

# Report of the working group into: **Joined up clinical pathways for obesity**

Prepared by a joint working group with representation from:

Association of Directors of Adult Social Services  
West Midlands Association of Directors of Public Health  
Bradford Metropolitan District Council  
Department of Health  
London Borough of Lambeth and Southwark  
National Institute for Health and Clinical Excellence  
National Obesity Forum  
NHS England  
Patient User Representatives  
Public Health England  
Rotherham Institute for Obesity  
Royal College of Physicians  
Staffordshire County Council Public Health Team  
Stoke On Trent City Council

## Joined up Clinical Pathways for Obesity: Report of the Working Group

This report has been prepared, on behalf of the Working Group, by: Jamie Blackshaw, Sam Montel, and Stuart King (Public Health England Obesity & Healthy Weight Team) and Ann Jarvis and Jonathan Valabhji (NHS England)

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# Contents

Contents	2
Executive Summary	4
Introduction and membership	5
Who is this report aimed at?	5
Issues	6
Background	7
Options appraisal	8
Conclusion	9
Next steps	10
Annex 1 – Working group: Terms of Reference	11
Annex 2 – Working group: Membership	13
Annex 3 - Definitions of the tiers, commissioning leads and patient journey	15
Annex 4 - Commissioning responsibilities : Options appraisal	17

# Executive Summary

NHS England and Public Health England convened a short-life working group, made up of a broad membership including representation from local commissioners and national health and social care bodies, to examine urgent issues that had emerged regarding the obesity care pathway.

Membership included:

Association of Directors of Adult Social Services  
West Midlands Association of Directors of Public Health  
Bradford Metropolitan District Council  
Department of Health  
London Borough of Lambeth and Southwark  
National Institute for Health and Clinical Excellence  
National Obesity Forum  
NHS England  
Patient User Representatives  
Public Health England  
Rotherham Institute for Obesity  
Royal College of Physicians  
Staffordshire County Council Public Health Team  
Stoke on Trent City Council

Reported variability in the commissioning of, and patient access to, certain local services, particularly multi-disciplinary team interventions (commonly referred to as 'tier 3' services) and the concerns around the impact of this on patients, consequently provided the basis for much of the working group's considerations.

The working group after considering a range of options concluded that in terms of future commissioning responsibility:

- Clinical Commissioning Groups (CCGs) were the preferred option as the primary commissioners for local weight management multi-disciplinary team 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 tiers 1 and 2 of the obesity care pathway

NHS England and Public Health England are now seeking views from interested parties on the conclusions of the working group and their implications before having further discussions with partners in local and central government about the way forward.

## Introduction and membership

A working group was established in September 2013 to examine issues that have arisen in the commissioning of, and access to, elements of the integrated obesity care pathway for adults and children (please refer to annex 1 for the Terms of Reference). The extent of the problem in some areas demanded that the working group convene, consider and proffer its conclusions within a timescale that reflected the urgent need for clarification. The objective was to develop collective recommendations, grounded within the scope of the current system, that would support national and local stakeholders take steps to identify and resolve the current issues. This report reflects the considerations of the working group and its exploration of the issues between September and December 2013.

The working group recognised that the funding and relative prioritisation of obesity services was outside the group's remit. Members wished to highlight the importance of obesity services in all tiers and the potential health benefits for patients.

NHS England and Public Health England (PHE) acting in good faith to support local stakeholders agreed to examine the issues. To do so effectively every effort was made to establish a broad interest working group spanning the entirety of the whole pathway and to consider the most appropriate future commissioning leadership arrangements for each tier, focussing on cohesion and benefit for the patient.

Details of the working group members, who were nominated by their respective organisations or groups are included in annex 2.

Given the importance of the contribution of local commissioning organisations in considering future options a further opportunity to comment was also provided to a wider range of clinical commissioning groups (CCGs) via the Commissioning Assembly, prior to the publication of this report.

## Who is this report aimed at?

Local and national views were represented on the working group. However, the working group strongly advocated the importance of inviting wider comments on implementation at a local

level and implications for delivery from national and local stakeholders. These include (but are not limited to):

- Local Authority Obesity Leads/Commissioners
- Directors and Assistant Directors of Public Health
- Directors of Adult and Children Services
- Clinical Commissioning Groups
- General Practitioners, physicians and surgeons
- Bariatric clinicians
- Service providers
- Dieticians
- Patient Groups

Comments will be reviewed by Public Health England and NHS England for use as part of the governance process on the next steps. Comments should be sent to [obesitycarepathway@phe.gov.uk](mailto:obesitycarepathway@phe.gov.uk) by 6<sup>th</sup> May 2014.

