SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement
Optional headings 5-7: optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	
Service	Tier 3 Weight Management Services
Commissioner Lead	West Hampshire CCG
Provider Lead	
Period	April 2016-April 2020
Date of Review	

1. Population Needs

1.1 National context and evidence base

Obesity is the second most common preventable cause of death after smoking in Britain today and is responsible for more than 9,000 premature deaths in England per year. At present more than half of the British adult population is overweight, with obesity trebling in the last 20 years to 22% of men and 23% of women. Obesity increases the risk of dying prematurely or developing diseases such as: cardiovascular, type 2 diabetes, hypertension, dyslipidaemias, some cancers, musculoskeletal problems etc.

The prevalence of obesity increases with age. There are strong links with obesity and social deprivation for women and children but not with men. Other factors that increase the risk of obesity are having a physical disability, a learning disability or being from certain ethnic minority groups.

Obesity has health implications at all stages of life. Being obese during pregnancy increases the risk of prematurity, stillbirth and neonatal death, and being obese in childhood has consequences for health and wellbeing in both the short and the longer term.[1]

Being overweight or obese as an adult significantly increases the risks of developing and dying from cardiovascular disease, cancer and kidney and liver disease and the risk increases as BMI increases.[2] Around 58% of Type 2 diabetes, 21% of heart disease and between 8-42% of cancers (endometrial, breast and colon) are thought to be caused by excess weight.[3] People with morbid obesity live on average 8–10 years less than people who are a healthy weight which is similar to the effects of life-long smoking.[2]

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[1] Doak, et al (2006) The prevention of overweight and obesity in children and adolescents. *Obesity Reviews 2006; 7:111-136.*

[2] Prospective Studies Collaboration. (2009). Body-mass index and cause-specific mortality in 900 000 adults: collaborative analyses of 57 prospective studies. Lancet; 373: 1083-96.

[3] Foresight (2007) Tackling Obesities: Future Choices. Government Office for Science. London.

1.2 Evidence for Effective Treatment

Nice states that a 5-10% loss in body weight can reduce the cardiovascular and metabolic risk factors associated with obesity. If improvements to body mass index (BMI) are achieved and maintained, this will reduce a range of conditions associated with obesity. This includes coronary heart disease, type 2 diabetes, stroke, hypertension, osteoarthritis and some cancers.

The estimated cost to the NHS of managing diseases related to overweight and obesity in Hampshire was £312.2 million in 2010 rising to £333.8 million in 2015; costs to the wider economy are considerably more (Department of Health).

The 2007 Foresight report[i] estimated that in 2050, costs attributable to people being obese or overweight would be £9.7 billion per year. Preventing a 1% increase in the number of people who are overweight or obese could save the NHS and local authorities around £97 million per year.

1.3 Local Need

It is estimated that 64% of the adult population of Hampshire are of an excess unhealthy weight, of which 22% are clinically obese. Nationally, the proportion of women that are clinically obese has risen from 17.8% to 27.5% from 1991-3 to 2008-10. For men the proportion rose from 14.9% to 27.6% during the same time period. The rate of obesity is continuing to rise, though at a rate of increase that is slowing. The estimated prevalence of obesity in adults varies by geographical area from 17% in Hart to 29% in Gosport. Add Southampton demographics

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

Commissioners have agreed to collaborate on this specification. The service will achieve positive changes to evidence three main outcomes:

- Sustained weight loss
- Increased physical activity
- Reduction of Co-morbidity

3. Scope

3.1 Aims and objectives of service

3.1.1
To innovate to deliver the expected weight management outcomes

3.1.2
To implement best practice contained in the NICE Obesity pathways4 and the guidance of the Royal Colleges5

3.1.3
Treatment of those patients not wishing/unsuitable for bariatric surgery who have complex obesity, where intervention is appropriate to stabilise their condition and optimise their health and wellbeing, prior to the patient being referred back into primary care for onward treatment

3.1.4
Clinical assessment and treatment of pre-bariatric surgery (Tier 4) patients in preparation for a surgical intervention

3.2 Service description/care pathway

3.2.1
In view of the ongoing paucity of evidence regarding the most effective model of tier 3 services compared with other pathway elements this will be a service improvement model that develops in the light of service delivery experience, evaluation and future evidence base developments.

