SPECIALISED ADULT MORBID OBESITY SURGICAL SERVICES

INTERIM COMMISSIONING POLICY

2009/10

<table>
<thead>
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<th>Version</th>
<th>Interim Commissioning Policy</th>
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<td>Approved By</td>
<td>SCG Board</td>
</tr>
<tr>
<td>Date Approved</td>
<td>16th January 2009</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Specialist Commissioning Team</td>
</tr>
<tr>
<td>Date Issue</td>
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1. BACKGROUND

1.1 This policy sets out the approach to the commissioning of surgery to aid weight reduction for adults with severe (morbid) obesity in Yorkshire and the Humber.

1.2 Severe obesity is defined as a body mass index (BMI) of 35–39 kg/m² with comorbidities, or a BMI of 40 kg/m² or more. It is a chronic condition that is associated with an increased risk of morbidities such as type 2 diabetes, hypertension, cardiovascular disease, osteoarthritis, dyslipidaemia and sleep apnoea. Obesity is also a psychosocial and social burden, often resulting in social stigma, low self-esteem, reduced mobility and a generally poorer quality of life.

1.3 The NICE clinical guideline¹ states that there is increasing recognition both in the UK and worldwide that there is an ‘obesity epidemic’. Estimates suggest that more than 12 million adults and 1 million children in England will be obese by 2010.

1.4 Surgery for the treatment of obesity, also known as bariatric surgery, is recommended as a treatment option for people with severe obesity when certain criteria are fulfilled. One of these is that all appropriate non-surgical measures have been tried but have failed to achieve or maintain adequate, clinically beneficial weight loss for at least 6 months but ideally for 12 – 18 months and in some cases for up to 5 years.

1.5 Bariatric surgery is also recommended as a first-line option (instead of lifestyle interventions or drug treatment) for adults with a BMI of more than 50 kg/m² in whom surgical intervention is considered appropriate and there are no contraindications for the surgery. However morbid obesity surgery for most people will not be the first choice of treatment, and in all cases the SCG will only commission morbid obesity surgical services in the context of an overall obesity management pathway as surgery alone will not have sufficient impact on the growing problem. Surgical services should only be accessed, in all but exceptional cases, following assessment and completion of a locality based weight management programme which PCTs should establish in line with NICE guidance and the local model previously agreed by the SCG in June 2008.

2. LOCAL POLICY CONTEXT

2.1 Bariatric surgery is regarded as a specialist, tertiary service as defined in the guidance established by the National Institute of Clinical Excellence (NICE) and by the Department of Health² within the specialised services national definition set.

2.2 The number of individuals within Yorkshire and the Humber with a BMI over 40kg/m² is estimated by NICE as 69,855, and of those it is estimated that around 1% (698) will have a BMI greater than 50 kg/m². HSE estimates suggest an even higher figure of 87,172 people with BMI >40 in the Yorkshire and Humber area.


² Department of Health (2002), Specialised Morbid Obesity Services (all ages) - Definition No. 35, Specialised Services National Definitions Set (2nd Edition)
2.3 By April 2009 all PCTs will have confirmed and have in place their process for triaging referrals to the surgical service. By April 2010 all PCTs will have a local weight management service in place, and that referral into a specialist morbid obesity surgery service will only be for those patients who have already undergone a local programme of weight reduction/management. Where a patient’s BMI is over 50 kg/m², and surgery is the preferred option, an initial referral to the local weight management programme will still be required, in order to ensure consistency and to make sure all alternatives have been fully explored. Revisional procedures will also require prior triage by weight management services unless on an emergency basis.

2.4 Available data within the NICE Commissioning Guide suggests that the benchmark rate of surgery at 5 years for a bariatric surgical service is 0.01% per year, or 10 per 100,000 population. This tool is of limited use locally because NICE acknowledge that rates will need to increase beyond this, given the expected need. In the Yorkshire and the Humber area the NICE benchmark would suggest 510 bariatric procedures per year (population 5.1 million). Recent estimates of surgical activity for 2007/08 showed activity in excess of this, at 543 procedures, with significant increases anticipated for 08/09 and beyond. The spread of bariatric surgical activity across PCTs is not equal, due to significant variation in referral policies and demand, with some PCTs commissioning well in excess of 10 per 100,000 and others under.

