need to treat diabetes itself but also because of the wide range of associated health conditions (both causes and effects) from which diabetics suffer. With Type 2 diabetes at least, a significant cause will be excess weight or obesity – itself the result of poor diet and lack of exercise. This is not to say that Type 2 diabetes is simply a side-effect of something else but the two often go hand in hand. On the other side of the account, the effects of diabetes include many of the health conditions that seem to regularly make the headlines today. In 2008, Diabetes UK's former chief executive, Douglas Smallwood, explained:

"Diabetes leads to heart disease, stroke, amputations, kidney failure and blindness and causes more deaths than breast and prostate cancer combined."[2]

A Range of Solutions

As a result, diabetics require a range of healthcare interventions to match the range of conditions from which they suffer; either to treat them or, preferably, to prevent them. In line with this view, Diabetes UK has created a list of 15 healthcare essentials that should be available to every diabetic, and those essentials perhaps best illustrate the impact that diabetes has or should have on the healthcare system. A summary of the 15 points is listed below but to read the whole paper **click here**.

Diabetes UK's 15 healthcare essentials that diabetics should receive[3]

Checks

1. Blood glucose levels measured at least once a year (HbA1c measurements).
2. Blood pressure measured and recorded at least once a year with a personal, individual target.
3. Blood fats (cholesterol) measured every year.
4. Eyes screened for signs of retinopathy every year.
5. Feet checked every year for skin condition, circulation and nerve supply.
6. Kidney function monitored every year with two tests: urine test for protein and blood test to measure kidney function.
7. Weight checked and waist measured to see if the patient needs to lose weight.
8. Support if the patient is a smoker, including advice and support on how to quit.

Care

9. Care planning to meet individual needs.
10. Education, in their local area, to help diabetics understand and manage their condition.
11. Paediatric care for children or young people.

12. High quality care if admitted to hospital.
13. Information and specialist care if planning to have a baby: diabetes control has to be a lot tighter and monitored very closely.
14. Access to specialist diabetes healthcare professionals, ophthalmologist, podiatrist or dietician, to help manage diabetes.
15. Emotional and psychological support.

NB: Children should receive more frequent HbA1c measurements and regular weight, height and general health checks from their healthcare team. Formal screening for complications generally begins at age 12.

Shortfalls in Care

Sadly, the delivery of these 15 essentials is too often honoured in the breach rather than in the performance. Diabetes UK's '15 healthcare essentials' survey conducted between September and November 2011 found worrying levels of people with diabetes who had not received many of the healthcare essentials. This ranged from just 6% of people who did not receive an HbA1c blood test to 22% of people who had not, or were not aware they had, received a yearly blood test, 25% of people who did not have their legs and feet checked and 42% of smokers who had not received support and advice on how to quit. Additionally, a shocking 37% of women who were pregnant or planning pregnancy had not been offered the relevant specialist advice and an unbelievable 72% of people who needed emotional or psychological support had not been offered this. And all of these would help to avoid Type 2 Diabetes developing into further (and costly to treat) complications.

It cannot even be said that these omissions are made to save money. Baroness Young (Barbara Young), current Chief Executive of Diabetes UK, speaking on the BBC ahead of a February 2012 edition of Radio 4's 'File on 4' on diabetes care said;

"Perhaps the most frustrating thing is that this is one of the few problems facing the government that does not require more investment. A colossal amount of money is already being spent on diabetes – about 10 per cent of the NHS budget – but too much of it is being used to treat the complications of diabetes rather than to prevent those complications developing in the first place."[4]

That is 10 per cent of the budget for a condition suffered by just over 5 per cent of the population.

A Lack of Awareness

Perhaps, inevitably in this day and age, the cost of diabetes is a fitting place to close. According to the Diabetes UK 2012 report, 'Silent Assassin', 10 per cent of NHS budget amounts to £1 million an hour treating diabetes and its complications.

Let's leave the last word to Douglas Smallwood:

"There is still a worrying lack of awareness about diabetes, its risk factors and the simple steps people can take to reduce their risk of developing [especially] Type 2 Diabetes and manage the condition."[5]

Stronger Together

Peter Dunwell, *Medical Correspondent*

Integrating treatments into a single programme can improve overall outcomes and improve quality of life

wider health gains from overall lifestyle change may not receive due recognition and support from health professionals.