3.2.2
In line with guidance from British Obesity and Metabolic Surgery Society with partners The service will as a minimum:

- Consist of a multidisciplinary team (MDT) containing at least, a dietician, a specialist nurse and a clinical psychologist with access to a bariatric physician, a liaison psychiatry professional and a physiotherapist
- All staff will be trained in appropriate psychological skills, one example of which would be motivational interviewing
- Investigate for obesity-related comorbidities that may be previously undiagnosed to optimise and modify all identified risks, and so that those referred for surgery are as fit as possible;
- Provide Lifestyle advice including access to a physical activity programme so as to promote health gains and general fitness individually tailored for each patient to optimise significant behaviour change characteristics
- Screen for psychological issues which may interfere with engagement, including anxiety and depression, self-harm and suicidal behaviours, 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, to identify the patient who may need additional long term support to understand their relationship and emotional function with food/or are at risk of self-harm after surgery
- Screen for bariatric surgery(via clinical psychologist and liaison psychiatry) to identify

[4] NICE 2014. Obesity pathway derived from the Obesity clinical guideline 43 (2006)
[5] BOMSS, RCS, BDA, RCGP, RCPsych, Faculty of PH, BPS, March 2014. Commissioning guide**:** Weight assessment and management clinics (tier 3)

the patient for whom surgery may be inappropriate (severe learning disability, active uncontrolled psychosis, severe personality disorder)
- For a patient with type 2 diabetes, strive for satisfactory glycaemic control before surgery

The service should will include or liaise as required with:

- A full multidisciplinary team (MDT) including a bariatric physician and a liaison psychiatry professional;
- Screening for rare hormonal or genetic causes for weight gain if there is clinical suspicion
- Cardiologists and respiratory physicians could also be involved by separate referral
- Assessment of risk using the Edmonton Obesity Staging System or similar
- Identification of 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
- Identification and management of weight gain associated with psychotropic medications
- Identification of patients who may need specific attention and support following surgery
- Promotion of weight loss during a short, supervised diet in order to make surgery technically feasible, and demonstrate engagement with the process
- Assessment of Macro- and micro-vascular risk and share the results before a referral for surgery
- Smoking cessation advice and appropriately refer for intervention
- Assessment of vitamin and micronutrient status and correct deficiencies
- Encourage patients to attend pre-surgery education sessions usually arranged by the bariatric surgery team if referral for surgery is being considered
- Meet as a team, led by the bariatric physician, to discuss all patients at least once *before* deciding on referral back to the GP or for bariatric surgery
- Report to commissioners using the National Obesity Standard Evaluation Framework

3.2.3 Service Implementation

The service provider shall work to the submitted detailed service implementation plan which will include:

