Reference: FOI.ICB-2526/030

Subject: Specialist Weight Management Services

I can confirm that the ICB does hold the information requested; please see responses below:

QUESTION	RESPONSE
1. Do you currently commission a specialist weight management service (Tier 3)?	Yes
2. If yes to question 1, does this specialist weight management service include the prescribing of GLP-1 receptor agonist therapies (such as semaglutide, tirzepatide)?	Yes
3. Is the specialist weight management service consultant-led? If so, please specify the medical speciality of the consultant(s) leading the service	Yes, although the ICB does not hold information regarding the exact medical speciality of the consultant leading the service. We advise you to contact the provider directly for more information; North Bristol NHS Trust (NBT) - https://www.nbt.nhs.uk/about-us/information-governance/freedom-information/request-information
4. Does the specialist weight management service include remote delivery options (such as virtual consultations, telephone appointments, or digital support platforms)?	Yes

5. Please provide a copy of the full service specification for the specialist weight management service that you commission, if one exists.	Please find a copy enclosed.

The information provided in this response is accurate as of 29 April 2025 and has been approved for release by Sarah Truelove, Deputy Chief Executive and Chief Finance Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

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SCHEDULE 2 – THE SERVICES

Service Specifications

Service Specification No.	
Service	BNSSG Tier 3 Multi-Disciplinary Weight Management Service
Commissioner Lead	BNSSG ICB
Provider Lead	
Period	One Year
Date of Review	31/03/2024

1. Population Needs

1.1 National/local context and evidence base

National Context
Obesity is a growing problem, impacting on the length and quality of life for patients. Being obese increases the risk of a number of conditions, including type 2 diabetes; musculoskeletal disease; some cancers; and depression. As Body Mass Index (BMI) increases so do the number of co-morbidities. The number of patients with ≥3 comorbidities increases from 40% for a BMI of <40kg/m^2, to more than 50% for BMI of 40-49.9 kg/m^2, and to nearly 70% for BMI 50-59.9kg/m^2.[1] Obesity also reduces life expectancy, a reduction of 8–10 years for the morbidly obese (BMI of 40kg/m2) [2].

In 2019, 64% adults in England were overweight, with 28% being obese and 3% morbidly obese (NHS Digital 2020a). Obesity is a significant health risk and is associated with increased risk of diseases including heart disease, diabetes, and some cancers. In 2019/2020 there were more than 1 million hospital admissions linked to obesity in England, an increase of 17% on the previous year. Rising rates of obesity translate to increasing costs for the NHS. In 2014/15 the NHS spent £6.1 billion on treating obesity-related ill health, this is forecast to rise to £9.7 billion per year by 2050 (NHS Digital 2021; Public Health England 2017). In England, the prevalence of obesity is not spread equally and on average, the greatest rates of obesity are seen in the most deprived parts of the country[3],

Obesity increases the cost of NHS service provision in all areas including increased costs for hospital provision, GP visits, maternity services and prescribing. The rise in diabetic prescribing costs is in part a consequence of rising levels of obesity[4].

NICE guidance (CG 189) – 'Obesity: identification, assessment and management' was published in November 2014 and updated July 2023[5]. The guidance states the conditions under which referral to Tier 3 are indicated. Criteria include circumstance when conventional treatment has been unsuccessful; the person has complex disease that cannot be managed in Tier 2; and the underlying causes of being overweight or obese

[1] NHSCB. Clinical Commissioning Policy: Complex and Specialist Obesity Surgery. April 2013.

[2] National Obesity Observatory. Briefing note. Obesity and life expectancy. August 2010. http://www.noo.org.uk/uploads/doc/vid_7199_Obesity_and_life_expectancy.pdf

needs to be assessed. The guideline clearly states that all those accessing Tier 4 bariatric surgery need to have previously been through a Tier 3 service.

The current BNSSG ICB criteria for Bariatric Surgery states surgery will only be considered as a treatment options for people with morbid obesity provided all the criteria are fulfilled. One of the listed criteria is that the individual has recently received and complied with a local specialist obesity service (non-surgical Tier 3 /4).[6]

Local context

Over half the adult population in Bristol are overweight or obese (55.7%). This is lower than the national average (63.5%) and the lowest of all core cities. Deprivation and poverty are associated with a higher risk of excess weight in Bristol and obesity even more so, but the relationship is complex and appears to affect women more than men in Bristol.

Some groups in Bristol have a higher risk of excess weight:
• Disability: Significantly more adults living with disability (64.8) have excess weight compared to the city average (47.5%)
• Age: More people aged 65 and over (55.2%) have excess weight compared to the city average (47.5%).
• Gender: Men (51.4%) are more likely to have excess weight than women (43.5%)

In Bristol local Tier 1 and Tier 2 work is based on this whole systems collaborative approach, involving a multitude of partnerships across the health system and the city to support 'healthy weight' environments and a focus on prevention (JSNA 2022.23 - Healthy Weight (bristol.gov.uk)).

