SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	
Service	**Adult Specialist Weight Management Services – Tier 3 (including post-surgery follow-up)**
Commissioner Lead	**NHS Leeds CCG**
Provider Lead	
Period	**1st April 2019 – 31st March 2022**
Date of Review	**September 2021**

Key Service Outcome

The service will work to reduce the burden of obesity and the impact of related comorbidities for patients in Leeds.

1. Introduction

1.1 Adult Specialist Weight Management Services – Tier 3

Tier 3 weight management services are integral to a tiered management approach for people with severe and complex obesity. They are also a pre-requisite for patients considering bariatric surgery.

The overarching aim of the service is to improve physical, emotional, psychological and social functioning for people with severe and complex obesity by the provision of a service designed to *promote* and *sustain* weight loss for a period of 12-18 months (this timescale is flexible depending on service model and patient need). It is anticipated that this will be achieved by:

- Raising patient's awareness of both the health and wider benefits of weight loss.
- Supporting patient activation for behaviour change including meaningful lifestyle changes (for example diet and physical activity levels), goal setting to increase patient self-efficacy and motivation for weight loss, maintenance and relapse prevention. This could be enhanced through working with other services and voluntary organisations.
- Working with patients and other providers within the local obesity/weight management pathway (shared decision making) to identify most appropriate treatment options. This will include identifying suitable patients for surgery. Patients deemed suitable for surgery will receive a comprehensive multi-disciplinary assessment, including pre-surgery requirements and realistic dietary and weight-loss expectations post-surgery.
- Ensuring that those patients who do not meet criteria for a surgical intervention remain motivated to facilitate weight loss within the service.
- Providing post-surgery care to patients following bariatric surgery for a minimum of two years.

1.2 Reducing Health Inequalities

It is the responsibility of the provider to be mindful of health inequalities in Leeds when providing this service. Health inequalities are the result of a complex and wide-ranging network of factors. People, who experience material disadvantage, poor housing, lower educational attainment, insecure employment or homelessness, are among those more likely to suffer poorer health and an earlier death, compared with the rest of the population.

Every contact with a patient provides an opportunity for a health promotion discussion. The Provider will ensure that staff are effectively trained and supported to use every contact with a patient as a health promoting intervention and to signpost to other appropriate services, which may help address other barriers to improved health. The provider will assess the patient's wider needs and contributing factors towards their obesity/barriers to change.

1.3 Weight Classification

Different weight classes are defined based on a person's body mass index (BMI) as follows:

- healthy weight: 18.5–24.9 kg/m2
- overweight: 25–29.9 kg/m2
- obesity I: 30–34.9 kg/m2
- obesity II: 35–39.9 kg/m2
- obesity III: 40 kg/m2 or more

The use of lower BMI thresholds (23 kg/m2 to indicate increased risk and 27.5 kg/m2 to indicate high risk) to trigger action to reduce the risk of conditions such as type 2 diabetes, has been recommended for black African, African-Caribbean and Asian (South Asian and Chinese) groups.

2. Population Needs

2.1 National / Local Context and Evidence Base

Obesity is directly linked to a number of different illnesses including type 2 diabetes, fatty liver disease, hypertension, gallstones and gastro-oesophageal reflux disease (NICE guideline CG184), as well as psychological and psychiatric morbidities. The Health and Social Care Information Centre reported that in 2011/12 there were 11,740 inpatient admissions to hospitals in England with a primary diagnosis of obesity: three times as many as in 2006/07 (Statistics on obesity, physical activity and diet – England, 2013). There were three times as many women admitted as men.

In England, the prevalence of obesity among adults has increased sharply during the 1990s and early 2000s. The proportion who were categorised as obese (BMI 30kg/m2 or over) increased from 13.2% of men in 1993 to 24.3% in 2014 and from 16.4% of women in 1993 to 26.8% in 2014 (Health Survey for England). By 2050 obesity is predicted to affect 60% of adult men, 50% of adult women (Foresight 2007).

There are significant inequalities in obesity prevalence within the population. Among women, obesity prevalence increases with decreasing socioeconomic status. However, the pattern is less clear for men. Male manual workers have higher rates of obesity than non-manual groups, and obesity prevalence rises with decreasing educational level among both men and women. However, obesity varies much less between men in different income groups, or living in areas of different levels of deprivation.

Obesity is associated with a range of health problems including type 2 diabetes, cardiovascular disease and cancer. The resulting NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year (Foresight 2007).