Not Unseen but not Understood

Most people who are overweight not only know they are overweight but also know the cause of their condition and that it has limited their life options. But, like smokers and drinkers, they seem able to divorce their perception of the condition from what they know are the likeliest consequences for themselves, seeing each of their conditions as discreet problems rather than as a network of interdependent health failures. It doesn't help that treatments are also often run as discreet programmes delivered by separate healthcare providers.

Also, many weight reduction and healthy maintenance programmes seem to limit quality-of-life; one reason why many people who need to lose weight cannot do so. The regime seems not to admit of any joy or pleasure. They accept the limitations and consequences of their condition because the alternative seems uninviting. Worse still, clinicians might also accept what should be an unacceptable situation. The Royal College of General Practitioners (RCGP) Clinical Champion for Nutrition for Health, Dr Rachel Pryke, in her paper, 'Nutrition for Health' states;

"obesity affects… over a third of adults with many more overweight. Obesity results in an estimated nine year reduction in life expectancy and impacts on all clinical specialities. However, it receives prioritisation from none."[6]

But that need not be the case.

A good starting point would be to understand the nature of being overweight or obese as a first step towards understanding why and how to face that challenge. The critical number for most people is body mass index (BMI) calculated from their weight in kilograms divided by their height in metres squared. From this, each individual can be placed on a scale between healthy weight and level 3 obesity.

Classification	BMI (kg/m2)
Healthy weight	18.5–24.9
Overweight	25–29.9
Obesity I	30–34.9
Obesity II	35–39.9
Obesity III	40 or more

Source: NICE

A Realistic and Achievable Programme

Now, understanding the scale of the problem it is possible to construct an achievable weight loss programme around realistic targets. Such a programme should not simply consist of a reduced calorie intake, but incorporate some of the other improvement factors that will not only help weight loss but will also begin to improve fitness and enhance quality of life. Again, from NICE, in Prof Amanda Howe's report on Quality Standard NHS healthcare topics:

"[the term] Obesity… does not convey the full impact that an unhealthy lifestyle has on disease and it risks focusing clinical endeavour too fixedly on BMI change. This means that wider health gains from overall lifestyle change may not receive due recognition and support from health professionals. We would like to see at least a modification of the obesity title to imply a wider remit of health gain, e.g. 'Adult Weight and Lifestyle Management'. A new additional heading of Fitness Promotion would be even better.

"The benefit of a separate 'Fitness Promotion' category would be to tackle the crucial impact of fitness (independently of coexisting obesity) in relation to heart disease and stroke, falls prevention, rehabilitation after orthopaedic surgery, mental health including depression, essential hypertension, childhood obesity [and] adult obesity. In fact, few conditions failed to be improved by an exercise component."[7]

With a proper and achievable programme, an individual will not only begin to feel better and really move themselves away from the health dangers zone but also will be able to see measurable improvements quite early into the programme, and this positive sense of achievement in itself along with the real improvements in health will contribute to a better quality-of-life. NICE again…

"Achieving and Maintaining a Healthy Weight

Everyone should aim to maintain or achieve a healthy weight to improve their health and reduce the risk of diseases associated with overweight and obesity, such as Type 2 Diabetes. People should follow the strategies listed below [in the report, there follows a list of strategies for weight loss and weight management]. *These may make it easier to maintain a healthy weight by balancing 'calories in' (from food and drink) and 'calories out' (from being physically active)…"*[8]

An Integrated Approach

Essentially, by integrating a weight loss programme into existing treatment frameworks for obesity and related conditions, clinical outcomes can be improved and quality of life enhanced. In the RCGP report with the Royal College of Psychiatrists, 'The management of patients with physical and psychological problems in primary care: a practical guide'[9] the authors note that it is normal in Western medicine to treat the problems of each system within the body as separate issues whereas, because they are often interlinked, it may well be beneficial to treat them together. As long ago as 2006 NICE noted that:

"it is unlikely that the problem of obesity can be addressed through primary care management alone. More than half the adult population are overweight or obese and a large proportion will need help with weight management. Although there is no simple solution, the most effective strategies for prevention and management share similar approaches. The clinical management of obesity cannot be viewed in isolation..."

