NHS England

CCG Pack

Appendix 7 Guidance for Clinical Commissioning Groups (CCGs): Clinical Guidance: Surgery for Severe and Complex Obesity

Guidance for commissioning obesity surgery

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Contents

1 Guidance Statement

NHS England will transfer the responsibility for the commissioning of severe and complex obesity services as a treatment for selected patients that have not responded to all other non-invasive therapies to clinical commissioning groups with effect from 1st April 2016. In creating this guidance NHS England has reviewed this clinical condition and the options for its treatment. It has considered the place of this treatment in current clinical practice, whether scientific research has shown the treatment to be of benefit to patients, (including how any benefit is balanced against possible risks) and whether its use represents the best use of NHS resources.

This guidance document provides an outline of the service and is guidance for Clinical Commissioning Groups to consider when commissioning this service. In particular this guidance relates to the criteria for referral and acceptance for surgery of this treatment for the population in England. This guidance document should be read together with the specification guidance.

2 Equality Statement

NHS England has a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved as enshrined in the Health and Social Care Act 2012. NHS England is committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. In carrying out its functions, the NHS England will have due regard to the different needs of protected equality groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

3 Plain Language Summary

NHS England has a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved as enshrined in the Health and Social Care Act 2012. NHS England is committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. In carrying out its functions, the NHS England will have due regard to the different needs of protected equality groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

4 Introduction

Obesity is a major public health problem due to its association with serious chronic diseases such as Type 2 Diabetes, hypertension, hyperlipidaemia which are major risk factors for CVD. Obesity is also associated with cancer, disability, liver disease, poor mental and psychological health, disability, reduced QOL and premature death. The obese state shortens life expectancy. The expected years of life lost is 13 years for men and 8 years for women, for men and women between 20-30 years of age with a BMI greater than 45. It is estimated that circa 6.8% of deaths are attributable to obesity.

Sixty – six percent or two thirds of men are overweight and obese. A quarter of men (24.7%) and women (24.9%) are obese. Trends in obesity prevalence in adults have shown a rise from just under 15% (1993-1995) to 25% (2011-2013). The trend line has been almost flat since 2005-2007. The trend in prevalence of severe obesity (BMI ≥ 40), over the same period has risen steeply from 1.5% to 3.5% in women but remained constant at 3.5% since 2009-11. In men the rise has been from < 0.2% to circa 1.2%.

BMI increases over time have been accompanied by increases in waist circumference. Taking both BMI and waist circumference into account, 23 % of men and 24% of women are held to be at very high risk of obesity- related ill- health. The prevalence of adult obesity shows an increase with age, from 45-74 years, for both men and women, The North West and Yorkshire and Humber sub-regional Hubs have the highest prevalence of obesity for women and the West Midlands for men. London has the lowest regional figures for both men and women. A North- South divide is very much evident. There is also evidence of a socio- economic gradient with a 10% difference in obesity prevalence between the highest income quintile and the lowest two income quintiles. There is a similar difference between those with no qualifications compared with those with NV04/5 or Degree and equivalent. Again a similar difference is seen with deprivation and with ethnicity; for Pakistani, Black/Caribbean women and Black/Caribbean men. [1,2,3]

The treatment of obesity should be multi-component. All specialist weight management programmes should include non-surgical assessment of patients, medical treatments and lifestyle changes such as improved diet, increased physical activity and behavioural interventions. There should be access to more intensive treatments such as low and very low calorie diets, pharmacological treatments, psychological support and specialist weight management programmes.
Surgery to aid weight reduction for adults with morbid/severe obesity should be considered when there is recent and comprehensive evidence that an individual patient has fully engaged in a structured, specialist weight loss programme; and that all appropriate non-invasive measures have been tried continuously and for a sufficient period; but have failed to achieve and maintain a clinically significant weight loss for the patients clinical needs (NICE CG 189 recommendations).4 The patient should in addition have received adequate education, been adequately counselled and prepared for obesity surgery.

This surgery, which is known to achieve significant and sustainable weight reduction within 1-2 years, as well as reductions in co-morbidities and mortality, is commonly known as obesity surgery. The current standard obesity operations are gastric banding, gastric bypass, sleeve gastrectomy and duodenal switch. These are predominantly undertaken laparoscopically.