## Issues

The working group was established in response to significant feedback from local stakeholders (and the wider public and media) and their concerns relating to the variation in the commissioning of, and access to, certain obesity services across England. In particular, it was evident that in some areas no organisations were commissioning multi-disciplinary team interventions, commonly referred to as tier 3 services. The working group defined the series of tiers for the purposes of this exercise and the group's summary overview of the pathway is provided in annex 3. The working group acknowledged that there are other models and descriptions of the obesity care pathway including that of the National Obesity Forum<sup>1</sup>, but felt that the definitions used provided a reasonable basis for developing its recommendations.

It is important to note that the working group's deliberations were underpinned by the fact that the commissioning of tier 3 services is a local consideration. Health and Well-being Boards form an essential part of this process and take an overview of commissioning to meet local priorities and the needs of relevant communities. Tier 3 services represent an important (and sometimes final) intervention as part of the wider obesity pathway, which consists of a series of tiered services. Across the pathway, services provide a framework of population/community based information, support and intervention; lifestyle weight management services; multi-disciplinary team interventions; and surgical/non- surgical services, including bariatric surgery.

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<sup>1</sup> [http://www.nationalobesityforum.org.uk/images/stories/Healthcare\\_Professionals/NOF\\_obesity\\_strategy\\_new\\_format\\_3.2b\\_C.ppt](http://www.nationalobesityforum.org.uk/images/stories/Healthcare_Professionals/NOF_obesity_strategy_new_format_3.2b_C.ppt)

A tier 3 obesity service is for obese individuals (usually with a body mass index  $\geq 35$  with co-morbidities or 40+ with or without co-morbidities) who have not responded to previous tier interventions. A tier 3 service is comprised of a multi-disciplinary team of specialists, led by a clinician and typically including: a physician (consultant or GP with a special interest); specialist nurse; specialist dietitian; psychologist or psychiatrist; and physiotherapist/physical activity specialist/physiology. The provision of tier 3 services is variable, with the absence of such services in many areas. In the absence of tier 3 services patients cannot ordinarily access bariatric surgery and it has not been clear who has primary commissioning responsibility for these tier 3 services.

The work of this group intended to recommend a clear position relating to commissioning so that informed decisions can be made by the responsible organisations, including a full understanding of the consequences of their decisions and with regard to access to tier 4 services such as bariatric surgery.<sup>2</sup>

## Background

This background reflects the currently available clinical guidance and adds context relevant to the issues considered by the working group.

The new health and care system, established to deliver the ambitions set out in the Health and Social Care Act, became fully operational from 1 April 2013 with one of the key changes being the transfer of public health services from Primary Care Trusts (PCTs) to Local Authorities<sup>3</sup>. Whilst a range of activity under the umbrella of nutrition, obesity and physical activity, transferred from PCTs<sup>4</sup> the determination as to what services were then commissioned remained a local consideration.

It is evident that at local and national level a range of organisations have an interest in supporting local communities with approaches to prevent and tackle obesity. There is a range of existing guidance available to support an integrated approach to practice and care throughout the obesity care pathway – this includes guidance from Department of Health<sup>5</sup> and the National Institute for Health and Clinical Excellence (NICE) Obesity Care Pathway<sup>6</sup>, which serves as the portal to a series of published and planned guidance relating to managing obesity.

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<sup>2</sup> Clinical Commissioning Policy: Complex and Specialised Obesity Surgery, NHS Commissioning Board, April 2013

<sup>3</sup> <https://www.gov.uk/government/publications/the-health-and-care-system-explained/the-health-and-care-system-explained>

<sup>4</sup> [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_132571](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132571)

<sup>5</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/142723/Weight\\_Management\\_Service\\_Spec\\_FINAL\\_with\\_IRB.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142723/Weight_Management_Service_Spec_FINAL_with_IRB.pdf)

<sup>6</sup> <http://pathways.nice.org.uk/pathways/obesity>

## Joined up clinical pathways for obesity: Report of the working group

NHS England's published clinical commissioning policy on the specialised management of severe and complex obesity outlines NHS funded routine access to the obesity services falling within the direct commissioning responsibilities of NHS England. Reflecting the principles of the NICE guidance, the policy recommends intensive and multidisciplinary assessment and support for individuals to enable them to have trialled and exhausted all non-invasive treatment options prior to potentially higher risk surgical approaches (NICE CG43 recommendations<sup>7</sup>).

