SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	26 November 2018
Service	Tier 3 Community Specialist Weight Management Service
Commissioner Lead	Mark Burgis, Head of Clinical Pathway Design, NHS North Norfolk Clinical Commissioning Group
Provider Lead	
Period	1st April 2015 to 31st March 2019
Date of Review	January 2019

1. Population Needs

1.1 National/local context and evidence base

In November 2010, the government published 'Healthy Lives, Healthy People: Our Strategy for Public Health in England', aiming to be the first major nation to reverse the rising tide of obesity and overweight in the population by ensuring that everyone is able to achieve and maintain a healthy weight. In 2011, the government published 'Healthy Lives, Healthy People: A call to action on obesity in England', which announced a new national ambition for a sustained downward trend in the level of excess weight averaged across all adults by 2020.

Data profiles for NHS North Norfolk CCG, NHS South Norfolk CCG and NHS West Norfolk CCG can be found on the Office of National Statistics site below:

https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/clinicalcommissioninggroupmidyearpopulationestimates

Table 1. Summary of estimated numbers of people in each weight category for each CCG.

CCG	Under weight BMI <18.5	Normal BMI 18.5-25	Over weight BMI 25-30	Obese BMI 30-40	Morbidly obese BMI >40
North Norfolk	**1724**	**45161**	**54517**	**35512**	**3820**
West Norfolk	1798	45110	52150	33746	3703
Health East	2597	63446	71879	46372	5092
Norwich	2920	62811	62492	39330	4533
South Norfolk	**2418**	**60344**	**68664**	**44463**	**4930**
Norfolk Total	11457	276872	309702	199423	22078

NICE Obesity Guidance recommends a range of services, including group based interventions at Tier 2, and specialist Tier 3 multidisciplinary weight management services to manage those patients with severe complex obesity (BMI>40, or BMI >35 with obesity related co-morbidities).

For the procurement of a Tier 3 clinic, NICE recommends the revised guidance published 3 March 2017 by the Royal College of Surgeons and the British Obesity and Metabolic Surgery Society.

http://www.bomss.org.uk/wp-content/uploads/2017/10/Revision-of-Commissioning-guide-Tier-3-clinics-04042017.pdf

The guidance states the treatment of obesity should be multi-component. Specialist (Tier 3 or Tier3/4) weight management programmes should include medical assessment of patients, treatments and lifestyle changes such as improved diet, increased physical activity, behavioural interventions, low and very low calorie diets, pharmacological treatments, psychological support and the consideration of referral for bariatric surgery if clinically appropriate. The staff within the team must have specialist Obesity qualifications (e.g. SCOPE certification) and training. Facilities should include the capacity to work from an appropriately equipped site, with specialised medical equipment and the ability to enable access to the appropriate level of physical activity.

Only once patients have successfully completed an intensive obesity management can they be referred for bariatric surgery under NICE guidelines,

North Norfolk CCG (NNCCG), South Norfolk CCG (SNCCG) and West Norfolk CCG (WNCCG) are providing this service specification to specify the delivery required by a Tier 3 Weight Management service for the population registered with a GP in NNCCG, SNCCG or WNCCG.

The service provider will accept referrals from NHS South Norfolk CCG (SNCCG), NHS North Norfolk CCG (NNCCG) and NHS West Norfolk CCG (WNCCG) who will have access to the contract arising from this specification for each of their registered populations. The service provider upon accepting each referral will provide the details of such referrals in the form of a reference number to the referring CCG. Such referrals will be invoiced for their whole programme if they attend for a minimum period of 6 weeks. The service provider will provide the details of such referrals in the form of a reference number to the referring CCG on completion of the minimum 6 week period. The reference number will not include any patient identifiable information.

The intention is that 199 patients in total will complete the service annually. Completer numbers for NNCCG are for up to 89 completers, and for up to 50 completers for SNCCG and for up to 60 completers for WNCCG. . If the activity is outside the 2018/19 planned level in Schedule 2B at the end of two consecutive quarters, the provider will notify the CCGs of the activity variation. Within 2 weeks of the notice to the Addressee for Service of Notices the Commissioners will discuss and agree a possible adjustment of a CCG's allocation from their contracted activity allocation. The provider shall be informed of any agreed change to the allocation. It will be the CCGs responsibility and prerogative to carry out any reallocation then inform the service provider. This process will not have any impact on the block payment.

