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Enhanced Service Specification

Weight Management 2023/24

Version 2, 1 April 2023

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1. Introduction

1.1. This enhanced service (ES) is subject to amendments from time to time. It is a national specification that cannot be varied locally.

1.2. This ES is offered by the Commissioner to all General Medical Services, Personal Medical Services and Alternative Provider Medical Services contract holders.

1.3. An ES is designed to cover and/or support enhanced aspects of clinical care, all of which are beyond the scope of essential and additional services. No part of this ES specification by commission, omission or implication defines or redefines essential or additional services.

1.4. All GP practices are offered the opportunity to sign up to this ES provided they meet the requirements of this specification. By signing up to deliver this ES, a GP practice agrees to a variation of its primary medical services contract to incorporate the provisions of this ES. The provisions of this ES are therefore deemed a part of the GP practice's primary medical services contract.

2. Commonly Used Terms

2.1. This specification is referred to as this "**ES**".

2.2. In this ES:

2.2.1. the "**Commissioner**" refers to the organisation with responsibility for contract managing these ES arrangements, which is NHS England.

2.2.2. a "**GP practice**" refers to a provider of essential primary medical services to a registered list of Patients under a General Medical Services contract, Personal Medical Services agreement or Alternative Provider Medical

Services contract who has agreed with the Commissioner to deliver this ES.

2.2.3. a GP practice's "**Obesity Register**" is its register of patients aged 18 years or over with a BMI ≥30 in the preceding 12 months which the GP practice establishes and maintains under the Quality and Outcomes Framework[1]

2.2.4. "**Weight management services**" are the services listed in paragraph 6.11; and

2.2.5. "**Referral allocation**" is the capped number of referrals to weight management services allocated to each GP practice that attract a referral payment under this ES.

2.3. In this ES words importing the singular include the plural and vice versa.

3. Background

3.1. In 2018/19 the majority of adults in England (63%) were living with excess weight with 26% of men and 29% of women living with obesity or severe obesity (NHS Digital, 2020).[2] The COVID-19 pandemic highlighted the importance of weight management. Living with excess weight puts people at greater risk of serious illness or death from COVID-19, with risk growing substantially as body mass index (BMI) increases.

3.2. As noted in the 2020 government policy document *Tackling obesity: empowering adults and children to live healthier lives*,[3] GP practices are often the first port of call when patients need health advice and support

[1] For the avoidance of doubt, although 2021/22 QOF indicator OB002 means a GP practice obesity register will contain patients with a BMI≥ 30, referrals under this ES should also include patients from Black, Asian and other minority ethnic groups with a BMI≥ 27.5.

[2] https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-obesity-physicalactivity-and-diet/england-2020/part-3-adult-obesity-copy

[3] https://www.gov.uk/government/publications/tackling-obesity-government-strategy/tackling-obesityempowering-adults-and-children-to-live-healthier-lives

(GOV.UK, 2020).[4] The government has stressed the need to increase the frequency of interventions for obesity in general practice care with a focus on improving referral pathways into weight management services in every local health care system. The continuing aim for 2023/24 is to ensure that everyone living with obesity and who wants support for weight loss is offered this.

3.3. To support this ambition, £100m per annum for the next three years was allocated through the Spending Review 2021 for healthy weight. This is in addition to the earlier commitments outlined in the NHS Long Term Plan to make weight management services available from 2021 to those living with obesity with diabetes and/or hypertension, and the doubling of the NHS Diabetes Prevention Programme over the next five years, including a new digital option to widen patient choice and target inequality.

3.4. There is good evidence to suggest that general practice plays a pivotal role in the identification of people living with obesity, discussion of the associated health issues and facilitating access to weight management services. There is also evidence to suggest that clinicians proactively offering weight management support is acceptable to patients living with obesity.[5]

4. Process

4.1. This ES begins on 1 April 2023 and shall continue until 31 March 2024 unless it is terminated in accordance with paragraph 4.2.

