

Reference: FOI.ICB-2627/002

Subject: Eligibility Criteria for Injectable Weight Loss Medication

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

QUESTION	RESPONSE
<p>Under the Freedom of Information Act 2000, I would like to request the following information regarding the use of injectable pharmacological treatments for overweight and obesity (e.g. GLP-1 receptor agonists or dual GIP/GLP-1 receptor agonists).</p> <p>Since the publication of NICE TA 1026 on 23 December 2024, up to 01 April 2026:</p>	
<p>1. Are injectable pharmacological treatments for overweight and obesity currently being initiated for patients as part of routine services commissioned or delivered by your organisation?</p> <p>If so, please identify which medication(s) are currently used as first-line injectable pharmacological therapy for overweight and obesity within commissioned services.</p>	<p>Yes.</p> <p>Liraglutide, semaglutide, tirzepatide – within adult specialist weight management services</p> <p>Tirzepatide – within primary care for adults</p> <p>Semaglutide – within specialist weight management services for children and young people</p>
<p>2. What are the eligibility criteria for patients to access injectable pharmacological treatments for overweight and obesity within your organisation?</p> <p>Where these criteria are already published online, please provide the relevant link and confirm whether the published criteria are currently being applied in practice.</p>	<p>Respective NICE TA criteria for liraglutide, semaglutide, tirzepatide – within specialist weight management services for adults</p> <p>Overview Liraglutide for managing overweight and obesity Guidance NICE</p> <p>Overview Semaglutide for managing overweight and obesity Guidance NICE</p> <p>Overview Tirzepatide for managing overweight and obesity Guidance NICE</p>

	<p>NHS England Interim commissioning guidance: implementation of the NICE technology appraisal TA1026 and the NICE funding variation for tirzepatide (Mounjaro®) for the management of obesity – within primary care for adults.</p> <p>NHS England » Interim commissioning guidance: implementation of the NICE technology appraisal TA1026 and the NICE funding variation for tirzepatide (Mounjaro®) for the management of obesity</p> <p>Semaglutide for severe obesity in children (12-18 years) within specialist weight management service - 6.9 Obesity (Remedy BNSSG ICB)</p>
<p>3. Please confirm whether the model of care through which these treatments are (or will be) delivered:</p> <ul style="list-style-type: none"> ○ Directly from general practice ○ Primary care-led weight management service (e.g. GP or pharmacist-led weight management service, community weight management hub, etc.) ○ Tier 3 specialist weight management services ○ Other (please specify). 	<p>General practice and specialist weight management services as described above.</p>
<p>4. Please confirm whether the relevant pathway within your organisation is currently:</p> <ul style="list-style-type: none"> ○ operational and accepting referrals ○ operational but limited (e.g. pilot sites) ○ approved but not yet implemented ○ currently under development. 	<p>Operational and accepting referrals</p> <p>Tier 3 & 4 Weight Management Service - BNSSG (Remedy BNSSG ICB)</p>
<p>5. Please provide copies of any key or current clinical pathways, service specifications, prescribing guidance, or referral criteria relating to the use of injectable pharmacological treatments for overweight and obesity, if held.</p>	<p>Please find all information relating to tirzepatide prescribing in primary care including prescribing guidance on Remedy our BNSSG referral pathways website - Weight Management - Tirzepatide (Mounjaro) (Remedy BNSSG ICB)</p>

Please find all information relating to Tier 3 and 4 specialist weight management services on Remedy our BNSSG referral pathways website - [Tier 3 & 4 Weight Management Service - BNSSG \(Remedy BNSSG ICB\)](#)

Please find all relevant medicines information on Remedy our BNSSG Joint Formulary website - [Home \(Remedy BNSSG ICB\)](#)

The service specification for Specialist Weight Management Services has been enclosed.