Where progress to tier 4 bariatric surgery is required the policy states that patients should undergo a service based weight loss programme (non-surgical tier 3/4), for a duration of 12 – 24 months, the minimum acceptable period being six months. The policy also recognises that patients completing tier 3 support who pro-actively manage their diet and exercise are more likely to subsequently succeed in the dietary control required post-surgery, and therefore maximise the outcomes of their surgery.

The working group acknowledged the draft tier 3 guide for weight assessment and management clinics developed by a collaboration of expert organisations<sup>8</sup> as a useful addition to other guidance available.

It is evident that the obesity care pathway has an important role within the whole system approach to tackling obesity, as outlined in the Foresight report<sup>9</sup>. This is further endorsed in the Department of Health's Call to Action<sup>10</sup>, and the recent Public Health England Advisory Board paper on Obesity and Early Approaches<sup>11</sup>.

In addition, NICE guidance on 'Obesity – Working With Local Communities' provides recommendations for an integrated local approach on obesity.<sup>12</sup> This emphasises the importance of working together to support the current system in delivering a service fit for local need.

The working group did not systematically review the current commissioning arrangements for obesity services. However, it is apparent that there are different models of commissioning currently in place at a local level and in some areas obesity services, including tier 3, are being commissioned by either Local Authorities or CCGs, or in collaboration.

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<sup>7</sup> <http://www.nice.org.uk/nicemedia/pdf/cg43niceguideline.pdf>

<sup>8</sup> <http://www.rcseng.ac.uk/providers-commissioners/docs/rcseng-bomss-commissioning-guide-on-weight-assessment-and-management-clinics>

<sup>9</sup> <http://www.bis.gov.uk/assets/foresight/docs/obesity/17.pdf>

<sup>10</sup> <https://www.gov.uk/government/publications/healthy-lives-healthy-people-a-call-to-action-on-obesity-in-england>

<sup>11</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/223979/PHE13-01\\_Obesity.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223979/PHE13-01_Obesity.pdf)

<sup>12</sup> <http://guidance.nice.org.uk/PH42>



# Options appraisal

The working group identified and explored six options in respect of the future commissioning responsibilities relating to the obesity care pathway:

1. tiers 3 & 4 commissioned together by NHS England
2. tiers 3 & 4 commissioned together by NHS England (with tier 3 commissioned as a specialised service)
3. tiers 3 & 4 commissioned together by CCGs
4. tiers 3 & 4 commissioned together by Local Authorities (i.e. LA responsible for all 4 tiers)
5. tier 4 with NHS England, tier 3 with CCGs, tiers 1 & 2 with Local Authorities
6. tier 4 with NHSE, tiers 1-3 with Local Authorities

Taking into account an initial assessment of the summary of risks and benefits (annex 4) the majority of the working group concluded that, in the future, CCGs represented the preferred option as primary commissioners for tier 3 services. This recognised their skills in the commissioning of clinically led multidisciplinary services and the opportunities afforded by collective oversight of related clinical conditions (co-morbidities). It is important to note that the working group majority view was that tier 3 services did not meet the criteria for specialised service commissioning.

Of the two options (3 and 5) that outlined this approach the working group recognised that at the current time moving tier 4, bariatric surgery, out of NHS England (as per option 3) in the short term might not be in patients' best interests. This reflects the relatively low volume of tier 4 activity and bariatric procedures in England and the known association between low volume centres for surgical procedures and poorer clinical outcomes. Moving tier 4, bariatric surgery, out of NHS England in the short term might also reduce the opportunity to resolve important issues on a 'do once' national basis, including approaches to revision surgery.

The majority of the working group felt however that whilst tier 4 services should remain as a specialised service in the short term, NHS England should review the transfer of all but the most complex adult bariatric surgery to local commissioning once locally commissioned tier 3 services are shown to be functioning well. It was suggested that the increase in availability of tier 3 services is likely to predicate an increase in volume of 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. The group queried whether, as part of any review, certain areas of specialised surgery, for example bariatric surgery for children and complex cases, should remain with NHS England.

The working group acknowledged that the conclusion would have a differing impact due to the variability of the provision of tier 3 and 4 services across England.

## Conclusion

The working group concluded that option 5 (tier 4 with NHS England, tier 3 with CCGs, tiers 1 and 2 with Local Authorities) was the preferred approach to commissioning responsibility within the current system. Furthermore, the working group expressed their view that NHS England should in the medium term prioritise early consideration of the transfer of the majority of adult bariatric surgery to local commissioning, through CCGs, once they have been shown to be functioning well with sufficient volume of patients to justify de-specialising the service. This should form an important consideration for the NHS England Clinical Reference Group for Severe and Complex Obesity and NHS England more broadly in respect of its commissioning approach. In providing this view the working group commented that this would build upon the collaborative nature of the new system and recognise the benefits of an integrated local commissioning system, including the clinical elements of tiers 3 and 4.

## Next steps

The working group has now concluded and PHE and NHS England would like to invite comments from national and local stakeholder organisations, principally concerning implementation at a local level and implications for delivery.

PHE and NHS England will publish a summary of any comments received and reference the organisations responding. The information provided may also be used to develop further guidance in accordance with the needs of health and Local Authority colleagues.

Comments should be sent to [obesitycarepathway@phe.gov.uk](mailto:obesitycarepathway@phe.gov.uk) by 6<sup>th</sup> May 2014.

Conclusions from the working group will be considered by NHS England's Directly Commissioned Services Committee<sup>13</sup> via the Specialised Commissioning Oversight Group and the joint NHS Public Health Committee. It is for these groups to consider, with input from NHS England, PHE and other stakeholders as appropriate, any implementation, support and advice that is required.

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<sup>13</sup> <http://www.england.nhs.uk/wp-content/uploads/2013/05/pol-0107.pdf>

# Annex 1 – Joined up clinical pathways for obesity – Working group: Terms of Reference

## **Purpose**

This short life working group has been established to examine issues that have arisen in the provision and access to, the integrated obesity care pathway for adults and children. In particular the group will examine access to more intensive, targeted and multidisciplinary approaches to weight management. The group will consider and make collective recommendations to member organisations in terms of steps towards how identified issues can be resolved.

## **Role**

- undertake, making use of the experience of member organisations, an examination and articulation of the current issues and difficulties being experienced in relation to access to 'tier 3' and 'tier 4' obesity support and services for adults
- work collectively to consider, describe and provide a statement of tangible and meaningful 'tiers' within the overall pathway, providing a more concrete base on which to base advice
- examine and clarify, or where necessary, make recommendations on the most appropriate commissioning leadership arrangements for each tier, focussing on cohesion and benefit for the patient
- explore collaborative opportunities across the membership
- work collectively to build in broad consultation on emerging issues, particularly from a local and patient perspective throughout the life span of the group
- communicate the role and progress of the group in developing and reaching its recommendations

## **Governance**

This group has been jointly established and reports to relevant committees within member organisations. At the conclusion of the group, member organisations will be asked to formally consider and consult with wider partners as required. Where agreed member organisations will

Joined up clinical pathways for obesity: Report of the working group

put in place action to deliver recommendations of the group, with feedback provided to the group Chair.

### **Meeting Arrangements**

The group will meet frequently over a period of ten weeks in order to complete its examinations and make recommendations to member organisations. Meeting dates as follows:

24 September 2013; 21 October 2013; 11 November 2013; and 2 December 2013.

### **Administration**

The meetings will be hosted and administered by Public Health England Diet and Obesity team.

