NHS
Derby and Derbyshire
Integrated Care Board

CLINICAL POLICY ADVISORY GROUP (CPAG)

Complex and Specialised Obesity Surgery Policy

Statement

NHS Derby and Derbyshire ICB, has deemed that **complex and specialised obesity surgery** should not be routinely commissioned unless the patient meets the criteria detailed in this policy.

These commissioning intentions will be reviewed periodically. This is to ensure affordability against other services commissioned by the ICB.

1. Background

Obesity and being overweight is a global epidemic. In England just over a quarter of adults (26% of both men and women aged 16 or over) were classified as obese in 2010 (Body Mass Index (BMI) 30kg/m2 or over).[1]

Obesity is directly associated with many different illnesses, chief among them insulin resistance, type 2 diabetes, metabolic syndrome, dyslipidaemia, hypertension, left atrial enlargement, left ventricular hypertrophy, gallstones, several types of cancer, gastro-oesophageal reflux disease, non alcoholic fatty liver disease (NAFLD), degenerative joint disease, obstructive sleep apnoea syndrome, psychological and psychiatric morbidities. It lowers life expectancy by 5 to 20 years. Direct costs of obesity are estimated to be £4.2 billion.[2]

The treatment of obesity should be multi-component. All weight management programmes should include non-surgical assessment of patients, 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 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 CG43 recommendations).[3] The patient should in addition have been adequately counselled and prepared for bariatric 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 bariatric surgery. The current standard bariatric operations are gastric banding, gastric bypass, sleeve gastrectomy and duodenal switch. These are usually undertaken laparoscopically.

Bariatric 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 bariatric 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 bariatric surgery is reported to be cost effective against a wider range of co-morbidities.

It is also important to ensure that surgery is not offered prematurely in a patient's weight loss pathway. Bariatric surgery is only one component of the multimodal lifetime treatment pathway: multidisciplinary medical assessment, preoperative management of comorbidities, conservative treatments and life-long follow–up care.

Patients need to be informed of the benefits and risks as well as the life- long implications of bariatric surgery. Morbid obesity is a complex syndrome for which bariatric surgery is a highly specialised intervention reserved for patients with a high clinical case of need and in whom all prior efforts of intensive weight reduction have failed.

2. Recommendation

Bariatric surgery is a treatment for appropriate, selected patients with severe and complex obesity that has not responded to all other non-invasive therapies. Within these patient groups bariatric surgery has been shown to be highly cost effective.

Bariatric surgery is recommended by NICE as a first-line option for adults with a BMI of more than 50kg/m2, in whom surgical intervention is considered appropriate.
However, it will be required that these patients also fulfil the criteria below.

Surgery will 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 and has been for at least five years. For the purpose of this policy, bariatric 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.
- There must be formalised Multi-Disciplinary Team (MDT) led processes for the screening of co-morbidities and the detection of other significant diseases.
- The individual has recently received and complied with a local specialist obesity service weight loss programme (non surgical Tier 3/4), described as follows:
  - This will have been for duration of 12-24 months. (For patients with BMI > 50 attending a specialist bariatric service, this period may include the stabilisation and assessment period prior to bariatric surgery). The minimum acceptable period is six months and there is evidence of attendance, engagement and full participation.
  - The patient has been 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. (Patients who lose sufficient weight to fall beneath the NICE guidance should not be considered appropriate for surgery).

The final decision on whether an operation is indicated should be made by the specialist hospital bariatric MDT. For all bariatric surgery candidates, an individual risk benefit evaluation will be done by the Bariatric Surgery MDT.

Any new/novel bariatric surgery procedures outside of this policy will not be routinely commissioned.

3. Rationale for Recommendation

In the short term, providing bariatric surgery as a solution to weight loss is significantly more expensive than conservative management and this cost has often been used as a reason for not commissioning surgical services, or limiting access. 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.
In 2009 a UK National Institute for Health Research (NIHR) HTA4 updated the economic review on bariatric surgery for obesity, broadening its scope to include obese as well as morbidly obese people. The UK HTA authors concluded that bariatric surgery appears to be a cost-effective treatment for obesity compared with non-surgical interventions.
However, their findings suggested that bariatric 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 bariatric procedures.

4. Useful Resources

- Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland (AUGIS). Provision of Services document 2011). Available from:

http://www.augis.org/pdf/reports/AUGIS_Provision_of_Services_Document.pdf

- National Institute for Health and Clinical Excellence. Bariatric surgical service commissioning guide. 2010. Available from: http://www.nice.org.uk/usingguidance/commissioningguides/bariatric/BariatricSurgicalService.jsp?domedia=1&mid=87F5267C-19B9-E0B5-D47104E7147082E9
- National Institute for Health and Clinical Excellence. Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. CG43, 2006. Last updated: 13 March 2015. Available from: http://guidance.nice.org.uk/CG43.
- British Obesity Surgery Patient Association. Available from: BOSPA - The British Obesity Surgery Patient Association (omicsonline.org)
- Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland (AUGIS). Provision of Services document 2016). Available from: Provision-of-Services-June-2016.pdf (augis.org)
- The Health Survey for England. Available from: Health Survey for England - Health, social care and lifestyles - NHS Digital
- Quality Improvement Scotland: Surgery to Aid Weight Reduction 2002. Available from: NICE MTA Guidance 46 - Surgery to aid weight reduction for people with morbid obesity (healthcareimprovementscotland.org)
- National Bariatric Surgical Registry. Available from: NBSR 2020.pdf (e-dendrite.com)
- Weight loss surgery - Types - NHS (www.nhs.uk)

5. References

1. Association for the Study of Obesity. Statistics – England 2012. Available from: http://www.aso.org.uk/useful-resources/statistics-england-2012/ Accessed 11/05/2023.
2. Department of Health. Obesity General information 2011. Available from: [ARCHIVED CONTENT] Obesity General Information : Department of Health - Public health (nationalarchives.gov.uk) Accessed 18/05/2023.
3. National Institute for Health and Clinical Excellence. Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. CG43, 2006. Available from: http://guidance.nice.org.uk/CG43 Accessed 11/05/2023.
4. Picot J, Jones J, Colquitt J L, Gospodarevskaya E, Loveman E, Baxter L, *et al*. The clinical effectiveness and cost-effectiveness of bariatric (weight loss) surgery for obesity: a systematic review and economic evaluation. *Health Technol Assess* 2009;**13**(41).
5. NHSE: Clinical Commissioning Policy: Complex and Specialised Obesity Surgery April 2013 (Reference : NHSCB/A05/P/a) appndx-6-policy-sev-comp-obesity-pdf.pdf (england.nhs.uk) Accessed 18/05/2023

6. Appendices

Appendix 1 - Consultation

All relevant providers/stakeholders will be consulted via a named link consultant/specialist. Views expressed should be representative of the provider/stakeholder organisation. CPAG will consider all views to inform a consensus decision, noting that sometimes individual views and opinions will differ.

Consultee	**Date**
Clinical Policy Advisory Group (CPAG)	June 2023

Appendix 2 - Document Update

Document Update	**Date Updated**
Version 1.0 Creation of Complex and Specialised Obesity Surgery Policy based upon: NHSE Clinical Commissioning Policy: Complex and Specialised Obesity Surgery.	May 2023