Obesity surgery is the most effective weight-loss therapy and has marked therapeutic effects on patients with Type 2 diabetes. The economic effect of the clinical benefits of obesity surgery for diabetes patients with BMI ≥35 kg/m has been estimated in patients aged 18-65 years. Surgery costs were fully recovered after 26 months for laparoscopic surgery. The data suggest that surgical therapy is clinically more effective and ultimately less expensive than standard therapy for diabetes patients with BMI ≥ 35 kg/m. Other groups have been less well studied but obesity surgery is reported to be cost effective against a wider range of co-morbidities.
Revision surgery is clinically indicated to treat complications arising > 90 days after the index obesity procedure.

A revision procedure is considered clinically necessary when there is documentation of a secondary surgical complication related to the original obesity operation or there is evidence of metabolic complications of obesity surgery (see below).

5 Definitions

Table 1: Body Mass Index (BMI) categories

Definition	BMI range (kg/m2)
Underweight	Under 18.5
Normal	18.5 to less than 25
Overweight	25 to less than 30
Obese	30 to less than 40
Obese I	30 to less than 35
Obese II	35 to less than 40
Obese III	40 and over
Overweight including obese	25 and over
Obese including morbidly obese	30 and over

Gastric banding
The gastric band (or sometimes referred to more fully as laparoscopic adjustable gastric band – LAGB) helps reduce the amount of food eaten. It acts like a belt around the top portion of the stomach, creating a small pouch. Patients feel full after eating only a small quantity of food. It is adjustable and reversible.

Gastric bypass
There are a number of variations of gastric bypass operation but the most popular one conducted in the UK is called a Roux–en–Y gastric bypass (RNY). At surgery, the top section of the stomach is divided off by a line of staples, creating a small 'pouch' stomach. A new exit from this pouch is made into a 'Y' loop from the small intestine so that food bypasses your old stomach and part (about 100-150cm) of the

small intestine. The size of stomach pouch and the length of small intestine that is bypassed are carefully calculated to ensure that patients will be able to eat enough for their body's needs at normal weight.

Sleeve gastrectomy
The sleeve gastrectomy reduces the size of the stomach by about 75%. It is divided vertically from top to bottom leaving a banana shaped stomach along the inside curve and the pyloric valve at the bottom of the stomach, which regulates the emptying of the stomach into the small intestine, remains intact. This means that although smaller, the stomach function remains unaltered.

Duodenal switch
The duodenal switch (DS) works primarily by malabsorption. The operation can be performed as an open operation through a midline incision from the base of the breastbone, or laparoscopically. Technically it is a complex operation which can take 5–7 hours to complete, and will usually require a post–op hospital stay of 4–6 days. Following a sleeve gastrectomy a short segment of the duodenum at the base of the stomach is left but the remainder cut and the second half of the small intestine bought up and joined to the duodenum (this part of the operation is very similar to a RNY gastric bypass but is slightly lower down in the digestive tract). The bypassed section of small intestine is then rejoined to carry bile and pancreatic juices to the latter part of the small intestine near where it joins the large intestine (colon). Digestion and absorption of fat depends on it mixing with bile (from the liver and normally entering the duodenum). As this mixing does not occur until much further on in the intestine after a DS, the body's ability to digest and absorb calories from fat is severely reduced. As a result weight drops, even when eating quite normally. Definitions adapted from BOSPA5

Models of care

A typical model for managing obesity is outlined as follows:

- Tier 4 – Severe and Complex Obesity Services (including obesity surgery and obesity medicine MDTs and specialist weight management programmes, post-surgical and annual follow up). It is important to note that Tier 4 includes not only bariatric surgery but also bariatric medicine. The latter will offer more specialist and intensive input than tier 3.
- Tier 3 - A primary/community care/secondary care based specialist, multi-disciplinary obesity team (MDT) and specialist weight management programme
- Tier 2 - Primary Care with Community Interventions
- Tier 1 - Primary Care - GP and Practice nurse identification, lifestyle advice and signposting to community services

6 Aim and Objectives

To advise on eligibility criteria for NHS commissioned severe and complex obesity surgery.