## Annex 2 – Joined up clinical pathways for obesity – Working group: Membership

Jonathan Valabhji (Chair)	NHS England, National Clinical Director for Obesity and Diabetes
Julian Barth	NHS England, Severe and Complex Clinical Reference Group Chair
Carl Bennett	Senior Health Improvement Specialist, Stoke on Trent Council
David Black	NHS England, Area Team Medical director – South Yorkshire and Bassetlaw team
Jamie Blackshaw (Secretariat)	PHE, Team Leader, Obesity & Healthy Weight
Julia Burrows	Consultant in Public Health, Bradford District Metropolitan Council
Dr Matthew Capehorn	Clinical Director, National Obesity Forum Clinical Manager, Rotherham Institute for Obesity
Ken Clare	Patient User Representative (from 11/11/13)
Pia Clinton	NHS England, Head of Commissioning Policy and Resources
Adrienne Cullum	Centre for Public Health, National Institute for Health and Care Excellence
Nicola Day	West Midlands Association of Directors of Public Health, Staffordshire County Council Public Health Team
Pete Fahy	Association of Directors of Adult Social Services
Nesta Hawker	NHS England, Regional Programme of Care Manager Internal Medicine (North)
Ann Jarvis	NHS England, Acute Portfolio Director and Women & Children's Programme Director
Jaci Joyce	Patient User Representative (from 11/11/13)
Stuart King (Secretariat)	PHE, Obesity & Health Weight
Margaret Kitchling	NHS England, Director of Nursing and Quality
Iris McMillan	Patient User Representative (from 11/11/13)

## Joined up clinical pathways for obesity: Report of the working group

Sue McLellen	NHS England, Head of Specialised Commissioning (London Region)
Helen Miller	Clinical Commissioning Group Chair, Gloucestershire
Samantha Montel (Secretariat)	PHE, Obesity & Healthy Weight
Michael O'Kane	Department of Health, Obesity and Food Policy
Bimpe Oki	Consultant in Public Health Southwark and Lambeth
James Palmer	NHS England, Clinical Director Specialised Services
Zubeda Seedat	Department of Health, Obesity and Food Policy
Dr Alison Tedstone	PHE, Director Diet and Obesity
John Wass	Royal College of Physicians
Simon Williams	NHS England, Programme of Care Lead, London region

## Annex 3 – Joined up clinical pathways for obesity working group: Definitions of the tiers, commissioning lead and patient journey

To note these definitions represent the considered views of the majority of the group at the time and were used as a reference to understand the context of tier 3 and 4. They are provided for information rather than as a definition.

Tiers	Description	Location	Commissioning lead (primary responsibility agency)	Referral Criteria	Patient Journey – what are the characteristics of the service users?
1 Behavioural	<p>Universal interventions (prevention and reinforcement of healthy eating and physical activity messages).</p> <p>Includes public health and national campaigns.</p> <p>Brief advice.</p>	Various	Local Authorities responsible for the provision of community based interventions which encourage healthy eating and physical activity.		<p>Overweight</p> <p>Exit to either tier 2 or exit from pathway.</p>
2 Weight management services	<p>Lifestyle weight management services.</p> <p>Normally time limited.</p>	Community / GP practice	<p>Local Authorities responsible for commissioning lifestyle weight management services.</p> <p>Local Authorities as lead agency engaging CCG's and NHS.</p>	Locally determined	<p>Individual defined as overweight and needs personal directed intervention/s in the community.</p> <p>Entry either self-referred or referred, possibly from from tier 1.</p> <p>Exit from pathway.</p>

Joined up clinical pathways for obesity: Report of the working group

Tiers	Description	Location	Commissioning lead (primary responsibility agency)	Referral Criteria	Patient Journey – what are the characteristics of the service users?
					Continuation with tier 2 services. Exit to tier 3.
3	A MDT clinically led team approach, potentially including physician (including consultant or GP with a special interest), specialist nurse, specialist dietitian, psychologist, psychiatrist, and physiotherapist.	Location flexible – hub / community / GP practice/ secondary care setting	CCGs as the future primary commissioners for tier 3 services, engaging with LA and NHS.	Very obese /morbidly Obese	An obese individual with complex needs who has not responded to previous tier interventions.  Engagement in tier 3 does not automatically lead to surgery.  Entry from either tier 2 or tier 4 or direct entry.  Exit to either tier 2 or tier 4 or exit from pathway.
4	Bariatric Surgery, supported by MDT pre and post op.		NHS England is responsible for the assessment and provision of surgery in the short term. In recognising the benefits of integrated commissioning, NHS England to conduct an early consideration of the elements of tier 4 that should transfer to CCG commissioning in the medium term.	Very obese /morbidly Obese	Entry- must have engaged with tier 3. Exit to tier 3 (post op support).



