Commissioning Policy

NHS Redditch and Bromsgrove Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

NHS Wyre Forest Clinical Commissioning Group

Specialist Weight Management Services (Adults aged 18 & over): Bariatric Surgery

October 2018

This policy applies to patients for whom the following Clinical Commissioning Groups are responsible:

- NHS South Worcestershire Clinical Commissioning Group (CCG)
- NHS Redditch & Bromsgrove Clinical Commissioning Group (CCG)
- NHS Wyre Forest Clinical Commissioning Group (CCG)

COMMISSIONING SUMMARY

Referral for Specialist Weight Management is a pre-requisite of NHS funded bariatric surgery and should be undertaken when:

a. All appropriate non-surgical measures have been tried but failure to achieve or maintain adequate, clinically beneficial weight loss

AND

b. Patient is committed to achieving significant weight loss

AND

c. BMI > 35 with significant morbidities
OR
BMI > 40 without co-morbidities
OR
Fits the above criteria but is unsuitable for Tier 2 services with needs that cannot be managed adequately in General Practice (6-12 month finite support)

Bariatric Surgery is commissioned for appropriate patients identified by the NHS funded Specialist Weight Management Service who:

- meet the eligibility criteria for referral to the Specialist Weight Management Service (as above); AND
- have adequately engaged with the service, fully understand the surgery, be well-informed and motivated to have surgery, with realistic expectations of outcomes); AND
- be medically optimised and have no contra-indication to surgery); AND
- understand the importance of complying with nutritional requirements before and after surgery and recognise the need for life-long follow up); AND
- engage with pre-surgery education groups and a joint clinical multi-disciplinary team meeting); AND
- are aware of the local Aesthetic Surgery Commissioning Policy stance on treatments to remove excess skin (eg. abdominoplasty) and the implications of this.

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Lead Executive/Director:	Ruth Lemiech, Director of Strategy
Name of originator/author:	Fiona Bates, Medicines Management/Public Health Project Lead
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Key individuals involved in developing the document:

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Circulated to the following individuals/groups for comments:

Name	Date	Version Reviewed
Clinical Commissioning Policy Collaborative, which includes: GPs, Commissioners, Medicines Commissioning, Public Health, Patient and Public Representatives	October 2018	1
Clinical Innovation group	October 2018	1

Version Control:

Version No	Type of Change	Date	Description of change
1	New Policy	October 2018	New Policy developed in line with local service specification requirements

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1. Definitions

1.1 **Obesity i**s defined as abnormal or excessive fat accumulation that may impair health. The most commonly used measure for classifying obesity is the body mass index (BMI), calculated as body weight in kilograms divided by height in metres squared (kg/m^2). In adults a desirable BMI is between 18.5 to 25 kg/m^2 and overweight is between 25 to 30 kg/m^2.

1.2 People are defined as being **morbidly obese** if they have a body mass index (BMI) either equal to or greater than 40kg/m². The National Institute for Clinical Excellence (NICE) guidance also defines people as being morbidly obese if their BMI is between 35kg/m² and 40kg/m² with the presence of significant co-morbid conditions that could be improved by weight loss.

1.3 The **Specialist Weight Management Service** is a hospital provided service aimed at improving and promoting weight loss and quality of life. The service provides the level of support needed to allow patients to lose the weight needed to improve their health and also to maintain that weight loss.

1.4 **Bariatric Surgery** is a term that covers a number of surgical interventions that are used to limit the calories that are consumed by altering the feeling of hunger and fullness through changes to the size of the stomach itself or by by-passing the stomach so food is absorbed within the small intestine instead.

1.5 **Gastric band** – a band is placed around the stomach, so you don't need to eat as much to feel full.