In South Gloucestershire an estimated 63% of adults are overweight or obese. In 2018/19 there were 1,615 admissions per 100,000 population in England but in South Gloucestershire the figure was 2,233 per 100,000 (https://beta.southglos.gov.uk/publications/joint-health-and-wellbeing-strategy/joint-health-and-wellbeing-strategy-2021-25/). Tier 2 and other services available are detailed here (Weight Management Services | One You South Gloucestershire (southglos.gov.uk).

In North Somerset 60.5% of adults (2019/20) are overweight or obese, similar to regional national averages with little change in this measure of last few years (North Somerset JSNA overview (n-somerset.gov.uk)). Further information on services available can be found Lose Weight | Better Health North Somerset (betterhealthns.co.uk)

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	**x**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**x**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	

Domain 4	**Ensuring people have a positive experience of care**	**x**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**x**

2.2 Local defined outcomes

It is expected that the BNSSG Tier 3 Multi-Disciplinary Weight Assessment and Management Service will result in the following outcomes:

- Reduction in body weight by 5-10% in 6-12months
- Improvement in co-morbidities (diabetes, BP, lipids, sleep apnea)
- Improvement in emotional wellbeing, low mood and self-esteem
- Reduction in the percentage of people electing for bariatric surgery through improving non-surgical options
- Improved pathway and outcomes for patients who do elect for bariatric surgery
- Improved patient satisfaction of local overweight and obesity pathway

A programme of audit and review will be undertaken at predefined intervals (as described in Local Outcome Measures table) to monitor service standards, outcomes and patient's satisfaction and the results will be shared with commissioner.

3. Scope

Aims and objectives of service

Aim

To provide an effective and efficient non-surgical weight management service for adults in the BNSSG ICB area with severe and complex obesity, with or without co-morbidities, through promoting life-long behavior change.

Objectives

- To reduce the number of people in BNSSG living with severe obesity, through improving their long-term health and reduce the burden of obesity related disease.
- To provide assessment, information, and treatment in accordance with NICE guidelines for BNSSG patients meeting the criteria for the service.
- To encourage long term behaviour change through promoting healthy eating, physical activity and recognising the psychological barriers to unhealthy relationships with food.
- To ensure psychological support is offered to patients who are identified as having psychiatric needs related to their obesity.
- To prevent / reduce / improve the management of any co-morbidities associated with severe obesity together with costs associated with these.
- To assess and treat obese patients who either do not qualify or want bariatric surgery and provide feedback to the GP with a long term management plan.
- Where appropriate, refer patients for Tier 4 surgical assessment and prepare these patients by supporting them to understand the risks of the surgery, the need for behaviour change pre and post-operatively and to assist in the decision making process.
- To function as part of a seamless care pathway for adult overweight and obesity, including signposting patients to community lifestyle services for ongoing support

3.2 Service description/care pathway

The Tier 3 Multi-Disciplinary Weight Management Service will provide a non-surgical service for BNSSG patients with severe or complex obesity. It will be a consultant-led specialist multidisciplinary weight management service, predominately aimed at people

with a BMI of 35 kg/m^2 or more and obesity related co-morbidity, or a BMI of 40kg/m^2 or more who have failed to lose weight in a Tier 1 and Tier 2 service or equivalent programme.

The Tier 3 service offers a 6-24 month programme of care comprising of consultant-led multi-disciplinary team assessments, group and individual treatment sessions. Patients who have been prescribed drug therapy in line with NICE TAG 664, TA875 or any other Technology Appraisal that requires up to 2 years monitoring and support will be able to access the Tier 3 service for the duration of their medication prescribing.

Digital based service

BNSSG ICB currently commission Tier 3 service as a mixed model of face to face (F2F) and non-face to face (NF2F) appointments and group sessions. With the introduction over last few years of the NHS England Digital Weight Management Programme and NICE evidence-based approach early value assessment on digital technologies for delivering specialist weight-management services, the Tier 3 services within BNSSG can be delivered virtually or a mixed model of F2F and NF2F. Digital weight-management technologies can be accessed online or through an app, and will provide a multidisciplinary programme and support from the service's multidisciplinary team (MDT) of healthcare professionals. Weight-management medicine can only be accessed alongside a programme from a specialist weight-management service. Digital specialist weight-management programmes should be delivered by appropriately qualified and experienced healthcare professionals and must include or have access to psychological monitoring. Any future changes to the commissioning of digital base non-face to face will be based on the outcome of NICE assessment of digital technologies for providing specialist weight management services expected in 2024.

The service will form part of BNSSG ICB obesity pathways where patients are expected to have seamless transition through the tiered services (as shown below in table 1).