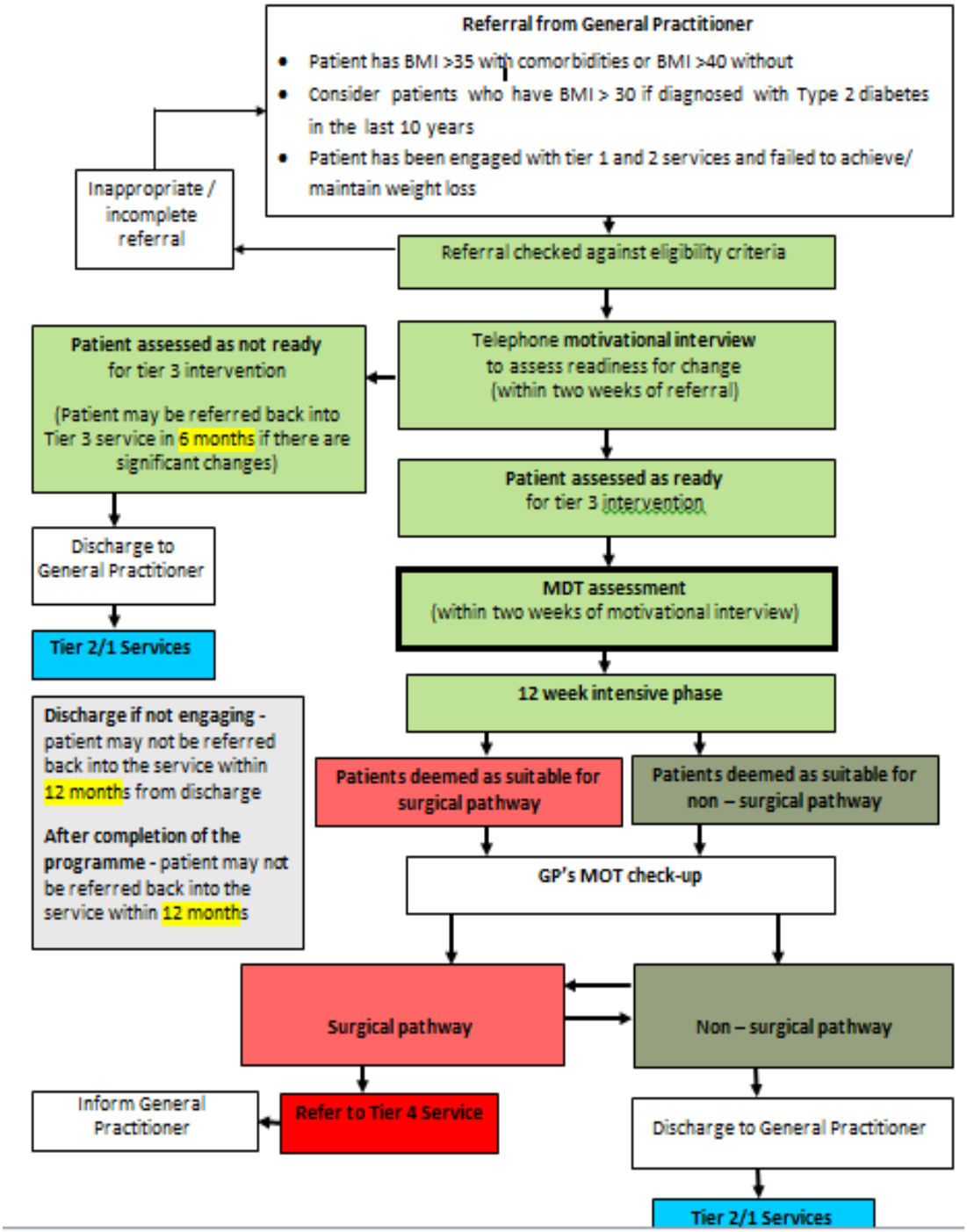
- staffing structure
- clear clinical and operational protocols and medical (physical and psychological) assessment tools
- detailed description of how the service outcomes will be met
- a description of how the service will work collaboratively with physical, mental health and community providers

3.2.4 Pathway

The service will offer a clinically led multi-disciplinary service to obese patients drawing on a wide range of expertise/disciplines to ensure an integrated and coordinated approach between the physical and mental health requirements of this client group.

There is an expectation that the commissioners and the provider will work in partnership to embed a facilitative referral process for GPs in order to maximise referrals.

The service fits within the following pathway of care for weight management:



See Appendix 1 for the surgical and non-surgical pathways

3.3 Population covered

To include patients registered at practices in the following NHS Clinical Commissioning Groups:

CCG	Number of practices	List of practices
NHS North Hampshire CCG	20	141124 NHCCG Practices .xlsx
NHS North East Hampshire and Farnham CCG	24	NEHFCCG practices.xlsx
NHS South Eastern Hampshire CCG	24	SEH practices.xls
NHS Fareham and Gosport CCG	21	F&G_PMs_Update_150401.xlsx
NHS Southampton City CCG	33	Southampton City CCG Practice2 Addres
NHS West Hampshire CCG	51	WH practices.xlsx

3.4 Any acceptance and exclusion criteria and thresholds

Patients who have:

- Engaged with tier 1 and 2 services over a 2 year period but failed to achieve/ maintain weight loss
- Have a BMI of >35 with obesity related comorbidities e.g. metabolic syndrome, hypertension, obstructive sleep apnoea (OSA), functional disability, infertility and depression if specialist advice is needed regarding overall patient management
- or a BMI of >40 without (reduced by 2.5 kg/m2 of BMI in Asians)
- Consider a lower threshold BMI >30 for patients with Type 2 Diabetes provided that they meet all of the other criteria
- Are registered with a GP within stated CCG localities
- Are 18 or over
- We would not expect the service to exclude people with mental illness who are able to engage with the service (to address parity of esteem[6]). An individual assessment of suitability should be made

