OVERWEIGHT AND OBESITY
WAKEFIELD AND DISTRICT
COMMISSIONING FOR TIER 2, TIER 3
AND ACCESS TO BARIATRIC
SURGERY POLICY

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<td>Wakefield Council DMT, Wakefield CCG Clinical Cabinet</td>
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Wakefield Council |
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1. **BACKGROUND**

1.1 This document sets out the commissioning intentions for overweight and obesity in the Wakefield District, including managing access to NHS Commissioned surgery to aid weight reduction for adults with severe (morbid) obesity.

1.2 Obesity is defined as a body mass index (BMI) of 30+ kg/m\(^2\) with co-morbidities, morbid obesity is defined as a BMI of 40 kg/m\(^2\) 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. As BMI increases the number of related co-morbidities increases.

1.3 The NICE clinical guideline CG189 states that there is increasing recognition both in the UK and worldwide that there is an ‘obesity epidemic’. In the UK rates of obesity nearly doubled between 1993 and 2011, from 13% to 24% in men and from 16% to 26% in women. In 2011, about 3 in 10 children aged 2–15 years were overweight or obese.

1.4 PHE figures released September 2014 estimate that 69.9% of the adult population in Wakefield has excess weight.

1.5 The NHS Commissioning Board Guidance Document Clinical Commissioning Policy: Complex and Specialist Obesity Surgery, April 2013, document makes it clear that treatment of obesity must be multi-component.

1.6 The NHS Commissioning Board will commission complex and specialised surgery as a treatment for selected patients with severe and complex obesity, that has not responded to all other non-invasive therapies, in accordance with the criteria outlined in: Clinical Commissioning Policy: Complex and Specialist Obesity Surgery, April 2013.

1.7 Surgery for the treatment of obesity, also known as bariatric surgery, is recommended as a treatment option for people with severe obesity when there is recent and comprehensive evidence that an individual patient has fully engaged in a structured weight loss programme, and that all appropriate non-invasive measures have been tried continually for a sufficient period (NICE CG43 and NICE CG189 recommendations). The patient should, in addition, have been adequately prepared.
for bariatric surgery.

1.8 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.

1.9 Commissioning of weight management services currently rests with the Local Authority (under review Sept 2014). These services must therefore be commissioned so that they provide appropriate access to surgical procedures should they be deemed necessary.

1.10 Weight Management services should also be commissioned so that they are compliant with NICE guidance.

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 Public Health England and is commissioned by NHS England.

2.2 The number of individuals within Yorkshire and the Humber with a BMI over 40 kg/m² was 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. Overweight and obesity prevalence has increased steadily since 1994. Healthy weight prevalence has shown reciprocal reduction.

2.3 In order to meet NICE compliance, all local authority districts should have a local weight management service in place, and that referral into a specialist morbid obesity surgery service is available only 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. NICE acknowledge that rates will need to increase beyond this,
given the expected need. Using these figures for Wakefield’s population of 327,000 the NICE benchmark would suggest at least 33 bariatric procedures per year.

2.6 Within Wakefield demand for surgery is likely to continue to increase because the prevalence of morbid obesity is increasing.

2.7 With rising levels of obesity there is an increase in other clinical long-term conditions, in Wakefield we are also likely to see an increase of diabetes. It is estimated that 3,000 people become diabetic each year in Wakefield, the majority of these will be type 2 and are likely to have been prevented through weight management interventions.

2.8 The Health and Wellbeing board has included healthy lifestyles as a prevention and also supporting people to self-manage long-term conditions as two of its priorities within the Health and Wellbeing strategy.

2.9 The LSB partners have also included increasing physical activity as one of the district outcome measures in acknowledgement of the impact of physical activity on prevention of long term conditions. Increasing physical activity is a key element to weight management.

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 may 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 robust commissioning policy that includes pathways to bariatric surgical service for the treatment of people with severe obesity include:

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

3.3.2 Improving performance and patient-centred clinical care through implementing the recommendations for bariatric surgery and specialist dietetic follow-up outlined in updated NICE clinical guideline CG189 on obesity.

3.3.3 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.