Ethnic differences exist in the prevalence of obesity and the related risk of ill health. For example, compared with the general population, the prevalence of obesity is lower in men of Bangladeshi and Chinese family origin, whereas it is higher for women of African, Caribbean and Pakistani family origin (as reported in 'Bariatric surgery for obesity' by the former National Obesity Observatory, now Public Health England's obesity knowledge and intelligence team, in 2011).

2.2 Local Context

Across Leeds there is a registered GP population of 860,000 (April 2018 - adults and children). The population of Leeds is ethnically diverse. The prevalence of overweight and obesity amongst adults (18 years and over) in the area with a BMI of above 35 recorded on their **Leeds** GP patient record in Leeds is outlined below, together with co-morbidities recorded.

Patients with a BMI of 35 or more, are aged 18+, and Leeds registered and resident April 2018. (denominator is Leeds registered and resident patients aged 18+ who have a BMI recorded, 9,240 patients with ineligible BMI are excluded)

Patients 18+ with BMI	**Count**	**Population aged 18+ with a recorded BMI**	***% of Leeds 18+ pop with BMI recorded April 2018***
BMI >35	51,448	603,558	8.5%
BMI >40	18,426	603,558	3.1%
BMI >45	6,712	603,558	1.1%
BMI >50	2,558	603,558	0.4%
BMI >55	1,064	603,558	0.2%
BMI >60	492	603,558	0.1%
BMI>70	177	603,558	0.0%

Of the patient cohort with a BMI greater than 35, in April 2018:

- 1944 patients with BMI>35 and COPD
- 2980 patients with BMI>35 and CHD
- 9729 patients with BMI>35 and Diabetes
- 2499 patients with BMI>35 and Cancer

Please note the co-morbidity numbers included are to provide a rough estimation only using Primary Care coding data available/conditions that practices have recorded.

2.2.1 Local Supporting Weight Management Infrastructure

Within NHS Leeds CCG there are 101 GP practices that will be able to refer into the Adult Specialist Weight Management service in addition to Tiers 1 and 2 related weight management services which are provided by One You Leeds and other commercial providers. Tier 4 bariatric surgery for Leeds patients is predominately undertaken by Leeds Teaching Hospitals NHS Trust.

Patients requiring weight management support with Diabetes also have access to Dietetic services provided by Leeds Community Healthcare. Patients at risk of diabetes in Leeds also have access to the National Diabetes Prevention Programme (NDPP) currently provided by Ingeus.

Children requiring weight management interventions aged 5-18, may access the 'Watch It' community based services provided by Leeds Community Healthcare. Programmes include the Healthy Families Programme, Eating Healthy, Getting Active and Staying Happy sessions.

The provider shall be required to work with all supporting weight management providers in Leeds and contribute to any Lifestyles interventions working groups that may be established.

3. Scope

This service specification is not intended to be a detailed operational policy but is aimed at providing clarity for the commissioner and the provider on what the overall expectations are in relation to service, clinical quality and performance requirements. The emphasis is on integration of services and collaboration to optimise patient care.

3.1 Aim and Objectives of the Service

The aim of the service is to provide specialist Tier 3 weight management interventions for people with a body mass index (BMI) of 40kg/m2 or higher, or >35kg/m2 with co-morbidities.

The objectives of the service are to:

a. Provide a clinically led obesity management service (including medical and psychological interventions) for severely obese patients for a period of 12-18 months (this timescale is flexible depending on service model and patient need).
b. Deliver and contribute to local care pathways and protocols supporting an integrated approach to reduce overall levels of obesity, in line with NICE guidance and evidence-based resources.
c. Provide treatment, education and support for patients, addressing contributory lifestyle factors through education and signposting with consideration of individualised and culturally appropriate dietary and physical activity advice.
d. Ensure that all patients are provided with a personalised weight loss programme tailored to meet their own needs with a focus on improving physical, emotional and social functioning.
e. Provide personalised weight management interventions, including Very Low Calorie Diet options (VLCD) under close medical supervision (for suitable patients).
f. Deliver a service that promotes realistic weight loss of between 5% - 10% over the course of the programme.
g. Promote maintenance of weight loss through appropriate pathways and peer support networks.
h. Work closely with other providers involved in the provision of Adult Weight Management Services in Leeds – this shall include referring patients into local mental health services using local knowledge of appropriate referral routes / pathways and healthy eating / cooking and physical activity services.
i. Act as the gateway to specialist morbid obesity surgical services, referring those who meet the criteria for bariatric surgery into specialist services.
j. Provide post-surgery follow-up care and specialist surveillance for a minimum of two years. To provide a co-produced maintenance plan for patients who are exiting the service, whilst providing ongoing support as required at the end of the programme (advice and guidance to patient/GP).
k. Improve knowledge, education and communication about the management of obesity for clinicians, particularly those in primary care.
l. Undertake home visits to patients who are housebound.
m. Reflect on patient feedback to further develop/enhance services.
n. Support the development of new service initiatives in Leeds; for example Low Calorie Liquid diets for newly diagnosed type 2 diabetes patients working with a range of partners.