Education for Better Outcomes

In the May 2011 report on preventing Type 2 Diabetes, NICE included the comment;

"lifestyle interventions aimed at changing an individual's diet and increasing the amount of physical activity they do can halve the number with impaired glucose tolerance who go on to develop Type 2 Diabetes. However, the greatest impact on the levels – and associated costs – of Type 2 Diabetes is likely to be achieved by addressing these behavioural factors in whole communities and populations."[10]

It will be by educating people to understand that overweight and obesity is not simply a standalone health condition, but is also a promoter of other poor health conditions, that the link in people's minds between overweight and obesity and reduction in life quality and expectancy will become stronger. Also, viewing an individual's conditions holistically rather than as separate cases, a treatment framework can be developed that addresses all conditions (the causes, manifestations and effects of ill-health) in one programme to improve clinical outcomes across the board.

Weight Management services can bring real benefits to diabetes patients. A recent report from NHS Research reveals that one in every 25 prescription items is now written for diabetes, accounting for about £9 Billion, about 10% of the entire health budget.
It is not surprising that the New Medicine Service has prioritised diabetes type 2 in the fight to reduce wastage and costs.

Obesity is a major contributor to the development of type2 diabetes and the rapid loss of excess weight will usually reverse the process.

Pharmacists who have been using the Lipotrim Patient Tracker have been able to document the efficacy of their Lipotrim weight loss and maintenance programmes

Getting evidence from services is no longer a luxury. With the new NHS bill every healthcare professional and service will have to demonstrate value. However, collating evidence has been a particular challenge for those who are not in the habit of documenting their services and many don't have the means to do this efficiently, relying too much on paper.

When it comes to weight services, the evidence from audits can be compelling. Using the **Lipotrim Patient Tracker**, you can instantly produce data to demonstrate benefits using a range of criteria, for example by gender, BMI, age and co-morbidities such as hypertension and diabetes, all at a click of a button.
It allows you to continuously audit your weight service while at the same time monitoring and supporting your patients.

Lipotrim
is a weight management service offered by over 2000 Pharmacies and GPs.
Call Valerie Beeson now on 01223-812812 to find out how you can offer the Lipotrim service to benefit your diabetic patients.

Lipotrim

Camilla Slade, *Staff Writer*

Achieving better clinical outcomes cost effectively

Modern VLCDs such as Lipotrim are nutritionally complete and NICE supports them when properly managed; in particular, the programme should be monitored.

Too Much and Too Little

One behaviour pattern, more than most, is responsible for unhealthy weight increase. People consume too many calories with too little activity to burn them off. We all understand that being overweight or obese is a problem in itself but, unfortunately, that also ripples out into a wider pool of poor health outcomes.

Overweight or obese people also risk or suffer a range of potentially life-threatening conditions including Type 2 Diabetes, high blood pressure, cardiovascular disease, musculoskeletal disorders (MSDs), liver disease, sleep apnoea, some cancers, infertility and even, it is now believed, Alzheimer's disease. NICE (the National Institute for Health and Clinical Excellence) recognises the wider implications where Type 2 Diabetes is concerned,

"Risk factors include being overweight or obese and whether or not someone is physically active."[11]

Any one of these conditions, let alone a combination plus excess weight or obesity, can be costly in a number of ways. It can limit life quality, life expectancy and, it has to be considered, it can be financially costly. All the conditions mentioned require medication, procedures and long-term treatment programmes simply to manage, let alone to resolve them. None of these is inexpensive and so either their prevention or an effective risk reduction programme will not only significantly increase health outcomes, with all the benefits that flow from that, but will also prove cost-effective.

Less Calories, Less Weight

One effective programme, in this context, is to reverse the ill effects of excess weight with a very low calorie diet (VLCD). Modern VLCDs such as Lipotrim are nutritionally complete and NICE supports them when properly managed; in particular, the programme should be monitored by a clinician and proper records kept to monitor health. For instance, while a long-term reduction in blood pressure will be beneficial to a high blood pressure sufferer, somebody on a VLCD program will need to be monitored to ensure that their blood pressure does not fall too far in the very early stages. Also the physiological impact of a VLCD may require either modification or even cessation of some prescribed medication.

But the long-term benefits are significant with many of the listed conditions either stabilising or actually reducing with weight loss. In fact, other than bariatric surgery, VLCDs are the most likely to put Type 2 Diabetes into remission. As can be seen, a VLCD is a lot more than simply 'eating less', and needs the context of a planned and properly supervised programme to achieve maximum effectiveness and maintain health. A programme of nutritionally balanced replacement meals makes effective management easier and Lipotrim does just that by combining a range of Total Food Replacement products, managed by a GP or through a nurse's clinic or pharmacy, with a computer based monitoring and health audit programme.

