

March 2017

Patient access to bariatric surgery

Introduction

There is growing evidence of rationing by clinical commissioning groups (CCGs) in England in an attempt to save money. Planned surgery is being targeted, particularly hip and knee operations. In late 2016, the Royal College of Surgeons (RCS) and the British Obesity and Metabolic Surgery Society (BOMSS) decided to look at whether bariatric surgery was also being rationed by the NHS, following evidence that the number of procedures had been declining. The National Bariatric Surgery Registry recorded 5,192 operations taking place in 2012/13 compared to 5,056 in 2015/16.

Until recently, NHS England held responsibility for commissioning bariatric surgery and their policy reflected National Institute for Health and Care Excellence (NICE) recommendations and clinical guidance. In 2015, a decision was made to delegate this to CCGs, although many have not yet been handed this responsibility from NHS England. As part of an ongoing phased transfer, we decided to examine the existing CCG policies for bariatric surgery. Freedom of Information (FOI) requests were sent to all CCGs in England to determine whether their policies complied with guidance from NHS England or NICE, or whether arbitrary referral restrictions are being put in place to reduce the number of eligible patients for bariatric surgery.

Results indicate that whilst the majority of CCGs are yet to take on the responsibility for commissioning bariatric surgery, six CCGs have already developed commissioning criteria that does not follow clinical guidance. These CCGs have put in place thresholds based on either smoking status or Body Mass Index (BMI).

Patient access to suitable treatment is also affected by the lack of consistency in who is responsible for commissioning Tier 3 weight management services. Patients are required to complete this stage of the process before being considered for Tier 4 bariatric surgery, so this has created a further barrier. As the transfer of responsibility is completed next month, the RCS and BOMSS have compiled this report to highlight the risks of denying or delaying treatment and to make recommendations to urgently address this issue.

Key findings

Data in this report is based on a 98% response rate from CCGs as 205 of the 208 CCGs in England responded to the FOI request.

- Six (3%) CCGs have their own policies in place for Tier 4 bariatric surgery which do not follow guidelines recommended by NHS England and NICE.

- 36 (17%) CCGs said they were following NHS England/ NICE guidelines for bariatric surgery.
- 163 (80%) CCGs said that they did not have a Tier 4 policy in place or that it was currently commissioned by NHS England.

Key recommendations

- The six CCGs with arbitrary requirements for bariatric surgery should revise their policies in line with national clinical guidance.
- NHS England should reiterate that access to NHS bariatric surgical treatment should be based on clinical need, and uniform across the UK.
- NICE and NHS England should continue to highlight the benefits of bariatric surgery.
- NHS England should confirm that all CCGs will be responsible for commissioning bariatric surgery from 1 April 2017, to address the confusion over who is responsible.
- NHS England should reiterate its commissioning guidance on Tier 4 bariatric surgery to CCGs, in advance of the transfer of responsibilities.

Background

What is bariatric surgery?

Bariatric surgery, also known as weight-loss or obesity surgery, describes a number of procedures used to treat patients with potentially life-threatening obesity. These procedures moderate patients' appetite and stimulate metabolism to cause substantial and sustained weight loss. They have proven to be effective, safe and cost effective in numerous scientific comparisons against any other treatment.

Bariatric surgery provided under the NHS is usually granted when other treatments, such as lifestyle changes, have not worked. A patient is defined as having "potentially life-threatening obesity" by the NHS if their BMI is 40 or above. Alternatively, if a patient has co-morbidities such as Type 2 diabetes with high blood pressure, they are seen having "potentially life-threatening obesity" with a BMI of 35 or above.¹

Benefits of bariatric surgery

Studies have shown bariatric surgery to be both clinically and cost effective. The procedure can help severely obese patients to reduce weight by as much as 25-35% in one year.² Losing excess weight can also improve patients' emotional well-being and restore their confidence. Other clinical benefits, such as improvement in mobility and quality of life, are outlined in the National Bariatric Surgery Register (NBSR) report. The report includes figures on 20,534 primary and 2,098 revisions/planned second stage procedures with an average length of hospital stay for all operations at 2.6 days.³

¹ <http://www.nhs.uk/conditions/weight-loss-surgery/Pages/Introduction.aspx>

² <http://www.nhs.uk/Conditions/weight-loss-surgery/Pages/Results.aspx>

³ <http://www.bomss.org.uk/clinical-outcomes-2016/>

Data from the 2014 report also showed that of those treated, 73.2% of men and 71.5% of women had functional impairment prior to surgery, which meant that they could not climb three flights of stairs without resting, for example.⁴ One year after surgery, 64% of patients with pre-operative functional impairment returned to a state of no impairment.