7 Criteria for commissioning

Obesity surgery is a treatment for clinically appropriate and selected patients with severe and complex obesity that has not responded to all other non-invasive therapies. Within these patient groups, obesity surgery has been shown to be highly cost effective for a period of 3-4 years.
Obesity surgery is recommended by NICE as a first-line option for adults with a BMI of more than 50kg/m^2, in whom surgical intervention is considered appropriate. However, it will be required that these patients also fulfil the criteria below in order to ensure adequate preparation and improve post – surgical compliance.

8 Eligibility Criteria

Surgery should only be considered as a treatment option for people with morbid obesity providing all of the following criteria are fulfilled:

- The individual is considered morbidly obese. For the purpose of this guidance and in accordance with previous and current NICE Guidance, obesity surgery will be offered to adults with a BMI of 40kg/m2 or more, or between 35 kg/m2 and 40kg/m2 or greater in the presence of other significant diseases. However, NICE have recently updated their guidance on obesity surgery (NICE CG189). This expands the above criteria - to the consideration of newly diagnosed diabetics (<10 years) between the BMI ranges of > 30 to < 35, for assessment of obesity surgery. Moreover, patients with newly diagnosed diabetes within the former group (≥35) should be expedited for consideration of obesity surgery. All groups will have been treated in a Tier 3 specialist weight management service. NICE guidance also includes consideration of assessment of newly diagnosed Asian diabetes patients at BMI levels2.5 kg/m2 less.
- There must be formalised MDT led processes for the screening of co-morbidities and the detection of other significant diseases. These should include:
- Disease / condition / Risk factor identification, diagnosis, severity / complexity assessment, risk stratification/scoring and appropriate specialist referral for specialist medical management. Such medical evaluation and optimization is mandatory prior to entering a surgical pathway.
- The individual has recently received and complied with a local specialist weight management programme (non-surgical Tier 3 mostly and Tier 4 in some urgent or complex cases)described as follows:
  This will have been for a duration considered appropriate by the MDT (previous requirement was for 12-24 months). For patients with BMI > 50 attending a specialist obesity service, this period should include the stabilisation and assessment period prior to obesity surgery (previous requirement was a minimum of 6 months). Patients with new onset type 2 diabetes may have their surgical assessment concurrently with the medical tier 3 service.

- The specialist obesity weight loss programme, MDT and location should be organized locally. This will be led by a professional with a specialist interest in obesity and include a physician, specialist dietician, nurse, psychologist and physical exercise therapist, all of whom must also have a specialist interest in obesity.
- There are different models of local MDTs. Important features are the multidisciplinary, structured and organised approach, lead professional leadership, assessment of evidence that all suitable noninvasive options have been explored, trialled with individual patient focus and targets. In addition to offering a programme of care, the service will select and refer appropriate patients for consideration for obesity surgery. MDT assessment processes and referral for complex case management and surgical referral must be formalised. Records must be kept and the service audited.

  The non-surgical Tier 3 / 4 service may be community or hospital-based but their role will include:
- Education (obesity risk factors, life- style factors, obesity related health risks, weight loss options)
- Specific Education Session on bariatric surgery
- Dietary advice/support (which may be delivered through specialist obesity dieticians)
- Enabling access to appropriate level of physical activity where not limited due to obesity related problems such as osteoarthritis, cardiorespiratory disease
- Exclusion of underlying contributory disease e.g. hypothyroidism, Cushing's
- Evaluation of co-morbidities (diabetes, sleep disorder breathing) and instigation of appropriate management plans including referral for expert management
- Evaluation of patient's engagement with non-surgical measures
- Evaluation and appropriate management of psychological and psychiatric factors relevant to obesity, eating behaviour, eating disorders, physical activity
- There is evidence of attendance, engagement and full participation in the above non-surgical Tier 3 / 4 service
- Engagement can be judged by attendance records and achievement of pre-set individualised targets.
- The patient has been formally assessed and referred by the lead physician/ clinician for the specialist obesity weight loss MDT.
- The patient has been unable to lose clinically significant weight (i.e. enough to modify co-morbidities) during the period of intervention.

The final decision on whether an operation is indicated should be made by the specialist hospital obesity MDT. For all obesity surgery candidates, an individual risk benefit evaluation will be done by the Obesity Surgery MDT, this will be informed by their own clinical assessment and information provided by primary care and by non-surgical Tier 3 / 4. There should be close liaison (and perhaps even overlap of personnel) between medical Tier 3/4 and Obesity Surgery MDT. For example, a specialist obesity physician would be on both MDTs. In some cases patients may need urgent bariatric surgery.

This preparation will ideally involve a six month preparation period in a Tier 4 medical obesity service.
The risk and benefit evaluation will consider:

- Existing co-morbidities and their reversibility
- Risk of future co-morbidities and their reversibility
- Patients age and general level of health
- Anticipated weight reduction
- Alternatives if obesity surgery is not undertaken
- Peri-operative morbidity and mortality
- Post-operative complications of obesity surgery

The Obesity Surgery Team will satisfy itself that:

- Obesity surgery is in accordance with relevant guidelines
- There are no specific clinical or psychological contra-indications to this type of surgery
- The individual is aged 18 years or above.
- The patient has engaged for an optimal period with non-surgical Tier 3 / 4 Services.
- The anaesthetic and other peri-operative risks have been appropriately minimised
- The patient has engaged in appropriate support or education groups/schemes to understand the benefits and risks of the intended surgical procedure
- The patient is likely to comply with the follow up programme that is required after any obesity surgical procedure to ensure -
- Safety of the patient,
- Best clinical outcomes are obtained and then maintained.
- Desired change in eating behaviour
- Change in physical behaviour as advised
- Finally the overall risk: benefit evaluation favours obesity surgery

Revision procedures will be covered by separate guidance.
Any new / novel obesity surgery procedures outside of policy will not be routinely commissioned. Where a clinician wishes to make a request for a new device/procedure, an application for exceptional funding through the CCG Individual Funding Request (IFR) process should be made in the first instance. The latter should be free to seek advice from the CRG leads (The later forum will be replaced by an Expert Clinical Group).

9 Patient pathway

Non-surgical and intensive management

The non-surgical and intensive medical and psychological management of morbidly obese patients in Tier 3/4 settings to optimise surgical risk and subsequent referral

process of eligible patients is an integral part of this pathway. This has already been described in section 4.

Pre-operative preparation

As it is an elective procedure it is critical that individuals being considered for obesity surgery are carefully selected, appropriately referred, fully evaluated and their medical condition optimised in order to achieve the best operative, post-operative and long term obesity and comorbidity outcomes. This is best done by MDTs at Tier 3 / 4 services.

This patient population has unique and challenging issues including an extensive range of medical and psychological and psychiatric comorbidities. Often patients have unrealistic expectations of the surgery. Therefore a multidisciplinary, comprehensive and timely assessment pre-operatively is of great importance.

The diagnostic work up, pre-operative evaluation, risk stratification and provision of counselling, education and information is best undertaken by a dedicated Tier 4 multidisciplinary team specialising in the management of morbidly obese patients including:

- Surgeons
- Anaesthetists
- Physicians
- Psychologists – will provide assessments and targeted interventions e.g. Cognitive Behavioural Therapy and also post-operative support
- Dieticians
- Nurses
- Radiologist
- Dedicated administrative support
- Access to Psychiatry*
- Access to Pharmacists*
- Access to Physiotherapists or sports and exercise medicine specialists*

* with special interest in obesity surgery

This team should also have links to independent patient support groups and also provide support and facilities for in-house patient support groups.

The surgical provider will have robust arrangements for surgical follow up and for receiving, assessing patients with post-operative complications and their emergency management by obesity surgeons. This includes access to a fully staffed emergency theatre on a 24 hour basis. There will also be a contact point for advice on queries.