Table 1: Descriptions of the four obesity service tiers and responsible commissioners in BNSSG

Tier		Responsible Commissioner
1	**Community based prevention and early intervention (self-care)** Including public health and national campaigns; self-referrals into franchised slimming companies, referrals to Health trainer services.	Public Health, Council
2	**Community and primary care weight management and dietician-led services** Including ASWMS (Weight Management on Referral service for Adults); GP Health Checks to identify overweight & obesity and referral on to other commissioned weight management services e.g. Weightwatchers and Slimming World.	Public Health, Council
3	**MDT clinically led weight management services Referral by GP services to a consultant-led** multi-disciplinary assessment, 1:1 and group support for patients; including selection and referral for surgery.	ICB
4	**Specialised Complex Obesity Services (including bariatric surgery)** Criteria based bariatric service supported by MDT pre and post op.	ICB

	https://remedy.bnssg.icb.nhs.uk/adults/weight-management/weight-management-tier-3-4-service-bnssg/	

Overview of Service Care Pathway:

Referral

- Patients meeting the referral criteria in section 3.4 may be referred into the service from GPs via eRS or nhs.net, or secondary care consultants.
- Criteria for referral to the provider will be:
  - Patients that do not want surgical intervention
  - Patients that are able and happy to have care received mainly or fully remotely
- Patients could be referred from NBT T3 WMS to other providers if a patient changes his/her mind about bariatric surgery, and/or deemed to be too high risk for surgery (10-20% expected). The patient needs to be happy with this transfer of care.

Months 0-6 in Tier 3 service

- At first contact patients will be given a named point of contact within the service and will be provided with detailed information on service pathway in order to improve patient understanding and alleviate anxiety.
- The service will triage and identify whether patients are seeking a surgical conclusion or medical support:
    - if surgical then have a Face to face (F2F) MDT consultation with psychologist and consultant will be held.
    - If medical, attend a virtual consultant-led clinic featuring a combination of consultant, specialist nurse, dietetic, and psychology consultations. .

Note patients can elect to change pathway during their period of supporting within the Tier 3 service in conjunction with the service leads.

- All patients will be discussed in the consultant-led multidisciplinary team (MDT) where clinical, psychological, social and lifestyle information will be reviewed. Patient's goals and expectations will be explored to enable an individual programme to be drawn up.
- Patients accepted into the service will participate in an intensive consultant-led 6-month programme of face to face, online and/or telephone support. This will include:
    - Individual or group therapy sessions – Dietetic and psychology sessions
    - Themed drop in sessions
    - Patients with diabetes will have one to one review with a diabetes specialist nurse or a clinician.
    - Patients with complex medical history will have one to one review with a clinician, if appropriate.
    - Blood test results review and obstructive sleep apnea risk assessment, with referrals to specialist services, if appropriate.
    - Patients with complex psychological history will have one to one psychology assessment, as appropriate (for example, people with very low mood/motivation/or self-esteem; food phobia/avoidance; and/or body dysmorphia/shame).
    - One to one review by a clinician or diabetes specialist nurse at 6 months, if appropriate.
    - Where required, MDT discussion to decide next steps, or discharge.

Months 6- 24 in Tier 3 service

NICE in TA 664 Liraglutide and TA 875 Semaglutide have stated that patients prescribed these drugs to support weight loss should continue to be supported with advice and lifestyle support during the duration of their 24 months maximum prescribing period.

Patients prescribed either of these drugs, or any new recommendation by NICE, will continue to be supported within the Tier 3 service throughout their prescribing.

The service has the option to retain patients for a further 6 to 24 months long term flexible follow up, this can include:

- Themed drop in sessions
- Telephone and email advice
- F2F or non-F2F consultations
- Individual or group therapy sessions – Dietetic and psychology sessions.

- Individual clinician and/or diabetes specialist nurse review, if appropriate.
- Where required, MDT discussion to decide next steps, or discharge.

This provider must be able to prescribe in line with NICE recommendations including accessing the NHS discount and delivering Liraglutide (Saxenda) and/or Semaglutide (Wegovy) to patients to ensure this medical management model is successful

Discharge

- Discharged back to GP with management plan (Non-surgical pathway)
  OR
- Referred for bariatric surgery assessment following MDT review (Surgical pathway)
  OR
- Where a patient who initially did not want bariatric surgery changes their mind about it, they could be referred directly to Tier-3 service as long as they had a one to one dietetic, psychologist and clinician reviews and any medical, dietetic or psychological issues have been addressed.

Multidisciplinary Team

The MDT should be led by a bariatric physician e.g., diabetologist/endocrinologist and contain at least: a dietician; a clinical/counseling psychologist; a prescriber and administration support. The patient should be able to access physiotherapist and other hospital specialties through GP referral e.g. Diabetes, Cardiology, Sleep Medicine and Respiratory teams as necessary.

Service Location

- Assessment; review clinics; Individual and group therapy sessions can be run remotely or in a hospital or community setting within BNSSG location.
- The service can be undertaken online, on the telephone or otherwise remotely.
- When considering F2F service locations the following should be taken into account:
  - Suitable equipment should be available for bariatric patients e.g., chairs with weight limits in line with health and safety requirements.
  - Rooms should have disability access including bariatric wheelchairs and mobility scooters.
  - The availability of patient transport and parking.

