SCEHDULE 2 – THE SERVICES

A. Service Specifications (B1)

Service Specification No.	**V8 Final**
Service	**Tier 3 Weight Management**
Commissioner Lead	**Calderdale CCG**
Provider Lead	
Period	**18 months: Jan 2017 – June 2018**
Date of Review	**6 months following contract award; ie June 2016**

1. PURPOSE

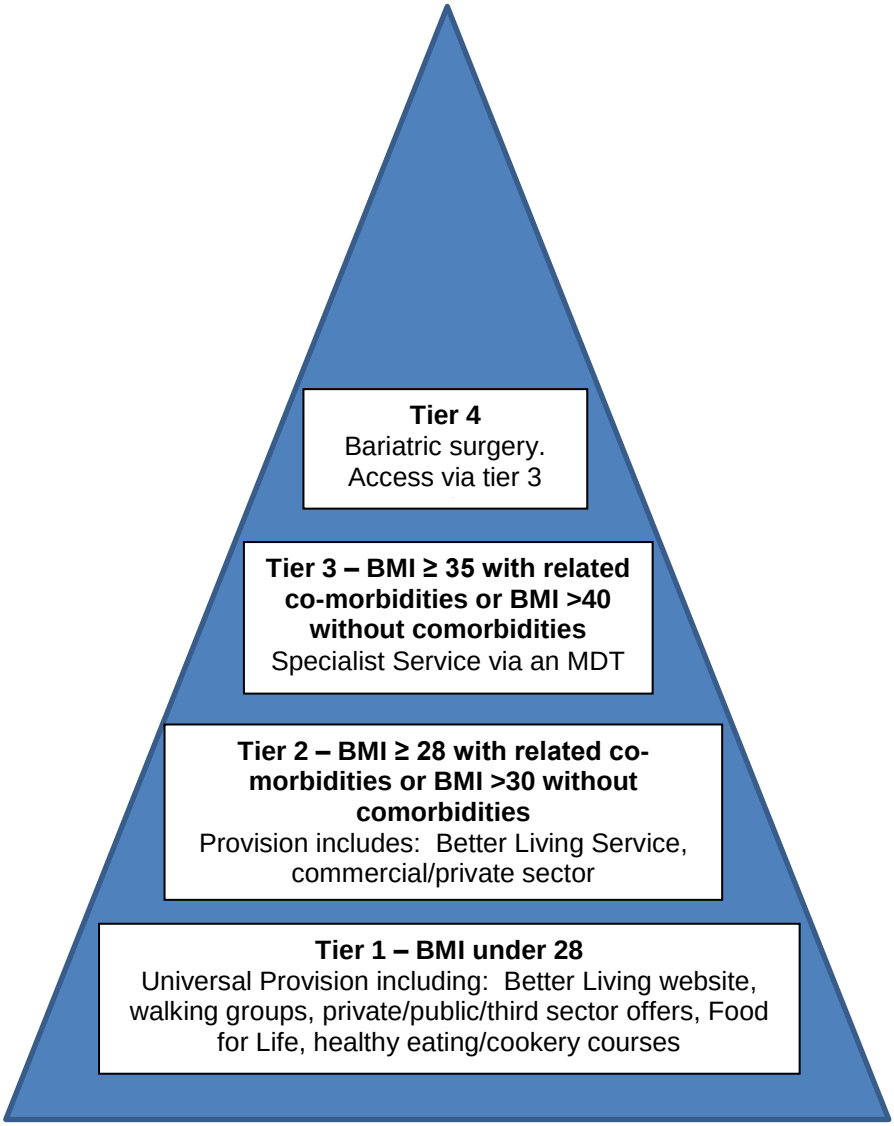
The Care Closer to Home (CCTH) approach provides a blue print for earlier intervention, prevention, greater independence and wellbeing for patients through community and primary care services. This vision is an inherent part of the design and delivery of the weight management pathway, reflecting the aim to integrate and join up primary, community and secondary care provision for the benefits of patients. This vision is crucial in the development of a safe and effective weight management pathway, and supports the national direction of travel in terms of integration, earlier intervention, prevention, patient choice and jointly agreed shared care plans. Although the CCG did not commission Tier 3 weight management services when the mapping of services to CCTH was completed this does not mean that this service should not align itself with the CCTH vision and approach to providing services as outlined above.