2.6 The planning and commissioning of morbid obesity surgery services will be managed through the Specialised Commissioning Group from 2009/10. Commissioning is likely to be more demanding in the first few years because the prevalence of morbid obesity is increasing, and the uptake of obesity surgery as a treatment option cannot be predicted with any certainty.

3.0 EVIDENCE BASE

3.1 Obesity is associated with increased morbidity and mortality. It is a risk factor for cardiovascular disease, hypertension, type 2 diabetes, cancer, musculo-skeletal disease, reproductive disorders and respiratory disorders. Adults with a BMI greater than 35 kg/m² have a rate of mortality at any given age double that of someone with a healthy BMI (range 20-25 kg/m²).

3.2 Adults who are defined as having severe obesity will often experience a decreased quality of life. There is a social stigma attached to obesity and those affected often face prejudice and discrimination. Severe obesity has a negative impact on mobility, productiveness, employment and psychosocial functioning. Many adults who are defined as having severe obesity are left feeling depressed, defensive and unable to live life to the full.

3.3 The potential benefits of robustly commissioning an effective bariatric surgical service for the treatment of people with severe obesity include:

- achieving long-term weight loss in people with severe obesity and decreasing overall mortality after surgery³
- reducing the development of new comorbid conditions and reducing healthcare use after surgery⁴

improving performance and patient-centred clinical care through implementing the recommendations for bariatric surgery and specialist dietetic follow-up outlined in NICE clinical guideline CG43 on obesity

- assessing service demand for people requiring bariatric surgery and specialist dietetic follow-up, and providing an opportunity for clearly defining the criteria for those requiring subsequent plastic surgery
- reducing inequalities by ensuring that all people who are severely obese have access to, and an assessment by, a multidisciplinary team
- ensuring the service is integrated and appropriate, and that clear referral pathways are in place so that bariatric surgery is provided alongside other clinical or public health weight management services and population health programmes
- increasing informed patient choice through the provision of information on a variety of procedures, thereby allowing the patient and clinician to jointly decide on the best intervention based on the best available evidence.

4. ROLE OF PRIMARY CARE/COMMUNITY BASED SERVICES

4.1 In 2009/10 access to NHS funded bariatric surgery should be directed through local NHS weight management services (pathway at Appendix 2), or via alternative PCT triage. This triage should include sufficient information to enable completion of the standard proforma in Appendix 1 including:

- BMI
- Eating and physical activity
- Emotional and psychological needs
- Social and educational factors
- Family history
- Associated co-morbidity
- Previous history/evidence of weight management/reduction efforts;

4.2 If agreed that the patient is clinically appropriate to receive surgery to aid weight reduction based on above assessment and the patient meets the PCT criteria (see section 5.) the following implications should be explained:

- The dangers of any surgery for a morbidly obese patient vs the risks of failing to lose weight and or of not having surgery to aid weight loss
- Large skin flaps as a consequence of rapid weight loss
- That plastic surgery to reduce skin flaps is not funded by the local health economy unless there are exceptional health reasons to undertake this surgery
- The possible inability to return to a normal diet, such as the potential for protein intolerance
- That surgery is not a cure for weight management but only part of the weight loss process

4.3 The role of the PCT/Locality based weight management service is ensure that only those patients who comply with NICE guidelines, have exhausted all appropriate non-surgical methods of weight loss and are suitable for surgical intervention are

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referred on for surgical opinion. If the individual is eligible for surgery the
PCT/Locality based weight management services will refer them to a designated
provider, using a core proforma (Appendix 1). The provider’s multi-disciplinary team
will then undertake a final specialist assessment of suitability for surgery.

5. REFERRAL FOR SURGERY

5.1 By April 2009 all PCTs will have confirmed and have in place a process, for triaging
referrals to the surgical service. By April 2010 all PCTs will have an agreed local
weight management service in place and referral into a specialist morbid obesity
surgery service will only be via this route. All referrals, including revisional
procedures, will be through this route. The only exception to this would be true
clinical emergencies, which should be handled in the usual way.

5.2 The service specification and role of the bariatric surgery provider is detailed in the
accompanying service specification document.

5.3 In this interim policy, PCTs will continue to apply their existing eligibility criteria for
bariatric surgery in order to ensure a manageable transition to NICE criteria for all
PCTs over time. There are currently two sets of criteria in use and the PCTs to
which each set of criteria applies are set out in Appendix 3. In addition some PCTs
currently have triage mechanisms in place, which prioritise patients within these
Criteria and this will continue during 2009/10.