The provider will if capacity allows, accept referrals on an Individual Funding Request basis in the event a CCG exceeds their contracted quota, i.e. 89 completers for NNCCG, 50 completers for SNCCG or 60 completers for WNCCG within a contract year.

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

Initial Outcomes

- A reduction in patients' weight of ≥1-5% within 6 months of joining the programme in 50% of attenders
- A reduction in patients' weight of ≥5% within 12 months of joining the programme in 70% of attenders
- A reduction in obesity related drug prescriptions
- An improvement in quality of life scores
- An increase in physical activity
- An increase in healthy eating

Intermediate Outcomes

- An improvement in Diabetic related morbidity

Long-term Outcomes

- A reduction in the incidence of obesity related illness – for example Diabetes (Hba1c score)
- An improvement in weight loss maintenance, sustained and continued weight loss
- Contribute to a reduction in the prevalence of adult obesity in North, South, and West Norfolk
- A reduction in prescriptions for medication for conditions linked to obesity
- A reduction in obesity related admissions for Diabetes and Musculoskeletal (MSK)

3. Scope

3.1 Aims and objectives of service

The aim of the Community Specialist Weight Management Service (CSWMS) is to improve the health and well-being of morbidly obese adults by supporting them to achieve and maintain a healthier weight and improve physical fitness, through making appropriate and sustainable lifestyle changes to their eating and physical activity habits.

The provision of a CSWMS is expected to:

- Support patients to make long-term lifestyle changes to manage their weight, improve their health status and their quality of life
- Manage the access to bariatric surgery
- Improve the screening process for those patients who are eligible for bariatric surgery

The key functions of this Tier 3 CSWMS will be:

- To deliver a high quality clinically led programme for individuals that are registered with a General Practice within the geographical area of North Norfolk CCG, South Norfolk CCG and West Norfolk CCG.

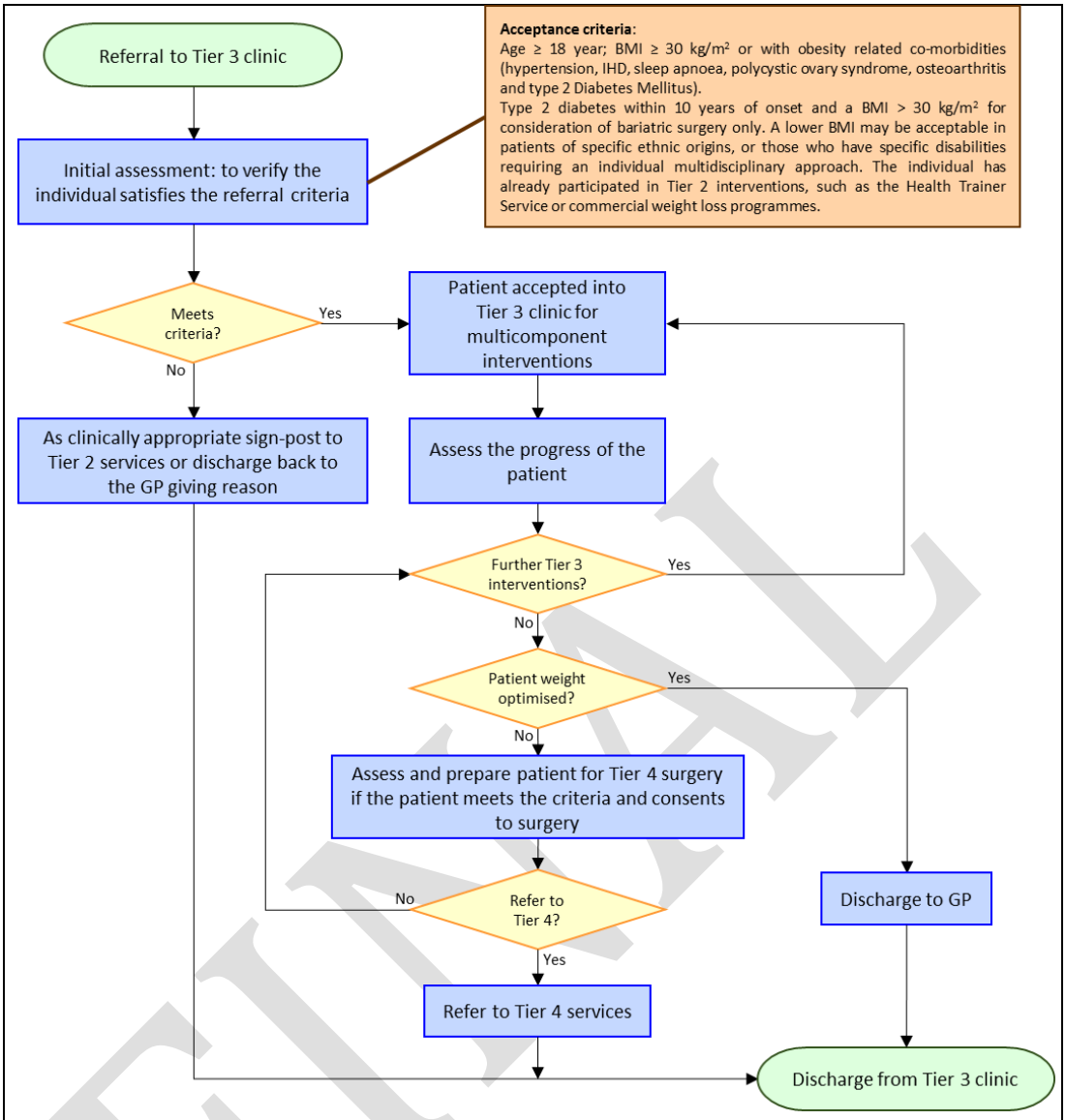
- The service will provide multi-disciplinary team assessment and intervention to motivated patients who fit the referral criteria and have tried other weight loss services but have not achieved their goals e.g. commercial weight loss programmes, primary care support or Tier 2 weight management services.
- The service will function as part of a seamless care pathway for adult overweight and obesity
- The service will, where appropriate, refer patients for Tier 4 surgical assessment, and will contribute to the pre-operative management of these patients.

