necs A care system support organisation

NHS

HWTO Patient Prioritisation Guideline

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Contents

1. Introduction

In February 2025, ICB executive agreed to commission the prescribing of Semaglutide, Liraglutide and Tirzepatide for managing overweight and obesity. This is within tier 3 specialist weight management drugs, in accordance with NICE technology appraisals TA875, TA664 & TA1026.

These medicines provide an opportunity to support patients to lose weight, but there is likely to be greater demand than funded courses available. In 2018/19 most 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). 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.

Moving into the 2025/26 financial year, £686k funding for these medicines has been agreed for use across all providers by NENC ICB – equating to approximately 566 treatment courses of semaglutide, liraglutide or tirzepatide for patients across the region.

This is welcome news for clinicians and patients, but it will not be sufficient for all patients clinically eligible for these treatments to be able to access treatment in the short term. It is anticipated that this funding will allow for treatment of approximately 15% patients eligible.

This guideline seeks to support clinicians when considering the use of semaglutide, liraglutide and tirzepatide – to provide an agreed prioritisation tool to ensure that the patients who will see the greatest clinical benefit have access to ICB funded treatment courses in NENC.

Please Note: Semaglutide and liraglutide are RED drugs for this indication and therefore prescribing cannot be passed to general practice for continuation, however tirzepatide is expected to be reclassified as Green allowing ongoing management in general practice. Please check the formulary listing for up-to-date status.

2. Existing Service Tiers

Currently, obesity services are offered to patients in a tiered approach.

1. Tier 1 – Universal Intervention – population level advice.
2. Tier 2 – Community based dietary advice & behavioural change support.
3. Tier 3 – Longer and more comprehensive MDT approach – Usually based in secondary care.
4. Tier 4 – As per Tier 3 – but including patients receiving bariatric surgery.

Under this system, access to medications such as semaglutide, liraglutide and tirzepatide will be via Tier 3 & 4 services only. When the ICB funded treatment courses are made available,

many of the patients eligible may not be known to Tier 3 and 4 services. Furthermore, management of these patients within secondary care may be challenging due to capacity issues.

Patients will also likely be aware of these changes because of local media campaigns. This will cause heightened expectation for patients who may expect that their GP will be able to initiate treatment quickly.

It is vital therefore that stakeholders across the ICB have access to a single document which provides clarity for initial access to these treatments.

3. Decision to Treat Pathway

As funding for these treatments is only likely to cover around 15% of users in a Trusts weight management service, it is important to ensure clinicians across NENC ICB are considering which patients to commence treatment is fair and consistent, and that the same considerations are being made. It is also encouraged to consider all patients in your service collectively.

Below is a range of considerations that, if followed uniformly across the region, should ensure this consistency. However, it does not remove clinicians right to exercise clinical judgement and is not designed to be overly prescriptive.

Detailed considerations and their justification is detailed below, with a step-by-step pathway included in *Figure 2*.

1. BMI Criteria

   To facilitate clear and consistent decision making, this ICB guideline is following the NHSE & NICE funding variation for the implementation of NICE TA for tirzepatide which uses a standard BMI and comorbidity threshold. This will apply to all three medicines included in this guidance. This includes the 3-phased roll-out as agreed within the relevant funding variation as described in Table 1 below.

Phase	Year	BMI Criteria
Phase 1	2025/26	≥40kg/m^2 with 4+ comorbidities
Phase 2	2026/27	≥35kg/m^2 to ≤39.5 kg/m^2 with 4+ comorbidities
Phase 3	2027/28	≥40kg/m^2 with 3+ comorbidities

Table 1 - BMI and Co-morbidity criteria for financial years 2025/26 through to 2027-28.

2. 4+ co-morbidities

   NHS England data suggests that around 138,400 patients are eligible for access to these medicines when considering the standard NICE requirements. When reviewing the demographics of these patients, the greatest benefit will be seen where BMI exceeds 40*, with the presence of 4 or more comorbidities.

   This initial consideration would reduce the number of patients to around 800 which is not only a more manageable number but also addresses those with the most complex multi-condition groups as opposed to targeting those with the largest BMI. *Figure 1* provides an overview of relevant co-morbidities, and the level of weight loss required to see the greatest benefit.