3.2 Service parameters to inform service model design

- The service will be provided to patients registered permanently or temporarily with a Leeds CCG GP, aged 18 years or over (referred to as Adults in this document) with a body mass index (BMI) of 40kg/m2 or higher, or >35kg/m2

with co-morbidities, who are referred into the service directly from GP or other qualified healthcare professional agreed with the commissioner. Patients should have already engaged with or tried to engage with other recognised weight loss services to reduce their weight or to maintain their weight; this would usually be for a period **of at least 12 weeks** in the last 12 months prior to referral.

- The service will deliver efficient and effective Tier 3 Weight Management interventions and shall also offer a range of tools to support patient's weight loss. Tools might include the use of paper diaries, peer support arrangements and the use of digital technology such as smartphone apps.
- The service will consist of a highly-specialised Multi-Disciplinary team including but not limited to a Consultant Physician or medical practitioner with advanced training in obesity management, Specialist Dietician, Specialist psychiatric support and staff able to provide psychological interventions with a supportive, understanding and motivational style of patient engagement. Access to physical activity specialists should also be considered.
- The main aim of this service must be to reduce the weight of patients referred by 3-5% at 12 weeks and 10% at 6 months – with weight loss sustained for 12-18 months (this timescale is flexible depending on service model) through sustainable behaviour change.
- The health benefits of 10% weight loss include:

- >20% decrease in mortality
- >30% decrease in diabetes related deaths
- 40% decrease in obesity related cancers
- fall of 10 mmHg systolic blood pressure
- fall of 20 mmHg diastolic blood pressure
- 30 – 50% fall in fasting glucose
- 50% fall in risk of diabetes developing
- 15% decrease in HbA1c
- 10% decrease in total cholesterol
- 15% decrease in LDL cholesterol
- 30% decrease in triglycerides
- 8% increase in HDL cholesterol

3.3 Inclusion / Exclusion Criteria

It is anticipated that the majority of referrals will be generated/referred by and then returned to the care of their General Practitioners.

General <u>inclusion</u> criteria – the patient should:

a. Be aged 18 years or over
b. Be registered with a GP in the Leeds CCG area
c. Have a BMI of over 40kg/m2, or between 35kg/m2 - 40kg/m2 with complex co-morbidities in the presence of other significant diseases which would improve with weight loss. Patients with lower BMI but a significant obesity related comorbidity can be referred for a single consultation or discussion with members of the MDT
d. Demonstrate engagement and commitment to lifestyle changes. Patients should usually have already engaged with or tried to engage with other recognised weight loss services to reduce their weight or to maintain their weight; this would usually be for a period **of at least 12 weeks** in the last 12 months prior to onward referral. Patients should be willing to engage with another service and understand this will require further time commitment on their part. Patients referred into Tier 3 who meet the clinical criteria but who have not accessed or engaged with another weight loss service (due to exclusions, for example) should be assessed to determine the suitability of the service for their needs and to assess supporting/alternative services available .

Specific <u>exclusion</u> criteria – the patient should not have:

i. Uncontrolled hypothyroidism
ii. Untreated Cushing's syndrome
iii. Poorly controlled psychiatric disorder
iv. On-going alcohol/drug abuse

3.4 Discharge Planning

A clear exit strategy should be in place, as part of the overall care pathway. The exit strategy should cover those who have completed an intervention/treatment option, chose to leave before completion of an intervention, and for whom the service proves to be inappropriate. A DNA and discharge policy will be in place for the service.

As part of the process, the provider will develop an approach to gain the satisfaction of patients. This will include both those who have completed an intervention/treatment and those who have not.

Once a patient's treatment has been concluded, or at key stages of their pathway, with consent of the patient a discharge summary (content of which to be negotiated between provider and commissioner) will be sent to the patients GP electronically.