Currently more than half of the population is overweight or obese. In 2014, 58% of women and 65% of men were overweight or obese. Obesity prevalence has increased from 15% in 1993 to 26% in 2014 (HSCIC April 2016). The Public Health Outcomes Framework records excess weight in adults for 2012-14 for Calderdale at 65.2% which is favourable when compared to 67.1% recorded for Yorkshire & Humber but less so when compared to England at 64.6%. Further the percentage of obese adults is 26.5% which is the same as the region but worse than England at 24%. (Active People's Survey 2012-14). Practices in Calderdale have recorded 13,349 patients with a BMI >35. Needs analysis by Public Health suggests that demand for the Tier 3 service in year 1 could be 37 patients rising to 111 patients by year 3 and 160 patients by year 5.

The NHS reforms that resulted from the Health and Social Care Act (2012) resulted in the responsibility for commissioning/providing weight management being split between three organisations; Local Authorities (Public Health) for tiers 1 and 2, Clinical Commissioning Groups (CCGs) tier 3 and NHS England tier 4. Commissioning of tier 4 will become the responsibility of CCGs in April 2016. In Calderdale we are taking this opportunity to align priorities and take a system wide approach to the issue of obesity. Weight management is a highly complex issue requiring a multitude of approaches. In Calderdale we have taken a co-ordinated approach to tackling the issue of obesity at tiers 1 and 2 through the Better Living Service and associated Better Living Movement.

This specification outlines the requirements for the provision of a safe and effective Tier 3 service leading to a high quality, person-centred weight management service for adults aged 16+ years who meet the service entry criteria and are registered with a GP Practice in Calderdale.

It specifically relates to the implementation of a Tier 3 multi-disciplinary team (MDT) providing specialised support in line with relevant best practice guidance and the current best available evidence base. It outlines clearly how the weight management pathway integrates with existing Tiers 1, 2 and 4 services; as shown in the following diagram:



2. EXPECTED OUTCOMES

2.1 LOCALLY DEFINED OUTCOMES

Outputs

- Clients are able to sustain behaviour change and improve lifestyle choices in relation to their weight
- Quality of life for clients is improved
- Nutritional intake/knowledge is improved
- Amount of physical activity undertaken during an average week is increased
- Priority groups are engaged and supported to manage weight
- Reduced prescribing of anti-obesity drugs

Outcomes

- Making every contact count through earlier identification and referral for services
- Equitable access to specialist weight management services for the registered population of Calderdale
- Support a reduction in the prevalence of obesity in adults in Calderdale
- Support an improvement in the management of long term conditions associated with obesity e.g. diabetes
- Support long term positive weight reduction and health improvement outcomes for clients whose intention is or is not to undergo bariatric surgery, but who participate in the tier 3 weight management

3. SCOPE

3.1 AIMS AND OBJECTIVES OF THE SERVICE

The purpose of this document is to provide an outcome-based service specification for the delivery of a safe and effective tier 3 weight management service which delivers appropriate and effective interventions to morbidly obese individuals registered with a GP in Calderdale. By improving the management and monitoring of this patient group, the Tier 3 Weight Management Service aims to support participants in leading active lives in the community and avoiding unnecessary hospital based treatment or admission; therefore reducing dependency on hospital based services and ensuring care is delivered closer to home.

The service will ensure:

- Clients understand their condition and are encouraged to self-manage to improve their own outcomes through the design of a personalised programme which promotes long term and sustainable behaviour change including effective education, support, intervention and promotion of self-care
- Patients are managed within the appropriate tier of service and only referred to Tier 3 MDT or Tier 4 bariatric surgery when there is a specific need for assessment or intervention
- Quick and timely access and effective intervention for all clients
- The management, assessment, care and treatment for patients presenting with weight management issues are provided in accordance with NICE guidelines
- The service is cost effective but does not compromise client's needs, maximises value for money and remains within the allocated budget aligned to performance indicators, efficiency targets and financial outcomes, comparable to the best performing CCGs in the country and directly accountable to Calderdale commissioners
- The service will improve the health outcomes for people diagnosed with co-morbidities including type 2 diabetes, hypertension, cardiovascular disease, osteoarthritis, fatty liver disease, gallstones, gastro-oesophageal reflux disease and depression
- To provide specialist support, guidance and interventions tailored to individual needs, following a comprehensive assessment process
- Assess suitability for bariatric surgery for individuals referred who wish to undergo surgical intervention and meet the necessary referral criteria
- Offer a comprehensive weight management intervention for those individuals who do not wish/are unable to undergo bariatric surgery, but meet the referral criteria for the service.
- Provide advice, consultation and intervention to support change and long term weight reduction
- Investigate the causes of each clients' weight gain
- Determine any psychological/physiological reasons for weight gain
- Provide specialist treatment, care and advice appropriate to the clients' needs and in line with clinical guidance