## Annex 4 – Joined up clinical pathways for obesity working group: Commissioning responsibilities – options appraisal

Option	Commissioning responsibility	Description	Benefits	Risks	Mitigating actions
1.	Tiers 3 & 4 commissioned together by NHS England	<p>Tier 4 remains a specialised service with funding centrally from NHS England.</p> <p>Further considerations of the approaches that are available to PHE and NHS England to explore included, for instance, the Section 7a Agreement which could be considered as an approach to set out NHS England commissioning responsibility for tier 3 (not as a specialised service).</p> <p>Detail on the provider for tier 3 services does not need to be determined.</p>	<p>Preserving specialist skills and expertise for tier 4.</p> <p>Help to draw tiers 3 &amp; 4 together, with the potential to increase the consistency of provision/access to tier 4 and benefit patient experience.</p>	<p>Potentially widen the gap between tier 2 &amp; 3, by for example a possible loss of connectivity between LA's and CCGs, and a relationship not yet established between NHS England and LA's.</p> <p>No evidence to suggest patient experience will be improved.</p> <p>This option could have a negative effect where currently tier 3 services exist through alternative arrangements, e.g. integrated services.</p> <p>Exploring the Section 7a</p>	<p>Encourage joined up working, to potentially include active local engagement, development of guidance or toolkits and informal consultation. Involving patient groups and patients.</p> <p>This may require additional work and support to align, although approaches will seek to minimise impact on existing local protocols and enable transition. This could include building in phased approaches, informal consultations to raised issues and</p>

Joined up clinical pathways for obesity: Report of the working group

				<p>Agreement approach as a potential approach increases political and wider interest in the issue - could potentially impact on timing.</p> <p>Lack of agreement on approaches leads to a failure to establish agreement to secure responsibility for tier 3 commissioning.</p>	<p>solutions.</p> <p>Cross organisational working DH/NHSE/PHE to anticipate likely barriers / challenges and seek options to address.</p> <p>The Joined up Clinical Pathways for Obesity working group is seeking the appropriate advice from the DH public health team and NHS England sources.</p>
2.	Tiers 3 & 4 commissioned together as specialist services by NHS England	Tier 3 and tier 4 both specialist services funded by NHS England.	<p>Preserving specialist skills and expertise for tier 4.</p> <p>Help to draw tiers 3 &amp; 4 together, with the potential to increase the consistency of provision/access to tier 4 and benefit patient experience.</p> <p>Potential for increased efficiencies with regards use of financial</p>	<p>Tier 3 may not meet the criteria to become a specialised service.</p> <p>If tier 3 is redefined as a specialised service, there is potential to widen the gap between tiers 2 &amp; 3, for example reducing the role of Health and Wellbeing boards and creating</p>	<p>NHS England to explore.</p> <p>Encourage joined up working, to potentially include active local engagement, development of guidance or toolkits and informal consultation. Involving patient groups and patients.</p>

Joined up clinical pathways for obesity: Report of the working group

			<p>resources.</p> <p>Effective tier 3 services can reduce the need for consideration of surgery, so pooling the budgets for tiers 3 and 4 could have intrinsic benefits.</p>	<p>barriers for patients moving from tier 2 to tier 3.</p> <p>Patient experience no evidence to suggest this would be improved.</p>	
3.	Tiers 3 & 4 commissioned together by CCGs	<p>Tier 4 would be de-specialised and moved out of NHS England.</p> <p>CCG's would have the commissioning responsibility for both tiers 3&amp;4.</p>	<p>Potential Integration between tiers 3 &amp; 4 services.</p> <p>Should the opportunity arise to enhance the obesity QoF then patient experience could be improved due to linkages between GP registers and provision/access to services.</p> <p>Potential for increased efficiencies with regards use of financial resources. Good tier 3 services can reduce the need for consideration of surgery, so pooling the budgets for tiers 3 and 4 could have intrinsic benefits.</p>	<p>Tier 2 could possibly be oversubscribed and become unsustainable due to being seen as a 'cheaper' option to tier 3. This could lead to potentially inappropriate referrals.</p> <p>De specialising tier 4 could undermine the service.</p> <p>Losing specialist knowledge of allocating funds for patients requiring tier 4.</p> <p>Moving tier 4 out of specialist commissioning will put pressure on local</p>	<p>Encourage joined up working, to potentially include active local engagement, development of guidance or toolkits, and informal consultation. Involving patient groups and patients.</p> <p>Investigate and scope out how best to position the commissioning role for CCGs.</p>

