NICE National Institute for Health and Care Excellence

Tirzepatide for managing overweight and obesity

Consultation on the application to vary the funding requirement – deadline for comments by 5pm on Thursday 24 October 2024. **To return, please upload to NICE Docs. If you have any queries, please contact TATeam1@nice.org.uk**

Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly.		
Organisation name –		**Royal College of General Practitioners**
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.		**None**
Name of commentator person completing form:		Michael Mulholland/Adrian Hayter
Comment number	**Section number**	**Comments** Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
Example 1		Submission Template Variation to Funding Period by NHSE
1	5	We are in general supportive of a phased approach in three parts as suggested (ABC) but question the rationale and evidence behind of the timescales for the phasing in stages B and C.
2	5 and Annex D	We are concerned that the implementation of 9 yrs over 7 phased cohorts shall mean that over the first 3 years the eligible cohorts shall move slowly to around 5% of the total eligible population. This shall have an unaccounted impact on general practice with regards to the potential impact of patients who do not meet the NHS criteria but who may meet the drug licence criteria seeking the support from NHS general practice. This role could be in supporting an understanding around the eligibility, making referrals into a local intermediate service or in house arrangements or accurate up to date recording of weight on a regular basis (this is not currently commissioned beyond QOF areas), There is also the risk of unintended consequences of patients seeking to increase their weight to meet the eligibility standards. We are concerned that as only 5% of the total eligible population shall in fact be **ineligible** after the first 3 years and that this may drive an increase in private clinics which may have two consequences a) not providing a holistic service which includes psychological, nutritional and exercise support b) cause a shift in the general practice workforce to support general practice weight loss clinics. There is a potential risk of this shift to private care on quality issues in NHS practice. Ongoing monitoring of chronic conditions is necessary whilst on Tirzepatide and regular medication review to ensure there is no negative impact of prescribing. There are a range of conditions where deprescribing or down titration of medication is required to avoid serious harm consequently. (This is seen currently with digital weight management services where the monitoring of prescribing disease monitoring takes place separately to a remote service). We call upon Commissioners to consider the opportunity to ensure more adequate funding to support GP retention and allow modelling for a greater GP workforce to deliver against this and other areas of new clinical practice.
3	5 and Annexe D	We are concerned that current commissioning arrangements by NHSE around weight management services are confusing (for both patients and professionals). There is a

		lack integration with services commissioned across ICBs through local authorities and health commissioners. We recognise and support the need to that in many areas of the country that diet exercise and behavioural approaches are not universally commissioned and support NICE Clinical Guideline 189 where pharmacological treatment should be considered after dietary exercise and behavioural approaches have been started and evaluated. We believe that an emphasis on dietary quality as well as reduced calorie diet is needed. The support of adequately trained dieticians and the specific support needed to consider of Ultra processed foods taking into account the evidence from metabolic ward studies. We recognise that malnutrition is also a risk in those who are living with obesity and the unmasking of mineral and vitamin deficiencies as well as conditions like sarcopenia in older patients is required to be considered in the clinical pathway. We welcome the modelling of Dietician sessions into the implementation plan in Annexe D however would need to understand the model of delivery within these sessions and how they integrate with general practice. We would support that these approaches continue alongside pharmacological treatment to deliver the improved sustainable outcomes that are needed. We are concerned about the separation of commissioning arrangements between ICBs and NHSE Specialised Services and call for a whole system approach to commissioning where commissioning occurs across the whole obesity pathway and funding is invested up front in the pathway.
4	5 Annexe D	We have concerns about the reliance on the SURMONT trial data and would recommend that during the review at the 3 yr period further evidence around the long term outcomes is taken into account with effectiveness data. The SURMONT - 4 trial showed that that withdrawing tirzepatide after 3 yrs led to a substantial regain of lost weight. If we need to adopt a sustainable long-term approach it is important that behavioural approaches continue to support patients and further health outcome data (not just weight) is collected to ensure the maximum benefit to patients with the least time on medication. The trial data was not well represented by groups from more deprived communities where confounding factors such as multiple comorbidities polypharmacy and confounding factors like malnutrition were not considered. We welcome the opportunity in the Funding variation and implementation pause at 3 yrs to consider real world evidence and would like to emphasise the need to take into account ensuring that we don't unintentionally widen the health inequality gap for deprived communities. An intensive population health driven personalised approach must be a part of future delivery and the equality impact assessment is welcomed and needs to be reviewed closely at every stage of implementation.
5	5 Annexe D	We are concerned that NHSE have identified five different delivery models in partnership with ICBs however the details of these 5 models has been redacted. We are therefore unclear on the role of general practice in these 5 models and call for openness and transparency with the RCGP. We believe that there can be increased additional capacity in general practice to meet demand with extra core funding. We believe that General Practitioners have the capability to support the treatment pathways and undertake prescribing and monitoring and recall of patients on this medication but to also coordinate a holistic personalised approach incorporating nutritional and exercise support. The RCGP GPwER in lifestyle medicine provides support and professional standards specifically around this area and we would like this to be recognised within the new models of care that are being developed.
6	6	We welcome that NHS England has not entered a commercial arrangement with Eli Lilly and recognise that this is on the basis of the first 3 years of implementation. We call for continued transparency around future funding arrangements as this has an

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		impact on workload and prescribing budgets which is under the management of general practice.
7	7	We call upon DHSE and NHSE to not only consider new costs of Tirzepatide and the creation of a new Tirzepatide pathway but to consider the opportunities for the GP workforce through extra retention of staff over this funding period. The investment in the service needs to include not only the costs of the time to deliver a service but the ongoing training and sustainability of the workforce through ongoing education and quality improvement. The current outline does not make it clear how much of this cost shall go to ongoing support for workforce retention and sustainability in general practice.
8	Whole document	We are concerned that the funding variation does not include information on the statutory duties to address the net zero emissions target. We would recommend that this is built into the implementation plan alongside the funding variation that is required. We would like to see this reflected in the commercial arrangements as well as service delivery and that a clear net zero impact assessment is made alongside the Budgetary Impact test. The RCGP remains committed to its priority of environmental sustainability and impacts to the environment.
9	9	We call upon NHSE and NICE to specifically work with RCGP in part A of the implementation period regarding clinical and pathway guidance (specifically with the Clinical policy team in RCGP). We have a team of clinical advisors many of which have experience in prescribing and weight loss support. We also have developed a framework for GPwER in lifestyle medicine which could support pathway implementation. Although we have so far not been a part of the process of design of the 5 models we feel it is important in terms of the central role of General Practitioners in delivering the pathway changes and the role of the College in supporting the delivery of quality of care by GPs. We need a clear understanding of the 5 proposed models and how General Practitioners work within each of these models and support is needed to give clarity to both the public and professionals. We would expect resources around local and national communication to be available.as well as pathway guidance at both a national and local level.

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 set of comments from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Please underline all confidential information in turquoise. If confidential information is submitted, please also send a 2nd version of your comment with that information replaced with the following text: 'confidential information removed'. See the Health Technology Evaluations manual (section 5.8.51) for more information.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Do not use abbreviations Do not include attachments such as research articles, letters or leaflets. For copyright reasons, we will have to return comments forms that have attachments without reading them. You can resubmit your comments form without attachments, it must send it by the deadline.

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- If you have received agreement from NICE to submit additional evidence with your comments on the appraisal consultation document, please submit these separately.

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