3.2 SERVICE DESCRIPTION/CARE PATHWAY

The provider will ensure the key roles are provided to deliver the service outlined below and achieve the service standards and outcomes.

Service Description – Tier 3 MDT

- Referrals for adults aged 16+ years with a BMI ≥35 with related co-morbidities or individuals with a BMI >40 if no co-morbidities are present; occasionally a patient may be referred whose BMI is below these thresholds if they have exceeded the thresholds in the past
- Referrals in pregnancy should refer to pre-pregnancy BMI or BMI at the start of pregnancy;
- Specialist services via an MDT including: bariatric physician, dietician, specialist nurse, clinical psychologist, , liaison psychiatry professional and access to a physical activity specialist (further support may be required on a case by case basis from a physical therapist, occupational therapist, endocrinologist and potentially other health professionals; it should be noted that this level of support/intervention is outside the scope of this service specification and will be through the standard NHS contract, however the Tier 3 MDT is expected to liaise with other relevant health/social care service provision);
- The MDT will be required to work closely together and convene weekly meetings to discuss the caseload. These meetings can be virtual, although it would be expected that members of the MDT would meet in person once per month;
- Interventions will be tailored to meet individual need/circumstances within the remit and resource of

the Tier 3 service offer;
- There will be clear service elements that cater for clients/patients who wish to proceed to surgery, those who do not and those who are undecided;
- Tier 3 services are part of an integrated pathway and as such link back to Tier 2 and upwards to Tier 4; the following must be considered prior to referral to Tier 3:
    - Discuss tier 2 services/previous weight loss attempts;
    - Assess capacity/willingness to engage;
    - Long history of dieting/yo-yo dieting may require direct tier 3 service;
    - Highlight/assess risk of tier 4 (surgery but also non-surgical) – eg risk to health, not an easy option;
- Direct access to tier 3 may be appropriate:
    - Potential benefits for obese patients with type 2 diabetes for direct referral to tier 3 or 4;
    - Use of lower BMI threshold for black African, African-Caribbean and Asian (South Asian and Chinese) when type 2 diabetes is indicated, dependent on a previous tier 2 attempt(s);
    - Where there are associated comorbidities and overall patient management indicates as appropriate.

Assessment and Intervention
- GPs will refer to Tier 3 services according to the referral criteria; ;
- Timely, convenient and personalised service based on joint decision-making and agreeing shared goals. Care and treatment options must be tailored to the patient's wishes and preferences. When a patient lacks the mental capacity to make a decision about entering a programme, or any other decisions during the programme, healthcare professionals should be able to evidence this with a mental capacity assessment, make a best interest decision and follow guidance from the Mental Capacity Act Code of Practice.
- Treating patients at the most appropriate location, close to the patient's home within 4 weeks from referral;
- There will be an intensive phase to the intervention for a duration of approximately 12 weeks where the client/patient has contact with the service at least weekly (method of contact is for determination by the MDT). There should then be a follow-up period of not less than 18 months. The service should innovate in how it accomplishes this and it must be tailored to individual need**;**
- Capture and record the information within the patient's clinical record.

Process
- Effective integrated weight management pathway for obese individuals;
- Effective tier 3 multi-disciplinary, community based service offer for Calderdale patients;
- Referrals to tier 4 bariatric services as appropriate, following assessment and intervention at tier 3 or for people with a BMI >= 40;
- Implement a programme to drive continuous improvement e.g. audit;
- Clients are supported to manage their weight and are able to sustain behaviour change in relation to their weight;
- Contribute to the development of a fully integrated approach to Health and Wellbeing in Calderdale.

Outputs
- Clients are retained in a programme of a minimum of 24 weeks and up to 104 weeks;
- Clients achieve and sustain a minimum of 5% weight loss at 12 weeks, continuing to a weight loss of 7% by 6 month follow up;
- Clients are supported to reduce weight through development of skills and knowledge, improve outcomes and prevent further weight gain.