Overall for the three years from 2013 to 16:

- The average patient body mass index (BMI) was 49.1 kg/m² and the average weight was 136.4 kg, indicating that the patients were twice the ideal weight for their height.
- 75.9% patients were female, 24.1% were male.
- The average number of obesity-related diseases for each patient, for example Type 2 diabetes, hypertension, sleep apnoea, functional impairment and arthritis was 3.59.

Data presented for 2015/16 demonstrates increasing disease burden and decreasing length of stay compared to the three years 2013/15, when there were on average 3.57 comorbidities, and the average length of hospital stay was 2.7 days.

Other co-morbidities of obesity noted in the NBSR are Dyslipidaemia, (a blood condition), Atherosclerosis (includes angina, MI, CABG, stroke), asthma, GORD (stomach acid problem), liver disease, poly-cystic ovarian syndrome (females only), depression and functional status (inability to climb three flights of stairs without resting).

In addition, the NBSR highlights the benefits of bariatric surgery for patients with co-morbidities, such as Type 2 diabetes. This condition can be pushed into remission within 48 hours of some types of bariatric surgery. During the three-year period between 2011 and 2013, 4,121 primary procedures were performed on patients with Type 2 diabetes; almost two-thirds of patients showed no indications of the condition two years after surgery and were able to stop taking medications for it.⁵ When considering the cost of diabetic drugs alone bariatric surgery can offer significant financial savings for the NHS.

In May 2016, diabetes clinicians and researchers representing 45 international organisations called for metabolic surgery to be recommended or considered as a treatment option for some people with Type 2 diabetes.

The new guidelines emerged from the Second Diabetes Surgery Summit, an international conference held in September 2015 at King's College London, and jointly organised with Diabetes UK, the American Diabetes Association, International Diabetes Federation, Chinese Diabetes Society, and Diabetes India. The guidelines were published in the journal, *Diabetes Care*, in June 2016.

Who is responsible for commissioning bariatric surgery?

In 2015, NHS England announced that the responsibility of commissioning adult severe and complex obesity surgery services was to be transferred to Clinical Commissioning Groups (CCGs) from April 2016.⁶ The Health Minister, David Mowat MP, later confirmed that the

⁴ http://www.bomss.org.uk/wp-content/uploads/2014/04/Extract_from_the_NBSR_2014_Report.pdf

⁵ Ibid

⁶ <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/09/comms-intents-16-17.pdf>

transfer is due to be completed by April 2017, when all CCGs will be responsible for commissioning obesity surgery.⁷

What does commissioning guidance say?

Clinical guidance produced by NHS England sets out the circumstances under which bariatric surgery should be commissioned. It states that surgery should only be considered as a treatment option for people with a BMI of more than 40 kg/m², or between 35 kg/m² and 40 kg/m² in the presence of other significant diseases.⁸ Patients must have tried and failed to achieve clinically beneficial weight loss by all other appropriate non-surgical methods and be fit for surgery.

NICE guidance also states that bariatric surgery should be considered for patients with a BMI of 40 or more, or between 35 and 40 and other significant disease, if all appropriate non-surgical measures have been tried.⁹ NICE expands on the above criteria to the consideration of newly diagnosed diabetics with a BMI of between 30 and 35.¹⁰ Bariatric surgery is also recommended by NICE as a first-line option for adults with a BMI of more than 50 “instead of lifestyle interventions or drug treatment”. Furthermore, NICE recommends that doctors should consider surgery for people of Asian origin who have recent-onset Type 2 diabetes at a lower BMI than other populations, as they are particularly vulnerable to the complications of diabetes.