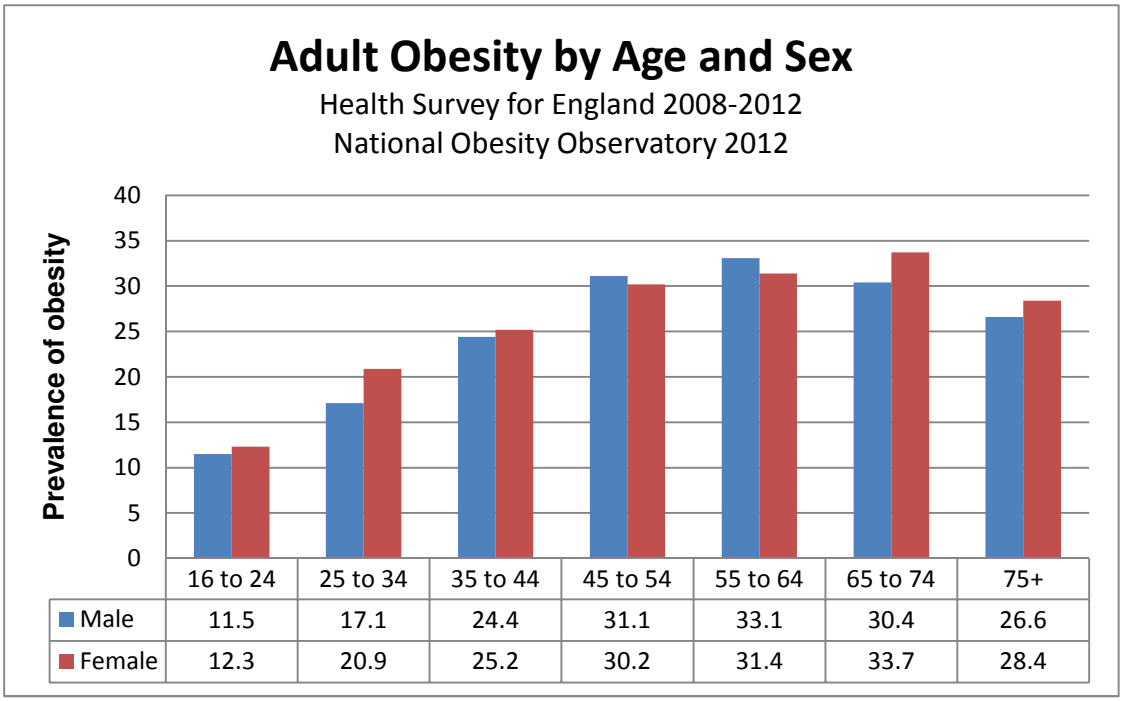
Structured, systematic and team-based follow up should be organised by the surgical provider for 2 years after surgery. Lifelong specialist follow up is also advocated. Although follow up will usually be led by the Tier 4 services, it will be delivered on the basis of formal shared care arrangements with primary care and defined provider and clinician responsibilities. Such an approach will monitor weight loss and comorbidity

outcomes, complications, adherence to iron, vitamin D/calcium and vitamin B12 supplementation, facilitate clinical suspicion of specific or combined micronutrient deficiencies leading to appropriate laboratory tests for confirmation. Psychological input, management of comorbidities, dietary and lifestyle advice and liaison with general practice will also be other functions of the follow up process. (Separate follow up guidance including consideration of automated annual recall systems will need to be developed for this).

10 Epidemiology and needs assessment

The Health Survey for England 8 shows that the proportion of adults (aged 16+) who are morbidly obese with a BMI 40kg/m2 or more has risen from 0.9% in 1993-95 to 2% (men) and 4% (women) in 2014. Based on a mean of 3%, the number of adults with morbid obesity in England would be around 1.63 million (population of England 2014 is about 54.3 million 8a); in a CCG covering a population of 500,000, one would expect around 24,000 morbidly obesity adults.

Predicting future trends in morbid obesity has proven difficult. Two different models have estimated markedly different prevalence figures. The first predicts a prevalence of almost 3% in men and 6% in women by 2030; the second predicts a prevalence of 1% for men and 4% for women by 2050. Straight-line extrapolation of the prevalence of adult men with BMI greater than 40 kg/m2 predicts a level of around 3% by 2050.



	16 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 to 74	75+
Male	11.5	17.1	24.4	31.1	33.1	30.4	26.6
Female	12.3	20.9	25.2	30.2	31.4	33.7	28.4

10.1 Implications of new NICE Guidance:

CG189: Recommendations for lowering of thresholds for patient with new onset type 2 diabetes (within the last 10 years)

Current	No of obesity surgical procedures	Total cost (14/15 tariff)
Patient with type 2 diabetes with a BMI of ≥35* *0.57% of eligible pop	2410	£12,473,000
Future recommendations		
People with a BMI ≥35 with a new diabetes diagnosis (within 10 years)	4810 (1.15% growth)	24,940,000
Above group with a BMI ≥30 - < 35	2948 (0.57% of eligible population)	15,256,000
Asians with new diabetes with BMI< 30	187	967,000
	7955	41,163,000

New updated NICE Guidance could potentially increase the number of obesity surgery procedures by 3 fold times if all of these patients were considered appropriate for surgery.