Discharge
Where patients are referred for tier 3 services discharge information will be provided to GPs.

3.3 ACCESSIBILITY

The service will have systems and policies in place to ensure it is responsive to the individual needs of its service users including all protected characteristic groups and demonstrates it makes all reasonable adjustments to ensure all aspect of services are accessible, appropriate and flexible, in accordance with the Equality Act 2010. The provider will actively gather patient/carer experience data, including equality data, from each patient using the service.

Referrals for adults aged 16+ years with a BMI ≥35 with related co-morbidities or individuals with a BMI >40 if no co-morbidities are present.

Following assessment by their GP patients will be referred for services appropriate to their need and based on previous interventions undertaken, including outcomes from attendance and engagement in Tier 2.

3.4 INTERDEPENDENCIES

The weight management pathway will have links with the following:

- Primary care services
- Secondary care services – bariatric surgery including post bariatric surgery support
- Community services – related to any co-morbidities
- Public Health – NHS Health Check, Better Living Service (Tiers 1 and 2) and Staying Well programmes
- Other specialist services as required – eg stop smoking, alcohol, mental health services
- Care Closer to Home

4. APPLICABLE SERVICE STANDARDS

Applicable National Standards
Royal College of Surgeons – Commissioning Guide: weight assessment and management clinics (tier 3) (March 2014)

The following NICE clinical guidance and quality standards describe the high-quality care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for people:

NICE Clinical Guidance 189: obesity: identification, assessment and management of overweight and obesity in children, young people and adults (November 2014); CG189 partially updates previous CG43.
https://www.nice.org.uk/guidance/cg189

5. APPLICABLE QUALITY REQUIREMENTS AND CQUIN GOALS

The Provider(s) will be expected to meet the essential standards of quality and safety set out by the Care Quality Commission (or any successor organisation) on its website at:
http://www.cqc.org.uk/content/regulations-service-providers-and-managers

This specification is in line with the Care Closer to Home specification and as such the provider will be expected to comply with the requirements of Infection Prevention and Control, Medication and Prescribing, reporting of incidents and serious incidents and the collection of patient and carer experience.

In addition, the provider will comply with the Calderdale CCG safeguarding standards relevant to the organisation. The provider will ensure that all staff receives the appropriate level of safeguarding training every 3 years. The provider will have an organisational safeguarding policy which references and complies with the West and North Yorkshire adult safeguarding policy and procedures.

The Tier 3 weight management service will provide an enhancement to existing services and ensure integration with existing Tiers at 1, 2 and 4.

6. KEY PERFORMANCE INDICATORS - QUALITY, PERFORMANCE & PRODUCTIVITY

The provider will put in place quarterly reporting against the Key Performance Indicators outlined below. The baseline will be set using Public Health modelling of demand/prevalence and the first quarter of the service will be set as the baseline as this is a new service and no previous baseline exists. The reporting will include service monitoring outcomes and patient satisfaction through use of a patient questionnaire.

KPIs

Information to be presented quarterly and to include: age, ethnicity, demography, and pregnant women

Measure	Threshold
• Number of referrals	

• Waiting time to receipt of service from referral	• 80% of patients seen within waiting time
• Retention/completion outcome including referrals to Tier 4 or Tier 2	• 60% of patients complete
• Patient outcomes including increased activity, weight reduction, improved diet	
• %of participants losing 5% bodyweight at 12 weeks	• 33% of patients
• %of participants losing 7% bodyweight at 6 months	
• Number of patients who request referral for bariatric surgery on completion of Tier 3	
• % improvement in mental wellbeing as measured by "validated tool" (to be agreed with the provider) at each measurement point	
• Patient satisfaction detailing experience, outcomes against goals set and evidence of increased knowledge, improved lifestyle and behaviour changes (quality of life)	

7. PRICES AND COSTS

Based on the Public Health modelling and a price per case of £800 the cost of providing this service will be:

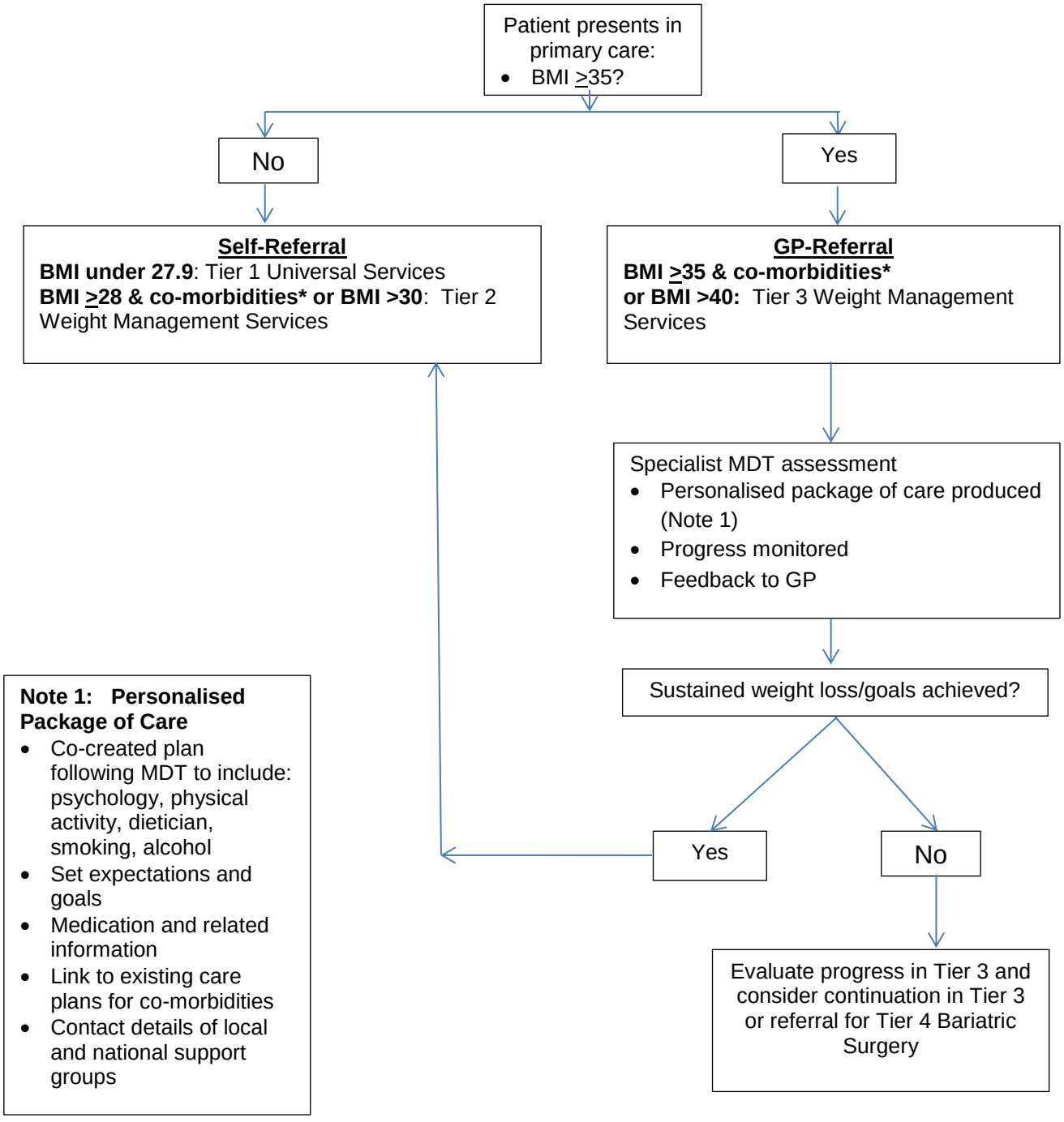
Year 1:
2017: 6 months 30 cases = **£24,000**

Year 2:
2017-18: Year 2 - 60 cases = **£48,000**

Total: 90 cases @£800 = **£72,000**

APPENDIX 1: Pathways

TIER 3 WEIGHT MANAGEMENT PATHWAY



Note 1: Personalised Package of Care

- Co-created plan following MDT to include: psychology, physical activity, dietician, smoking, alcohol
- Set expectations and goals
- Medication and related information
- Link to existing care plans for co-morbidities
- Contact details of local and national support groups

*Co-morbidities including: Type II Diabetes, Hypertension, Fatty Liver Disease, established Cardiovascular Disease, Osteoarthritis, Dyslipidaemia, Sleep Apnoea