# SCHEDULE 2 – THE SERVICES

## A. Service Specifications

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| **Service Specification No.** | 02/GMS/0033 |
| **Service** | Tier 3 Weight Management Programme |
| **Commissioner Lead** | Long Term Conditions, Frail Elderly and End of Life |
| **Provider Lead** | Spire Hospital Southampton |
| **Period** | 1ST April 2016 |
| **Date of Review** | |

## 1. Population Needs

### 1.1 National/local context and evidence base

**Background**
NHS England Policy: Complex and Specialised Obesity Surgery outlines the model of care for managing obesity as follows:

Tier 1 – Primary care with community advice.
Tier 2 – Primary care with community interventions.
Tier 3 – A community/primary care based multi-disciplinary team (MDT) to provide an intensive level of input to patients.
Tier 4 - Specialist obesity services including surgery.

**Evidence**
The prevalence of obesity in England is one of the highest in the European Union and in 2010 just over a quarter of adults were classified as obese (Body Mass Index (BMI) 30kg/m2 or over). Obesity is associated with many different illnesses including:

- type 2 diabetes
- cardiovascular disease and stroke
- obstructive sleep apnoea
- some forms of cancers e.g. bowel
- degenerative joint disease
- psychological problems (DH, 2003)

Healthy Lives, Healthy People - a call to action on Obesity in England (2011) states that action is essential because of the risk it poses to people's health, its impact on their lives and the lives of their families, and its impact on the NHS and economy as a whole

NICE Guidance CG43 on Management of Obesity recommends that patients should have access to a comprehensive care pathway offering multi-disciplinary support to patients who have failed to achieve their weight loss goals through primary care intervention.

NICE also states that surgery to aid weigh reduction for adults with morbid/severe obesity should be considered when there is recent and comprehensive evidence that an individual has fully engaged in a structure weight loss programme to increase the effectiveness of interventions to prevent overweight and obesity

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

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| **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

The expected outcomes of this service will be:

- Patients achieve weight loss over a 6 month period as part of working towards long term goals:
  - BMI <50 - 90% will achieve 3-5% weight loss
  - BMI >50 - 98% will plateau with no weigh gain as a minimum
- Patients will maintain and sustain weight loss (with post discharge monitoring at 6 months from end of treatment).
- Patient's self-esteem and self-confidence/self-efficacy is enhanced (measured through a validated tool).
- Patients will be empowered to ultimately self-manage their weight maintenance goals.
- Referrals for bariatric surgery assessment will be appropriate leading to improved outcomes.

Patients referred to this service may have a range of co-morbidities and key outcomes in addition to weight loss which are:

- Improved diabetes care and reduced complications.
- Improvements in co-morbidities associated with morbid obesity and reduced treatment costs.

## 3. Scope

### 3.1 Aims and objectives of service

**Aim**

The aim of the Tier 3 WMP is to:

- Support patients to make long-term lifestyle changes to manage their weight, improve their health status and their quality of life.
- Provide expert advice and recommendations for each patient to inform the pathway to bariatric surgery.
- Improve the pre-operative preparation and outcomes for those patients who are considered appropriate for bariatric surgery.

**Objectives**

The objectives of the Tier 3 WMP are to:

- provide a single point of access to a multi-disciplinary team ;
- provide assessment and treatment in accordance with NICE guidance;
- provide a time-limited (6 months) weight management treatment programme through a combination of approaches for all patients assessed as suitable;
- support patients with severe difficulties or complex needs relating to their weight, to make appropriate lifestyle changes to lose weight and maintain weight loss;
- provide further assessment by specialist psychologist and/or consultant physician if required;
- empower patients to ultimately self-manage their weight maintenance goals including

sign-posting to relevant local services e.g. Dorset LiveWell;
- provide an outcome report for each patient on completion of the programme and recommendations on future management and appropriateness for onward referral for bariatric surgery assessment;
- offer a flexible model of care, located in one or more accessible locations to provide care closer to home for patients where possible;
- collect, collate and report data for this service to the commissioner;
- contribute to the continuous improvement of the service, including proposals to improve quality, efficiency and outcomes;
- develop and maintain effective working relationships with other service providers within the weight management care pathway;
- work with primary care colleagues to support them to provide appropriate information about weight management treatment;
- work with the commissioner, primary care and other stakeholders, to agree and review treatment and referral protocols and pathways.

### 3.2 Service description/care pathway

**Service Description**
The Tier 3 WMP will provide an intensive level of support to morbidly obese patients through a multi-disciplinary team of experts incorporating health screening and assessment, motivation and change therapies, nutrition and cooking advice, physical activity and general health education.

The multi-disciplinary team will include:
- Weight Loss Nurses & Healthcare Assistants (weight loss support workers)
- Dieticians
- Physical Activity Specialists
- Psychological Therapists
- Specialist GPs
- Endocrinologist
- Other specialists as necessary

The service will provide an individualised six month programme, tailored to individuals' needs and incorporates the required elements of the interventions available. This tailored programme will fully support patients to stabilise weight gain but preferably achieve a weight loss of at least 3-5 % of their excess body weight and help patients sustain this over the years ahead. The programme will also assist patients in meeting their personal health improvement goals and supporting them in making vital lifestyle changes.

The programme will include an initial one-hour assessment with a weight loss support worker to explore the patient's current health status, previous experience of attempting to lose weight and a range of lifestyle factors. The specialist weight loss support worker will identify a weight loss target which is appropriate and realistic for the individual and plan a six month programme to achieve this.

An example programme is likely to include:
- Initial assessment with a weight loss support worker.
- Monthly check up with your weight loss support worker (to discuss your progress, help sort out any difficulties and weigh you)
- 3 'motivation and change therapy' sessions.
- At least 6 facilitated physical activity sessions.
- Attendance at a 'cook and eat' session.
- Attendance at support group sessions.
- Final assessment with your weight loss support worker.

All patients will be given a pedometer when they attend their initial assessment and advised to wear this daily to monitor their step count.

Some patients with specific health conditions may be required to see specialist dieticians, GP or other qualified professionals.

All patients will be offered access to psychological treatment and support and will be encouraged to access the self help and support groups and resources available.

Attendance and motivation will be monitored closely by the expert team. All patients will be required to attend **ALL** sessions that are deemed necessary to achieve the programme goals. Failure to do this may result in discharge from the service, back to the GP, ceasing the patient's progress along the local weight management pathway.

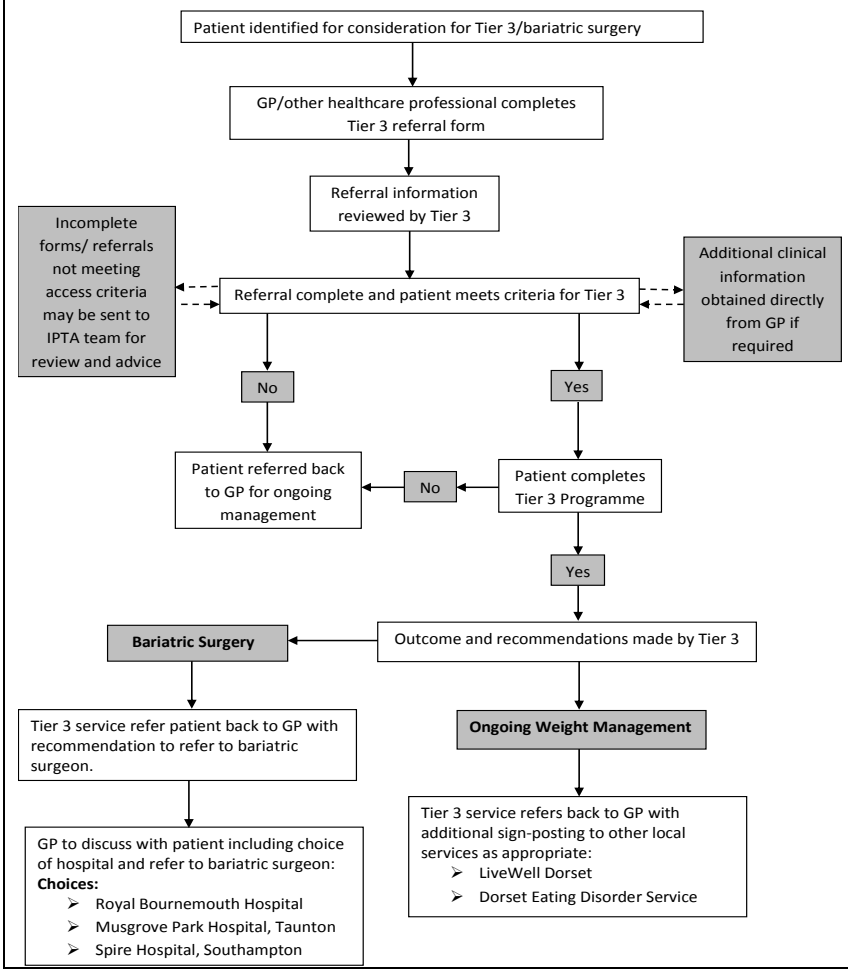
**Location of services**
The service will be hosted by Spire Hospital Southampton with out-reach clinics in locations across Dorset to provide care as close to home as possible for patients.

Patients may receive contact by email/post and phone in addition face to face sessions.

**Transport**
The Tier 3 WMP will book and take responsibility for transport if required for patients who meet NHS patient transport eligibility criteria.

The Tier 3 WMP will provide patients with information about the NHS Hospital Travel Cost Scheme if applicable:
www.**nhs**.uk/**NHS**England/Health**costs**/Pages/**Travelcosts**.aspx

**Tier 3 Weight Management Care Pathway**



### 3.3 Any acceptance and exclusion criteria and thresholds

**Referral process**
Referral to the Tier 3 WMP will be made either by the GP or other appropriate Health Care professional supported by the patients GP using the agreed Dorset CCG referral form **Appendix 1**.

On receipt of a referral the Tier 3 service will review the referral information against the Dorset CCG access criteria.

Tier 3 will liaise directly with the referrer to obtain any further clinical information if required.

Incomplete referrals may be shared with Dorset IPT Team for review and discussion with the patient's GP if appropriate.

Referrals that do not meet the access criteria will be returned to the referrer giving reasons for the non-acceptance of the patient into the weight management service at that time and include suggested/appropriate course of action/support.

Patients who do not meet the referral criteria may be referred to the Dorset IPTA team to consider approval for the Tier 3 WMP on exceptional grounds.

**Referral Criteria**
The service will offer access to adults aged 16 years and over who are registered with Dorset CCG GPs.

Patients will be referred to Tier 3 WMP in line with Dorset CCG Criteria Based Access Protocol (CBAP) **Appendix 2**.

All patients referred for consideration for Tier 3 WMP must meet the NICE guidance for bariatric surgery:

- BMI of >35, in the presence of diabetes and/or other significant co-morbid conditions;
- BMI >40 without the presence of diabetes and/or other significant co-morbid conditions.

Patients will only be considered for referral to Tier 3 WMP if evidence is presented to demonstrate:

- sustained and co-ordinated Tier 1 and 2 community interventions have been tried and failed.
- the patient understands the aims and limitations of treatment, and what treatment involves and be willing to commit to the programme.

**Clinical Exclusions:**

- Any patient with serious uncontrolled disease, e.g. angina, asthma, COPD, heart failure, aortic stenosis.
- Recent complicated myocardial infarction and/or awaiting further investigation.
- Uncontrolled arrhythmia that compromises cardiac function.
- Blood pressure at rest above 180mg Systolic, 120mg Diastolic.
- Patients with an unstable psychiatric disorder or a clearly defined eating disorder e.g. bulimia nervosa or binge eating disorder.
- Acute infection

**Discharge Process**
On completion of the programme the Tier 3 WMP will provide an outcome report to the patient's GP and recommendations regarding future weight management and suitability for referral to Tier 4 services for bariatric surgery assessment. A copy of this report will be sent to the patient and other relevant health care professional as appropriate.

It will be the responsibility of the GP to make a referral for bariatric surgery assessment following discussion with the patient including offering the patient a choice of hospital provider.

Patients who have not fully complied with the Tier 3 Programme will be referred back to their GP for on-going weight management in primary care.

On completion of the programme, patients will routinely be sign-posted to local services in Dorset to support them to maintain and continue their weight loss goals.

**Patient and Carer information**
The service will support patients with information about their treatment and other related issues.

The service will provide clear patient centred information, to make patients aware of what will happen to them during the investigation/procedure and enable the patient to make informed decisions.

The service will provide appropriate assistance for patients who do not speak, read or write English or who have communication difficulties (e.g. hearing, oral or learning disabilities);

Service user views will be a central part of the outcomes monitoring process.

### 3.4 Interdependence with other services/providers

The service will ensure close working relationships with all relevant stakeholders to attain optimum outcomes, address the needs of individual patients and maximise the use of service resources. This will include:

- GP practices
- Dorset Individual Patient Treatment Requests Team
- Nurse specialists
- Dieticians
- Psychologists
- Mental health services including the Eating Disorders Service
- Physiotherapists
- Bariatric Surgery Service Providers
- LiveWell Dorset
- My Health My Way
- Services concerned with the treatment of medical complications of morbid obesity:
  - Cardiovascular services, including hypertension, dyslipidaemia and cardiac rehabilitation services
  - Respiratory services, including asthma, sleep apnoea and chronic obstructive pulmonary disease services
  - Endocrinology services, including services for diabetes and polycystic ovarian syndrome
- Dorset CCG
- NHS England
- Local Authority Social Services Departments
- Patient Transport Services
- Patient Forums

**Relevant networks and screening programmes**.
The provider will contribute to any relevant network of weight management service providers locally and in the wider region.

The provider will develop links with, and inform patients about, relevant clinical and patient support networks and groups. Whilst not part of the service, the WMS will identify and encourage patients to join local patient support group(s) for those with morbid obesity, if appropriate/available.

## 4. Service

### 4.1 Applicable national standards (eg NICE)

- NICE CG 43: 'Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children' (2006).
- Department of Health 'Healthy Lives Healthy People - a call to action on Obesity in England' (DH , 2011).
- National Commissioning Board Policy A5: 'Complex and Specialist Obesity Surgery' December 2012.
- National Commissioning Board Service Specification A5: Severe and Complex Obesity.

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

### 4.3 Applicable local standards

- Dorset CCG Access Criteria for Tier 3 Weight Management Programme
- Dorset CCG Policy for Individual Patient Treatments (April 2012)

http://www.dorset.nhs.uk/yourhealth/making-sense-of-local-treatment-policies.htm

## 5. Applicable quality requirements and CQUIN goals

### 5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

### 5.2 Applicable CQUIN goals (See Schedule 4 Part E)

## 6. Location of Provider Premises

**The Provider's Premises are located at:**

**Spire Hospital Southampton, Chaleybeate Close, Southampton SO16 6UY**

## 7. Individual Service User Placement