1.6 **Gastric bypass** – the top part of the stomach is joined to the small intestine, so you feel fuller sooner and don't absorb as many calories from food

1.7 **Sleeve gastrectomy** – some of the stomach is removed, so you can't eat as much as you could before and you'll feel full sooner

1.8 **Exceptional clinical circumstances** are clinical circumstances pertaining to a particular patient, which can properly be described as exceptional, when compared to the clinical circumstances of other patients with the same clinical condition and at the same stage of development of that condition (i.e. similar patients). A patient with **exceptional clinical circumstances** will have clinical features or characteristics which differentiate that patient from other patients in that cohort and result in that patient being likely to obtain significantly greater clinical benefit (than those other patients) from the intervention for which funding is sought.

1.9 A **Similar Patient** is a patient who is likely to be in the same or similar clinical circumstances as the requesting patient and who could reasonably be expected to benefit from the requested treatment to the same or a similar degree. The existence of more than one similar patients indicates that a decision regarding the commissioning of a **service development** or commissioning policy is required of the Commissioner.

1.10 An **individual funding request (IFR)** is a request received from a provider or a patient with explicit support from a clinician, which seeks exceptional funding for a single identified patient for a specific treatment.

1.11 An **in-year service development** is any aspect of healthcare, other than one which is the subject of a successful individual funding request, which the Commissioner agrees to fund outside of the annual commissioning round. Such unplanned investment decisions should only be made in exceptional circumstances because, unless they can

be funded through disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.

2. Scope of policy

2.1 This policy is part of a suite of locally endorsed Commissioning Policies. Copies of these Commissioning Policies are available on the following website address: http://www.redditchandbromsgroveccg.nhs.uk/about-us/strategies-policies-and-procedures/commissioning-ifr/

2.2 This policy applies to all patients for whom the Worcestershire CCGs have responsibility including:

- People provided with primary medical services by GP practices which are members of any one of the CCGs and
- People usually resident in any of the areas covered by the CCG's and not provided with primary medical services by any CCG.

2.3 This policy applies to adult patients (aged 18 and over) who are obese and who have exhausted all appropriate non-surgical measures but have failed to achieve or maintain adequate, clinically beneficial weight loss.

2.4 Obesity related services for children are the commissioning responsibility of the local authority and NHS England.

2.5 Where a patient's clinical presentation does not clearly meet the requirements for secondary care referral within the context of this policy, and where a GP is uncertain or concerned about the appropriate treatment/management pathway, referral for Advice & Guidance should be considered as an alternative to a referral for clinical assessment.

2.6 There may be occasions when a GP referral is made for specialist assessment which appears to meet the policy requirements, but which on specialist clinical examination either does not meet the clinical criteria for surgery or is not considered clinically suitable for surgery. Such patients should be discharged without surgery.

2.7 For patients who do not fall within the eligibility criteria set out in the policy but where there is demonstrable evidence that the patient has exceptional clinical circumstances, an Individual Funding Request may be submitted for consideration. The referring clinician should consult the Commissioner's "Operational Policy for Individual Funding Requests" document for further guidance on this process.

For a definition of the term "exceptional clinical circumstances", please refer to the Definitions section of this document.

3. Background

3.1. The NHS Constitution, which details the principles and values that guide the NHS, has been applied in the agreement of this policy.

3.2. NHS Redditch & Bromsgrove Clinical Commissioning Group, NHS South Worcestershire Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group consider all lives of all patients whom they serve to be of equal value and, in making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability except where a difference in the treatment options made available to patients is directly related a particular patient's clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment.

3.3. 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 in excess of £4.2 billion.

3.4. As BMI increases the number of obesity-related comorbidities increases. The number of patients with ≥ 3 comorbidities increases from 40% for a BMI of < 40 to more than 50% for BMI 40-49.9 to almost 70% for BMI 50-59.9 and ultimately to 89% for BMI > 59.9.

3.5. People who are defined as having morbid 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. Morbid obesity has a negative impact on mobility, productiveness, employment and psychosocial functioning. Morbid obesity affects the individual's quality of life both mentally and physically.

3.6. Weight loss improves obesity-related comorbidities and may have a mortality benefit. The treatment of obesity should be multi-component. The intensity of intervention depends on the degree of obesity and presence of comorbidities. Management should begin in primary care and move to a specialist setting, when initial measures, including lifestyle changes and drugs, have failed. All Specialist Weight Management Service treatment 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 and psychological support where appropriate.