Although CCGs are not required by law to follow such guidance (apart from NICE ‘technology appraisals’), failure to provide a clear rationale for deviating from NICE guidance could potentially leave CCGs open to legal challenges. This follows on from a 2014 legal case, which ruled that CCGs are under an obligation in public law to have regard for NICE guidance and to provide clear reasons for any general policy that does not follow NICE guidance.¹¹

Tier 3 weight management services and Tier 4 bariatric surgery

The NHS England and Public Health England Working Group defined a tiered system of weight management services in 2013. They recommended the introduction of Tier 3 multidisciplinary weight management services for severe obesity.¹² The service consists of an intense weight-loss programme, supported by dieticians and specialists in obesity who supervises patient progress. Tier 3 services consist of largely community-based services, where patients are referred to by GPs.

However, there is a current lack of consistency as to who is responsible for commissioning Tier 3 services across the country. This has created confusion for surgeons and hospitals about whether patients have gone through the correct pathways of care, and can therefore access surgery. A 2016 NICE consultation on the quality standard for ‘obesity: clinical

⁷ <https://www.theyworkforyou.com/wrans/?id=2016-12-06.56366.h&s=Tier+4+Specialised+Complex+Obesity+Services#g56366.q0>

⁸ <https://www.england.nhs.uk/wp-content/uploads/2016/05/appndx-7-obesity-surgery-guid.pdf>

⁹ <https://www.nice.org.uk/guidance/cg189/chapter/1-Recommendations#surgical-interventions>

¹⁰ *ibid*

¹¹ http://www.mills-reeve.com/files/Publication/b41bf907-e2bd-4399-ac79-31e5f0904dc2/Presentation/PublicationAttachment/4bcc6330-b26a-4d44-a77d-3b4b2b15ec17/RosevThanet_200488838.pdf

¹² <http://www.britishjournalofobesity.co.uk/journal/2015-1-1-25>

assessment and management' found that a number of stakeholders had expressed concern.¹³ One stakeholder responded that “there is currently poor provision of Tier 3 services” and another noted that “there is variability in the availability of Tier 3 services, and also in their make-up and function.” Another commented “on the lack of Tier 3 services and confusion regarding the commissioning of these services.”

All individuals are required to have attended and complied with local Tier 3 services before they can be considered for Tier 4 services, which consists of hospital-based specialist care, including bariatric surgery.¹⁴

Findings

FOI requests were sent to all 208 Clinical Commissioning Groups (CCGs) in England on 21 October 2016. The FOI requested a copy of each CCG’s “policy on the commissioning of Tier 3 weight management clinics and Tier 4 bariatric surgery.”

Responses were received from November to December 2016 and the CCG policies were then compared with the current guidance from NHS England and NICE.

A total of 205 (98%) CCGs responded to the FOI and of those, 36 CCGs (17%) indicated that they were following either NHS England or NICE guidelines for commissioning bariatric surgery. However, six (3%) CCGs responded to say that they have policies for Tier 4 bariatric surgery in place that **do not** comply with NHS England or NICE guidelines.

These policies are listed in the table below.