The key deliverables of this Tier 3 Community Specialist Weight Management Service are:

- That each eligible obese adult referred to the service is offered a comprehensive multi-disciplinary assessment in line with NICE guidelines
- That each individual assessed as suitable for the service is given an individual, tailored treatment plan consisting of effective and appropriate therapeutic and educational interventions.
- Interventions will address patients' presenting needs and enable them to develop coping strategies and make behaviour changes to achieve an initial weight loss of 5-10% body weight and sustained weight loss towards longer term goals, in line with clinical guidelines.
- Each adult meeting the NHS Commissioning Board criteria for Tier 4 referral will be assessed for suitability for referral to Tier 4.
- Adults found suitable for Tier 4 will be referred in line with criteria.

3.2 Service description/care pathway

The pathway as detailed below shall be adhered to by the provider:



The CSWMS will offer a single point of access to their multi-disciplinary team. Patients will be offered community based support via multiple disciplines including but not limited to:-

- Dietician
- Physician
- Nursing
- Psychological therapy
- Lifestyle/exercise advisor
- Other appropriate professional

The provider shall be wholly responsible for the administration and promotion of the uptake of the services and ensure smooth running of the service. Referrals numbers will be based on population need and it is expected a minimum of 199 patients in total will complete the programme annually (approximately 400 new referrals in total) per year.

Patients shall be referred onto the scheme via their GP practice following a lifestyle assessment detailing:

- A positive readiness to change assessment through use of a validated tool

- height, weight, and BMI
- relevant medical history – computer generated encounter sheet
- screening blood tests Full blood count, fasting glucose and lipids, thyroid function test, renal and liver function tests, HbA1c test, B12, Folate, Ferritin and Vit D
- list of current medications

The provider will produce and agree an appropriate referral form to capture the above information.

As a minimum requirement the service provider must comply directly with the recommendations in the latest NICE guidance. Assessment and treatment will be offered in accordance with current NICE guidance.

3.2.1 Pathway Detail

Communication with GP

The Service Provider is responsible for ensuring that the patient's referring GP is sent a typed summary outlining the initial assessment and treatment plan, outcomes and follow-up arrangements (as appropriate). This will be provided after initial assessment, at the 6 month review and at the end of treatment. This will be sent within 7 working days of the relevant appointment. Letters will be marked private and confidential and have a return address on the envelope. All correspondence must:

- Reflect NHS standards for information governance and data protection
- Be copied to the patient in accordance with DH policy
- In the event of there being an urgent need to inform the GP of a specific clinical need this will be telephoned to the GP as soon as possible.