4.2. This ES may be terminated on any of the following events:

4.2.1. the Commissioner is entitled to require that the GP practice withdraws from this ES as set out in this ES;

4.2.2. the Commissioner is entitled to terminate this ES where the GP practice has failed to comply with any reasonable request for

[4] https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-andhealth-inequalities/obesity/

[5] The Lancet: https://www.sciencedirect.com/science/article/pii/S0140673616318931?via%3Dihub

information from the Commissioner relating to the provision of the services pursuant to this ES; or

4.2.3. the GP practice terminates this ES.

4.3. The Commissioner must invite all GP practices to participate in this ES by 14 April 2023. GP practices must sign up to participate in this ES on or before 28 April 2023 unless the Commissioner agrees otherwise. GP practices must record their agreement to participate in this ES in writing to the Commissioner.

4.4. Payment under this ES is conditional on GP practices:

4.4.1. entering into this ES, including any variations and updates; and

4.4.2. complying with the requirements of this ES, including development of a supportive environment and patient support (including dialogue with the patient) and referral.

4.5. A GP practice's participation in this ES shall only continue for so long as it is in compliance with its terms and if it does not do so the Commissioner will be entitled to require that the GP practice withdraws from the ES.

5. General Requirements

5.1. Each GP practice participating in this ES will:

5.1.1. comply with any reasonable request for information from the Commissioner relating to the provision of the services pursuant to this ES;

5.1.2. have regard to all relevant guidance published by the Commissioner or referenced within this ES;

5.1.3. take reasonable steps to provide information to patients about the services pursuant to this ES, including information on how to access the services and any changes to them;

5.1.4. ensure that it has in place suitable arrangements to enable the lawful sharing of data, including patient records, to support the delivery of the services, business administration and analysis activities under this ES in line with data protection legislation; and

5.1.5. ensure that any sub-contracting arrangements related to the provision of services under the ES, comply with the requirements set out in the statutory regulations or directions that underpin its primary medical services contracts in relation to sub-contracting, which will also apply to any arrangements to sub-contract services under the ES.

6. Service Delivery Specification[6]

6.1. Despite obesity being a recognised risk factor for the development of several long-term conditions and serious illness with COVID-19, and despite prevalence of obesity remaining high, there is evidence that the numbers of people identified by general practice as living with obesity fell during the pandemic.

6.2. The aims of this ES are:

6.2.1. to support practices to develop and implement a proactive approach to the identification of patients living with obesity; to work with wider system partners on developing pathways which incorporate multi-modal access options including online, telephone and face to face and to empower patients to actively provide and update their practice with this information online. For the purpose of this enhanced service obesity is defined as a BMI ≥ 30 or ≥ 27.5 for those of Black, Asian and other minority ethnic groups; and

6.2.2. to support practices to engage with individual patients living with obesity and, following a conversation with the patient, to refer

[6] GP practices must ensure they have read and understood all sections of this document as part of the implementation of this programme and to ensure understanding of the payment regime.

patients who are ready to make behavioural changes to appropriate weight management programmes.

Component 1: Developing a supportive environment

6.3. **Education and training:**

GP practices must assure themselves that those practice and PCN staff involved in referral and signposting conversations have the necessary skills and training on conversational approaches to lifestyle and weight management.

Practices may wish to consider whether those staff involved in making referrals to weight management services should complete the healthy weight coach training programme. A healthy weight coach engages and supports people living with overweight or obesity to make positive changes to their health and health behaviours with the aim of promoting a healthier weight.

Full information on the healthy weight coach e-learning programme for primary care networks, healthcare and pharmacies at https://www.gov.uk/government/publications/healthy-weight-coach-elearning-programme-for-primary-care-networks-healthcare-practices-and-pharmacies.

A reference guide has been developed for primary care networks, healthcare practices and pharmacies interested in training staff, and individuals interested in undertaking training, to become a healthy weight coach

The training is available on two eLearning platforms:

- Personalised Care Institute's eLearning platform
- Health Education for England's eLearning for Healthcare hub

The training guidance document and supporting resources can be found at Healthy weight coach elearning programme - PCNs and Practices Support Hub - Integrated Care (future.nhs.uk)

The healthy weight coach e-learning content is identical regardless of which e-learning platform is used.

