NICE National Institute for Health and Care Excellence

Resource impact summary report

Resource impact
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Resource impact summary report

This summary report is based on the NICE assumptions used in the resource impact template. Users can amend the 'Inputs and eligible population' and 'Unit costs' worksheets in the template to reflect local data and assumptions.

This report and the accompanying template support both the NICE technology appraisal for tirzepatide and the NICE guideline for overweight and obesity management. The report and accompanying template also replace the existing report and template for the NICE technology appraisals for semaglutide (TA875) and liraglutide (TA664) for managing overweight and obesity. The template gives an overview of a variety of different interventions for people with overweight and obesity and allows users to build a comprehensive view of resource requirements.

NICE has recommended tirzepatide as an option for managing overweight and obesity, alongside a reduced-calorie diet and increased physical activity, in adults, only if they have:

- an initial body mass index (BMI) of at least 35 kg/m^2 and
- at least 1 weight-related comorbidity.

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

If less than 5% of the initial weight has been lost after 6 months on the highest tolerated dose, decide whether to continue treatment, taking into account the benefits and risks of treatment for the person.

These recommendations are not intended to affect treatment with tirzepatide that was started in the NHS before this guidance was published. People having treatment outside these recommendations may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS healthcare professional consider it appropriate to stop.

The level of activity for bariatric surgery is not expected to change as a result of the guidance. But, the recommendations give healthcare professionals more flexibility in offering surgery to people who can benefit from bariatric surgery without needing to exhaust every other possible treatment first. In the long term, increased use of GLP-1 receptor agonists may reduce the demand for bariatric surgery.

Low- and very low-calorie diets are currently offered to people with a diagnosis of type 2 diabetes within the last 6 years under the diabetes path to remission programme. The recommendations in the guidance make this available to more people and users are encouraged to assess locally the likely uptake of these interventions.

Eligible population for tirzepatide

Table 1 shows the number of people who are eligible for tirzepatide in each of the next 3 years. These figures include the impact of the predicted population growth but do not include any increase in the prevalence or include any adjustment for people who qualify with a lower BMI as detailed in the guidance recommendations.

Table 1 Total population eligible for tirzepatide in England for the first 3 years

Eligible population	Population as per TA	Population as per NHS England policy
Current year	3,600,000	0
Year 1	3,640,000	97,500
Year 2	3,670,000	240,000
Year 3	3,700,000	280,000

Abbreviations: TA, technology appraisal.

The assumptions used to calculate the eligible population are shown in table 2.

Table 2 Assumptions and sources for eligible population

Assumption	Source
25.4% of adults have a BMI of 30.0 to 39.9 kg/m^2	Health Survey England

Assumption	Source
29.5% of these have a BMI of 35.0 to 39.9 kg/m^2	EAG analysis
69.9% of these have at least 1 weight-related comorbidity	Analysis of GP practice data of people with hypertension, dyslipidaemia, obstructive sleep apnoea, atherosclerotic cardiovascular disease, type 2 diabetes, prediabetes and non-alcoholic fatty liver disease
3.5% of adults have a BMI of 40.0 kg/m^2 or more	Health Survey England
71.0% of these have at least 1 weight-related comorbidity	Analysis of GP practice data of people with hypertension, dyslipidaemia, obstructive sleep apnoea, atherosclerotic cardiovascular disease, type 2 diabetes, prediabetes and non-alcoholic fatty liver disease

Abbreviations: BMI, body mass index; EAG, external assessment group.

Treatment options for the eligible population

The current treatment options available for the eligible population are liraglutide, semaglutide, diet and exercise, very low-calorie diets (meal replacement) and bariatric surgery.

Tirzepatide is a further treatment option and is the first GLP-1 receptor agonist to be recommended for use as an option for treating obesity outside a specialist weight management setting (it is recommended for use in all settings).

For more information about the treatments, such as dose and average treatment duration, see the resource impact template.

Financial resource impact (cash items)

The key drivers of financial resource impact are:

- the large eligible population
- treatment costs and the cost of wraparound care.

Users should use the template to assess locally the resource impact of implementing the guideline and the technology appraisal guidance.

For further analysis or to calculate the financial impact of cash items, see the resource impact template.

Capacity impact

The NHS England prescribing policy for tirzepatide has targeted 3 cohorts of people in the first 3 years. These are people with a BMI of:

- 40 kg/m^2 or more and 4 or more comorbidities in year 1
- 35 to 39.9 kg/m^2 and 4 or more comorbidities in year 2
- 40 kg/m^2 or more and 3 or more comorbidities in year 3.