Of the number of people with Type 2 diabetes estimated by QOF data (2012/130 to be 2,524,604; 30% will have diabetes duration of 1-4 years, 30.3% will have diabetes duration of 5-9 years, 30% for ≥ 10 years and 10% will have diabetes less than one year.

Of the 2,523,604 people with Type 2 diabetes: 14.42% will have BMI (35-39.9), 9.18% BMI(≥ 40), 28.87% (30-<35). It is notable that 29% of the total will have a BMI of 30-<35. This latter figure is greater than those with BMI > 35 which equates to 24%. This will mean considering obesity surgery for potentially twice as many patients with diabetes as are presently eligible.

It is important to note that the costs identified by NICE relate only to the costs for obesity surgery procedures. Certainly all CCGs will have to commission Tier 3 and 4 services as well as increase their capacity to afford increased access to patients with BMI ≤ 30, appropriate specialist capability to assess and manage Type 2 Diabetes and select patients for obesity surgery. CCGs will also have to commission additional structured follow up to ensure that the savings identified by NICE related to the 60 % remission rates and prevention of down-stream costs (medications, diagnostic investigations, complications management and treatment) can be realised in the medium and longer term. Diabetes remission is influenced by both non BMI and BMI factors. The latter will be impacted by prevention of pre-operative weight regain. The additional obesity surgical activity identified by CG189 and costs will also be influenced by diabetes duration cut-offs.

11 Governance arrangements

Providers, surgeons, premises, on site services and obesity surgery activity throughput should at least meet the IFSO Guidelines6 for Safety, Quality, and Excellence in Bariatric Surgery.

However, it is recognised that the IFSO hospital and surgeon volume standards were meant to imply minimum volumes only (100 per hospital and 50 per surgeon). There is clear data to show that mortality and complication rates, both for bypass and banding are better with greater volumes, and the data are a continuum, so the more cases that are done, the better the outcomes are likely to be, just as for all other examples of elective surgery.

In addition, there are two benefits of commissioning only high volume providers: higher volumes can support sustainable levels of funding to support infrastructure development (nurses, dieticians, psychologists), and they allow a number of surgeons to take part in an on call rota e.g. 1 in 4 is practical whereas 1 in 2 is not.7

Thus major centres should be supported and other centres started only for capacity reasons. There are no hospital or surgeon volume data for sleeve gastrectomy or duodenal switch but there is no reason to doubt that the same relationship exists and that therefore the same governance rules should apply.

Appropriate Tier 3 and 4 MDT composition, specialist multi-professional inputs and process design for all stages of the pathway. Organisational arrangements for patient safety (elective and emergency) should be risk assessed, regularly tested and improved. Protocols should be audited especially the use of questionnaires for clinical assessment, generic interdisciplinary roles and substitution / expansion of professional roles i.e. use of GPs or other therapists for band-fills as an alternative to consultant radiologists; use of Skype, telephone etc. for consultations.
The Tier 4 surgical and medical services should be seamless both pre- and post-operatively with the medical Tier 3 service.
The collection and submission of data to the National Bariatric Surgical Register is mandatory. There should be audit of the timeliness and completeness of data submitted and the adequacy of administration support provided.
The obesity surgical provider will be responsible for the organisation of structured, systematic and team based follow up for 2 years. Just before this period is finished the surgical provider will make arrangements to hand over and share care and follow up with primary care. The tier 4 service will provide annual reviews. Band maintenance arrangements should be confirmed.

12 Evidence Base

In the short term, providing obesity surgery as a solution to weight loss is significantly more expensive than conservative management. However the remission of co-morbidities as a result of surgery or the associated weight-loss means that the overall cost of managing a patient on a care pathway that includes surgery is more cost effective in the long term than one without.

The Canadian and New Zealand Health Technology Assessment (HTA) agencies[9,10] both reported the cost per quality-adjusted life year (QALY) for obesity surgery compared to non-surgical interventions for obesity to be within acceptable cost-effectiveness thresholds and concluded that obesity surgery is cost effective. However, they also reported the relative paucity of data on cost effectiveness, the poor quality of the economic evaluations undertaken to date and inability to make recommendations for obesity surgery techniques.