Once all the sessions are completed then HEE's eLfH certificate of completion is generated automatically. The learner can download the certificate and print it if required or store as a PDF copy.

Learners can access the e-learning programme through the PCI. The training is endorsed by the PCI and on completion learners can receive 2½ continuous professional development (CPD) points and a PCI certificate for their learning portfolios.

Other training resources include:

- Public Health England's Let's Talk About Weight:
  https://www.gov.uk/government/publications/adult-weight-management-a-guide-to-brief-interventions

  https://www.e-lfh.org.uk/programmes/obesity/
- Making Every Contact Count:
  https://www.makingeverycontactcount.co.uk/training/
- Moving Healthcare Professionals programme:
  https://www.sportengland.org/campaigns-and-our-work/movinghealthcare-professionals
- The BWeL trial:
  https://trialsjournal.biomedcentral.com/articles/10.1186/1745-6215-14-393
- A video from the BWeL trial on how to have effective referral conversations
  https://www.phc.ox.ac.uk/supportive-and-effective-conversations-about-weight-management-referrals
- Royal College of General Practice:
  https://elearning.rcgp.org.uk/course/view.php?id=534
- Royal College of Physicians:
  https://store.rcplondon.ac.uk/product?catalog=Raising-the-topic-and-discussing-obesity-with-patients

6.3.1. Protected learning time for practice staff is important and commissioners should support this as part of routine learning activity.

6.4. **Development of a practice-based approach to the identification and support of people living with obesity:**

6.4.1. GP practices must develop and implement a protocol for the identification and support of patients living with obesity which seeks to:

- normalise conversations about weight and weight management in all consultations, not just those for long-term condition management;
- recognise that these conversations need to be handled sensitively, using shared decision-making principles, to understand if a patient would want to be referred. Having a conversation with the patient about weight and obtaining their permission for referral is required to qualify for payment under this ES.
- consider how all opportunities for the identification of people living with obesity are maximised, including how this can be achieved during telephone, virtual and face to face consultations.
- encourage patients to provide the practice with information on their weight, BMI and other self-reportable health information;
- record an updated BMI annually, where a patient has had a BMI recorded in their record that indicates they are living with obesity;
- record and maintain details of available weight management services and how to refer to them.

6.5. **Review and maintenance of the GP Practice Obesity Register:**

6.5.1. In agreeing to sign up to this ES, GP practices commit to restoring the practice Obesity Register to, at a minimum, the level of recording at either 31 March 2020 or 31 March 2021, whichever is higher (insofar as that is possible and /or clinically indicated).

Component 2: patient support and referral

6.6. For individual patients recorded on the QOF Obesity Register as of 31 March 2020 and those identified as living with obesity during the service period, the GP practice should make an individual assessment of patient readiness to engage with weight management services and record the outcome of this assessment in the patient record. This should include ensuring a recent (within 12 months) BMI is recorded (unless clinically inappropriate to do so) and an offer of a referral to an appropriate weight management or specialist service.

6.7. This individual assessment of willingness to engage with weight management services is an integral part of the referral process; there is no minimum number of referrals a GP practice has to make.

6.8. All referrals to Weight Management Services must be made by suitably trained and competent GP practice or Primary Care Network (PCN) healthcare professionals.

6.9. Prior to referral, a healthcare professional must obtain informed patient consent to engage with weight management services and the patient's consent to the referral (or the name of the person who gave consent to the referral and that person's relationship to the patient), including sharing of relevant patient information, must be recorded in the patient record. Having a conversation with the patient about weight and obtaining their permission for referral is required to qualify for payment under this ES.

6.10. All patients identified as being ready and able to engage with weight management services as set out in paragraph 6.9 should be referred to the most clinically appropriate service, recognising that some of these patients may have additional risk factors making them eligible for more specialist services e.g. non-diabetic hyperglycaemia, diabetes or hypertension.