Even early in the programme, weight loss can bring about health improvements plus, through reduction in the need to treat previous health issues and the prevention of future health problems, it can be very cost-effective. But to be most effective, weight loss needs be long-term and, again, a holistic program such as Lipotrim can support the very long-term to ensure that improved health translates into a better life.

Working with nature to do what is best for a patient's body, a VLCD such as Lipotrim does not simply maintain the body against a range of health problems, but can reduce or reverse those problems to arrive at a better clinical outcome, enhanced life quality and reduced cost of health maintenance.

Reform to Rethink

Camilla Slade, *Staff Writer*

NHS Reforms will have significant impact on the role and work of GPs, including in diabetes and weight management

GPs at the Heart of Things

One well broadcast intention of NHS reforms is to reverse the polarity of power in healthcare delivery, putting the patient in the driving seat. However, most people will not have the clinical knowledge or knowledge of NHS facilities to design and manage their own treatment programme. The pivotal person will be the General Practitioner (GP). But treatment plans should be co-ordinated around the needs of the patient rather than around the priorities of the health service and, to achieve this, GPs will work across a number of disciplines when treating conditions such as diabetes. And they'll have to work with their patients in structuring a treatment programme.

For many GPs, this represents a shift from simply passing their patients into a diabetes care system that works to the direction of a Primary Care Trust (PCT), to having to rethink how the condition is treated and what elements of support and expertise will be necessary to achieve cost savings and improved patient outcomes. In order to be able to make informed choices about their patient's treatment and to assemble the right delivery team for each patient, GPs will need access to detailed and up-to-date information and thinking about those parts of the NHS that can deliver the care. That guidance is available through NHS Diabetes.

NHS Diabetes

NHS Diabetes uses technology to deliver appropriate information and to enable GPs to discover the latest thinking, and share experiences and learned knowledge with colleagues. The new guidance targets patient experience with GPs having the objective to,

"[engage] patients and carers to obtain their involvement and views… and [develop] networks to support integration across care pathways."[12]

Or, in English, help patients to access the care they need from whichever parts of the NHS can best provide it. This also meets one concern voiced by Diabetes UK in October 2011 for the new NHS Commissioning Board and clinical commissioning groups to… *"report every year on how [they are] achieving their remit of ensuring integration of services for healthcare professionals to co-operate in the best interests of patients."*[13]

NICE (the National Institute for Health and Clinical Excellence) offers guidance for GPs having to undertake this rethink;

"Management of diabetes typically involves a considerable element of self-care, and advice should, therefore, be aligned with the perceived needs and preferences of people with diabetes, and [their] carers. People with… diabetes should have the opportunity to make informed decisions about their care and treatment in partnership with their healthcare professionals… Good communication between healthcare professionals and patients is essential. It should be supported by evidence-based written information tailored to the patient's needs."[14]

NHS Diabetes also offers a number of online support pathways (Diabetes care areas) to which GPs have access to help them organise and arrange appropriate support for their patients. These Diabetes care areas also provide a good guide to what services are available and that a GP needs to consider.

Diabetes care areas available through NHS Diabetes

- Cardiovascular care;
- Children and young people;
- Diagnosis and continuing care;
- Education;
- Emotional and psychological support;
- End of life;
- Equality in diabetes;
- Prevention and risk management;
- Eye services;
- Foot care;
- Emergency and inpatient ;
- Kidney care;
- Mental health and learning difficulties;
- Neuropathy care;
- Pregnancy;
- Services for older people;
- User involvement.

The NHS Diabetes website offers Webinars, Podcasts, Blogs and BrowseAloud capability for people with visual impairment: all to assist GPs and their diabetes patients towards

"People with diabetes already need at least 14 different NHS services. Getting it right means they can lead long and healthy lives. Getting it wrong could mean amputation, kidney failure, blindness and a shorter life."

well informed decisions. In theory, a GP who knows their patient and has all the facts at their fingertips should be able to arrange an integrated care and improvement programme for that patient, and avoid duplications and waste. This, in turn, should either reduce the 10% of NHS budget currently taken up with diabetes care or improve the outcomes achieved from that 10% expenditure.