3.7. 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. However bariatric surgery is not a cure for obesity on its own and is not suitable for all patients presenting due to permanent lifestyle changes required after surgery to avoid putting weight back on. Careful counselling and preparation of patients prior to surgical intervention is therefore essential to ensure appropriate intervention and optimise post-operative outcomes.

3.8. 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. In general, bariatric surgery reduces calorie intake by altering hunger and fullness through changes to the stomach and/or small intestine. The current standard bariatric operations are gastric banding, gastric bypass and sleeve gastrectomy; these are usually undertaken laparoscopically. For a definition of the terms above, please refer to the Definitions section of this document.

4. Relevant National Guidance and Facts

4.1 **NICE Clinical Guideline: Obesity: identification, assessment and management (CG189, 2014) r**ecommends that bariatric surgery is a treatment option for people with obesity if all of the following criteria are fulfilled:

- They have a BMI of 40 kg/m2 or more, or between 35 kg/m2 and 40 kg/m2 and other significant disease (for example, Type 2 diabetes or high blood pressure) that could be improved if they lost weight.

- All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss.
- The person has been receiving or will receive intensive management in a Tier 3 service.
- The person is generally fit for anaesthesia and surgery.
- The person commits to the need for long-term follow-up.

It also recommends that bariatric surgery is the option of choice (instead of lifestyle interventions or drug treatment) for adults with a BMI of more than 50 kg/m2 when other interventions have not been effective.

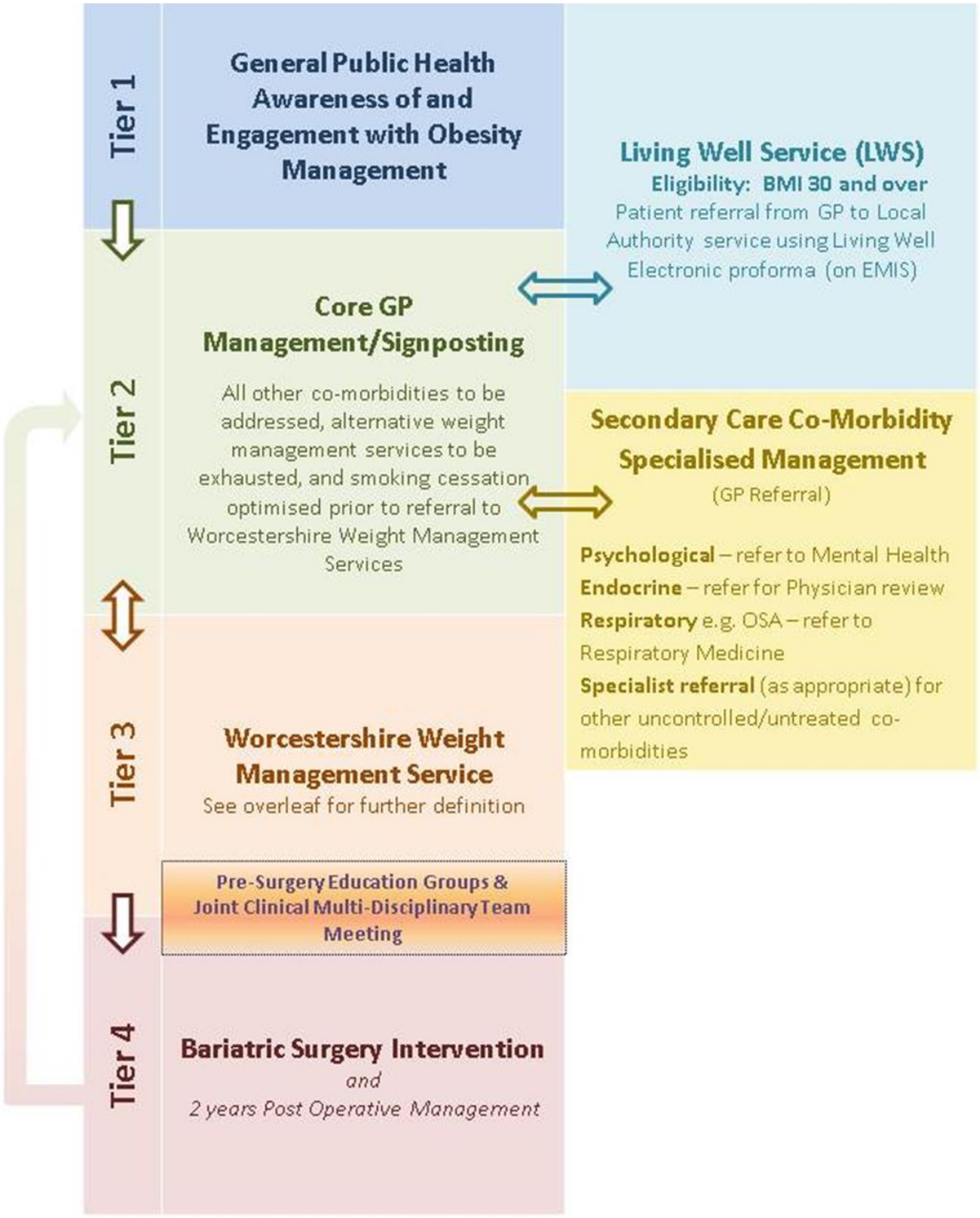
4.2 The prevalence of obesity in England is one of the highest in the European Union. In England just over a quarter of adults (26% of both men and women aged 16 or over) were classified as obese in 2010 (Body Mass Index (BMI) 30kg/m2 or over).