Referral into the service

- The patient will meet the criteria referred to in section 3.4 and within the BNSSG ICB commissioning policy.
- The service will accept referrals using a Tier 3 Multi-Disciplinary Weight Management Service referral form from the patients GP via eRS or nhs.net or secondary care consultant where full details can be provided. A referral must be accompanied with completed blood investigations; height; weight BMI at time of referral and must include details of how the patient has actively/persistently engaged with losing weight over the last two years with a structured Tier 2 service or equivalent programme.
- A patient information leaflet describing the service will be made available for GPs to download and given to patients at the time of the referral discussion. Alternatively, the service will send this leaflet to the upon receipt of the referrals. This will clearly explain the service to the patient and manage expectations of weight loss surgery.

- The service will ensure all referrals are screened for appropriateness, including identifying any psychological and lifestyle issues which may interfere with the patient's engagement in the programme. The service will engage with referrers to ensure the most appropriate patients are referred for assessment.
- Patient should be offered an MDT assessment 18 weeks from referral.
- Following assessment the patient will be offered the first appointment within 12 weeks of MDT assessment.

In the Tier 3 Multi-Disciplinary Weight Assessment and Management Service:

- The patient should have their weight and height measured and the trend in BMI assessed.
- A dietary history should be taken to ascertain the patient's feelings and expectations about potential outcomes and willingness to consider treatment options, and information and education should be provided so that he/she has appropriate understanding of the relationship between eating habits and weight, aiming to:
    - Help them understand the necessary changes in eating habits to improve health, and identify risk factors and vulnerabilities so that interventions can be planned to address and improve them.
- Encouragement should be provided for weight loss or maintenance, and structured eating plans, meal replacements and Very Low Energy Diets may be considered.
- The bariatric physician should consider screening for rare hormonal or genetic causes for weight gain if there is clinical suspicion.
- The bariatric physician should investigate for obesity-related comorbidities that may be previously undiagnosed, in particular type 2 diabetes, hypertension, OSA, heart failure, atrial fibrillation, chronic kidney disease, non-alcoholic fatty liver disease and depression, to optimise and modify all identified risks, and so that those referred for surgery are as fit as possible; cardiologists and respiratory physicians could also be involved by separate referral if patients need super-specialist care.
- The Edmonton Obesity Staging System or similar should be considered as a means of assessing the risk from obesity-related disease in individual patients.
- Patients will be signposted to community lifestyle services through health improvement teams/health trainers giving patients informed choice in terms of community interventions (e.g., exercise groups; exercise on prescription programmes; health walks; specialist gym programmes; kitchen/cooking programmes).
- Given the high prevalence of psychiatric comorbidity the patient should be screened for psychological and lifestyle issues which may interfere with engagement, including anxiety and depression, self-harm and suicidal behaviors, eating disorders such as binge eating and bulimia nervosa, borderline personality disorders, alcohol / substance misuse, childhood adversity and blocks for voluntary weight which are not clearly understood, so as to identify the patient who may need additional long term support or who may be at risk of self-harm after surgery. A 'time out policy' should exist which will allow a patient to exit and return into the Tier 3 service once these issues are addressed.
- When screening for bariatric surgery the clinical psychologist should:
    - Identify the patient for whom surgery may be inappropriate (severe learning disability, active uncontrolled psychosis, severe personality disorder).
    - Identify individuals not presently suitable for surgery (e.g., untreated or unstable mental health presentation, active alcohol or substance misuse, active eating disorder, self-harm in past 12 months, dementia, current non-adherence to treatment and recent significant life event e.g., bereavement or relationship breakdown) and provide an intervention or access to treatment before reassessing for surgery.
    - Identify and manage weight gain associated with psychotropic medications.

    - Identify the patient who may need specific attention and support following surgery.
- After a mental health assessment, a traffic light system may be useful to identify a patient who is not currently suitable for surgery or who may be suitable although deemed at higher risk and requires psychological treatment before being considered for surgery.
- For a patient with type 2 diabetes:
    - The team should strive for satisfactory glycaemic control before surgery (HbA1c < 68 mmol/mol) but inability to achieve this within a reasonable. period of time should not be a bar to or delay referral for bariatric surgery.
    - Macro- and micro-vascular risk should be assessed, and the information made available before a referral for surgery.
- Smoking cessation advice should be given, and appropriate referral made for a long term solution.
- Vitamin and micronutrient status should be assessed, and deficiencies corrected, to include recognition of diets deficient in protein, in those being referred for bariatric surgery.
- The patients should attend a bariatric surgery education session arranged by the bariatric surgery team if referral for surgery is being considered.
- The MDT, led by the bariatric physician, should meet physically or audiovisually, to discuss the patient before deciding on referral back to the GP or for bariatric surgery.
- Patient information leaflets written in plain English and other languages as appropriate should be provided for all proposed interventions.

Patients exiting the service
Patients should routinely stay in the service for 6 months, however patients who are failing to achieve their goals should be reassessed at the 6 month review and may be offered a further 6 months in the service.