- Triaging of referral forms by Clinical Lead or Obesity Specialist Nurse within two weeks of referral – rejection of inappropriate referrals informing referrer and issue of standardised information to successful referrers.

- Initial assessment should be offered within four weeks of referral and should include:
    - Analysis of diet, diet history and issue of a diet diary for 7-14 days
    - Analysis of lifestyle, including physical activity, alcohol history, smoking history
    - Screening of readiness to change and identification of potential barriers to weight loss e.g. motivation, self-efficacy and self esteem
    - Psychological assessment
    - Weight and height measurements
    - Body measurements, including BMI and waist circumference
    - Medical history
    - Current medication
    - Blood pressure
    - Baseline bloods if not already done
    - EQ 5 DL QOL score
    - Epworth Sleepiness Scale score

Patients not suitable for the treatment programme at any point in the process will be sent back to GP with feedback and recommendations. The patient will also be supported to access more appropriate services.

Specialist medical assessment and / or registered psychological assessment will be provided to patients identified as requiring this service at initial assessment. A traffic light system to identify the patient who needs to be assessed by a registered psychologist may be useful, particularly those being considered for referral for surgery.

Patients requiring further medical or psychological assessment before progressing into the programme should be offered this within 15 working days of the initial assessment. This assessment should be provided by a physician or qualified psychologist or equivalent as appropriate. Patients suitable for the programme but requiring additional psychological support to participate will be offered additional individual psychological sessions.

All assessment findings must be recorded in the patient's record.

3. Treatment programme – The length of individual packages of care will usually be a maximum of 12 months.

The patient will receive at least 12 sessions over a 12 month period. These will include initial assessment and final measurement, can be one to one or groups but should include both of these session arrangements. They will be reviewed and their treatment plan updated as required. Patients may also receive contact via other media.

The provider shall be responsible for following-up those patients who DNA appointments; to understand the reasons for doing so and this should be reported back to the commissioner.

Patients with more complex psychological needs will be offered additional sessions with a qualified psychologist or equivalent. Patients with very complex needs will be referred back to their GP for referral to a registered psychologist.

Given the multi-faceted nature of obesity and the physical and psychological complexity of this patient group, there will be a flexible treatment pathway and some patients may be offered a combination of individual and group treatment, depending on each patient's clinical need. The CSWMS clinical team also reserve the right to modify the treatment package again depending on the clinical need of the patient.

The patient will be given oral and written information, appropriate to their individual abilities regarding:

- Lifestyle (diet, physical activity and behaviour)
- Local physical activity options
- Personal weight loss goals
- Behaviour modification

Encouragement will be provided for weight loss and/or maintenance, and structured eating plans, meal replacements and Very Low Energy Diets may be considered.

The service should investigate for obesity-related comorbidities that may be previously undiagnosed, in particular type 2 diabetes, hypertension, obstructive sleep apnoea (OSA), heart failure, atrial fibrillation, chronic kidney disease, non-alcoholic fatty liver disease and depression, to optimise and modify all identified risks, and so that those referred for surgery are as fit as possible; cardiologists and respiratory physicians could also be involved by separate referral if patients need super-specialist care.

The Edmonton Obesity Staging System or similar will be used as a means of assessing the risk from obesity-related disease in individual patients.

Lifestyle advice will include access to a physical activity programme so as to promote health gains and general fitness individually tailored for each patient.

Given the high prevalence of anxiety and depression the patient will be screened for psychological or lifestyle issues which may interfere with engagement, including eating disorders such as binge eating, borderline personality disorders, alcohol / substance

misuse, and other barriers which are not clearly understood, so as to identify the patient who may need additional long term support or who may be at risk of self-harm after surgery.

Recognising that most will have multiple previous episodes of cyclical weight loss/regain, and that absolute weight loss per cycle may be modest, patients should not be made to achieve a set weight loss target before referral to the bariatric surgery service as a means of 'qualifying' for surgery; instead they should expect to lose weight during a short, supervised diet in order to make surgery technically feasible, and demonstrate engagement with the process.

Smoking cessation advice should be given and appropriate referral made for a long term solution.