3.5 Information Technology Infrastructure

The provider must be able to accept all referrals into the service electronically from Primary Care systems (within Leeds these are EMIS Web and SystmOne) via the NHS E-Referral Service.

The provider must have access to an HSCN compliant connection.

The provider must utilise and access Leeds Care Record ensuring all communication with referrers is electronic.

Providers renting clinical rooms at GP practices (if applicable) must not utilise the practice HSCN connection. However, where the GP practice is HSCN compliant (N3 replacement), providers will be able to apply for a secure and separate part of this line for their own systems use. However, there will be an annual charge for this from the CCG.
The Provider must use their own supplied IT equipment (PCs, laptops, server, printers and scanners).

3.6 Access to Bariatric Surgery

The service will provide a Multi-Disciplinary Team approach in order for patients to be triaged and considered for bariatric surgery. The MDT will assess compliance and appropriateness for surgery for each patient on an individual basis, working in line with NICE Obesity Guidance CG189 and Tier 3 Weight Management Services Commissioning guide by the Royal College of Surgeons and Local Leeds Guidelines. This should include a psychiatric and psychological assessment. The decision to refer patients on for bariatric surgery will be taken by the health professionals who have been involved in the care that particular patient's care plan. The service will also provide input into Tier 4 MDT discussions with the bariatric service provider to discuss the most appropriate bariatric surgery procedure for the patient. Patients approved for bariatric surgery must be offered patient choice with regards to where they are referred for their bariatric surgery procedure. Patients to be referred for consideration of bariatric surgery must be referred in line with the latest NHS Leeds CCG Policy. (This is currently being finalised).

3.7 Collaborative Partnerships

The service will link with all relevant networks and local services, in particular the Local Authority funded community weight management services, and ensure that patients are made aware of local services that are available to them. The Adult Specialist Weight Management Service will work closely and develop joint care pathways with the providers of other stages of the service; this shall include referring patients into local mental health services using local knowledge of appropriate referral routes / pathways.

The service provider may where necessary refer patients into secondary care services for the treatment of obesity-related conditions, such as sleep apnoea. The provider will develop referral pathways with the bariatric surgery providers commissioned by the CCG.

3.8 Medicines Management

The provider will have the required clinical expertise to prescribe appropriate medicines from the Leeds formulary, (found at http://www.leedsformulary.nhs.uk/) and prescribe in line with Leeds Traffic Light Classifications (found at http://nww.lhp.leedsth.nhs.uk/common/guidelines/detail.aspx?id=55) and will comply with the Leeds formulary and Traffic Light Classifications at all times. Where the service remains clinically responsible for the patients, they will be responsible for prescribing costs in line with these classifications.

Note: Non NHS Service Providers who do not have an N3 connection will not be able to access the Traffic Light list. Please contact the Medicines Optimisation Team for a copy at :-lseccg.medicinesoptimisationcommissioning@nhs.net

3.9 Exit Arrangements

The Provider will be required to agree an exit plan with the Commissioner to ensure the smooth transfer of patients to alternative providers in the event of termination by either Party or on expiry of the contract in accordance with General Conditions 18 (GC18).

The plan will include but not limited to the following:

- Removal of the Provider from the e-Referral portal;
- Timescales for seeing, treating and referring patients;
- The offer of a choice of providers to patients, arrange for the transfer or discharge back to the referring GP;
- Transfer of patients notes;
- Response line for queries after closure.

3.10 Data Reporting

Metrics will be agreed as part of the NHS Standard contract.

As a minimum, data returns submitted to the commissioner should include the reason for referral to the service, age, gender, ethnicity and postcode, using standard classification systems wherever possible. Equality monitoring for all patients, including referrals and DNAs where appropriate, should also be recorded and reported quarterly. Equality monitoring should include physical, sensory or learning disabilities.