Patients prescribed Liraglutide or Semaglutide in line with the NICE TAs will stay within the service for up to 24 months as long as the patient continues to engage with the service and taking the medication.

The patient should be referred back to the GP when:
- They do not engage with the team (e.g., resistant to recommended health and lifestyle changes; >1 DNA for initial assessment; > 2 consecutive DNAs for other sessions).
- Obesity-related diseases have been addressed and the team agrees with the patient that ongoing treatment and management plans can now appropriately be provided by the GP. Including recommendations for further support from community lifestyle services including Tier 1 & Tier 2.
- The patient does not want to be considered or does not appear to be appropriate for referral for bariatric surgery assessment or does not appear to be suitable for the Weight Assessment and Management clinic.
- Within five working days of discharging the patient a discharge report will be sent to the GP detailing:
    - Assessment findings and treatment
    - Weight loss achieved
    - Details on onward referral if relevant
    - Recommendations for further management if relevant

The patient should be referred for bariatric surgery if the Tier 3 Weight Assessment and Management Clinic is satisfied that:
- It is clear to both patient and service that surgery is the best option for ongoing weight loss and optimization of health and non-surgical methods are no longer viable.
- The patient is adequately engaged with the team (engagement can be judged by attendance records and achievement of pre-set individualised targets e.g., sustained weight loss of 5% body weight within 6-12 months of being in the

service), fully understands the surgery, is well-informed and motivated to have surgery and has realistic expectations.
- All management options have been put to the patient including the characteristics of the various surgical procedures available and the risks and side effects.
- The patient is medically optimised
- There is no medical, surgical, nutritional, psychological, psychiatric or social contraindication.
- The patient understands the importance of complying with nutritional requirements before and after surgery and recognises the need for life-long follow up.

The patient may remain within the Weight Assessment and Management Clinic for up to 24 months if:

- They have complex weight-related comorbidity and the MDT agrees to keep them under review with option to attend drop in sessions, or
- They are being prescribed Liraglutide or Semaglutide

3.3 Population covered

Patients who are registered with BNSSG GP and 18 years old and over.

3.4 Any acceptance and exclusion criteria and thresholds

3.4.1 Commissioning Policies and Exceptional Funding

The Commissioners require the Providers to comply with the commissioning policies process and referrals will only be accepted in line with the contracting Commissioners published referral policy and acceptance criteria.

The Commissioning Policies list (previously named INNF list) identifies those interventions which are subject to access criteria either on a Criteria Based Access (CBA), Prior Approval (PA) or Exceptional Funding (EFR) basis, will be published on the Commissioner's website. These treatments and conditions shown in the Commissioning Policies list are not routinely funded and clinicians should adhere to the requirements within the policies prior to treating patients. Treatments provided that are outside these criteria will not be funded.

Commissioners will require providers to comply with audit processes which will be undertaken after each quarter of activity to monitor compliance with the clinical criteria for carrying out restricted treatments set out in the individual commissioning policies for excluded and restricted procedures. The terms of reference for each audit including the treatments and patient files to be audited will be supplied to the provider ahead of each audit. In the event that a procedure is carried out without meeting the criteria expressly stated and agreed in commissioning policy (for excluded and restricted procedures) the Commissioner will not be liable for the cost incurred by the provider. Where it is accepted that in a number of cases treatment should not have been undertaken as the patient did not meet the criteria for treatment, the percentage of these cases against the total cases reviewed will be calculated, and the percentage of all activity undertaken against that policy during that quarter will be reimbursed

Each month, the Commissioner will identify any patients who have had a treatment without the required EFR or PA approval and present the provider with the details of the patients seemingly treated without approval. The provider will investigate the list provided by the Commissioner to assess whether there is clear evidence of approval from the Commissioner to proceed with treatment or that there is good clinical reason for this i.e. patients have been referred and treated on the two week wait pathway. Where there is no evidence that the Commissioner approved funding, payments will be refunded in full for that patient's intervention including the cost of any follow ups or complications related to that specific treatment

Acceptance Criteria

The access criteria for the service is set out in the Weight Management Service Commissioning Policy - https://bnssg.icb.nhs.uk/directory/weight-management-service-tier-3-and-tier-4-service/

The BNSSG Tier 3 Multi-Disciplinary Weight Assessment and Management Service will not discriminate between service users on the grounds of sex, age, race, gender reassignment, marital status, disability, religion, sexual orientation or any other non-medical characteristics.

Exclusion Criteria:
The following patients should not be referred (although the option of seeking Individual Funding approval is available):

- Patients who are currently **successfully** losing weight with dietetic or reputable evidence-based weight management intervention.
- Pregnant women - Women becoming pregnant during the programme will be able to pause the programme ('time out policy') and return to the service following the birth.
- Patients who have been previously referred into the service and have left the pathway early or have disengaged from the services, who are seeking to re-enter as a re-referral will not be eligible within 24 months.
- Uncontrolled hypertension/heart condition/medical condition preventing increase in activity level
- Patient with unstable or severe mental illness beyond the expertise of primary care
- Patients with active eating disorders
- Patients who have made suicide attempts within the last year
- Patients who have self-harmed in the past 3 months
- Patients who have made plans to commit suicide in the past 3 months
- Bariatric surgery

Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes clinically exceptional circumstances exist that warrant deviation from the rule of this policy.