Vitamin and micronutrient status should be assessed and deficiencies corrected, to include recognition of diets deficient in protein.

Prescription of anti-obesity medication may be recommended in exceptional circumstances. Patients will only be accepted into the service if the Orlistat they use is prescribed. The CSWMS is not expected to prescribe anti-obesity medication.

When screening for bariatric surgery the service will:

- Identify the patient for whom surgery may be inappropriate (severe learning disability, active uncontrolled psychosis, personality disorder)
- Identify individuals not presently suitable for surgery (e.g. untreated or unstable mental health presentation, recent significant life event e.g. bereavement or relationship breakdown, active substance misuse, active eating disorder and self-harm) and provide an intervention or refer to appropriate services before reassessing for surgery
- Identify the patient who may need specific attention and support following surgery

For a patient with type 2 diabetes:

- The team should strive for satisfactory glycaemic control before surgery (HbA1c < 68 mmol/mol) but inability to achieve this within a reasonable period of time should not be a bar to or delay referral for bariatric surgery
- Macro- and micro-vascular risk should be assessed and the information made available before a referral for surgery

The service will offer flexibility to all patients in terms of offering one to one or group support, depending on the needs of the patient. In order to provide both flexibility to the patient and a cost effective service, the provider should consider innovative means of service delivery such as:

- Telephone follow ups
- Email bulletins
- Telephone/email advice line
- Web based help and information
- Social networking/media
- Texting

Patients may receive contact only if necessary by email/post and phone in between face to face sessions.

There will be at least a 12 week and 24 week re-assessment for all patients participating in the programme.

Frequent MDT meetings shall be held by the provider to ensure that all care professionals involved in the programme discuss jointly the patient's progress/issues on a regular basis.

Information will be provided to the patient's own GP at regular intervals and at discharge.

The service must maintain seamless links with primary care, the tier 2 Health Trainer Service and tier 4 services.

In view of the paucity of evidence regarding multi-disciplinary approaches to the management of obesity, this service will aim to continually improve and develop in the light of service delivery experience, evaluation and future evidence based development.

Resource Requirements
The provider shall ensure that the programme has:

- A dedicated GP Clinical lead (whom should aim to hold a SCOPE Certificate in Obesity Management or Equivalent Qualification) or a bariatric physician.
- Obesity Specialist nurse (with appropriate qualifications).
- A dedicated Healthcare Assistant responsible for linking in with all other local services / sign-posting patients.
- A dedicated administrator
- A qualified psychologist or equivalent with experience in managing obesity and binge eating
- A specialist Dietician
- A health trainer
- An exercise specialist with experience with patients with BMI>40
- Access to a gym or exercise room with equipment suitable for people with BMI>40.

The provider shall have assessment and treatment protocols that are flexible to meet individual patient's needs within the given time frame for treatment and include an early discharge policy for patients who are not actively engaged with treatment.

The provider shall make all reasonable efforts to gather self-reported data on disengaged patients and include in monthly reporting as above.

After twelve months of treatment the patient will be reassessed and discharged or referred onwards, as appropriate.

Once the weight loss goal has been achieved maintenance advice should be reinforced.

Discharge Arrangements

Patients should not routinely stay within the service for longer than twelve months. Patients who are failing to achieve their goals should be reassessed and more intensive/frequent support offered. The patient should be referred back to their GP when:

- He/she does not engage with the team, for instance if resistant to recommended health and lifestyle changes
- Obesity related diseases have been addressed and the team agrees with the patient that ongoing treatment and management plans can now appropriately be provided by the GP and
- The patient does not want to be considered or does not appear to be appropriate for referral for bariatric surgery assessment or does not appear to be suitable for the CSWMS.

Within seven working days of discharging a patient or referring on, a discharge report or referral letter will be sent to the GP as referrer, and the Level 4 service (if referring on). The report will detail:

- Assessment findings and treatment given
- Weight loss achieved

- Details of onward referral if relevant
- Recommendations for further management, if relevant.

Patients who have completed a treatment programme or who are discharged during treatment cannot access the service within 6 months of discharge, and must be re-referred in the usual way.

Patients must be offered the required patient satisfaction questionnaire at discharge.

Patients completing the programme will be offered a follow up appointment by the service post 12 months discharge.

Onward Tier 4 bariatric referrals

The patient should be referred for bariatric surgery if the CSWMS is satisfied that :

- The patient is adequately engaged with the team, fully understands the surgery, is well-informed and motivated to have surgery and has realistic expectations.
- All management options have been put to the patient including the characteristics of the various surgical procedures available and the risks and side effects
- He/she is medically optimised
- There is no medical, surgical, nutritional, psychological, psychiatric or social contraindication
- He/she understands the importance of complying with nutritional requirements before and after surgery and recognises the need for life-long follow up.

NICE guidance recommends bariatric surgery as a treatment option for adults with obesity on fulfilment of the following criteria:

- BMI of 50+
- BMI>40 with co-morbidity specifically of pharmacologically treated type 2 diabetes that could be improved if the patient lost weight.
- Type 2 diabetes within 10 years of onset and BMI>30 in some circumstances
- All appropriate non-surgical measures have been tried but have failed to achieve or maintain adequate, clinically beneficial weight loss
- The person has been receiving or will receive intensive management in a specialist obesity service.
- The person is generally fit for anaesthesia and surgery and commits to the need for long-term lifestyle change and follow-up care.

Patients meeting criteria for bariatric surgery should be offered an assessment. The CSWMS team will prepare a detailed synopsis of the patient's profile from both a physical, and a psychological perspective.

Patients will be assessed against the guidance published March 2017 by the Royal College of Surgeons and the British Obesity and Metabolic Surgery Society and NICE guidance NG189. Patients fitting eligibility criteria will be offered a psychological assessment in line with NICE guidance.
http://www.bomss.org.uk/wp-content/uploads/2017/10/Revision-of-Commissioning-guide-Tier-3-clinics-04042017.pdf

The provider is responsible for preparing all paperwork and assessment to support referrals to Tier 4.

Days/Hours of Operation
The CSWMS will offer a flexible model of care. Where possible, patients will be seen at a time convenient for them and therefore evening and weekend appointments should be made available if required.

It is understood that clinicians require time off for leave and CPD requirements – it is anticipated that during these periods, patients will be offered appointments with other clinicians within the service, as treatment programmes allow this flexibility.

If a clinic or group session is cancelled, patients must be notified by the CSWMS at the earliest opportunity and the next available appointment or group session offered. Where this has had a significant impact on service delivery the commissioner should be notified.

Location
The service provider will be responsible for providing the venue from which the service will be delivered. The site must demonstrate compliance with all building regulations and requirements, including DDA requirements.

The service should be provided in the North Norfolk CCG geographical area. The location used must be accessible to patients from NNCCG, SNCCG, and WNCCG in terms of public transport routes, car parking and disabled access.

Equipment
The provider will ensure that all appropriate equipment is available for the service to enable complete service delivery.

In addition equipment, the provider shall provide all patients with diet diaries, leaflets, advice on electronic resources and provide for relevant posters/leaflets within the service premises.

The provider will be responsible for ensuring appropriate and secure IT systems are in place for the delivery of the service. This will include appropriate systems that are IG toolkit compliant for storing and updating patient records and service monitoring/reporting requirements. If the service chooses to use email as a method of communication, an NHSmail (nhs.net) account will be used.

Reporting
Alongside performance monitoring, an annual report of quarterly data collections will be provided and will include the following data for all patients who participate in the scheme:

- Gender
- Age
- GP Practice
- Ethnicity
- Socio-economic status (education status as proxy measure)
- Summary of dietary intake/behaviour upon joining the programme 2 item food frequency questionnaire
- Physical Activity Status/Behaviour upon joining the programme GPPAQ
- Starting Weight (measured not estimated)
- Quarterly Weight (measured not estimated)
- Finishing Weight (measured not estimated)
- Height
- Starting BMI
- Finishing BMI
- BMI Change
- Summary of dietary intake/behaviour upon exiting the programme 2 item food frequency questionnaire
- Physical Activity Status upon exiting the programme GPPAQ
- % of initial weight loss
- Change in weight (kg)
- Change in HbA1c (in Diabetics)
- Drop-out rate
- Numbers of completers

- Numbers of new referrals
- Numbers of complaints, with details on the actions taken as a result of the complaint

3.3 Population covered

The service is available for adults who are registered with a GP practice in NNCCG, SNCCG and WNCCG.

3.4 Any acceptance and exclusion criteria and thresholds

Patients shall be referred by their practice nurse or GP if they fulfil the following criteria:-

- A BMI of above 40 (morbidly obese) or
- A BMI of above 30 and with obesity related co-morbidities (hypertension, IHD, sleep apnoea, Polycystic ovary syndrome, osteoarthritis and type 2 Diabetes Mellitus).
- Type 2 diabetes within 10 years of onset and a BMI>30 for consideration of bariatric surgery only
- A lower BMI may be acceptable in patients of specific ethnic origins, or those who have specific disabilities requiring an individual multidisciplinary approach.
- Age 18 and over
- The patient has already participated in Tier 2 interventions, such as the Health Trainer Service or commercial weight loss programmes
- People with failed gastric bands who need definitive bariatric surgery

Exclusion criteria

Services not specifically stated as part of this specification are excluded from this schedule. Any services provided outside the terms of the Agreement shall have the CCG's specific consent in advance. Excluded are:

- Patients under the age of 18
- Patients who do not satisfy the referral criteria
- Patients with unstable or severe mental or physical illness beyond the expertise of Primary Care
- Patients with severe active eating disorders
- Patients who have previously had bariatric surgery with the exception of failed gastric band patients who now are considering definitive bariatric surgery
- Women whom are pregnant
- Palliative Care Patients
- Have been through the scheme within the previous 12 months (exceptions may be made on specific occasions at the health care professional discretion and in agreement with the commissioner)

Patient Exit Criteria

- Achieved target BMI
- Target weight achieved and completed 12 month programme
- DNA x 2
- Failure to attend regularly as agreed within the contract the patient signed at the commencement of the programme
- Offensive or abusive behaviour

Accessibility

The provider shall not discriminate between service users on the grounds of sex, age, race, gender reassignment, marital status, disability, religion, sexual orientation or any other non-medical characteristics.

The provider shall work with patients, and their carers, if appropriate, in ways that foster partnerships and promotes self-management. The service shall seek to improve provision

of services and include within its annual review service users' comments using comments and suggestion boxes; patient satisfaction surveys and local complaints process.

If patients require a carer or support worker to help them manage their lives independently they should attend sessions with their carer or support worker. Staff working for the provider shall make reasonable adjustments to meet vulnerable people's needs and receive appropriate training to ensure they can do this.

3.5 Interdependence with other services/providers

Key relationships shall include:

- CCG Commissioning lead
- CCG Public Health lead
- CCG Contracts Manager
- CCG GP practices
- Commissioning Support Unit
- District Councils

The provider shall be expected to establish positive working relationships with other local providers to ensure that patients receive a comprehensive service, but also to ensure that clinical governance, education and development activities take place across the whole system. Key interdependencies include:

- NNCCG GP Practices
- NNCCG
- Health Trainers and Tier 2 weight management services
- Providers of severe and complex obesity services (Tier 4)
- The Norfolk and Norwich University Hospital – Endocrinology. The provider must establish good working relationships with the Endocrinology team.
- Services concerned with the treatment of medical complications of morbid obesity:
- Cardiovascular services, including hypertension 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
- Gastrointestinal services
- Orthopaedics
- Infertility services, including those being treated for polycystic ovarian syndrome
- Eating disorders service

The integrated service that the individual and carer receive must not be fragmented or duplicated.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Delivery of the service in line with Standard Evaluation Framework (SEF) for Weight Management Interventions guidelines (National Obesity Observatory).

In addition, the service shall be delivered in accordance with:

- Department of Health (DH), *'Obesity Care Pathway and Your Weight Your Health'* (DH, 2005)

    - National Institute of Health and Clinical Excellence (NICE), *'Obesity: identification, assessment and management of overweight and obesity in children, young people and adults'* (CG 189 (2014))