   **Use lower BMI thresholds (usually reduced by 2.5kg/m^2) for people from South Asian, Chinese, other Asian, Middle Eastern, Black African of African-Caribbean ethnic backgrounds.*

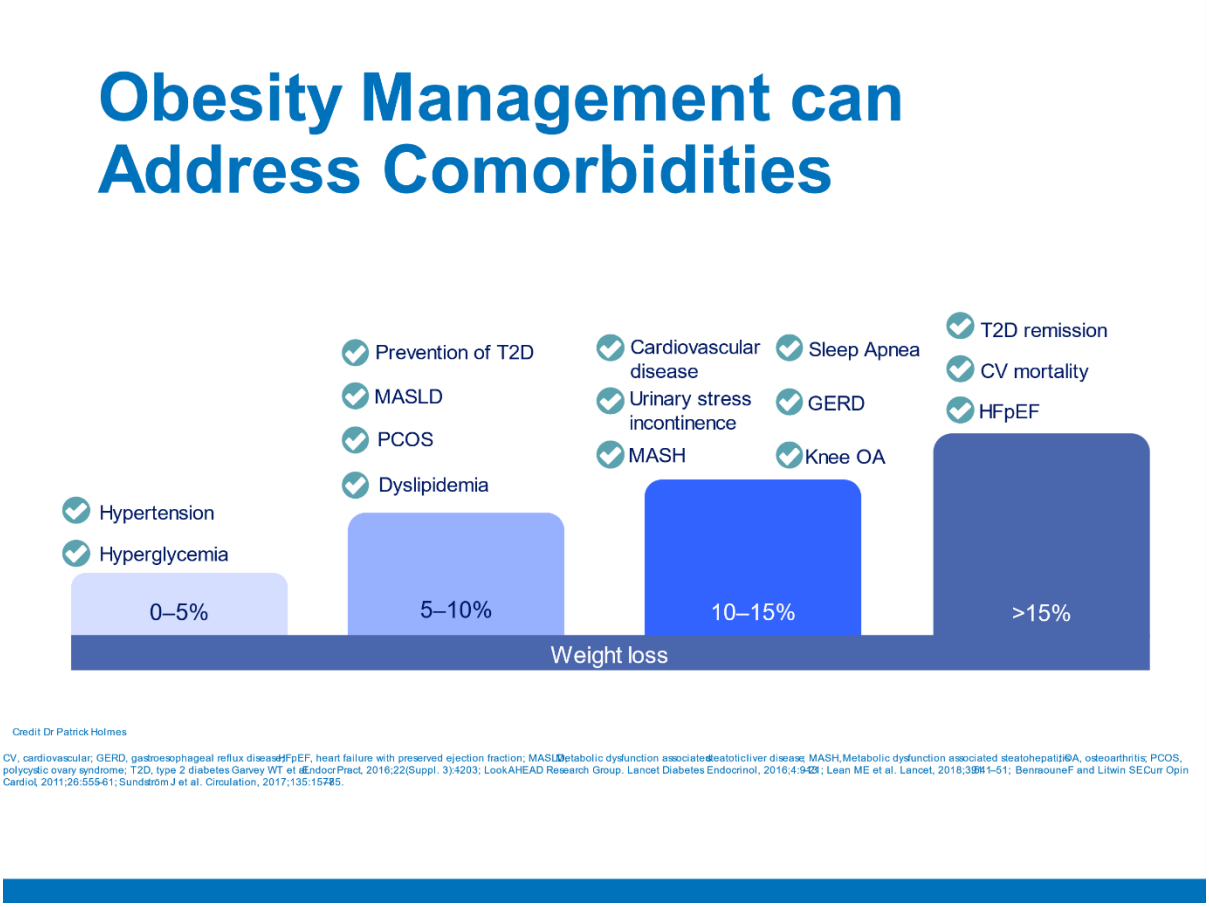

Figure 1 - Obesity Management Comorbidities

3. Protected Comorbidities

   Protected comorbidities are those which have a direct relationship to obesity, and it is known that reduction in weight may have significant impact upon these issues. It is the

recommendation of the group that these are a 3rd line treatment consideration, whereby less than 4 comorbidities are present, but 2 or more of the following is confirmed:

- Atherosclerotic vascular disease, cardiac conditions which will improve with weight loss
- Hypertension
- Dyslipidemia
- Obstructive sleep apnoea
- Prediabetes mellitus
- Type 2 diabetes
- Metabolic associated steatotic liver disease (MASLD)

In patients who require this treatment outside of these guidelines' decisions should made by the Specialist Weight Management MDT or Specialist Weight Management Service Lead Clinician*

4. Time Sensitive Interventions

   Consideration should be given to those patients who may not meet the previous co-morbidity related criteria but have time sensitive interventions which are currently being delayed or impacted by their BMI. Where patients are awaiting surgery or treatment for cancer or other life-threatening/significantly life-impacting illnesses, then consider prioritising these patients using BMI >35.

5. Level of Deprivation

   It is recognised that patients living in high levels of deprivation may see a significant benefit from reduction in weight, therefore where known high levels of deprivation are a factor, this may be considered alongside the other criteria.