Individual cases will be reviewed at BNSSG ICB Exceptional Funding Panel upon receipt of a completed application form from the patient's GP, Consultant or Clinician. Applications cannot be considered from patients personally.

Where it is felt the exclusion criteria should be applied, the provider should make all reasonable attempts to discuss this with the patient and where appropriate, the patients GP to ensure that the decision is informed, and evidence based.

3.5 Interdependence with other services/providers

The provider must co-operate and collaborate with GPs, community services (including Tier 2 providers/equivalent providers) and acute specialist service providers (including Tier 4 bariatric surgical team) to ensure patients entering and exiting the service are managed appropriately.

3.6 Medicines Management
The Provider shall ensure that any prescribing must follow the current recommendation of BNSSG drug formulary, NICE technology appraisals and guidance and in accordance with all relevant regulations. Provider shall ensure the safe and legal storage, dispensing, disposal of medicines and prescriptions.

The costs of medicine will be a pass-through cost, and payable by the commissioner in addition to the local prices set out in Schedule 3C. Where direct discounts are given by

drug companies to support NHS PAS schemes, the provider will pass the actual discounted cost to the ICB.

3.7 Equality of Access

The Provider shall ensure the premises (if applicable) from which the service is to be provided shall be fully compliant with the Disability Discrimination Act (2005), the Equality Act (2010) and any other statute or common law relevant to the provision of the service and relating to Equality and Discrimination.

The Provider will treat all patients in a safe and appropriate environment depending upon age and any existing medical conditions. The provider must ensure that services deliver consistent outcomes for patients regardless of;

- Gender
- Race
- Age
- Ethnicity
- Income
- Education
- Disability
- Sexual Orientation

The Provider shall provide appropriate assistance and make reasonable adjustments for patients and carers who do not speak, read or write English or who have communication difficulties, in order to:

- Minimise clinical risk arising from inaccurate communication
- Support equitable access to healthcare for people whom English is not a first language
- Support effectiveness of service in reducing health inequalities

People with visual, hearing, or cognitive impairment; problems with manual dexterity; a learning disability; or who are unable to read or understand health-related information (including people who cannot read English) or neurodivergent people may need additional support to use digitally enabled programmes.

People's ethnic, religious, and cultural background may affect their views of digitally enabled weight management interventions. Healthcare professionals should discuss the language and cultural content of digitally enabled programmes with patients before use.

3.8 Interdependence with other services/providers

The Provider has a responsibility for the interface and development of appropriate pathways with other services; ensuring services are communicated to potential referrers. The provider will be required to work in co-operation with (and not limited to);

- ICB Commissioners including the referral and Exceptional Funding Request service
- GPs, and any other ICB approved referrers
- Commissioning Support Unit
- Local acute trusts including consultants, anaesthetists and other staff
- Diagnostic services
- Local primary and community teams
- Social services
- Independent and third sector providers (voluntary sector)
- Patient, Advice and Liaison services (PALS)

3.9 Training/ education/ research activities

3.9.1 Staffing and training

It is the responsibility of the Provider to recruit/provide suitable personnel and as such the Provider will determine the exact person specification. However the following guidelines will apply to all staff groups including temporary staff e.g. agency:

- All staff will be required to satisfy appropriate DBS checks.
- Staff will have the appropriate clinical and managerial qualifications for their role.
- All staff shall be appropriately trained / qualified and registered to undertake their roles and responsibilities.
- Professional accountability must be formulated within an agreed governance structure.
- Appropriate supervision arrangements for all levels of staff will be in place, including induction and clinical supervision.
- Staff will participate in regular personal performance reviews including the development of a personal development plan.
- All staff will be required to attend relevant mandatory training.

As set out by the Care Quality Commission (CQC), registration documentation will be held on record by the Provider for all medical staff and will be available for inspection. A certificate of registration will be prominently displayed by the Provider in all sites (if delivering face to face service) that the service is provided from.

3.10 Information Governance

All organisations that have access to NHS patient data must provide assurances that they are practicing good information governance and use the Data Security and Protection Toolkit to evidence this.

The Data Security and Protection Toolkit is a Department of Health Policy delivery vehicle that the Health and Social Care Information Centre (HSCIC) is commissioned to develop and maintain. It draws together the legal rules and central guidance and presents them in a single standard as a set of information governance and data security assertion. The Provider is required to carry out self-assessments of their compliance against these assertions.

The Provider will identify an Information Governance lead.