4.3 Using both BMI and waist circumference to assess risk of health problems, 22% of men were estimated to be at increased risk; 12% at high risk and 23% at very high risk in 2010. Equivalent figures for women were: 14%, 19% and 25%. In the UK obesity rates 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.

4.4 Overweight and obesity is a global problem. The World Health Organization (WHO; Obesity and overweight: fact sheet 311) predicted that by 2015 approximately 2.3 billion adults worldwide will be overweight, and more than 700 million will be obese.

5. Patient Eligibility

5.1 The **Worcestershire Weight Management Pathway for Adults** is outlined below and comprises a number of tiers and support services:



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Living Well Service	**The Living Well Service offers realistic and practical support to help:** • Improve diet • Plan healthy meals including portion guidance to enable weight loss at a healthy rate • Become more physically active including activity guidance to move more and build strength • Improve emotional wellbeing • Connect to activities taking place in the community • Get involved with the project and support others • Access services that can support service users to reach goals and ambitions • Empower patients to manage their weight in order to facilitate progression through clinical pathways where required
Core GP Management and Signposting	**Core GP Role:** • Awareness of Tiered Obesity Management Services and appropriate signposting/referral of patients to these services • Oversight of patients throughout the obesity pathway incorporating: 1. Primary care management 2. Complex Diseases and/or Comorbidity management 3. Referral to necessary services with documented history & outcomes • Management of patients unsuitable for onward referral to other obesity management pathways
Specialised Weight Management	**Referral for Specialised Management (including psychological assessment/dietetic advice):** 1. All appropriate non-surgical measures have been tried but failure to achieve or maintain adequate, clinically beneficial weight loss **AND** 2. Commitment to achieving significant weight loss **AND** 3. BMI > 35 with significant co-morbidities (especially diabetes) **OR** BMI > 40 without co-morbidities **OR** Unsuitable for Tier 2 services with needs that cannot be managed adequately in General Practice (6-12 month finite support)
Unsuitable for Tier 3 or 4 Services?	**The following patient groups are unlikely to be suitable for specialised weight management services unless the clinical issue/circumstance has been addressed by an appropriate specialist in advance of referral:** • Unstable mental health condition (including suicidal ideation) • Addictive personality disorder, active and untreated drug/alcohol addiction • Life limiting illness