Data will also be collated as detailed in the National Obesity Observatory Standard Evaluation Framework, Essential Criteria of the Core Elements and made available to the commissioner. Suggested KPI reporting requirements are documented below and will be finalised during contract negotiation following procurement award:

Description	Measure	Reporting
Total number of referrals into the Tier 3 service		Monthly report
Total number of eligible patients seen for an initial assessment within 6 weeks of referral	Minimum 90%	Monthly report of % achievement including activity
Total number of patients who start and complete the programme (attendance at 75% of planned sessions)	Minimum 75%	Monthly report of % achievement including activity
Total number of patients achieving a minimum of 3% (average) body weight loss – 12 weeks after treatment commences	Minimum 65%	Monthly report of % achievement including activity
Total number of patients achieving 5-10% body weight loss – 6 months after treatment commences	Minimum 50%	Monthly report of % achievement including activity
Total number of patients referred onto Tier 4, surgical services	N/A	Monthly report
Total number of patients being managed by the service post-surgery		Monthly report
Percentage of patients reporting overall satisfaction with the service	To be agreed	Patient survey at 6 and 12 months post service commencement.
Patient self-reports of psychological, physical and social well-being - improved quality of life at 6, 9 and 12 months	Standardised self-report measures – EQ-5D, PHQ9, GAD7	Annual report
Improved dietary habits at 6, 9 and 12 months	Increase in fruit and vegetable consumption, reduction in saturated fat consumption	Annual Report
Improved physical activity habits at 6,9 and 12 months	Increase in daily activity undertaken	Annual Report
Improved clinical indicators at 6, 9 and 12 months compared with beginning of programme • Reduction in blood pressure	Collection of data for analysis. Minimum 50% of patients.	Annual Report

Description	Measure	Reporting
Reducing Inequalities Report	Report to compare access to the service and outcomes for women and men of different ethnicities and for women and men of different socio economic status. Report should evidence data collection, identification of inequalities, action plan development and action plan implementation.	Annual Report
• Blood glucose levels (HbA1c for diabetic patients) • Changes in medications		

4. Applicable Service Standards

4.1 Applicable National Standards

The National Institute for Health and Care Excellence (NICE) has a suite of guidance on obesity including the following:

- The Current Landscape of Obesity Services – a report from the All-Party Parliamentary Group on Obesity (May 2018)
- Maintaining a healthy weight and preventing excess weight gain among adults and children (2015)
- Obesity: identification, assessment and management of overweight and obesity in children, young people and adults (2014)
- Weight management before, during and after pregnancy
- Obesity – working with local communities
- Body mass index and waist circumference thresholds for intervening to prevent ill health among black, Asian and other minority ethnic groups
- Physical activity: brief advice for adults in primary care
- Behaviour change – individual approaches
- Managing overweight and obesity in adults – lifestyle weight management services

Resources are provided by:

- Royal College of Surgeons Commissioning Guide: Weight Assessment and Management Clinics
- Fair society, healthy lives: strategic review of health The Marmot Review 2010
- The National Obesity Observatory National Obesity Forum

5. Premises and Hours of Operation

5.1 Location(s) of service delivery

- The service shall be delivered from two or more appropriate local venues across Leeds – this might include local hospital/health centre locations. Consideration should be given to areas of Leeds where rates of obesity are the highest.
- The provider will source and provide a choice of locations where patients can choose to be seen in community locations, (GP practice, voluntary organisations, community service or other location) and will offer flexibility in terms of appointment times. Venues will be identified and paid for by the service provider in suitable premises that are compliant with the Disability Discrimination Act. The Commissioner reserves the right to visit premises and to gain assurance that the quality of the environment is suitable.
- The provider may also consider the delivery of appointments via non-traditional face-to-face routes; i.e. via online consultation. Other formats of delivery may be beneficial.
- The Provider will ensure that the venues are readily accessible and appropriate for the patient and potential patients including:
    - Geographically accessible for patients arriving by public transport, by car and on foot
    - Structurally and physically accessible, including:

- Meeting the needs of patients who are defined as being obese (e.g. grab chairs, specialist bariatric scales capable of weighing up to 300kg, large blood pressure cuffs, etc.).
- Providing sufficient space to enable 1:1 sessions and/or groups sessions as may be appropriate to the service
- Providing a private discrete area to enable personal measurements to be taken
- Providing facilities which are suitable for the delivery of the services and compliant with regulatory requirements

The Provider will be responsible for undertaking any location/venue risk assessments.

5.2 Days / Hours of Operation

The provider will ensure the service will be available during daytime hours with sufficient clinics to meet national referral to treatment waiting time criteria (maximum of 18 weeks). Opening times and days will be flexible and responsive to local need to meet demand. Flexible opening should also be considered such as evenings and weekends if there is sufficient local demand.

6. Applicable Contractual Requirements – (quality ,incentives, information and reporting).

6.1 Applicable Quality and Incentive Scheme Requirements (See Schedule 4A-E)
6.2 **Applicable Reporting and Information Requirements (See Schedule 6**

Location of Premises

The providers premises are located at: