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.	BL/BTH/82
Service	Specialist Weight Management Service
Commissioner Lead	Ben Tulloch
Provider Lead	Nick Lane
Period	(to be confirmed)
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Obesity is a major public health problem. 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 per year in England. (Ref: Healthy Weight, Healthy lives: a cross-government strategy For England, 2008).

The number of obese people in the UK has trebled in the last 20 years, with one in four men and one in five women now obese. Government predictions have suggested a rise in the levels of obesity in the future, such that by 2025 among 21 to 60 year olds, almost a half of men and over a third of women are predicted to be obese. It claimed the cost of obesity to the economy overall is around £16bn a year, and likely to rise to £50bn a year if left unchecked. Costs to the NHS, currently £4.2bn a year, are predicted to more than double by 2050.

In 2007, 24% of adults (aged 16 or over) in England are classified as obese (BMI 30 kg/m^2 or over); an overall increase from 15% in 1993

Men and women are equally likely to be obese, however men were more likely than women (41% compared to 32%) to be overweight (BMI 25 to less than 30 kg/m^2)

Thirty-seven per cent of adults had a raised waist circumference (over 88cm in women, over 102 cm in men) in 2007 compared to 23% in 1993. Women were more likely than men (41% and 33% respectively) to have a raised waist circumference.

Using both BMI and waist circumference to assess risk of health problems, for men: 19% were estimated to be at increased risk; 13% at high risk and 21% at very high risk. Equivalent figures for women were: 15% at increased risk; 16% at high risk and 23% at very high risk. (Ref: Statistics on obesity, physical activity and diet: England. The Health and Social Care Information Centre. 25th February 2009)

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

3. Scope

3.1 Aims and objectives of service

3.1.1. Aims:

The aim of the service is to support patients through a local specialist obesity service (Tier 3), as required prior to consideration for bariatric surgery or as part of the Lancashire wide weight management pathway. This will be in a community setting or at home to maintain a healthy diet and lifestyle. The key components of the service are set out in the criteria for the specialist weight management service as follows:

- Improve weight or other measures of obesity
- Improve physical health and management of co-morbidities
- Improve nutrition
- Improve physical activity
- Improve self-esteem and psychological health
- Improve overall quality of life
- Identify appropriate candidates for bariatric surgery

3.1.2. Objectives:

- To provide a quality service meeting National Targets and local need.
- To meet the individual needs of patients following assessment.
- To determine individual health and health care needs in an obese individual by a multidisciplinary assessment
- To improve outcomes of eligible individuals who are referred to the service and who often have significant co-morbidities that require diagnosis and clinical management including appropriate medical treatments.
- To motivate, empower and support individuals to make and sustain healthy lifestyle changes which result in weight loss.
- Support the prescribing of anti-obesity drugs.
- Ensure patients progress through appropriate assessment and treatment prior to referral for bariatric surgery
- To meet the requirements of the CCG for patients referred for bariatric surgery, in line with the pre surgery requirements of the collaborative commissioning service specification for bariatric surgery.
- Develop services closer to homeworking flexibly to meet the needs of service users where practical.

3.2 Service description/care pathway

To provide a range of weight management interventions and support, including 1:1, group sessions, and pre-bariatric engagement for those patients identified as needing weight management. To be revised and in-line with the National Commissioning Board contract for weight loss surgery.

The provider of a local specialist obesity service shall assess patients, develop personal plans and targets and provide access to a range of evidence based interventions for the specialist management of morbidly obese adults. The range of professionals in a local specialist service will include the following:

- Specialist medical lead with evidence of relevant post graduate experience/training in this field
- Dietitian with evidence of relevant post graduate experience/training in this field
- Psychology practitioners with evidence of relevant post graduate experience/training in this field
- Identified clinical staff with the ability to independently prescribe appropriate medication Occupational Therapists with experience of relevant post graduate experience/training in this field
- Physiotherapist with evidence of relevant post graduate experience/training in this field.

On confirmation of suitability to enter the full programme, an MDT assessment should comprise the clinical, psychological, lifestyle and nutritional elements for each client. The assessment should cover:

- Medical obesity related problems and medication
- Presenting symptoms and signs
- Eating behaviour and dietary patterns
- Psychological problems and psychological distress
- Social and family factors, including personal and family history of obesity and related co-morbidities
- Willingness and motivation to change
- Potential of weight loss to improve health

The MDT assessment should provide a proposed individualised treatment plan which provides a range of interventions appropriate to individual needs. The resulting action plan should detail the programme for the patient. The plan should include weight loss goals, dietary goals, physical activity plan and behaviour motivation objectives. The plan should inform a patient held record of progress.

It is recognised that the model of local specialised obesity services will vary, however the key elements of a local specialised obesity service are as follows:

- Appropriate Clinical Leadership from either a Medical Consultant or GP with Special Interest clinical
- An MDT comprising Medical, Dietetic, Psychology and Occupational Therapy professional input that is specialist, dedicated and appropriately resourced to meet service need.
- A system of governance that ensures a good, effective, safe and integrated service that optimises outcomes.
- Utilisation of a chronic, long term disease model for follow up and surveillance following weight loss surgery.
- Provides post graduate training and education for junior doctors, nurses, dietitians, psychologist, therapists in a primary and secondary care setting as needed to enhance the service delivery.