5.2 **Referral for Specialist Weight Management** is a pre-requisite of bariatric surgery and should be undertaken when:

a. All appropriate non-surgical measures have been tried but failure to achieve or maintain adequate, clinically beneficial weight loss
AND
b. Patient is committed to achieving significant weight loss
AND
c. BMI > 35 with significant morbidities
OR
BMI > 40 without co-morbidities
OR
Fits the above criteria but is unsuitable for Tier 2 services with needs that cannot be managed adequately in General Practice (6-12 month finite support)

The Patient's GP will be required, prior to referral to Worcestershire Weight Management Service, to:

- ✓ Complete the following blood tests within 12 months before referral:
  - TSH (within 6 months preferable)
  - HbA1c
  - FBC
  - Renal profile
  - Liver Function Tests
- ✓ Ensure that all other co-morbidities have been addressed. If the patient is at risk of obstructive sleep apnoea (OSA) ensure that they have been referred for sleep studies before referral to weight management services; referral recommended when Epworth Sleepiness Scale (ESS) ≥ 10.
- ✓ Ensure the patient has exhausted all other available weight management services in Tier 1 and 2
- ✓ Provide smoking cessation advice and sign-posting to available services.
- ✓ Ensure the patient wishes to engage with the Tier 3 service and is able to commit to attending regular appointments

When the GP is assured that referral is appropriate, the GP to Specialist Weight Management Referral Proforma (Appendix 1) should be completed including the following information:

- The patient's weight, height and current BMI
- Access to and engagement with Tier 1 and 2 weight management services
- The outcome of any screening for rare hormonal or genetic causes for weight gain if there is clinical suspicion
- The outcome of any investigations into obesity-related comorbidities that may be previously undiagnosed, in particular type 2 diabetes, hypertension, Obstructive Sleep Apnoea (OSA), heart failure, atrial fibrillation, chronic kidney disease, non-alcoholic fatty liver disease and depression, to optimise and modify all identified risks, and so that those referred for surgery are as fit as possible; specialists could also be involved by separate referral if patients need super-specialist care

Notes:

1. *Morbidly obese patients with intracranial hypertension should be referred as a priority.*
2. *The following patient groups are unlikely to be suitable for specialised weight management services unless the clinical issue/circumstance has been addressed by an appropriate specialist in advance of referral:*
   - *Unstable mental health condition (including suicidal ideation)*
   - *Addictive personality disorder, active and untreated drug/alcohol addiction*
   - *Life limiting illness*

5.3 **Bariatric Surgery** is commissioned for patients identified by the Tier 3 Specialist Weight Management Service who it considers may benefit from surgical intervention. They should:

- meet the eligibility criteria for referral to the Tier 3 Specialist Weight Management Service; AND
- have adequately engaged with the Tier 3 Service, fully understand the surgery, be well-informed and motivated to have surgery and have realistic expectations of outcomes; AND
- be medically optimised; AND
- have no medical, surgical, nutritional, psychological, psychiatric or social contraindication; AND
- understand the importance of complying with nutritional requirements before and after surgery and recognises the need for life-long follow up

The transition to Tier 4 should be seamless and will involve members of both Tier 3 and 4 services. Identified patients will be required to engage with pre-surgery education groups and a Joint Clinical Multi-disciplinary team (MDT) meeting. These meetings/groups will ensure that patients:

- meet all criteria previously outlined
- are aware of all management options including the characteristics of the various surgical procedures available and the risks and side effects (specifically potential benefits, longer-term implications of surgery, associated risks, complications and perioperative mortality)
- are aware of the local Aesthetic Surgery Commissioning Policy stance on treatments to remove excess skin (eg. abdominoplasty) and the implications of this for them.

When it is determined that surgical intervention is appropriate for the patient, the choice of surgical intervention should be made jointly with the person, taking into account:

- the degree of obesity
- co-morbidities
- the best available evidence on effectiveness and long-term effects
- the facilities and equipment available
- the experience of the surgeon who would perform the operation

A Blueteq proforma (Appendix 2) should be completed for all eligible patients that proceed to bariatric surgery intervention.