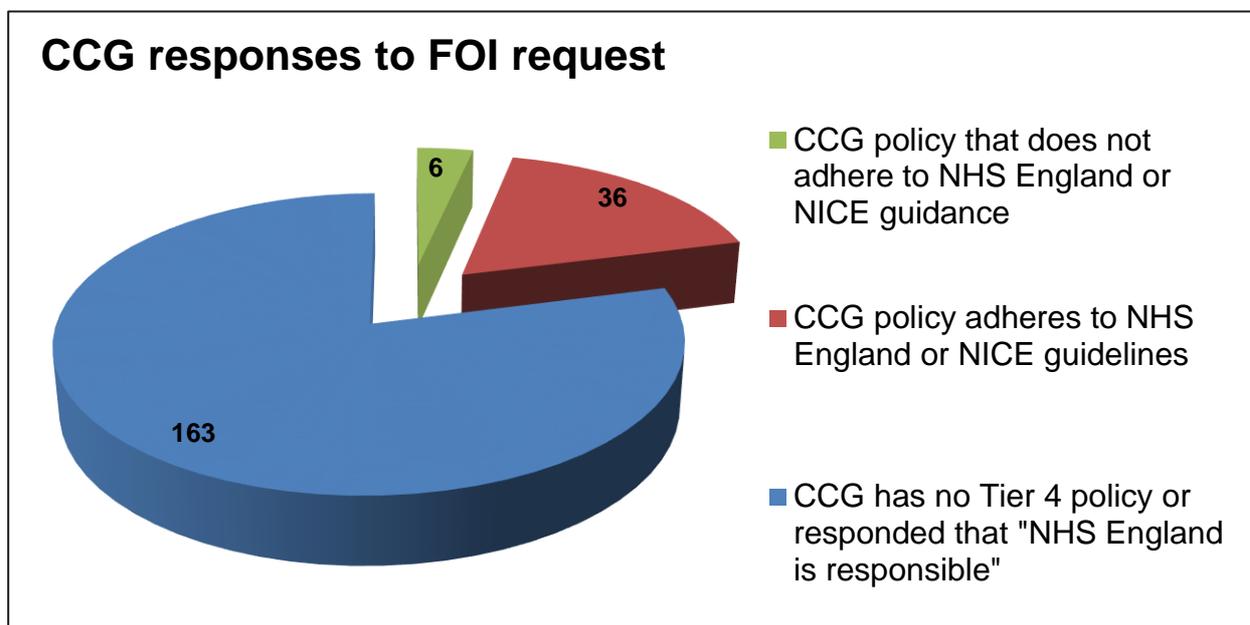
CCG	Tier 4 policy
East Riding	BMI > 50.
Mid Essex	Must be a non-smoker at the time of referral as confirmed by carbon monoxide monitor.
Solihull*	BMI > 50 with any of the following co-morbidities: hypertension, obstructive sleep apnoea or dyslipidaemia. Bariatric surgery will also be considered for patients with a BMI > 45 with diabetes.
Vale of York	BMI > 50 or BMI of 45-50 with co-morbidities such as diabetes.
Wolverhampton*	BMI > 50 with or without co morbidities and patients with a BMI of equal to or greater than 45kg/m2 with diabetes.
North East Essex	All patients who are smokers should be referred to smoking cessation services before the initial assessment appointment.

* These CCGs have since informed us that they intend to review their policies for Tier 4 services although it is unclear whether they plan to comply with NICE guidance.

¹³ <https://www.nice.org.uk/guidance/QS127/documents/consultation-summary-report>

¹⁴ <https://www.england.nhs.uk/wp-content/uploads/2016/05/appndx-7-obesity-surgery-guid.pdf>

The remaining 163 (80%) CCGs said that they did not have a Tier 4 policy in place or that it was commissioned by NHS England.¹⁵ Responses also revealed that many CCGs were waiting for NHS England to transfer the responsibility of Tier 4 services to them.¹⁶ This is now scheduled for completion in April 2017.



Conclusion and recommendations

The findings from the FOIs reveal that six CCGs are restricting access to routine surgery for either smokers or patients with a BMI of less than 50 (or 45 with co-morbidities), both of which are in contravention of national clinical guidance. Patients are considered obese if their BMI exceeds 30 and yet some CCGs are requiring a BMI of over 50 (referred to as 'super obese') before being referred for bariatric surgery. These commissioning policies have the potential to impact a significant proportion of the population and create a postcode lottery for patients trying to access treatment across the UK. Bariatric surgery can restore good-health as well as lead to cost-savings for the NHS in the long-term and, as scientific studies have shown, the procedure is particularly beneficial for patients who also suffer from diabetes.

Surgeons and clinical experts have been clear that stopping smoking before surgery can potentially improve outcomes and recovery from surgery. However, decisions about whether to proceed with surgery should always take place between the clinician and patient, informed by clinical evidence and not arbitrary thresholds. We therefore call on the six CCGs to revise their policies for bariatric surgery in line with national guidelines. NHS England must also communicate the benefits of bariatric surgery to CCGs and urgently advise commissioners to follow clinical guidance, to prevent more CCGs from restricting access to treatment.

¹⁵ <https://www.england.nhs.uk/wp-content/uploads/2014/03/owg-join-clinc-path.pdf>

¹⁶ <https://www.england.nhs.uk/wp-content/uploads/2016/05/devolved-services-ccg-guid-obesity.pdf>