Figure 2 - Prioritisation Consideration Pathway

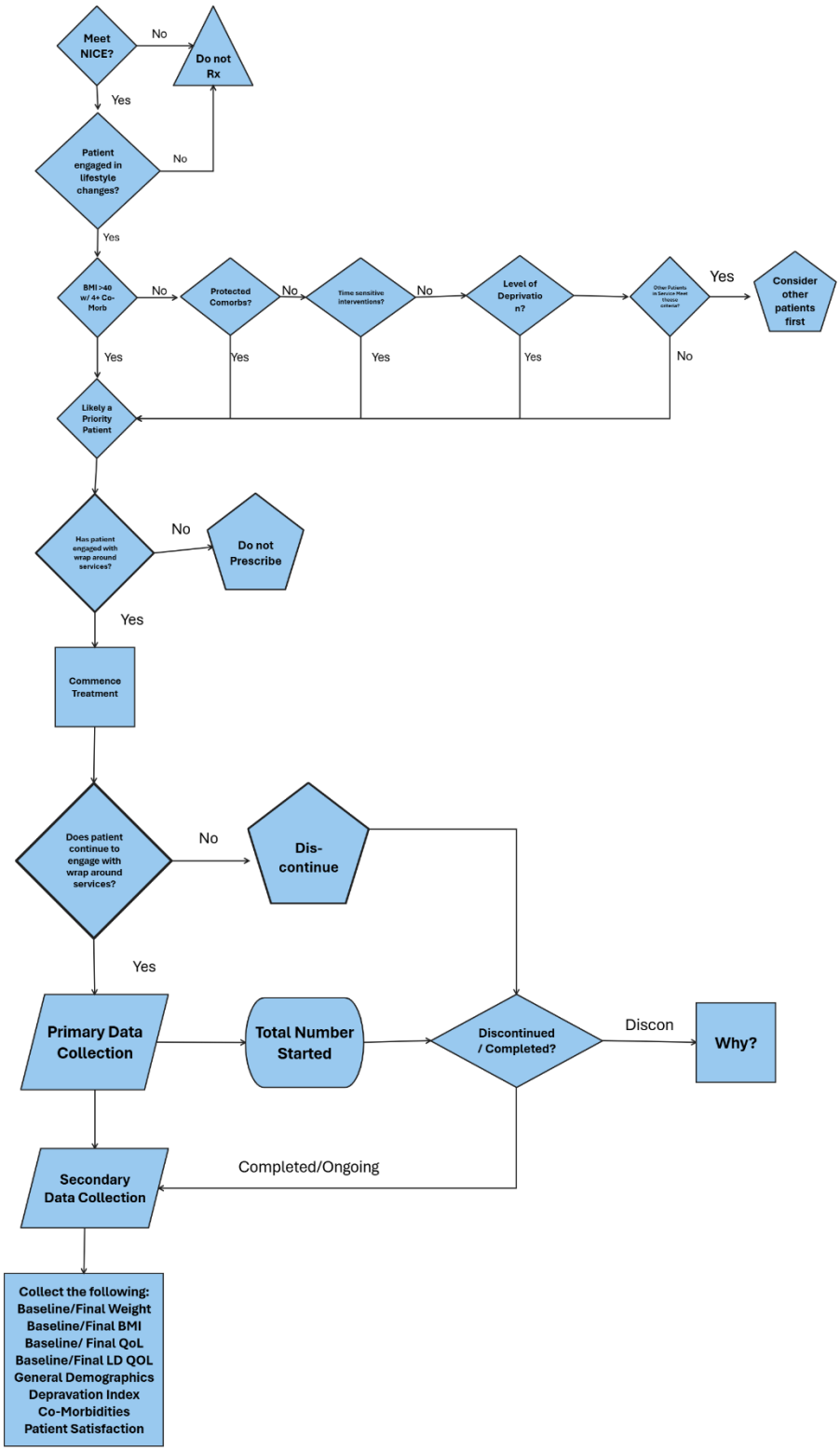

Figure 3 - Decision to Treat Pathway

4. Implementation

This guideline has been prepared by specialist clinicians across NENC and supported by Clinical Effectiveness Group (CEG). Following agreement by NENC ICB, it is expected this guideline will be used as a decision-making aide by when initiating patients on these treatments at a Trust level.

5. Ongoing Monitoring

It is important to ensure that the use of these treatment courses is not only targeted to where the most benefit will be seen, but also that the desired outcomes are being achieved. It is requested that patients initiated on Semaglutide, Liraglutide and Tirzepatide are monitored to ensure ongoing treatment is appropriate.