6. Supporting Documents

- Worcestershire Service Specification: Specialist Weight Management Services (Tier 3 and 4). October 2018
- Worcestershire CCGs: Operational Policy for Individual Funding Requests
- Worcestershire CCGs: Prioritisation Framework for the Commissioning of Healthcare Services
- NHS England: Ethical Framework for Priority Setting Resource Allocation
- NHS England: Individual Funding Requests
- NHS Constitution, updated 27th July 2015
- NICE Clinical Guideline: Obesity: identification, assessment and management (CG189) 2014

7. Appendices

Appendix 1: Referral Form for Consideration of SPECIALIST WEIGHT MANAGEMENT (Adults aged 18 and over)

PATIENT DETAILS			
Date of Referral:		Date Referral Received:	
GP Practice:		Referring GP:	
Patient Name:		Patient Date of Birth:	
Patient Address:		Patient's Ethnicity:	
		Is an interpreter required? If yes please indicate language	**YES / NO** ……
		Patient Contact Number:	
NHS Number:		Hospital Number (if known):	

Current Weight:		Height:		Current BMI:	

POLICY CRITERIA – extract from full policy, which is accessible via this link
http://www.redditchandbromsgroveccg.nhs.uk/about-us/strategies-policies-and-procedures/commissioning-ifr/?assetdet1029359=39308

Please confirm:	**Tick Applicable Indication**
1. All appropriate non-surgical measures have been tried but failure to achieve or maintain adequate, clinically beneficial weight loss AND	☐ (*required)*
2. Patient is committed to achieving significant weight loss AND	☐ (*required)*
3. BMI > 35 with significant morbidities OR	☐ *or*
BMI > 40 without co-morbidities OR	☐ *or*
Fits the above criteria but is unsuitable for Tier 2 services with needs that cannot be managed adequately in General Practice (6-12 month finite support)	☐

CO-MORBIDITIES

Please confirm that co-morbidities have been optimised: **YES / NO**

Has the patient got learning difficulties? **YES / NO**

Does the patient have a history of mental health issues? **YES / NO**
(please provide detail below)

Notes:

- If the patient is at risk of obstructive sleep apnoea (OSA) ensure that they have been referred for sleep studies before referral to weight management services.
- Smoking cessation should be optimised before referral to weight management services
- The following patient groups are unlikely to be suitable for specialised weight management services unless the clinical issue/circumstance has been addressed by an appropriate specialist in advance of referral:
    - Unstable mental health condition (including suicidal ideation)
    - Addictive personality disorder, active and untreated drug/alcohol addiction
    - Life limiting illness

Patient's previous medical history to populate

Patients current medication list to populate

EXAMINATION/PMH/DH/ALLERGIES

The following blood tests should have been done in the last 12 months, results to populate

TSH, HbA1c, FBC, Renal profile, Liver Function Tests.

Please also provide results and outcome of any screening for rare hormonal or genetic causes for weight gain if there is clinical suspicion:

PATIENTS NOT MEETING THE POLICY

For patients who do not fall within the eligibility criteria set out in the policy but where there is demonstrable evidence that the patient has clinically exceptional circumstances, an Individual Funding Request may be considered. The referring clinician should consult the Commissioner's "Operational Policy for Individual Funding Requests" document for further guidance on this process.
http://www.redditchandbromsgroveccg.nhs.uk/strategies-policies-and-procedures/commissioning-ifr-policies-a-z/

Appendix 2: Blueteq Prior Approval Proforma (Bariatric Surgery)

Prior Approval Form - Bariatric Surgery (including revisions)			
APPLICANT DETAILS			
Clinician Making Request:		**GMC Code:**	*
Clinician First Name:	*	**Clinician Title**	
Clinician Surname:	*	**Telephone:**	*
Clinician Designation:	*		
Email (nhs.net):	*		
PATIENT DETAILS			
Patient Name:	**********	**GP Practice Name:**	
NHS Number:	**********	**GP Practice Code:**	
Hospital Number:		**Patient DOB:**	__/__/____
Patient Age:			
Patient Height (Meters):		**Patient Weight (Kilograms):**	
Patient BMI:			