6.11. Acceptable referrals will include:

NHS Digital Weight Management services[7] for those with hypertension and/or diabetes. This should be the default option for this cohort of patients; Individuals who satisfy all the following eligibility criteria may be referred to this service:

- Aged 18 or over
- Diagnosis of diabetes (type 1 or type 2) or hypertension or both
- A BMI of 30kg/m² or higher in people from White ethnic groups adjusted to 27.5kg/m² or higher in people from Black, Asian and other ethnic minority groups.
- Local Authority funded tier 2 weight management services;

NHS Diabetes Prevention Programme for those individuals with non-diabetic hyperglycaemia aged 18 years or over, up to and including eighty years old. Individuals who are over eighty years old are eligible to access the Service if their GP provides written confirmation to the Provider that the GP perceives the benefits of the NDPP to outweigh any potential risks of participating in a weight loss programme for that individual.

Referrals to the NHS Low Calorie Diet Programme in those ICSs where the pilot is taking place.

Individuals who satisfy all the following eligibility criteria may be referred to this service:

- Aged 18 to 65 years;
- Diagnosed with Type 2 diabetes within the last 6 years;
- A BMI of 27kg/m² or higher in people from White ethnic groups adjusted to 25kg/m² or higher in people from Black, Asian and other ethnic groups.

[7] https://www.england.nhs.uk/digital-weight-management/

- A HbA1c measurement taken within the last 12 months, with values as follows:

    - If on diabetes medication, HbA1c 43 to 87 mmol/mol; or

    - If not on diabetes medication, HbA1c 48 to 87 mmol/mol;

    provided that if there is any concern from the referrer that HbA1c may have changed since last measured, such that repeat testing may indicate that the individual would not be eligible for the Service at present, HbA1c should be rechecked by the referrer before the referral is considered; and

- Have attended for monitoring and diabetes review when this was last offered, including retinal screening, and commit to continue attending annual reviews, even if remission is achieved;

or

Tier 3 services (in line with local service inclusion criteria).and Tier 4 services.[8]

6.12. None of the above activity needs to be undertaken as part of a discrete or standalone consultation. Practices are likely to carry out the assessment of readiness and the referral itself opportunistically, as part of a broader consultation or patient contact. Many of the patients that practices will wish to refer will have co-morbidities that mean that they are already in regular contact with health care professionals in the practice.

7. Payment and Validation

7.1. To maximise referrals while ensuring expenditure stays within the £7.2m funding envelope for 2023/24, a referral allocation mechanism will apply.

[8] https://oen.org.uk/managing-obesity/nhs-tiered-care-weight-management-pathway/

7.2. Each practice that signs up to this ES will be notified of its referral allocation based on the practice Obesity Register at 31 March 2020.[9] This referral allocation will, at a minimum, be 12% of the number of patients on the practice's Obesity Register at 31 March 2020.

7.3. Practices will be entitled to £11.50 per referral to one of the services listed at 6.11, up to the limit of their referral allocation. Only one referral per patient may be claimed under this ES.

7.4. Practices must make a manual claim to their commissioner for payment. Claims must be on the basis of the number of unique patients with:

(1) a qualifying referral (coded on the basis of the SNOMED codes below) in the period of this ES;

Referral to weight management service	1326201000000101

- **Diabetes Prevention Programme for those with non-diabetic hyperglycaemia:**

  SNOMED code is: 1025321000000109 "Referral to National Health Service Diabetes Prevention Programme (procedure)"

- **Low Calorie Diet:**

  SNOMED code is: 1239571000000105 "Referral to total diet replacement programme (procedure)"

- **NHS Digital Weight Management Programme:**

[9] Because of limited practice ability to record patients' BMI during the COVID-19 pandemic, many practice obesity registers were artificially smaller on 31 March 2023, so a reference date of 31 March 2020 has been used instead.