- NICE, *'Guidance on behaviour change at population, community and individual level'* (Public Health Guidance PH006, 2007)
- National Obesity Forum Obesity Guidelines and Toolkit http://www.nationalobesityforum.org.uk/index.php/healthcare-professionals.html
- National Obesity Observatory, *'Standard Evaluation Framework for Weight Management Interventions'* (NOF, 2009)
- Department of Health (DH) 'Healthy Lives Healthy People - a call to action on Obesity in England' (DH , 2011)
- Scottish Intercollegiate Guidelines Network (SIGN), *'Management of Obesity. A national clinical guideline'* (Clinical Guideline 115, 2010)
- NICE guidance 'Weight Management Before, During and After Pregnancy' (Public Health Guidance 27, 2010).
- Obesity: identification, assessment and management NICE Clinical guideline shed: 27 November 2014 nice.org.uk/guidance/cg189
- Commissioning guide: Weight assessment and management clinics (tier 3) 3 March 2017 by the Royal College of Surgeons and the British Obesity and Metabolic Surgery Society
- NICE Guidance 'Managing Overweight and Obesity in Adults – Lifestyle Weight Management Services' (Public Health Guidance 53, May 2014)

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

Commissioning Guide: weight assessment and management clinics (tier3) (Royal College of Surgeons 2013)

4.3 Applicable local standards

The provider shall ensure that patients and their carers can routinely access the service. The provider shall agree a protocol to gather sufficient and relevant information to determine its ability to meet the needs of the individual concerned.

4.3.1 Care Quality Commission (CQC)
The provider shall be registered with the CQC and shall provide NNCCG with evidence of their registration. When registered the provider shall be expected to adhere to the CQC regulations and cooperate fully in any inspections and audits. The provider shall inform NNCCG, SNCCG and WNCCG of any inspection visits or other investigations and outcomes of such visits. The provider shall inform NNCCG of any concerns regarding compliance against any of the CQC essential standards identified by the provider or the CQC.

4.3.2 Patient Experience
Patients and/or carers shall receive relevant information in a format which is appropriate for the patient's individual needs.

The provider shall be expected to demonstrate that patients are actively engaged and involved in service development and evaluation. The core clinical team will include patient representatives, and patient literature will be reviewed by the patients on this group.

The provider shall give patients the opportunity to comment on their experience of using the service through patient surveys, Patient and Public Involvement work, PALS, complaints and other activities. It is expected that surveys will be repeated annually or earlier if indicated by previous survey results.

The provider shall demonstrate how systemic patient feedback is used to shape and improve services through the collation, analysis and actioning of patient satisfaction survey outcomes.

Complaints: The service provider shall have in place a complaints process and process for signposting patient to PALS service that comply with all the requirements in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and have in place systems of investigation and learning to prevent recurrence of complaints and PALs concerns.

4.3.3 Patient Safety
The Provider should contemporaneously report all Serious Incident (SI) to NNCCG, SNCCG and WNCCG.

4.3.4 Protection of Vulnerable Adults
The Provider must work within the Commission for Social Care Inspection Safeguarding Adults' procedures and guidelines (2007) and Norfolk Vulnerable Adult Protection Committee adult protection policy (2008).

The aim is to ensure that all responsible agencies and individuals work together to prevent abuse and safeguard adults where possible, and where preventative measures fail, to deal sensitively and effectively with incidents of abuse.

In order to comply with these requirements the Provider must have:-

- Senior management commitment to the importance of safeguarding and promoting the welfare of vulnerable adults
- A clear statement of the service's responsibilities towards vulnerable adults available for all staff
- A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of vulnerable adults
- Service development that takes into account the need to safeguard and promote welfare and is informed by the views of service users, families and carers
- Effective interagency working to safeguard and promote the welfare of vulnerable adults
- Arrangements for appropriate and proportional information sharing in response to safeguarding concerns

4.3.5 Information Governance
Providers shall maintain the confidentiality of Personal Data entrusted to it in accordance with the provisions of the Data Protection Act 1998. If the provider is storing or processing patient identifiable information, the provider is required, to complete a data protection registration in accordance with the Information Commissioner guidance. http://www.ico.gov.uk/what_we_cover/data_protection/notification/do_i_need_to_notify.aspx

4.3.6 Infection Control
NNCCG, SNCCG and WNCCG expect the Provider to comply with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, implement best practice from Saving Lives in respect to hand hygiene and to adhere to all DH and NNCCG guidance. Accessed via:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110288

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

5.2 CQUIN goals (See Schedule 4 Part [E]). Not applicable.

6. Location of Provider Premises

The Provider's Premises are located at:

Fakenham Medical Practice
Meditrina House
Trinity Road
Fakenham
Norfolk NR21 8SY

7. Individual Service User Placement

Not applicable