Joined up clinical pathways for obesity: Report of the working group

			<p>A knock on effect of commissioning Tier 3 services may result in an incentive to enhance tier 2 services.</p> <p>Enhanced input from Health and Wellbeing boards.</p>	<p>level delivery. If no ring fence for CCG, funds could be diverted into other priorities, other than tier 4.</p> <p>Transactional costs may increase without necessarily the benefit to patients.</p> <p>CCG focusses attention on T3 &amp; 4 not involving other local partners.</p> <p>Variation in provision and access to services for patients.</p>	
4.	Tiers 3 & 4 commissioned together by LAs (i.e. LA responsible for all 4 tiers)		<p>Potential to integrate the pathways.</p> <p>Potential for increased efficiencies with regards use of financial resources. Good tier 3 services can reduce the need for consideration of surgery, so pooling the budgets for tiers 3 and 4 could have intrinsic benefits.</p>	<p>Moving tier 4 out of specialist commissioning will put pressure on local level delivery.</p> <p>Potentially undermining tier 4 service.</p> <p>Results in uncertainty on the lead in supporting local authorities to</p>	<p>To encourage broad engagement and views when the report of the working group is published and ensure that the views are considered going forward.</p>

Joined up clinical pathways for obesity: Report of the working group

				<p>deliver these joined up services.</p> <p>Potential Lack of clinical input into commissioning – potential cost implications.</p> <p>Transactional costs may increase without necessarily the benefit to patients.</p> <p>Potential lack of enthusiasm from LAs to commission services.</p> <p>Unable to evidence cost savings for social care.</p> <p>Too diverse a portfolio for one organisation.</p> <p>Pressure on funds may see it diverted to other priorities. Access to clinical services not as efficient.</p>	
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Joined up clinical pathways for obesity: Report of the working group

				Variation in provision and access to services for patients.  Transactional costs increased.	
5.	Tier 4 with NHS England, tier 3 with CCGs, tiers 1 & 2 with LAs	Provides an integrated and collaborative care pathway operating within the current systems, providing local assessment of need and assures universality of tier 4 services.	<p>Preserving specialist skills and expertise for tier 4.</p> <p>Local Health &amp; Wellbeing Boards can hold system to account.</p> <p>Universality for tier 4.</p> <p>Take responsibility for working to ensure effective partnership working between Health &amp; Wellbeing Boards, CCGs and LAs.</p> <p>A physician led multidisciplinary team (ie. Tier 3) is more aligned to health and CCGs than to local authorities</p>	<p>Competing priorities of finance within the system leads to ongoing issues with tier 3.</p> <p>This option could have a negative effect where tier 3 services exist through any current alternative arrangements, e.g. integrated services</p> <p>CCGs may set own thresholds for tier 3 provision.</p> <p>Unintended consequences, including patients being forwarded to tier 4 or tier 2 at a pace which is to the detriment of the patient (i.e. being sent to 'less costly'</p>	<p>This may require additional work and support to align, though approaches will seek to minimise impact on existing local protocols and enable transition. This could include building in phased approaches, informal consultations to raised issues and solutions.</p> <p>Ensure effective partnership working between all parties to promote tier-interaction.</p> <p>Ensure strict criteria and pathways are followed to reduce risk of referral up or down tiers inappropriately.</p>

Joined up clinical pathways for obesity: Report of the working group

				<p>tier 2 prematurely, not accepted into tier 3, or premature release into tier 4).</p> <p>Variation in provision and access to services for patients.</p>	
6.	Tier 4 with NHSE, tiers 1-3 with LA		<p>Consistency of approach across tiers 1 – 3.</p> <p>Potential cost saving from combining delivery teams (at varying levels) across tiers 2 and 3.</p>	<p>No funding currently allocated for tier 3 services which places an increased financial and resourcing burden on LAs.</p> <p>Placing the commissioning and contract management responsibilities with LAs colleagues, who may not have expertise in clinical service commissioning. Majority of quantifiable savings made in tier 3 services are to CCG and NHSE, not to LAs, and so become difficult to sell to elected members</p>	

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				Variation in provision and access to services for patients.  LA priorities differing across country.	
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