SNOMED code is 1402911000000108 – Referral to National Health Service Digital Weight Management Programme (procedure)

SNOMED code is: 1402911000000108 - Referral to National Health Service Digital Weight Management Programme (procedure)

- **Specialist Weight Management Services:**

SNOMED code is: 1403011000000103 - Referral to National Health Service Tier 3 specialist weight management service (procedure)

SNOMED code is: 1402991000000104 - Referral to National Health Service Tier 4 specialist weight management service (procedure)

and

(2) a BMI recorded within two years at the point of referral of ≥ 30, or of ≥ 27.5 for patients from Black, Asian and other minority ethnic groups

7.6. Claims for payments for this programme should be made monthly, after the referral has been made. This should be within 12 days of the end of the month when the referral was made. Payments will be made monthly by commissioners

7.7. Commissioners may access GP practices' QOF returns for the financial year 2023/24 in respect of their Practice Obesity Registers to verify the updated register, as required under paragraph 6.5.1,[10] but only as part of their normal contract management responsibilities.

7.8. Practice-level referral allocations will be kept under regular review. Commissioners will be entitled to increase referral allocations where practices have achieved these, and are entitled to reduce referral allocations for practices from 1 October 2023 if the data available to commissioners shows that, for the period up to 31 August 2023 (or the

[10] See 2021/22 QOF indicator CB002

nearest data collection date), a practice has achieved less than 40% of their total referral allocation. This reallocation of funding entitlements between practices will help to maximise practices referrals through the scheme

7.9. Local commissioners may waive the referral allocation mechanism entirely, with any excess referral payments beyond their share of the available £7.2m national funding to be met from existing local commissioner funding allocations.

7.10. Commissioners are responsible for post payment verification. This may include auditing practice payments to ensure that they meet the requirements of this ES.

Annex A: Provisions relating to GP practices that terminate or withdraw from this ES (subject to the provisions below for termination attributable to a GP practice formation or merger) and New GP practices

1. Where a GP practice has entered into this ES but its primary medical services contract subsequently terminates or the GP practice withdraws from this ES prior to the end of this ES, the GP practice is entitled to a payment in respect of its participation if such a payment has not already been made, in accordance with the provisions set out below. Any payment will fall due on the last day of month following the month during which the GP practice provides the information required.

2. In order to qualify for payment in respect of participation under this ES, the GP practice must comply with and provide the Commissioner with the information in this ES specification or as agreed with the Commissioner before payment will be made. This information should be provided in writing within 28 days following the termination of the contract of the GP practice's withdrawal from this ES.

3. The payment due to a GP practice whose primary medical services contract subsequently terminates or that withdraws from this ES prior to the end of this ES will be based on the number of completed patient referrals (as set out in section 8), prior to the termination of the primary medical services contract or withdrawal from this ES.

Provisions relating to GP practices who merge or are formed

4. Where two or more GP practices merge or a new primary medical services contract is awarded and as a result two or more lists of registered patients are combined, transferred (for example from a terminated practice) or a new list of registered patients is developed, the new GP practice(s) may enter into a new or varied arrangement with the Commissioner to provide this ES.

5. In the event of a practice merger, the ES arrangements of the merged GP practices will be treated as having terminated (unless otherwise agreed with the Commissioner) and the entitlement of those GP practice(s) to any payment will be assessed on the basis of the provisions of section 8 of this ES.

6. The entitlement to any payment(s) of the GP practice(s), formed following a practice merger, entering into the new or varied arrangement for this ES will be assessed and any new or varied arrangements that may be agreed in writing with the Commissioner will begin at the time the GP practice(s) starts to provide this ES under such arrangements.

7. Where that new or varied arrangement is entered into and begins within 28 days of the new GP practice(s) being formed, the new or varied arrangements are deemed to have begun on the date of the new GP practice(s) being formed and payment will be assessed in line with this ES specification as of that date.

8. Where the GP practice participating in the ES is subject to a practice merger and:

    8.1. the application of the provisions set out above in respect of practice mergers would, in the reasonable opinion of the Commissioner, lead to an inequitable result; or,

    8.2. the circumstances of the split or merger are such that the provisions set out above in respect of practice mergers cannot be applied,

the Commissioner may, in consultation with the GP practice or GP practices concerned, agree to such payments as in the Commissioner's opinion are reasonable in all of the circumstances.

New contract awards

9. Where a new primary medical services contract is awarded by the Commissioner after the commencement of this ES, the GP practice will be offered the ability to opt-in to the delivery of this ES provided it is before the date set out at paragraph 4.3.

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

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