Data is split into primary and secondary data collection. A breakdown of these can be seen in Table 1, and example KPI Data Collection templates are available in Appendix 3.

Primary Data Collection	
Required Data	**Comments**
Number of Patients Initiated in your Service	
Number of patients who had treatment discontinued	e.g. intolerated does, didn't meet NICE criteria of 5% weight loss at 6 months or non-engagement with regular appointments
Number of patients completed	Max funded duration = 12 months
Secondary Data Collection	
Weight & BMI	Change in Weight & BMI
Diabetes Status	Change in HbA1c levels of patients with T2DM
Quality of Life (QoL) Score	Change in EQ-5D-5L scores of participants (as an example)
Learning Disability QoL Score	Change in Personal Wellbeing Index-Intellectual Disability score(s) of participants (as an example)
Participant satisfaction	How happy/satisfied participants were with the weight loss service. **In this instance, the weight management service should select the questionnaire/method they feel is most appropriate for their use.**

Demographic Details	Ethnic Background, Age, Gender/Sex
Deprivation Index	
Co-Morbidities	Document any impact on existing co-morbidities.

Table 2 - Data Collection Definitions

6. Stopping Criteria

Due to the limited number of funded courses, and the 12-month funding duration per patient, it is critical to ensure fair and consistent criteria is applied to the cessation of treatment. The following are general guidelines, and it will be good practice for the clinician initiating treatment to have the discussion with the patient about the stopping criteria before commencing and ensure their understanding and agreement with these criteria.

Stopping Criteria	
1	Maximum of 12 months of treatment from the date the drug was started
2	When the patient achieves 20% weight reduction, if its earlier than 12 months
3	If the patient does not achieve 5% weight reduction by 6 months
4	If the patient does not show any further weight reduction for more than 2 consecutive months
5	If the patient was initiated on treatment for any specific purpose, within the funding variations criteria (for example to make them suitable for a surgical procedure, assisted fertility) it should be stopped when they become suitable for the procedure
6	If the patient is unable to maintain the lifestyle changes
7	If the patient fails to attend the review appointments on more than 1 occasion
8	If the patient undergoes bariatric surgery/ listed for bariatric surgery, before the 12 months treatment is completed
9	If the clinician and/or patient does not feel the clinical improvement or benefits of the treatment are satisfactory
10	If the patient develops intolerance, side effects or complications
11	If the patient fails to actively engage with the wrap around support services* provided

Table 3 - Stopping Criteria

*Wrap around support services include specialist weight management services, national weight management provision and other locally commissioned services.

These agreed criteria can be added to data collection to document reasons for non-completion of treatment and provides assurance for clinicians that discontinuing treatment for these reasons is acceptable and appropriate.

Appendix 1 – Prioritisation Table

Priority Level	Key Criteria	Comments
1	Patients with cancer or in pre-malignant state	Patients with cancer or pre malignant conditions in which weight loss will improve outcomes or aid access to therapies
2	Organ Transplant	Patients requiring urgent weight loss for organ transplant
3	Fertility	Weight loss required for assisted conception in women under the care of a fertility service, in cases where weight loss would be beneficial
4	Life-Limited Co-morbidities (i)	Patients undergoing planned time-sensitive surgery for life-limiting conditions, where high BMI is the primary barrier for surgery and weight loss would be beneficial (for example a patient with limited mobility due to osteoarthritis knees needing urgent knee replacement or Neurosurgery)
5	Bariatric Surgery	Part of staged bariatric procedure: patients with BMI more than 60 being planned for bariatric surgery- to use GLP-1 analogue as part of the staged bariatric procedure (initial GLP-1 analogue use- followed by intragastric balloon- followed by bariatric surgery). this should be considered only for patients who agreed to progress to bariatric surgery
6	Genetic Issues	Proven genetic causes for obesity (example MC4 R gene mutation)
7	Life-Limited Co-morbidities (ii)	Life-limiting conditions like chronic kidney disease stage IV, ischaemic heart disease with 2 or more episodes, obesity in association with familial hypercholesterolaemia)
8	>4 co-morbidities	Patients with 4 or more qualifying comorbidities (See *Appendix 2* for co-morbidities list)

Appendix 2 – KPI Data Collection (Example)

Primary Data Collection Example

Month	1	2	3	4	5	6	7	8	9	10	11	12	Totals
New Patients Started													
Patients Discontinued													
Reasons for Discontinuation													

Secondary Data Collection Example

Demographics				Baseline					12-Month Review				
Patient Ref	Ethnicity	Age	Gender	Weight	BMI	DM Status	QoL Score	LD QoL	Weight	BMI	DM Status	QoL Score	LD QoL