Exclusions:

- Pregnant and breast feeding women
- People with unstable ischaemic heart disease
- Patients who DNA an assessment appointment reschedule once only, before being discharged from the programme.
- For people who have accessed the service within the previous 12 months and attempted to engage with the programme, the MDT will need to make a careful assessment as to whether they could benefit for a second course of treatment

3.5 Interdependence with other services/providers

- Extensive shared care arrangements with GP practices
- Direct referral to Tier 2 weight management services, which will vary according to local authority commissioner

[6] http://www.england.nhs.uk/ourwork/qual-clin-lead/pe/

- Liaison with Tier 4 services to support best preparation for surgery

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- NICE Obesity guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (NICE clinical guideline 43, 2006)
- Healthy Weight; Healthy Lives National Obesity Strategy (2008)
- National Obesity Observatory, 'Standard Evaluation Framework for Weight Management Interventions (NOF 2009)
- Scottish Intercollegiate Guidelines Network (SIGN) Management of Obesity. A national clinical guideline' (Clinical Guideline 115, 2010)
- NICE guidance 'Weight Management before, during and after Pregnancy' (Public Health Guidance 27, 2010).

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

BOMSS, RCS, BDA, RCGP, RCPsych, Faculty of PH, BPS, March 2014. Commissioning guide**:** Weight assessment and management clinics (Tier 3)

4.3 Applicable local standards

- Care Pathway for Overweight and Obese Adults (East Hampshire, Fareham and Gosport Primary Care Trusts 2005, for Hampshire and Isle of Wight Public Health Network)
- Hampshire Healthy Weight Strategy

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

- The Provider will have in place appropriate structures to continuously improve the quality of the service and safeguard high standards.
- The service provider is expected to:
  - measure patients weight at entry into the service and at regular intervals thereafter including at 6 months/exit from the service;
  - agree with each patient patient defined quality of life goal
- The detailed quality requirements are listed in Schedule 4 Quality Requirements.

5.2 Applicable CQUIN goals

None

6. Location of Provider Premises

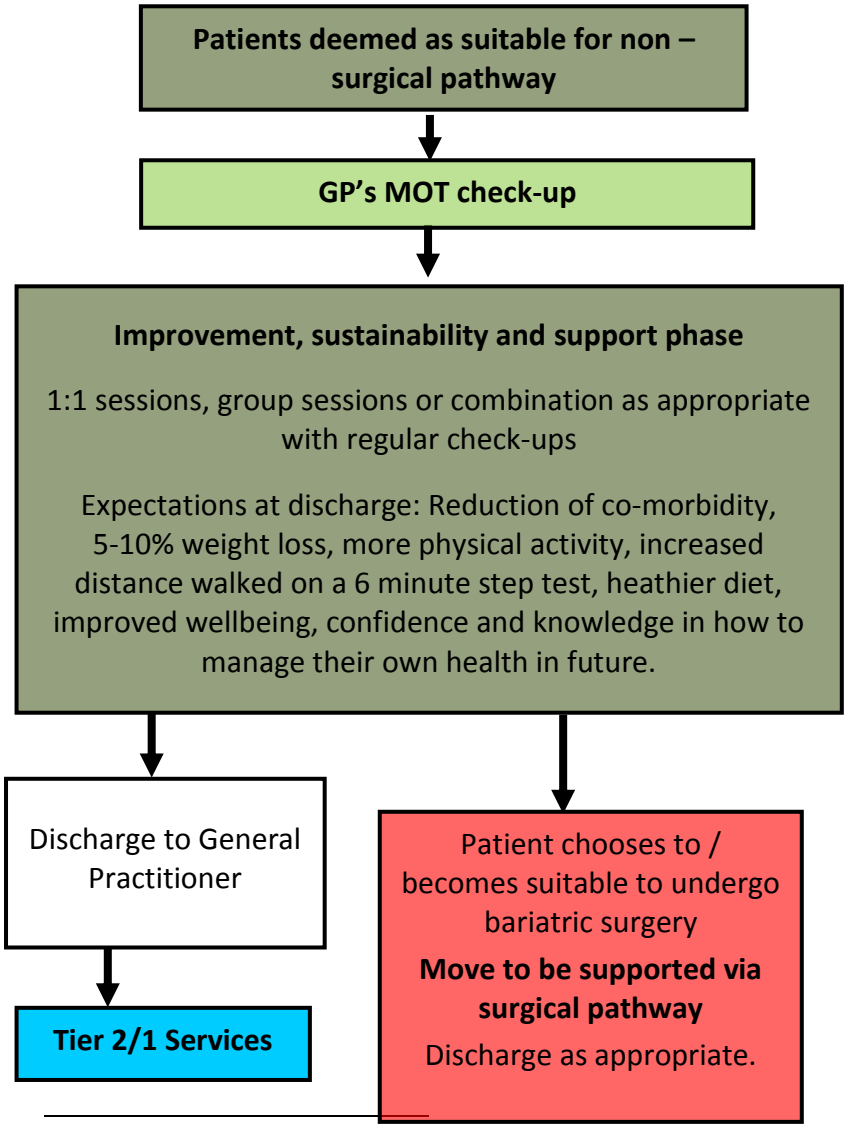
It is expected that the provider will deliver care as close to home as possible across a variety