- Engages with appropriate local, regional and national networks to provide CPD opportunities for staff and respond to best practice guidelines.
- The undertaking of service evaluation and audit.
- Planning and organisation of in partnership with relevant stakeholders of events that are pathway oriented.
- Undertakes consultant referrals to other specialities for the management of co-morbidities e.g. sleep services, cardiology, respiratory etc
- Undertakes pre-bariatric assessments, education, preparation and referral to identified surgical providers
- Assessment, investigation and management of co-morbidities including pre and post surgery, and long term follow up.
- Provides MDT input (clinical assessment and management, practical support) post-surgery, at discharge and has key role in follow up and annual reviews
- Provides nutritional assessment.

3.2.1. Service model:

The service model may be flexible but must meet the outlined criteria requirements as set out in the bariatric service specification for LSOS

Local Specialist Obesity Service (LSOS):

Bariatric Surgery Assessment: A programme for those who are felt to meet the eligibility criteria for bariatric surgery and may wish to proceed with surgical intervention. The determination of bariatric surgery as an appropriate treatment option should be confirmed after a specialist Multi-Disciplinary Team (MDT) assessment by the LSOS. The patient should be advised of suitability and offered a six month intensive programme prior to final re-assessment and formal referral for surgery.

The LSOS would provide, and patients would be expected to attend, an intensive clinical management as well as activity, lifestyle and education programme that introduces the client to bariatric surgery. The patient should also be able to access, according to their needs, specialist information, advice, education and counselling from a range of specialist, dedicated professionals with an interest in obesity including: dieticians, physical activity specialists, psychologists and occupational provided via group work or on a domiciliary basis. The patient would be ultimately expected to show a commitment and understanding of the altered eating behaviour and healthy lifestyle they will have to adhere to after surgery and their coping skills.

3.2.2. Care Pathway

Care Pathway demonstrated in Appendix A

3.3 Population covered

The service will cover patients registered with a Blackpool CCG GP.

3.4 Any acceptance and exclusion criteria and thresholds

- Patients must be registered with a Blackpool CCG GP

For entry into the tier 3 LSOS:

- Patient must be referred by a Blackpool CCG GP or a Blackpool Teaching Hospitals Employed Consultant
- Patients must have a BMI of >35 with co morbidities
- BMI > 40 without co morbidities
- Patients must be aged 16 or above

These criteria could change depending on what treatment the LSOS is going to provide.

If the MDT prescribes drugs as part of its patient treatment the BMI criteria should change.

According to NICE clinical guidance 43 if you prescribe drugs as part of your treatment the BMI brackets should change to >35 **without** co morbidities and >30 **with** co morbidities.

Non – compliance issues and reasons for discharging back to referrer

Failure to comply with provider's access policy.

- Failure to attend two or more booked appointments.
- Do not reply to telephone support; follow up letters, do not return calls, referral letters and or emails etc on two occasions

Where the needs of a service user require an alternative or more specialised service the Provider will provide full assistance to:

- Discuss and agree the needs of the service user;
- Review the choice of services available;
- Book an appointment and/or provide information that will enable the service user to make an appointment.

3.5 Interdependence with other services/providers

- The Provider will ensure that there are good mechanisms in place for joint working and communications with other service providers relevant to the pathway of care for service users coming into contact with the Services, including regular meetings and evaluations of service delivery. These other providers will include Diabetic, COPD and Coronary Rehabilitation services.

- The Services will provide an enhanced level of service to complement existing commercial weight management and General Practice services within Primary Care. The expertise to be held in the delivery of the Services will be a recognised resource to the local health and social care community, being applied through the provision of appropriate advice and support as required.

- The provider will ensure the synergistic relationship between community dietetics, tier 2 services and the general practice weight management service provision remains. This includes peer support and education, and minimum standards of collaborative data collection for each service user.

- The management information to be generated by the Provider in the delivery of the Services will provide an essential source of intelligence to the Commissioner and partner organisations to assist in planning, monitoring and developing future service provision and will need to be regularly synthesised, analysed and shared including the need for compliance with the management information reporting requirements specified within this Agreement and Schedules.

- The Providers and the Commissioners will liaise closely together to ensure a coordinated approach to the marketing and promotion of the Services to the population of Blackpool.

- The Provider will ensure timely engagement with appropriate local governance forums where the Services have a dependency upon their formal support.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

NICE clinical guidance 43, public health guidance 35, public health guidance 38, public health guidance 42 and public health guidance 44

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

Measuring up- Academy of Medical Royal Colleges 2013

Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in adults-National Institutes of Health

Action on obesity comprehensive care for all- Royal College of Physicians-2013

Commissioning guide : Weight assessment and management clinics (tier 3)- British Obesity & Metabolic Surgery Society

4.3 Applicable local standards

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: Clifton Street, Blackpool.

7. Individual Service User Placement

8. Performance & Productivity	*Indicator*	*Threshold*	*Method of Measurement*	*Frequency of Monitoring*
Development KPI % of referrals accepted	% of referrals received that are accepted into the service	Baseline to be set 2016/17	Included within Commissioner level KPI Report	Monthly
Development KPI % of accepted referrals that complete treatment	% of all accepted referrals that complete treatment	Baseline to be set 2016/17	Included within Commissioner level KPI Report	Monthly
Development KPI % of accepted referrals that are referred for bariatric surgery	% of all accepted referrals referred for bariatric surgery	Baseline to be set 2016/17	Included within Commissioner level KPI Report	Monthly
Development KPI % of accepted referrals with an improved score on the Warwick Edinburgh Wellbeing Scale	% with improved score at completion compared to acceptance	Baseline to be set 2016/17	Included within Commissioner level KPI Report	Monthly
Development KPI % referred to Active Blackpool	% of all accepted referrals that are referred to Y Active	Baseline to be set 2016/17	Included within Commissioner level KPI Report	Monthly

Appendices

A - TIER 2/3 LSOS PROCESS MAP