3.3.4 Reducing inequalities by ensuring that all people who are severely obese have access to, and an assessment by, a multidisciplinary team.

3.3.5 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.

3.3.6 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 most appropriate intervention based on the best available evidence.

3.3.7 Providing lifestyle advice and support that can be used by individuals and their families to improve their quality of life and support them in managing other long-term conditions.

3.3.8 A reduction in long-term care costs and NHS costs – through better control and prevention of illnesses and preventing bariatric surgery where clients take control of their weight issues prior to surgery.

3.4 Clinical benefits of bariatric surgery for patients with a BMI 35kg/m² (estimated over age range 18-65 years), suggest that surgery costs are fully recovered after 26 months. Making bariatric surgery more cost effective than standard therapy for diabetic patients with a BMI 35+kg/m².

3.5 The NHS tool calculates the cost of Obesity and Overweight to Wakefield as £102m in 2010 likely to rise to £109 million in 2015. This is just the estimated cost to the NHS and does not include personal cost to the individuals, work productivity or social care costs.

3.6 NICE has calculated that a lifestyle intervention that costs less than £200 per person is cost effective for overweight and obesity assuming as little as 1 kg of weight can be lost and this weight loss can be maintained over life.

3.7 The NHS Commissioning Board Policy outlines a care pathway for managing Obesity:
• **Tier 1** - Primary Care + Community Advice
• **Tier 2** - Primary Care + Community Interventions
• **Tier 3** - Primary/community based Multi-disciplinary team (MDT) to provide intensive levels of input
• **Tier 4** - Specialised COMPLEX Obesity Services (including Surgery)

3.6 The pathway should ensure that those patients who can manage their weight without access to the tier 4 service are encouraged and supported to do so. Where access to tier 4 is deemed appropriate the pathway must be designed to ensure that eligibility criteria for surgery will have been met. The criteria should prevent perverse incentives (e.g. patients increasing their body weight to gain access to surgery).

4. **ROLE OF PRIMARY CARE/COMMUNITY BASED SERVICES**

4.1 From 2014/15 access to NHS funded bariatric surgery should be directed through local authority weight management services. This should include sufficient information to enable completion of the standard proforma in Appendix 1.

4.2 The Local Authority (in partnership with the CCG) will commission a community weight management programme that will be NICE compliant and will operate at tier 2 and tier 3.

4.3 The aims of the tier 2/3 services will be to:-

4.3.1 Foster independence and self-management (including self-monitoring).
4.3.2 Provide strategies for ongoing support once the programme or referral period has ended, (which may include the programme itself, online resources or support groups, other local services or activities, and family or friends).
4.3.3 Stress the importance of maintaining new dietary habits and increased physical activity levels in the long term to prevent weight re-gain and discuss strategies to overcome any difficulties in maintaining the new behaviours.
4.3.4 Encourage dietary habits that will support weight maintenance and are sustainable in the long term.
4.3.5 Lead to an average weight loss of at least 3%, with at least 30% of participants losing at least 5% of their initial weight.

4.4 In addition to the tier 2/3 service the local authority will also ensure that a full programme of tier 1 interventions and advice is available within the community this will be in the form of a wellbeing service to support behaviour change interventions and also specific targeted support services. Community social marketing will also be delivered in line with the national Change4life programme and other behaviour
change principles.

4.5 Providers of tier 1 services and interventions, along with GPs, practice nurses, other hospital services, and other health services will be able to refer clients to the weight management tier 2/3 service.

4.6 All referrals will be triaged to ensure that they need the service (meet the acceptance criteria), and that they are signposted to the correct part of the service.

4.7 Tier 3 will not receive direct referrals – all patients who attend tier 3 service will have first been triaged at tier 2.

4.8 Patients who are triaged as needing tier 3 intervention but want to attend the tier 2 programme should first be assessed by the clinician in tier 3 to ensure there are no underlying health conditions that may make attendance at tier 2 unsafe. If the clinician is sure that attendance at tier 2 will be safe the patient choice should be followed and the clinician should refer them back to tier 2.