of locations and with some domiciliary support.

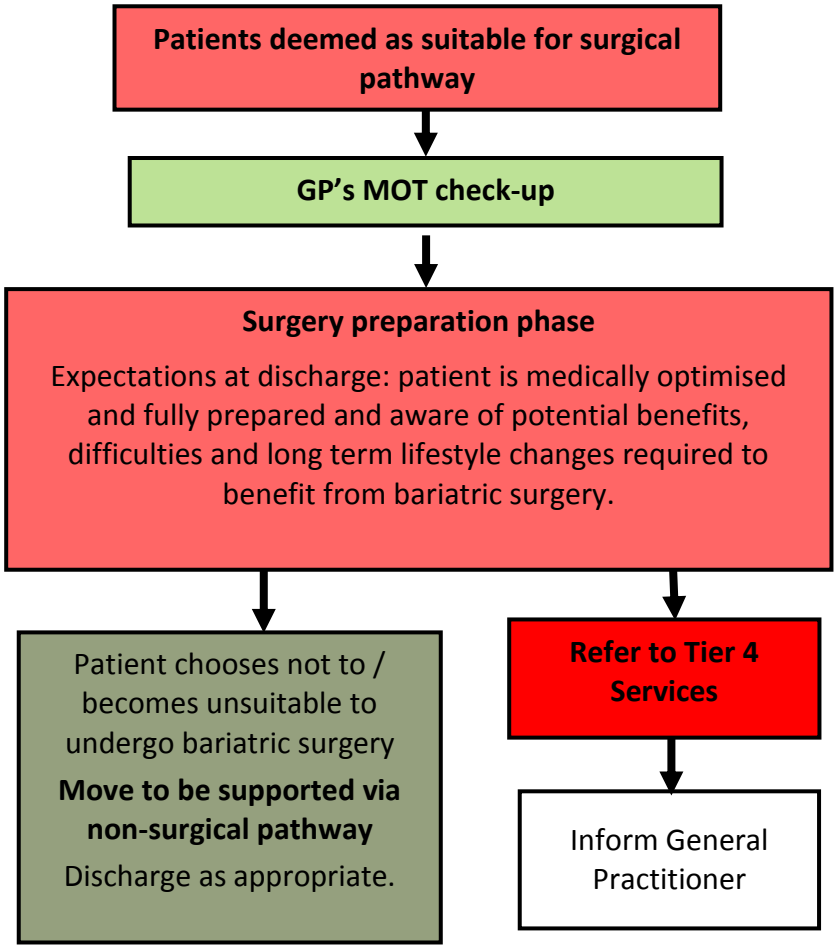
The Provider's Premises are located at:

7. Individual Service User Placement

APPENDIX 1 Non-surgical pathway



Surgical pathway



Discharge if not engaging - patient may not be referred back into the service within 12 months from discharge

After completion of the programme - patient may not be referred back into the service within 12 months

[i] Government Office for Science and DH, October 2007. Tackling obesities: future choices Foresight project looking at how we can respond to rising levels of obesity in the UK.