The Provider must complete and provide evidence that they have achieved a satisfactory position for their organisation's Data Security and Protection Toolkit through meeting all the mandatory requirements, https://www.dsptoolkit.nhs.uk/

Final publication assessment scores reported by organisations are used by the Care Quality Commission when identifying how well organisations are meeting the Fundamental Standards of quality and safety - the standards below which care must never fall.

The Provider shall comply with all relevant national information governance and best practice standards including NHS Security Management – NHS Code of Practice, NHS Confidentiality – NHS Code of Practice and the National Data Security Standards. The Provider will participate in additional Information Governance audits agreed with the Commissioner.

3.11 Subcontracting

The Provider shall ensure that no part of the services outlined in this specification may be subcontracted to any other party than the approved Provider without the prior agreement and approval of the Commissioner.

3.12 Notifying and agreeing changes to services

Providers must ensure that they seek Commissioners' consent to planned service changes as proposed Variations under GC13. If changes are made without Commissioner agreement, the Commissioner may be entitled under the Contract to refuse to meet any increased costs which ensue.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The Provider will have robust processes for reviewing, assessing, implementing and monitoring NICE technology appraisals and guidance.

Any and all treatments undertaken by providers as part of the service must be robust, evidenced based, clinically effective treatments and the Provider must be qualified and registered to provide these treatments.

- NICE guidance (CG 189) – 'Obesity: identification, assessment and management' 2014, updated July 2023
- Obesity: working with local communities (NICE PH42, 2012 (updated 2017)
- Weight management: lifestyle services for overweight or obese adults (NICE PH Guidance PH53, 2014)
- The service should ensure bariatric surgery is only considered for people in the Tier 3 service who meet the eligibility criteria for bariatric surgery specified in *NHS England Clinical Commissioning Policy: Complex and Specialised Obesity Surgery, April 2013*
- NICE TA875 - Semaglutide for managing overweight and obesity
- NICE TA664 - Liraglutide for managing overweight and obesity

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- Commissioning guide: weight assessment and management clinics (tier 3), March 2014, British Obesity and Metabolic Surgery Society
- Care Quality Commission (CQC): The Service Provider will register with CQC if the service fulfils requirements for registration.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

Please refer to Local Quality Schedule. No CQUIN scheme is applicable for this service.

6. Location of Provider Premises

The services are provided remotely.

The Provider's CQC head office is located at:
Runway East, 20 St. Thomas Street, London, SE1 9RS

Appendix 1 – Local Quality Indicators

Performance review of the whole service will be undertaken at agreed intervals, and both Commissioner and Provider will work together to agree future performance as and when appropriate.

QI	Indicator	Definition	Target	Rationale/Description	Reporting frequency
Clinical and behavioural effectiveness:					
1.	Number of patients achieving weight loss ≥5% and ≥10% body weight at 6 & 12 months	Percentage change in body weight and BMI at as result of Tier 3 service at 6 and 12 months	• >60% of patients achieving weight loss of >5% at month 6 compared to the initial assessment • >20% of patients achieving weight loss of >10% at month 6 compared to the initial assessment • >60% of patients achieving weight loss of >5% at month 12 compared to the initial assessment • >20% of patients achieving weight loss of >10% at month 12 compared to the initial assessment	Report showing: • BMI and Weight at MDT assessment (per patient and average) • BMI and Weight at 6 and 12 months (per patient and average) • % change in weight between assessment and 6/12 months (per patient and average) • % of total patients achieving ≥5% and ≥10% body weight at 6 & 12 months	6 monthly
2.	Number of patients achieving sustained weight loss ≥5% and ≥10% body weight at 18 months	Percentage change in body weight and BMI at as result of Tier 3 service at 18 months	• >30% of patients achieving weight loss of >10% at month 18 compared to the initial assessment	Service will phone contact patients at 18 months to access patients most recent weight. Report showing: • BMI and Weight at MDT assessment (per patient and average) • BMI and Weight at 18 months (per patient and average) • % change in weight between assessment and 18 months (per patient and average)	At 18 months post service start

