Will recent recommendations on the commissioning of weight management services affect the way we manage our patients in practice?

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Obesity is on the increase, as well as comorbid conditions, such as diabetes and obstructive sleep apnoea. The four-tiered weight management care pathway for obesity is now well established by many organisations, and in many recent guidelines. This article provides an overview of the recent recommendations and asks how this will affect patient care in the long term.

Article points

1. The *Report of the working group into: Joined up clinical pathways for obesity* has made recommendations on the weight management care pathway for the care of people with obesity.
2. Forward-thinking commissioners are required to commission all tiers of weight management for long-term contracts of a minimum 10-year period, to allow for service development.

Key words

- Commissioning
- Policy recommendations
- Weight management pathway

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Obesity is arguably the biggest public health epidemic that we face in the Western world today, and it is increasing (World Health Organization [WHO], 2013). As the prevalence of obesity increases we may need to expect other medical problems to increase in prevalence as it is associated with causing or aggravating over 50 common medical conditions, including important life-threatening ones such as diabetes, cardiovascular disease, obstructive sleep apnoea (OSA) and other respiratory conditions, and many cancers (WHO, 2000). Rather than treat the consequences of these conditions we should focus our attention on dealing with the cause, and this should be done in a primary care setting.

If current trends continue then projections made by the 2007 Foresight Report (Butland et al, 2007) suggest that by 2050, 50% of adults will be classified as obese by BMI, with direct and indirect costs of obesity that could cost the NHS an estimated £49.9 billion per year. Common sense might suggest a need to focus on prevention; however, the evidence base for effective preventative measures just does not exist. Unless we tackle all of the different factors involved in the cause of obesity we will not begin to tackle this epidemic, and this will require planning and resources. Safe and effective structured weight management will be crucial to controlling this epidemic, maintaining a healthy weight and reducing the rise in diabetes among individuals at risk (NICE, 2006; 2011).

Recently, focus has been on the care pathway for obesity management, specifically looking at the criteria for the tiers of interventions for more complex and severe obesity, together with recommendations on who should have responsibility for the commissioning of weight management interventions.

The weight management pathway

The weight management pathway is now accepted to be formed by four tiers, and the Department of Health (2014) recently demonstrated the differences between the tiers as follows (but states it is for information rather than as a definition):

Tier 1: *Behavioural – Universal interventions (prevention and reinforcement of healthy eating and physical activity messages), which include public health and national campaigns, and providing brief advice.*

In practice, this represents the primary activity carried out by local and regional public health teams with the identification of individuals and advice given by healthcare professionals often in the primary care setting, such as GPs, nurses,

health visitors and school nurses, together with support from pharmacists, local leisure providers and allied organisations.

Tier 2: *Weight management services – Lifestyle weight management services, which are normally time limited.*

Tier 2 of the weight management pathway represents our local community weight management services, that provide community-based diet, nutrition, lifestyle and behaviour change advice, normally in a group setting. Further recent recommendations have suggested that commercial providers may be an effective choice for commissioners for this level of intervention (NICE, 2014).

Tier 3: *Clinician-led multidisciplinary team (MDT) – An MDT clinically led team approach, potentially including physician (including consultant or GP with a specialist interest), specialist nurse, specialist dietitian, psychologist, psychiatrist and physiotherapist.*

Tier 3 comprises the specialist weight management clinics that provide non-surgical intensive medical management with an MDT approach that consists of bariatric physicians or GPs with specialist interest, obesity specialist nurses, specialist dietitians and "talking therapists" to identify and manage psychological barriers to weight loss and often provide specialist exercise therapists.

Tier 4: *Surgical and non-surgical – Bariatric surgery, supported by MDT pre- and post-operation.*

Tier 4 accounts for bariatric surgery performed in secondary care with pre-operative assessment and post-operative care and support.

Recent organisational changes

In April 2013, the NHS faced considerable change, with Government health reforms making Public Health England responsible for weight management but moving public health into Local Authority control. This has created new challenges where locally elected, non-medically trained individuals may now influence the purse strings for essential NHS services such as weight management.

However, some pre-existing challenges remained unanswered such as that addressing the apparent "postcode lottery", with varying provision of bariatric surgery across the country. With the NHS restructure came NHS England recommendations, prepared by the NHS Commissioning Board Clinical Reference Group for Severe and Complex Obesity, who intended to address these concerns: The *Clinical Commissioning Policy: Complex and Specialised Obesity Surgery* (NHS Commissioning Board, 2013). In this policy, the NHS Commissioning Board reviewed obesity as a clinical condition and the options for treatment. It has considered the place of each treatment in current clinical practice, whether scientific research has shown the treatment to be of benefit to people with obesity (including how any benefit is balanced against any possible risks), and whether

its use represents the best use of NHS resources. This policy document outlines the arrangements for funding of this treatment for the population of England.

Summary of the NHS Commissioning Board *Clinical Commissioning Policy* guidelines

The aims and objectives were to define the eligibility criteria for NHS-commissioned complex and specialised obesity surgery, and to avoid the previous "postcode lottery". It also intended to prevent "perverse incentives"; for example, individuals should not become more eligible for surgery by increasing their body weight. It also clarified that where bariatric surgery is recommended by NICE as a first-line option for adults with a BMI of more than 50 kg/m^2, in whom surgical intervention is considered appropriate, it will be required that these people also fulfil the other suitability criteria (summarised below). The policy document also states that the selection criteria should not forbid bariatric surgery for people who have lost weight with non-surgical methods, but does state that individuals who lose sufficient weight to fall beneath the NICE guidance should not be considered appropriate for surgery.

The NHS Commissioning Board now recommends that only the following procedures be considered on the NHS:

- Gastric banding.
- Gastric bypass.
- Sleeve gastrectomy.
- Duodenal switch.

Revisional procedures will only be considered electively for clinical reasons due to complications and will require prior approval unless they are required on an acute emergency basis. Any new or novel bariatric surgery procedures outside of this policy will not be routinely commissioned and there is no recommendation made in these guidelines with reference to procedures such as abdominoplasty.

The surgical team will maintain systematic and team-based follow-up for the individual who undergoes the procedure for 2 years after surgery, but life-long specialist follow-up is advocated within the non-surgical medical MDT.

The eligibility for bariatric surgery includes the need to fulfil all of the following criteria (summarised from the policy document):

- The individual is considered morbidly obese, defined as a BMI >40 kg/m^2 or between 35 kg/m^2 and 40 kg/m^2 in the presence of other significant diseases (i.e. now in line with previous recommendations in NICE CG43 [2006]).
- Morbid or severe obesity must have been present for at least 5 years.
- There should be mandatory medical evaluation in a formalised MDT-led process prior to entering a surgical pathway.
- The patient should receive and comply with a local specialist obesity service weight loss programme for 12–24 months. The minimum acceptable period is 6 months.
- The treatment of obesity should be multi-component and should include access to more intensive treatments such as low and very low calorie diets, pharmacological treatments, psychological support and specialist weight management programmes. The non-surgical management of obesity prior to bariatric surgery should include:
  - Education.
  - Dietary advice and support.
  - Access to an appropriate level of physical activity.
  - The exclusion of underlying contributory disease.
  - An evaluation of comorbidities (including assessment for OSA).
  - An evaluation of psychological factors relevant to obesity, eating behaviour, physical activity and patient engagement.
  - Evidence of attendance, engagement (judged by attendance records) and full participation, with a measure of achievement of pre-set individualised targets (e.g. steady and sustained weight loss of 5–10%, or maintaining constant weight whilst stopping smoking).
  - An assessment of the individual by the lead physician and the weight-loss MDT.
  - The assurance that the individual has been unable to lose clinically significant weight (i.e. enough to modify comorbidities) during the period of intervention.

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Page points

1. Prior to April 2014, there was variation in the availability of what would be considered tier 3 specialist centres for the multidisciplinary team provision of weight management.
2. Although the option of having one organisation responsible for the commissioning of all four tiers of weight management intervention was considered, it was generally believed that too much responsibility would be left with one organisation that might not particularly have the experience for commissioning surgery or indeed complex medical conditions.

Current opinion

The proposals addressed some of the findings in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report into bariatric surgery (NCEPOD, 2012) and have been largely welcomed, although concern has remained. Initially there was concern that lowering the BMI threshold for bariatric surgery to NICE recommended levels across England would create an increase in demand for bariatric surgery that would not be currently affordable without additional funding. However, with the required need of 12–24 months treatment in a non-surgical MDT for medical management together with the need to meet a list of other requirements prior to referral, in practice, there has been an initial reduction in the number of bariatric procedures being performed. The British Obesity and Metabolic Surgery Society (BOMSS) subsequently produced their recommendations supplementing this guidance on what was expected of tier 3 providers in practice and the commissioning of such services (BOMSS, 2014).

Controversy remains over certain aspects of the guidance, which are still being debated. Many clinicians have questioned the length of time required in the non-surgical, medical MDT management, especially in the case of people with a BMI of more than 50 kg/m^2, arguing that this is too long, although in reality, whether this is too long might depend on the frequency of medical input that could be provided for the patient in the respective services. Many others have questioned whether patients that lose weight and fall below the NICE criteria should be excluded from consideration for surgery, given they met the criteria at the time of entry into the (tier 3) service, and that they may still be obese with, or at risk of, comorbidity. In practice, the NHS Commissioning Board policy document for severe and complex obesity, which may have been intended to address the variation of availability and provision of bariatric surgery in the country, only served to highlight an even bigger "postcode lottery" in the availability of suitable tier 3 non-surgical MDT services.

Prior to April 2014, there was variation in the availability of what would be considered tier 3 specialist centres for the MDT provision of weight management. In some areas, these services were being commissioned by Public Health England and, therefore, the Local Authority. In others, services were being commissioned by Clinical Commissioning Groups (CCGs), but in the majority of areas, there was no specific tier 3 service, or a variation of it was being provided by the surgical tier 4 providers.

In late 2013, a Department of Health working party was set up to consider the reported variability in the commissioning of, and patient access to, certain local services (particularly MDT interventions), and the concerns around the impact of this on people with complex and severe obesity. After considering a range of options, the working party concluded the following in terms of future commissioning responsibility (Department of Health, 2014):

- CCGs were the preferred option as the primary commissioners for local weight management MDT interventions (tier 3).
- NHS England should consider the transfer of all but the most complex adult bariatric surgery (tier 4) to local commissioning once the predicted increase in volume of tier 4 activity has been realised and once locally commissioned tier 3 services are shown to be functioning well.
- Local authorities should remain as the commissioners of tier 1 and 2 of the obesity care pathway.

It was suggested that the increase in availability of tier 3 services is likely to predicate an increase in volume of people seeking bariatric patients and thereby naturally transfer the provision of tier 4 services to the CCGs by virtue of it no longer being a specialised service. In reality, having the same commissioner responsible for tiers 3 and 4 would encourage sufficient funding and resources at a tier 3 level, as obvious financial savings would be seen with more successful medical management, and a corresponding reduction in tier 4 bariatric surgery procedures.

Although the option of having one organisation responsible for the commissioning of all four tiers of weight management intervention was considered (in reality Public Health England under Local Authority control), it was generally

believed that too much responsibility would, therefore, be left with one organisation that might not particularly have the experience for commissioning surgery or indeed complex medical conditions (despite the previous track record of public health having commissioned drug misuse services and sexual health). Instead we are now left with the four interventions (tiers) being commissioned by three different organisations, which will rely very heavily on good communication and co-operation to ensure fully integrated services.

Having one organisation commissioning all weight management interventions could have ensured fully integrated local Healthy Weight Frameworks, and any fear of reducing down funding streams might not have been an option when only that one organisation had full and sole responsibility for managing the obesity epidemic. Instead service providers are faced with the uncertainly that if any one organisation reduces funding of their respective tier of intervention it may have a knock-on effect on the overall care pathway.

Questions for the future

Weight management services, therefore, face an uncertain future, with CCGs now responsible for the provision of tier 3 services. However, given that CCG budgets need to be planned in advance, will it be a further year or two before we start seeing more tier 3 specialist centres providing MDT interventions, and will this have an impact on the availability and provision of bariatric surgery?

Will some CCGs, like that of Rotherham where Public Health England (and, therefore, the Local Authority) currently fund the Rotherham Institute for Obesity, an example of best practice for tier 3 services (National Obesity Forum, 2009), decide on local variation and delegate responsibility for tier 3 service provision to stay with Public Health England? In areas that do this, will the local authorities agree and continue authorising the funding of such services, or see an opportunity to save money that now falls within their control, especially given than weight management is not currently a mandated service for any commissioner? They may accept that treating the obese will save the NHS and the wider society more money than it costs in the long-term, but this may not help them meet their own budgetary restrictions during that financial period.

In order to ease some uncertainty, we require forward-thinking commissioners to commission all tiers of weight management for long-term contracts of a minimum 10-year period, to allow for service development. This should be done in conjunction with encouraging primary care to refer into these services, possibly through financial incentives such as the Quality Outcome Framework or Directed/Local Enhanced Services, and whilst planning to make the provision of weight management services mandatory. ■

"In order to ease some uncertainty on the provision of services, we require forward-thinking commissioners to commission all tiers of weight management for long-term contracts of a minimum 10-year period."

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