Getting it Right Matters

As the NHS's own guidance says,

"People living with diabetes and other long-term conditions are much more likely to achieve better outcomes if they have the skills and knowledge needed to manage their own health and are able to work in partnership with the people delivering their care. This means the delivery of safe, effective and efficient diabetes care that is seamless across organisational boundaries." This is important because, as Barbara Young, chief executive of Diabetes UK explained in October 2011, "*People with diabetes already need at least 14 different NHS services. Getting it right means they can lead long and healthy lives. Getting it wrong could mean amputation, kidney failure, blindness and a shorter life."*[15] It is a significant additional responsibility that is being transferred to GPs along with the commissioning power.

Nutrition

There is also one other group of specialists with whom GPs will need to work when managing the overall care of diabetes patients. Nutritionists traditionally work at both ends of the weight management spectrum from malnutrition right across to overweight and obesity. The Royal College of General Practitioners (RCGP) highlights the importance for GPs of being able to work with nutritionists and includes in its own function to, *"Support GP consortia in commissioning appropriate high-quality nutrition care services"*[16].

GPs will need to consider the range of areas where nutritionists have particular skills including food science, biochemistry and physiology, health promotion, nutrition at different stages in life and the effect of nutrition on disease. All of these will be useful to an overweight, obese and/or diabetes patient. Their training prepares nutritionists to contribute to practical nutrition research projects, process and analyse biological samples and educate patients on the benefits of healthy eating as well as helping them to achieve a healthy diet.

Summary

Following NHS reform, rather than simply referring diabetes patients into a large and homologous 'diabetes care' system, the GP will design, manage and monitor a clinical care programme for each individual diabetes patient's needs – drawing on and co-ordinating the skills of a range of specialists to deliver that programme.

Make What Works Work Well

John Hancock

The future for weight management and diabetic care may not look much different but it should work better

Facing the Real Issue

Weight management, with the poor health and clinical problems caused by excess weight is a growing problem around the world so, unless the effectiveness of treatments can improve at a faster rate than the combined factors behind the accumulation of excess weight, it seems that weight management and related conditions such as Type 2 Diabetes will be with us for some time.

But if this sounds like a counsel of despair, it isn't: as well as qualitative improvements to current treatment programmes in the future, there are more radical treatments being researched. According to a September 2011 report, 'The Future of Weight Management…' from Research and Markets:

"Although advances have been made in the treatment of obese and overweight patients, no 'magic bullet' yet exists… Despite rapid strides toward an ideal anti-obesity agent, the role of diet, exercise, and behaviour modification must be considered the cornerstone for any potential future pharmacotherapy."[17]

It really is that simple but people still hanker for a solution that delivers all the benefits of a healthy lifestyle without the need to live one. The future challenge will be how to make necessary changes understood and how to deliver them in a way that is not seen as removing the 'style' from lifestyle.

Different Solutions; Same Objective

Many developments in areas like the treatment of Type 2 Diabetes relate more to improvements in the delivery of established programmes, such as the replacement of various drug cocktails with a single injection ('Byetta' is one product) before meals. Where excess weight and obesity are concerned there is a growing group of people who opt for one of the bariatric surgery solutions but, of course, as with any surgery this does entail risks.

The more radical changes are in treatments such as using hypnosis to address where addictive and compulsive behaviours lead to overweight and obesity. Also, research is growing into genetics as the basis for new treatments to eliminate or neutralise inbuilt tendencies towards excess weight. Perhaps more conventionally, a lot of research is considering how family and environmental factors influence consumption and activity levels with a number of community and individual education and supported programmes in place to address that. For instance, the UK Department of Health's Change4Life campaign sets out to improve the way people live in small ways but across a broad range of consumptions and activities. This is seen as a key policy to address weight problems in the future.

Notwithstanding all of these developments, the underlying issues tomorrow will be little different from today: too much consumption and too little activity. So, the challenge in the future will remain to find a programme that addresses those problems and is acceptable to the people whose condition it seeks to improve.

Planned, Agreed and Appropriate

The UK's National Institute for Health and Clinical Excellence (NICE) addresses this in its guidelines for dealing with overweight and obesity,

"Regular, non-discriminatory long-term follow-up by a trained professional should be offered. Continuity of care in the multidisciplinary team should be ensured through good record keeping. The choice of any intervention for weight management must be made through negotiation between the person and their health professional. The components of the planned weight-management programme should be tailored to the person's preferences, initial fitness, health status and lifestyle."