				• % of total patients achieving ≥5% and ≥10% body weight at 18 months	
3.	Changes in patients' psychological wellbeing (emotional wellbeing, low mood and self-esteem)	Percentage of patients with a measurable improvement in psychological wellbeing (emotional wellbeing, low mood and self-esteem) as result of Tier 3 service at 6 months	• 100% patients have psychological wellbeing scores recorded at initial assessment and review • 85% patients achieve sustained improvement in psychological wellbeing at 6 months	Positive change in psychological wellbeing measured using psychometric tools (emotional wellbeing, low mood and self-esteem) at 6 months (and 12 months if patient in service for extra 6 months) Report showing initial score and scores at 6 months (and 12 months if patient in service for extra 6 months)	6 monthly
4.	Improvement in co-morbidities	Percentage of patients with a measurable improvement in co-morbidities (blood pressure; HBA1c and lipid profile) as result of Tier 3 service at 6 months and 12 months	• >50% of patients with elevated blood pressure on referral demonstrating a measurable improvement at 6 months • >50% of patients with elevated HBA1c on referral demonstrating a measurable improvement at 6 months or a changes in medication as a result of weight loss • >50% of patients with elevated lipid profile on referral demonstrating a measurable improvement at 6 months	Report showing number of patients demonstrating an improvement in co-morbidities at 6 months (and 12 months if patient in service for extra 6 months) showing: • % of patients demonstrating a reduction in blood pressure (if elevated at referral) • % of patients demonstrating a reduction in HBA1c or change in medication as a result of weight loss (if elevated at referral) • % of patients demonstrating improved lipid profile (if elevated at referral)	6 monthly
QI	**Indicator**	**Definition**	**Target**	**Rationale/Description**	**Reporting frequency**
Numbers referred/demand management:					
1	Service capacity	Details of the caseload on a monthly basis – indicating number of referrals, number of discharges with reasons and where discharged to	Indicative Activity Plan per year: • MDT assessments • Patients completing Tier 3 service	Information to be supplied each month: • No. of referrals per month • No. of discharges indicating: – Successfully completed pathway indicating length of time in pathway	Monthly

			.	& indicate where referred onto e.g. GP or Tier 4 services – Patients leaving the pathway early or disengaging from the service indicating at which stage of the pathway they have left. Indicate reasons for leaving where known.	
2	Inappropriate referrals	Details on numbers of inappropriate referrals on a monthly basis	• No more than 10% inappropriate referrals	Information to be supplied each month. • No. of inappropriate referrals per month indicating: – Source of referral – Reason for referral being inappropriate – Action taken on each inappropriate referral – Identify any common themes in inappropriate referrals and action plan to address eg education of referrer	Monthly
3	MDT assessment to take place within 12 weeks of the referral being received	All patients to have an assessment with the MDT within two weeks of the referral being received	• 100% of patients should have a MDT assessment within two weeks of the referral being received	Report indicating the date of referral and date of MDT assessment per patient.	Monthly
4	12 week intensive programme to commence within 12 weeks of MDT assessment	All accepted patients to commence the 12 week intensive programme (group or one-to-one) within 2 weeks of MDT assessment	• 100% of accepted patients should start the 12 week intensive programme within 2 weeks of MDT assessment	Report indicating the date of MDT assessment and start date of 12 week intensive programme (group or one-to-one) per patient.	Monthly
5	Number of patients successfully completing the Tier 3 service and discharged from the service at 6 and 12 months	Number of patients fully completing Tier 3 service at 6 and 12 months as proportion of total number who started	• No more than 10% DNAs • >90% of patients starting pathway remain in service at 6 months • <10% of patients starting pathway require months 6-12 in the service	Data to be supplied: • Number of DNA patients • Number of patients who have successfully completed and are discharged from the pathway at 6 and 12 months as a percentage of those who started the pathway	Monthly

6	Number of patients requesting bariatric surgery	Reduction in the number of patients requesting onward referrals to Tier 4 bariatric surgery services in preference to self-management (Baseline figure = patients identified as wanting surgery)	• 40% reduction in the number of patients wanting referral onto tier 4 services for bariatric surgery between initial assessment and leaving the Tier 3 service.	Data to be supplied: • No. of patients wanting to be considered for bariatric surgery at initial assessment • No. of patients wanting to be considered for bariatric surgery at 6 and 12 months	Monthly
Satisfaction with service:					
7	Patient satisfaction Report	Qualitative data on patients views of the service including those disengaging early	• 90% of patients completing Tier 3 service are satisfied with care provided	Patient satisfaction with the service and outcomes are measured routinely (method to be agreed with commissioners). Evidence that quantitative and qualitative data have been used to improve service delivery, including from those that disengage from the service early. Health Watch patient complaint data	6 monthly
8	Wider pathway satisfaction and efficiency report	Qualitative data on Tier 4 provider view of 'readiness for surgery' of Tier 3 referred patients Qualitative data on Tier 2 provider view of 'suitability' of any patients successfully completing Tier 3 and re-referred to Tier 2 Qualitative data from referrers into the service, doctors and Tier 2 providers as to 'what works' and 'what needs to improve'	• 90% of patients referred on to Tier 4 service are deemed 'ready' to engage • 100% of patients referred back to Tier 2 are deemed 'suitable' and able to benefit from provision	Data to be supplied: • No of patients referred on to Tier 4 who are deemed ready to engage and those not • No of patients referred back to Tier 2 on completion of service and number deemed 'suitable' and able to engage and benefit • Opinions of referrers into the service and staff around performance.	6 monthly

		Qualitative data from staff of the service as to ‘what works’ and ‘what needs to improve’			
9	Number of Patients leaving programme and reasons for doing so [DNA following initial engagement]	Quantative data on the number of patients commencing the T3 pathway and leaving the programme without completing it and without achieving weight loss goals Qualitative data on the reasons for patients disengaging with the service	• tbc	This will assist providers in commissioners in assessing the successfulness of the programme and judging patient satisfaction in service provision	6 monthly