1. PATIENT ELIGIBILITY

Please confirm that the patient meets the requirements for bariatric surgery within the Worcestershire CCG Policy "Weight Management Services"

☐ Yes ☐ No
* Required

2. CLINICAL INDICATION

Please confirm the clinical indication for surgery:

- ☐ BMI > 35 with significant co-morbidities
- ☐ BMI > 40 without co-morbidities
- ☐ Revisional surgery following prior bariatric surgery

Where co-morbidities, please indicate which of the following:

- ☐ Cardiovascular disease
- ☐ Diabetes
- ☐ Dyslipidaemia
- ☐ Hypertension
- ☐ Osteoarthritis
- ☐ Sleep apnoea
- ☐ Soft tissue infections
- ☐ Stroke
- ☐ Venous insufficiency
- ☐ Other

3. SURGICAL INTERVENTION

Please confirm the nature of surgery to be undertaken:

- ☐ Band
- ☐ Sleeve
- ☐ Bypass
- ☐ Revisional

4. SURGICAL REVISION

When (date) was original bariatric surgery undertaken?:

How was the original bariatric surgery commissioned? Please Select

Please provide the reason for the revisional surgery:

ANY OTHER INFORMATION

Please input any additional information (Documents must be added from the patient notes)

SUBMISSION DECLARATION

I confirm that the above information is complete and accurately describes the patient's condition.

Submitting User * Submitting User Email *

Date *

8. Equality Impact Assessment

Organisation	NHS Redditch & Bromsgrove CCG, NHS South Worcestershire CCG, NHS Wyre Forest CCG		
Department	Contracts	Name of lead person	Fiona Bates, Helen Bryant
Piece of work being assessed	Specialist Weight Management Service: Bariatric Surgery Commissioning Policy		
Aims of this piece of work	To provide guidance to patients and clinicians in both primary and secondary care on the medical/clinical requirements for specialist weight management and bariatric surgery funded on the NHS within Worcestershire		
Date of EIA	02102018	Other partners/stakeholders involved	Clinical Commissioning Policy Collaborative
Who will be affected by this piece of work?	Patients, GPs and Consultants		

The prevalence of obesity varies by region and with gender, age, household income (in women but not men), education and socio-economic background, and ethnicity.

Single Equality Scheme Strand	**Baseline data and research on the population that this piece of work will affect.** What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**	**Is there likely to be a differential impact?** Yes, no, unknown
Gender	Men are more likely to be overweight or obese than women (68% of men compared with 58% of women), but women are more likely to be morbidly obese (defined as obesity III or obesity II with comorbidities [3.6% of women compared with 2.2% of men]). 39% of women in the 2nd lowest household income quintile were obese compared with 17% of women in the highest income quintile. The CCG policy endorses the provision of NHS funded weight management services and surgery based on the individual's clinical case history, so being male or female should not be a factor in the decision making process or the application of the policy.	No
Race	There are ethnic differences in the prevalence of obesity and the related risk of ill health. For example, compared with the general population, obesity is most prevalent among black African,	Yes