4.9 The triage element (based on the eligibility criteria) will discuss with adults considering a lifestyle weight management programme:

4.9.1 What the programme does and does not involve

4.9.2 Realistic goals they might hope or expect to achieve and the wider benefits of the programme

4.9.3 Other local services that may provide additional support (for example, local walking or gardening groups)

4.9.4 Any financial costs (including any costs once a funded referral has ended).

4.9.5 Explore with participants any issues that may affect their likelihood of benefiting from the programme

4.9.6 Discuss any previous or ongoing strategies to manage their weight (acknowledge what the person has already achieved), any positive or negative experiences of weight management programmes, any concerns they may have, or barriers they may face, in relation to joining the programme, the process of change or meeting their personal goals.

4.10 It is intended that access to tier 2/3 services will be triaged by the Wellbeing service, due to be procured in 2015/16.

4.11 Eligibility criteria
4.11.1 Adults who are obese (that is, with a BMI over 30 kg/m\(^2\), or lower for those from black and minority ethnic groups) or with other risk factors (comorbidities such as type 2 diabetes)
4.11.2 Where an adult is at risk of diabetes, in a prediabetic state.
4.11.3 Where there is capacity, access for adults who are overweight should not be restricted (that is, for people with a BMI between 25 to 30 kg/m\(^2\), or with other risk factors (comorbidities such as type 2 diabetes)
4.11.4 There should be no upper BMI or upper age limit for referral.
4.11.5 At the Provider's discretion and with parental permission access to teenage young people who are making an informed choice to lose weight and meet the criteria on weight can be allowed.

4.12 The tier 2 service will provide:
- Education
- Dietary advice / support which ensures specific dietary targets.
- Access to appropriate level of physical activity where not limited due to obesity related problems such as osteoarthritis, cardio respiratory disease.
- Community delivery at a variety of times so as to ensure client choice and sustainability.
- A long term support package for those clients making weight loss achievements.
- A personalised support programme for the patient to follow.
- Use a variety of behaviour-change methods, (problem solving; goal setting; how to carry out a particular task or activity; planning to provide social support or make changes to the social environment; self-monitoring of weight and behaviours that can affect weight; and feedback on performance)
- Links and signposting to other services and support programmes on offer across the district.
- Strategies on how to reduce sedentary behaviour and the type of physical activities that can easily be integrated into everyday life and maintained in the long term.
- Monitoring of weight, indicators of behaviour change and participants' personal goals throughout the programme.

In addition the tier 2 service will apply the following NICE guidance:
- Provide an integrated approach across the district by identifying local services, facilities or groups that could be included in the local obesity pathway, which meet the needs of different groups (e.g. walking programmes), the whole system approach and all the available options must be available to both professionals and patients.
- Be aware of the effort needed to lose weight, prevent weight regain or avoid any furtherweight gain. Also be aware of the stigma that adults who are overweight or
obese may feel or experience and ensure the tone and content of all communications is respectful and non-judgemental - the terminology used to describe someone’s condition should respect how they like to be described.

- Ensure equipment and facilities meet the needs of most adults. Be aware that people may feel anxious about being weighed and measured
- Discussions should take place at the outset and at other times, if someone is having difficulty attending or participating in the programme, which focus on life-long lifestyle change and the prevention of future weight gain.
- Last at least 3 months and include a ‘weigh-in’ at each session.
- Ensure achievable goals for weight loss are agreed for different stages – including within the first few weeks, at the end of the programme or referral period (as appropriate) and provide a goal for 1 year on.

Any tier 2 service commissioned will have to demonstrate that it is effective at 12 months or beyond. (NICE review has shown the following UK services to be effective at 12 to 18 months; Rosemary Conley, Slimming World and Weight Watchers.)

4.13 The tier 3 service will include:

4.13.1 Evaluation of co-morbidities (diabetes/sleep disorder breathing etc) and instigation of appropriate management plans
4.13.2 Exclusion of underlying uncontrolled contributory disease
4.13.3 Evaluation of patients engagement.
4.13.4 Evaluation of patients psychological factors relevant to obesity, eating behaviours, physical activity etc
4.13.5 Evaluation of dietary requirements and consumption
4.13.6 Evaluation of patients ability to take part in physical activity programmes
4.13.7 Previous history/evidence of weight management/reduction efforts (over the last 5 years)
4.13.8 Input from a MDT which includes a registered dietitian, registered practitioner with a special interest in obesity, psychologist and a qualified physical activity instructor

4.14 The tier 3 service will 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 referred on for surgical opinion. If the individual is eligible for surgery the tier 3 service will refer them to a designated tier 4 provider, using an agreed proforma.