The information provided in this response is accurate as of 16 April 2026 and has been approved for release by Dr Ananthakrishnan Raghuram, Chief Clinical Leadership and Delivery Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service	BNSSG Tier 3 Multi-Disciplinary Weight Management Service
Commissioner Lead	BNSSG ICB
Provider Lead	xx
Period	1 April 2026-31 March 2027
Date Last Reviewed	January 2026

1. Population Needs
<p>1.1 National/local context and evidence base</p> <p>National Context</p> <p>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 $<40\text{kg/m}^2$, 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/m^2)².</p> <p>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,</p> <p>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.</p> <p>NICE guideline (NG246) – ‘Overweight and obesity management’ was published in January 2025³The guidance states the conditions under which referral to specialist services (Tier 3) are indicated. Criteria include circumstance when less intensive management has been unsuccessful; the person has complex disease states or needs that cannot be managed adequately in behavioural overweight and obesity management services (for example, the extra support needs of people with learning disabilities) and the underlying causes of being overweight or obese needs to be assessed. The guideline</p>

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

³ [Overview](#) | [Overweight and obesity management](#) | [Guidance](#) | [NICE](#)

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).

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
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2.2 Local defined outcomes

BNSSG's mission is "Healthier together by working together."

"People enjoying healthy and productive lives, supported by a fully integrated health and care system - providing personalised support close to home for everyone who needs it."

BNSSG Integrated Care System aims

BNSSG's Strategy and Joint Forward Plan have been developed to align with, and support, the four aims of integrated care systems:

- Improve outcomes in population health and health care
- **Tackle inequalities in outcomes, experience and access**
- **Enhance productivity and value for money**
- Help the NHS support broader social and economic development.

BNSSG Joint Forward Plan <https://bnssghealthiertogether.org.uk/library/joint-forward-plan-2025-30/> (first published June 2023 and updated regularly) sets out how BNSSG ICB will deliver on the national vision of high-quality healthcare for all, through equitable access, excellent experience, and optimal outcomes until 2030.

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

3.1 Scope

The Provider shall be accredited to provide NHS services via the Commissioner's accreditation process following Provider Selection Regime regulations. This process includes submitting evidence of the clinical pathways used for each specialty the Provider intends accepting referrals for. Pathways will comply with current National Institute for Clinical Excellence (NICE), relevant Royal College guidance or pathways and the Commissioner's own policies (e.g. commissioning policies).

Providers shall be required to deliver such elective services at NHS National Payment Scheme prices, or where no national price exists then local prices shall apply.

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/m² or more and obesity related co-morbidity, or a BMI of 40kg/m² 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.

Patients who have been prescribed drug therapy in line with NICE TA1026 will also be able to remain in the service for two years. A policy for ongoing monitoring and support will be developed and shared during 2025.

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 (DTAC Certified), 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 based non-face to face will be based on guidance published by NICE and or NHS England.

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

Overview of Service Care Pathway:

Referral
<ul style="list-style-type: none"> ● 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: <ul style="list-style-type: none"> ○ 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 reviewed 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), Semaglutide (Wegovy) or Tirzepatide (Mounjaro) to eligible 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 the 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.

Applicable to surgical pathways

- 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 weight loss medication 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 weight loss medication in line with NICE TAs.

3.3 Population covered

BNSSG ICB is commissioning these services on behalf of patients registered with a GP for which BNSSG ICB is responsible commissioner. The Provider premises will be located within BNSSG only. Under Patient Choice rules, patients from outside of BNSSG may choose to select the provider and in these circumstances an invoice for payment should be directed to the appropriate responsible ICB.

This service is provided to patients who are registered with BNSSG GP and 18 years old and over.

3.4 Clinical Responsibility

For the avoidance of doubt the Patient's GP shall remain the most responsible person within the overall care pathway. Once a referral has been accepted medical responsibility for the patient's care will transfer to medical staff employed by the Provider, whether directly or through sub contractual agreement.

3.4.1 Commissioning Policies and Exceptional Funding

The Commissioner requires the Provider to comply with the Commissioning Policies process and referrals will only be accepted in line with the Commissioner published referral policy and acceptance criteria.

The Commissioning Policies 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 and are published on the relevant Commissioner's website (see Schedule 2G). These treatments and conditions shown in the Commissioning policies lists 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.

The Commissioner will require the Provider 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 to the Commissioner.

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 commissioned). 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 12 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.

3.4.2 Patient consent

The Provider shall ensure that written informed consent is provided for all procedures/surgeries carried out, in compliance with General Medical Council. If English is not the first language, the patient is supported by a translation service.

Where appropriate, the Provider will send the necessary procedure information and consent forms to patients ahead of their appointment so the patient is prepared for their appointment and consent can be obtained. The clinician will nonetheless give the patient a clear explanation of the procedure/surgery, the after effects and risks at their appointment before undertaking the procedure/surgery.