This approach to implementation within primary care as a novel care setting for tirzepatide in the management of obesity, focuses on managing primary care capacity and enabling access for people with the highest clinical need. The approach considers comorbidities as the main qualifier in clinical prioritisation, in association with BMI to phase access. Table 3, shows the average number of GP appointments yearly for people in these cohorts, based on a NICE analysis of Clinical Practice Research Datalink (CPRD) data of a cohort of 11 million people with a BMI of 30 to 34.9 kg/m^2 and no weight-related comorbidities shown as a baseline for comparison.

Table 3 Average GP appointments per year by BMI and comorbidities

Cohort	Mean GP appointments per year
BMI of 40 kg/m^2 or more and 4 or more comorbidities	18.0
BMI of 35.0 to 39.9 kg/m^2 and 4 or more comorbidities	17.0
BMI of 40 kg/m^2 or more and 3 or more comorbidities	15.0
BMI of 30 kg/m^2 to 34.9 and 0 comorbidities	7.0

Abbreviations: BMI, body mass index.

For analysis or to calculate the financial capacity impact from a commissioner (national) and provider (local) perspective, see the resource impact template.

Using the template

The resource impact template can be used to estimate the resource impact at a variety of local and national levels based on NICE assumptions or user entered assumptions. Wherever light blue cells are present, users can enter missing information or amend the information already in the template.

Inputs and eligible population

This tab is used to calculate the eligible population and input uptake and the price of the various interventions available to the population. There is a requirement to enter the population who will be eligible at lower BMI thresholds because of their ethnicity, the number of people assessed for medicines in a non-specialist setting, the proportion who will go onto receive the medicine and the proportion who will receive either face to face or digital support. This is to ensure the capacity impact for the initial assessment is captured for all people undergoing the assessment.

Resource requirements

This tab is used to input the number and length of various capacity-impacting elements of interventions such as GP appointments, nurse appointments, dietician support and the staff band and pay grade of the person delivering the intervention. Titration appointments can be entered under GP, nurse, pharmacy or a combination of all 3 depending on local arrangements. They should be entered based on people using the maximum dose (this will automatically be weighted by the template). Resource requirements are separated into specialist and non-specialist settings. Users can input an appointment length and the number of appointments required for a variety of interventions per person per year and this will feed into calculations in the capacity tabs. Table 3 shows the estimated resource requirements for prescribing tirzepatide as set out in annex B of NHS England's funding variation request for TA1026. Local practice may vary but these are included here to assist organisations who may be having difficulty estimating the resource requirements. The figures in table 4 assume all titration appointments are performed by GP.

Table 4 Resource requirements as outlined in NHS England funding variation

Resource type	Slot length (minutes)	Slot requirement first treatment year	Slot requirement subsequent treatment years
GP	10	21	3
Nurse	10	7.5	3
Healthcare assistant	10	1	0
Pharmacy	10	3	3
Dietician	30	5	4
Psychologist	30	5.5	3

Unit costs

This tab is used to calculate the annual cost of various interventions based on information entered into the inputs and eligible population tab and additional information entered directly into the blue cells in this tab. The unit costs calculated in this tab are used with the eligible population and uptake data to assess the annual resource impact in the financial impact (cash) tab. Weighting for the dose in use are considered for tirzepatide to calculate the average cost for the population receiving tirzepatide. This is not required for the other drug treatment options. Discontinuation rates are applied for tirzepatide, semaglutide and liraglutide.

Events

The events tab is used to calculate potential events savings as a result of people achieving at least 20% reduction in weight for a variety of interventions. Users can input the proportion of people expected to achieve a reduction in weight of at least 20% for a variety of interventions and the template will calculate the reduction in negative health events over 5 and 10 years.

Summary

This tab summarises the resource impact in cash and capacity terms using information entered in the first 3 tabs.

Financial impact (cash)

This tab gives a breakdown of the annual cash cost of implementing the guidance based on information entered in the inputs and eligible population and unit costs tabs. Some of the information in this tab is summarised in the summary tab.

Capacity non-specialist services and capacity specialist services

These tabs calculate the capacity impact of implementing the guidance for specialist and non-specialist weight management settings based on information entered in the inputs and eligible population and resource requirement tabs. Some of this information is summarised in the summary tab.

Payscales

This tab lists the different agenda for change payscale hourly costs that can be used in the resource requirements tab. Users can select either Higher Cost Area Supplements (HCAS) or non-HCAS annual salary costs for use in the calculations and are also able to amend the hours used to calculate the hourly rate

Key information

Table 5 Key information

Time from publication to routine commissioning funding	For the funding variation cohort identified: 90 days in specialist weight management settings, 180 days in non-specialist settings
Commissioners	Integrated care boards
Providers	Specialist and non-specialist weight management services
Pathway position	Can be used at any stage of treatment in combination with diet and exercise

About this resource impact summary report

This resource impact summary report accompanies the NICE guideline on overweight and obesity management and the NICE technology appraisal on tirzepatide for managing overweight and obesity and should be read with them. See terms and conditions and on

the NICE website.

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