4.15 Before referring a client onto tier 4 the tier 3 provider will ensure that the client understands that:
4.15.1 That surgery is not a cure for weight management but only part of the weight loss process.
4.15.2 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.
4.15.3 Large skin flaps as a consequence of rapid weight loss.
4.15.4 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.
4.15.5 The possible inability to return to a normal diet, such as the potential for protein intolerance.
4.15.6 The client is making an informed choice to move to tier 4 and not to continue to try supported weight management.
4.15.7 The decision to provide surgery is made at tier 4 and referral from tier 3 does not mean that surgery will automatically happen.

4.16 Prior to referral to tier 4 Specialist Service, tier 3 will ensure:

4.16.1 There is evidence of attendance, engagement and full participation in tier 3 service (including appropriate physical activity). Engagement can be judged by attendance records and achievement of pre-set individualised targets (e.g. a steady and sustained weight loss of 5-10%).
4.16.2 The patient has been assessed and referred by the lead physician/clinician for the specialist obesity weight loss MDT
4.16.3 The patient has been unable to lose clinically significant weight during the period of intervention. Patients who lose sufficient weight to fall beneath the NICE guidance should not be considered appropriate for Surgery

4.17 It is essential that where different providers are offering obesity and weight management services, and where two commissioning organisations are commissioning services, that these work together as a whole rather than as disparate services. The service user should experience this as one programme offering whatever option is best for their health improvement.

5. REFERRAL FOR SURGERY

5.1 Referral to tier 4 will be made via a standard proforma Appendix 1 (developed by the West Yorkshire Specialist Commissioning group in 2010). The final decision as to whether a patient will receive obesity surgery is made at tier 4 service.
5.1 Wakefield Council in partnership with Wakefield CCG have reviewed processes, for triaging referrals to the surgical service. The organisations will review existing
services and have agreed revised commissioning arrangements for local weight management service in place and referral into a specialist morbid obesity surgery service. As per NICE recommendation, referral 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 Revisional surgery will only be routinely commissioned where it is deemed to be ‘urgent’, i.e. causing significant pain/discomfort and/or the patient is unable to tolerate solid foods, or where the original procedure has clearly failed and the patient meets the eligibility criteria for surgery.

5.3 NICE have set criteria for people who are eligible for bariatric surgery these are :-

- BMI of 40kg/m\(^2\) or more or between 35kg/m\(^2\) and 40kg/m\(^2\) and other significant disease that could be improved if they lost weight.
- The individual has been receiving and complied with a weight management programme (Tier 2/3) 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 24 months, (This may include the pre–operative stabilisation period whilst waiting for tier 4 surgery)
- 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.
- That Morbid obesity has been present for at least 5 years.
- 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/m\(^2\) 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

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 CCG/LA will need to consider requests through Exceptional Cases Panels.

7. PLASTIC SURGERY

7.1 Patients must 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 Wakefield CCG has a policy for referral to plastic surgery services. This should be referred to and 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 policy on plastic surgery following bariatric surgery needs 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. Revision of this policy may be necessary in line with potentially increasing demand.
APPENDIX 1

REFERRAL PROFORMA FOR ASSESSMENT AND TRIAGE FROM LOCAL AUTHORITY 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? Yes/No

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

Morbidity: ......................................................................................................................................

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Past medical and surgical information
(General Lifetime Weight history, other co morbidities, previous surgery)

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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

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<th>Duration of weight loss activity</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, e.g. 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 WAKEFIELD

Obese Adult

GP refers to Shape your Weight

Shape your Weight Triage

Tier 2 Service Community intervention

30+BMI no co-morbidities

Not losing weight

Morbid obesity or specified co-morbidities

Appropriate for Surgery?

yes

no

Tier 3 Service MDT intervention

Tier 4 Provider Specialised MDT