3.4.3 Cancer pathway

If a patient of the provider is discovered to have, or suspected to have, cancer, an onward referral will be made by the Provider's consultant or healthcare professional to the central cancer team at a provider NHS trust providing a multi-disciplinary team for that particular cancer type (within 24 hours). These referrals are required to align with the relevant referral criteria (e.g as published on [Home \(Remedy BNSSG ICB\)](#) .

The method for making such onward referrals shall be via electronic mail unless other means are agreed by the Commissioner. This may be subject to change in line with relevant guidance. The Provider will communicate with the patient's GP on the same day that the discovery or suspicion of cancer is made.

The Provider will inform the patient of such onward referral either whilst they remain as a patient at the Provider's facility, or within 24 hours of discovery and onward referral.

If the required pre-assessment is out of scope of the existing pathway providers must advise the patient to urgently make a GP appointment for further assessment.

The above also applies to providers' patients on privately funded pathways.

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 provider will be required to complete a Blueteq form prior to the prescribing of appropriate weight loss medication. This will ensure that the ICB is able to track and monitor spend against High Cost Drugs.

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.

Drugs under the formulary can only be prescribed where the provider is able to access the NHS discounted price. The ICB will work with the provider and pharmaceutical companies to enable access to the discounted rates where possible.

3.7 Pathology

The Provider will have in place a contract with an accredited pathology service and will share details with the Commissioner.

3.8 Discharge summary

Communication with the patient's GP will occur on the day of discharge by sending a discharge summary report to the GP within 24 working hours and a copy will also be given to the patient. The aim should be to deliver this information electronically by secure network.

The report must be documented in the patients' records, communicated to the patient, the GP and to relatives/carers as appropriate and should form part of any onward referral to other healthcare services.

3.9 Transfer of Care Protocols

The Provider must ensure robust processes are in place for the rapid transfer to relevant specialties within secondary care where the patient's condition warrants this transfer. These protocols must be agreed with the secondary care provider and attached to the contract in section 2J.

3.10 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.

3.11 Interdependence with other services/providers

The Provider has a responsibility for the interface and development of appropriate pathways with other services and local providers. The Provider will be required to work in co-operation with (and not limited to);

- Commissioners
- GPs, optometrists, dentists and any other ICB approved referrers
- Commissioning Support Unit
- Acute NHS trusts including consultants, anaesthetists and other clinical and non-clinical staff
- Diagnostic services
- Local primary and community teams
- Social services
- Independent and third sector providers (voluntary sector)
- NHS Patient Transport Services (PTS)
- Emergency transport / ambulance services
- Patient, Advice and Liaison services (PALS)

3.12 Staffing and training

It is the responsibility of the Provider to recruit/provide suitable personnel and 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 that the service is provided from.

In addition, 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.

3.13 Information Governance

All organisations that have access to NHS patient data must provide assurances that they are practising good data security and use the Data Security and Protection Toolkit online self-assessment to evidence this yearly.

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

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.

3.14 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.

3.15 Notifying and agreeing changes to services

The Provider must ensure that they seek Commissioner' consent to planned service changes as proposed Variations under General Conditions. 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.

The Provider must deliver services in accordance with current Best Practice in healthcare and the range of policy and clinical / operational practice guidance relating to these services, complying in all respects with the standards and recommendations.

Assessments, diagnostics and treatments undertaken by Provider as part of the service(s) commissioned must be robust, evidenced based, clinically effective treatments and the Provider must be qualified and registered to provide these treatments.

- Overweight and obesity management NG246 (published 14 January 2025)
- 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 NICE TA1026 – Tirzepatide 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

6.1 The premises from which the Provider's services are commissioned are located at:

To be added per provider

Alternative premises can be commissioned under this contract at other locations when there is prior agreement from the Commissioner and where they are registered with the CQC.

Premises will be accessible by public transport and have car parking facilities.

The Provider will manage their occupation of any premises in such a way as to provide the best possible experience for patients arriving, leaving and using the facility, and to support the delivery of the Service.

The Provider will be responsible for ensuring the locations used offer a safe environment. This includes ensuring the premises continue to meet regulatory standards and any applicable NHS standards; remain suitable for delivery of the service and be safe and appropriate for users with particular needs.

A contingency plan will be in place which includes plans to address operational contingencies which may occur.

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