Means to reduce obesity and excess weight levels and curb or reverse Type 2 Diabetes are already well-known. It is finding acceptable, supportive and well-managed delivery programmes for those treatments and educating people to understand how that will benefit them that is likely to distinguish the future.

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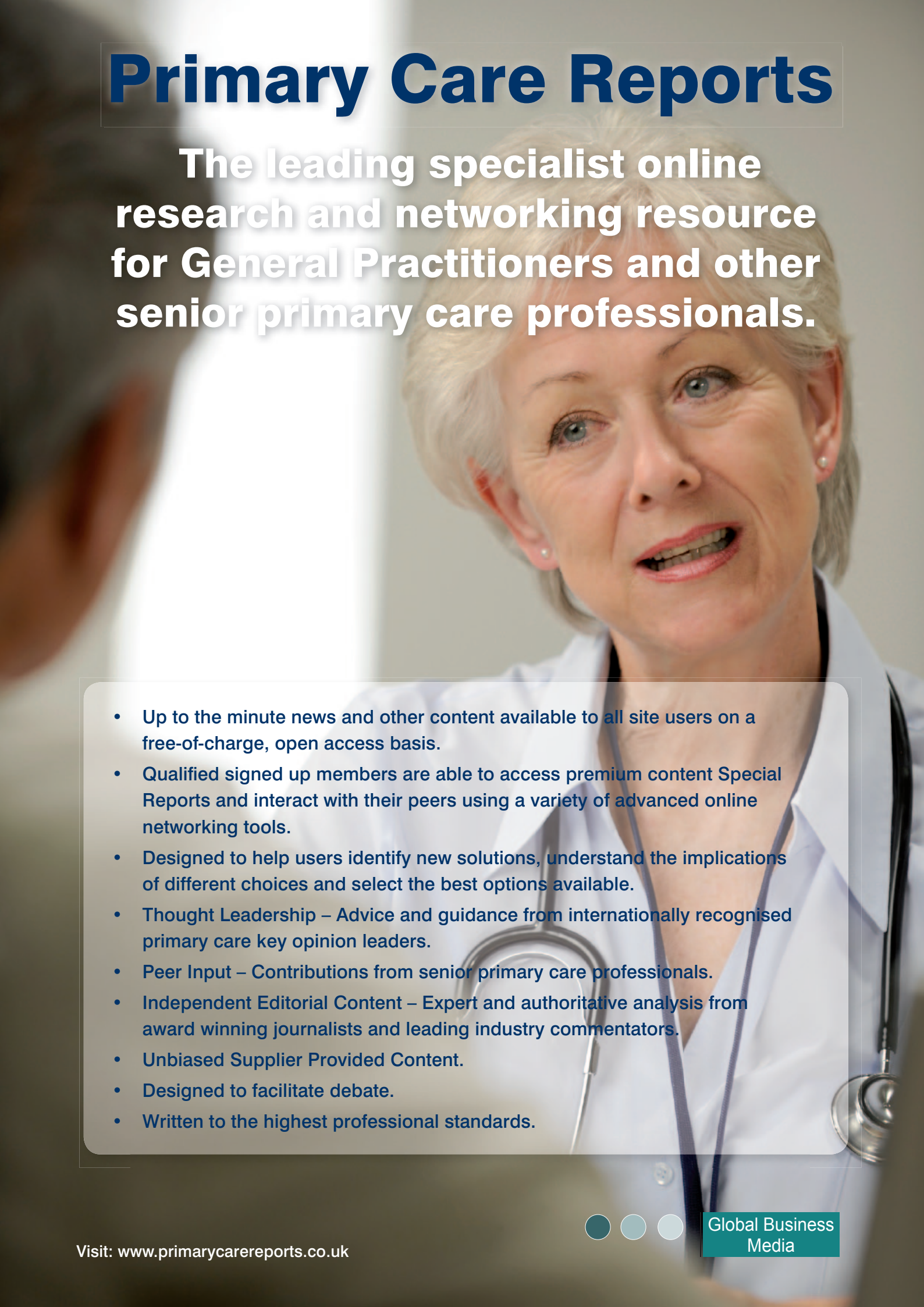

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