5.3.1 Criteria Set A (NICE criteria)

- BMI of 40kg/m² or more or between 35kg/m² and 40kg/m² and other significant
disease* that could be improved if they lost weight.
- the individual has been receiving and complied with a weight management
programme in a locality based weight management service which may have
included equivalent medical secondary care assessment and intervention;
- the individual is aged 18 years or over;
- there is evidence that all appropriate and available non-surgical measures,
which may include commercially provided weight loss support programmes,
have been adequately tried for a period of at least 6 months, ideally 12 to 18
months, and potentially up to five years, but has failed to maintain significant
weight loss (i.e. ≥10%);
- there are no specific clinical or psychological contraindications to this type of
surgery;
- the individual is generally fit for anaesthesia and surgery; and
- the individual is committed to the need for follow-up by a doctor and long-term
compliance with an altered lifestyle and dietary habit post-operatively.

In addition, bariatric surgery is recommended as a first-line option (instead of
lifestyle interventions or drug treatment) for adults with a BMI of more than 50 kg/m²
in whom surgical intervention is considered appropriate.

*Significant disease could include

- established cardiovascular disease
- osteoarthritis
- type 2 diabetes
• sleep apnoea
• severe hypertension
• history of transient ischaemic attacks or stroke
• severe lower limb major joint disease requiring orthopaedic intervention, otherwise precluded on the basis of a BMI
• dyslipidaemia

5.3.2 Criteria Set B (Restricted criteria)

Bariatric surgery is recommended as a treatment option for people with obesity if all of the following criteria are fulfilled:

• a BMI of 50 kg/m² or greater without obesity related co-morbidity;
• a BMI of 45 kg/m² or greater in the presence of a significant disease* which may be amenable to treatment if obesity is modified by surgery, and/or have:
• a condition which requires surgery at the same time as bariatric surgery, based upon clinical need and urgency for such surgery, such as cholecystectomy, hernia repair
• a condition which needs surgery or complex technological intervention as soon as possible after bariatric surgery, such as hip or knee replacements.
• a condition for which surgery is withheld until weight loss is achieved e.g. spinal pathology or awaiting IVF for infertility
• a condition that although surgically treatable is at a high risk of recurrence in the presence of obesity e.g. incisional hernia.

*Significant disease could include

• established cardiovascular disease
• osteoarthritis
• type 2 diabetes
• sleep apnoea
• Severe hypertension
• History of transient ischaemic attacks or stroke
• Severe lower limb major joint disease requiring orthopaedic intervention, otherwise precluded on the basis of a BMI
• dyslipidaemia

6. EXCEPTIONAL TREATMENT

6.1 Bariatric surgery will not be routinely commissioned for patients who fall outside of these criteria except in exceptional circumstances. In these cases PCTs will need to consider requests through Exceptional Treatment Panels.

7. PLASTIC SURGERY

7.1 Patients should be advised that procedures such as abdominoplasty and removal of skin flaps following substantial weight loss are not routinely funded by the NHS.

7.2 Each local primary care trust has a policy for referral to plastic surgery services. The eligibility of a patient for referral following significant weight loss therefore,
should be discussed with their General Practitioner/ Local weight management service, before a final decision to proceed with surgery is taken.

7.3 Clear local policies on plastic surgery following bariatric surgery need to be available for patients considering surgery as the requests for this type of surgery are likely to grow in line with an increased demand for the initial weight loss surgery.

8. ESTIMATED COMMISSIONING LEVELS FOR PLANNING PURPOSES

8.1 2009/2010
Planned activity will need to be monitored at least quarterly in consortia in conjunction with the service lead in the SCG, with any agreed amendments to plan incorporated in-year.

<table>
<thead>
<tr>
<th>PCT</th>
<th>09/10 projected activity (surgical procedures – new referrals)</th>
<th>Criteria set</th>
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8.2 5 Year Plan

**Estimated Total for Yorkshire and Humber**

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<tr>
<th>PCT</th>
<th>09/10 projected activity</th>
<th>10/11</th>
<th>11/12</th>
<th>12/13</th>
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<tr>
<td>Total</td>
<td>892</td>
<td>1250</td>
<td>1748</td>
<td>2098</td>
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**APPENDIX 1**

**DRAFT REFERRAL PROFORMA FOR ASSESSMENT AND TRIAGE** FROM PRIMARY CARE PROVIDER TO SPECIALIST MORBID OBESITY SURGERY PROVIDER

**Patient details**

**Current medical information**

Name: 

D.O.B: 

Address: 

Hospital Number: 

Patients telephone number: 

Gender: M □ F □

Weight: Height: BMI: Does the patient Smoke? 