In 2009 a UK National Institute for Health Research (NIHR) HTA[11] updated the economic review on obesity surgery for obesity, broadening its scope to include obese as well as morbidly obese people. The HTA reviewed five original economic evaluations (including four economic models) and undertook a primary economic evaluation adopting an NHS and personal social services perspective to develop a state-transition model comparing surgical to non-surgical interventions with a time horizon of 20 years. The UK HTA authors concluded that obesity surgery appears to be a cost-effective treatment for obesity compared with non-surgical interventions. However, their findings suggested that obesity surgery is likely to be less cost effective in less obese subjects and there was limited evidence to enable conclusions to be drawn on the relative cost effectiveness of different obesity procedures.

Quality Improvement Scotland (2010)[12] noted that economic analyses to date have typically assumed observed weight loss lowers both the severity and incidence of obesity-related comorbidities and associated treatment costs which, while reasonable assumptions, remain to be verified.

In 2011 the NHS South East Coast Health Policy Support Unit released a policy recommendation incorporating an economic analysis with a time-horizon of 10 years.[13] This showed obesity surgery is cost-effective in the medium term, reaching a break-even point within 3-years of surgery. This analysis supported the UK HTA conclusions that surgery is less cost effective in less obese patients. A study of cost-utility of obesity surgery for morbid Obesity in Finland[14] was published in 2011, showing similar results.

13 Rationale behind the guidance

Obesity surgery for the morbidly obese is an increasingly available intervention. However, surgical intervention is not the whole solution and appropriate clinical selection of fully informed and educated patients is important.

It is also important to ensure that surgery is not offered prematurely in a patient's weight loss pathway. Obesity surgery is only one component of the multimodal lifetime treatment pathway Medical and psychological assessment and optimization are also important to achieve and retain the benefits of obesity surgery.

Patients need to be informed of the benefits and risks as well as the life- long implications of obesity surgery.

With informed choice, patients are better able to cope with the eating restrictions of a post surgically altered gastrointestinal anatomy and comply with mandatory follow up for monitoring to prevent nutritional deficiencies; the management and review of comorbidities; and adjustment of medications and dosage post operatively.
Preparation in a Tier 3 service will improve patient awareness of their role and responsibility in following a healthy lifestyle to consolidate surgically achieved weight loss and resolution of comorbidities.

Patients also need information about when and where and from whom to seek help, advice and to attend for regular follow up and the actions to take in the event of the onset of surgical complications as well as gastrointestinal symptoms/ side effects arising from an altered anatomy.

Morbid obesity is a complex syndrome for which obesity surgery is a highly specialist intervention reserved for patients with a high clinical case of need and in whom all prior efforts of intensive weight reduction have failed. Patients should also be motivated and adequately prepared for surgery to ensure their post-surgical compliance which is necessary for success. Patient selection processes should ensure that only those patients who stand to benefit the most from surgery are offered it. As a highly specialist intervention, obesity surgery should only be undertaken by appropriately specialist trained and experienced surgeons with appropriately high caseloads working within multidisciplinary specialist teams in hospitals where these operations are commonly performed and who have the requisite institutional experience.

14 Mechanism for funding

Severe and complex obesity services, including obesity surgery MDTs responsible for the: pre-assessment, operative and perioperative management, postoperative and elements of longer term follow up, where it occurs within the specialist service, will be funded by the Clinical Commissioning Groups (CCGs). Tier 4 services will include obesity medicine MDTs and further specialist weight management programmes.

Tier 1, 2, 3 services will be commissioned and funded by Clinical Commissioning Groups (CCGs). Population prevention / health promotion measures and strategies will be funded from local authorities. This may be subject to variation depending on local arrangements for joint commissioning.

15 Audit Requirements

Mandatory compliance by Obesity Surgery providers with National Bariatric Surgery Registry15 requirements, including 100% provision of required data fields.
Development of data- set for follow- up is needed.

16 Documents which have informed this guidance

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17 Links to other policies

Primary care commissioning policies on cosmetic plastic surgery procedures

Policies on referral to private sector providers

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