	Caribbean, and Pakistani women and least prevalent among Chinese and Bangladeshi men [NICE, 2014]. People of Asian family origin have comorbidity risk factors that are of concern at different BMIs (lower for adults of an Asian family origin). The CCG policy endorses the provision of NHS funded weight management services and surgery based on the individual's clinical case history, so having different ethnicity is not generally a factor in the decision making process or the application of the policy. However this may not be the case for people of Asian family origin whose comorbidity risk factors are of concern at a lower BMI.	
Disability	Obesity rates for adults and children with disabilities are significantly higher than for those without disabilities, with differences remaining even when controlling for other factors. Reasons for this disparity include lack of healthy food options for many people with disabilities living in restrictive environments, difficulty with chewing or swallowing food, medication use contributing to changes in appetite, physical limitations that can reduce a person's ability to exercise, constant pain, energy imbalance, lack of accessible environments in which to exercise or fully participate in other activities, and resource scarcity among many segments of the disability population. The CCG policy endorses the provision of NHS funded weight management services and surgery based on the individual's clinical case history, so having a disability should not be a factor in the decision making process or the application of the policy.	No
Religion/ belief	A study published in 2014 and based on adults aged over 16 years who completed the 2012 Health Survey for England found that BMIs of those who described themselves as religious were on average 0.91kg per square metre higher. The most striking correlation was among Christians, followed by Sikh men. The association between religion and obesity is unclear and unexplored in the general English population; some association may be explained demographically, but was not accounted for by smoking status, alcohol consumption or physical activity level. The CCG policy endorses the provision of NHS funded weight management services and surgery based on the individual's clinical case history, so religion/belief should not be a factor in the decision making process or the application of the policy.	No
Sexual orientation	There is no evidence to confirm whether sexual orientation increases the risk of obesity and requirement for medical or surgical intervention	No

	The CCG policy endorses the provision of NHS funded weight management services and surgery based on the individual's clinical case history, so sexual orientation should not be a factor in the decision making process or the application of the policy.	
Age	In England, 27% of adults are obese (a rise from 15% in 1993) and a further 36% are overweight [House of Commons, 2017; NHS Digital, 2017]. About 35% of the population are projected to be obese in 2030. In 2011, about 3 in 10 children aged 2–15 years were overweight or obese. The age group most likely to be overweight or obese is the 55–64 age group, but only by a small margin. The CCG policy endorses the provision of NHS funded weight management services and surgery based on the individual's clinical case history for adults only, so adult age should not be a factor in the decision making process or the application of the policy. However these services are not commissioned by Worcestershire CCGs for children.	Yes
Social deprivation	The prevalence of obesity varies by region and with household income (in women but not men), education and socio-economic background. Obesity was generally more prevalent in the North of England and the Midlands than in the South of England. 39% of women in the 2nd lowest household income quintile were obese compared with 17% of women in the highest income quintile. According to the 2017 OECD Obesity Update, social inequalities in overweight and obesity are strong, especially among women. The available data shows that less educated women are 2–3 times more likely to be overweight than those with a higher level of education. The CCG policy endorses the provision of NHS funded weight management services and surgery based on the individual's clinical case history, so social deprivation should not be a factor in the decision making process or the application of the policy.	No
Carers	There is no evidence to confirm whether being a carer increases the risk of obesity and requirement for medical or surgical intervention The CCG policy endorses the provision of NHS funded weight management services and surgery based on the individual's clinical case history, so being a carer should not be a factor in the decision making process or the application of the policy.	No
Human rights	The CCG policy does not seek to impact on an individual's human rights.	No

Equality Impact Assessment Action Plan

Strand	Issue	Action required	How will you measure the outcome/impact	Timescale	Lead
Age	Weight management service and bariatric surgery only commissioned for adults	Surgical intervention is not generally recommended in children or young people. Bariatric surgery may be considered for young people only in exceptional circumstances, and if they have achieved or nearly achieved physiological maturity. (NICE 2006) Non-surgical interventions for children are the commissioning responsibility of local authorities. Specialist surgical intervention for morbidly obese children is the commissioning responsibility of NHS England.	n/a	n/a	n/a
Race	People of Asian family origin have comorbidity risk factors that are of concern at different BMIs (lower for adults of an Asian family origin). Diabetes tends to occur at lower BMIs in Asian patients due to greater abdominal adiposity	Consider an assessment for bariatric surgery for people of Asian family origin who have recent-onset type 2 diabetes at a lower BMI than other populations as long as they are also receiving or will receive assessment in a tier 3 service (or equivalent). (NICE 2014) Such considerations will be made via the IFR process.	Monitor completion of Blueteq proformas and IFR applications.	Annual	Contract team