How many units of alcohol does the patient consume per week? 

Morbidity:

**Past medical and surgical information**

*(General Lifetime Weight history, other co morbidities, previous surgery)*

Please provide details of the following where available:-

- Dietician report / history / information
  *(A primary care dietician report should be included but it is accepted that initially PCT’s may have to commission this externally until primary care pathways fully developed and staffed)*
- Counsellor or Psychiatrist OR Psychological report / history / information
- Morbid obesity preventative services report / history
- Details history of pharmacological morbid obesity management
- Confirmation that screening has been undertaken where appropriate for underlying conditions likely to cause Morbid Obesity i.e. endocrine disorder
- Copy of recent blood test results, eg U and E, LFTs, Lipids,Glucose and TFT
Weight Loss History

<table>
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<th>Duration of weight loss activity</th>
<th>Method (diet, psychological therapy, using exercise, drug therapy)</th>
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Please describe efforts to lose weight by diet, for example, indicate what type of dietary measures tried and what dietary advice given; where the advice was from; what the subsequent weight loss was;

Describe a summary of the various methods the patient may have attempted at weight loss by themselves, eg slimming clubs, lifestyle changes, exercise regime,

Describe efforts to lose weight using psychological therapy e.g., has the patient been referred for cognitive behavioural therapy or another form of psychotherapy in relation to weight loss; when was this, who delivered it and what was the outcome.

Describe effort at weight reduction through exercise. Is the patient able to exercise; does the patient take regular exercise; has the patient been advised not to exercise? Describe present exercise behaviour. What, if any, exercise interventions have been recommended to this patient.

Describe efforts at weight reduction using drug therapy, such as Orlistat or Sibutramine e.g. when used, for how long, outcome, why stopped use;

Confirm with the patient that removal of excess skin by surgery subsequent to weight loss is subject to local PCT policies and will not be routinely funded through the NHS.

Please attach a copy of a dietician’s assessment of this patient

Exceptional Circumstances Only
If you are referring this patient for obesity surgery under exceptional circumstances please give details and confirm funding.

…………………………………………………………………………………………………………………
…………………………………………………………………………………………………………………
…………………………………………………………………………………………………………………

please tick
FUNDING AGREED BY PCT

Referring clinician (in capitals please), address and contact details

Name .................................................................................................................................

Profession ..........................................................................................................................

GP Practice ........................................................................................................................

Signature............................................................................................................................... Date Referral ..............................................

Additional information may be provided in a covering letter. Please send this form to
APPENDIX 2
PROCESS FOR ACCESSING NHS FUNDED SURGERY TO AID WEIGHT REDUCTION IN YORKSHIRE AND THE HUMBER

FOR 09/10 PCTS HAVE CONFIRMED TRIAGE MECHANISMS WHERE LOCALITY BASED WEIGHT MANAGEMENT SERVICES DO NOT YET PROVIDE THIS ROLE. THESE ARE SET OUT IN APPENDIX 4

Morbidly Obese Adult

GP refers into local weight management service

Locality based weight management service
Non surgical weight management interventions in the primary and secondary settings

Suitable for surgical referral

Meets Appropriate criteria A or B in 09/10

Specialist morbid obesity surgery provider

Surgery and post op care

YES

Referral made to surgical service

YES

Surgery for surgery

NO

Agreed Suitable for surgical referral

Agreed NOT Suitable for surgical referral

PCT exceptional treatment panel

Does NOT Meet Appropriate criteria A or B in 09/10

Local weight management service

Non surgical weight management interventions in the primary and secondary settings

Back to GP for further discussion and review

PCT commissioned services

18 week pathway
APPENDIX 3.

PCT INTERIM REFERRAL CRITERIA 2009/10

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<th>PCT</th>
<th>Criteria set</th>
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# APPENDIX 4

## 2009/10 INTERIM TRIAGE ARRANGEMENTS BY PCT

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