

## SHIP8 Clinical Commissioning Groups Priorities Committee

**Policy Recommendation:** Bariatric surgery procedures in severely obese adults who have failed to respond to lifestyle and tier 3 interventions

**Date of issue:** June 2016

The Priorities Committee has reviewed the evidence for Bariatric surgery procedures in severely obese adults who have failed to respond to lifestyle and tier 3 interventions and recommends that:

**Bariatric surgery (limited to adjustable gastric banding, sleeve gastrectomy and Roux-en-Y gastric bypass performed at a recognised specialist centre with a multi-disciplinary team) will be prioritised as a treatment option for people with obesity if all the following criteria are fulfilled:**

- They have a BMI of 40 kg/m<sup>2</sup> or more, or between 35 kg/m<sup>2</sup> and 40 kg/m<sup>2</sup> and either type 2 diabetes mellitus (T2DM) or uncontrolled hypertension (after all medical therapies have been tried) that may be improved if they lost weight.
- All appropriate non-surgical measures (including Tier 2 and Tier 3 interventions) have been tried for at least 12 months continuously but the person has not achieved or maintained adequate, clinically beneficial weight loss.
- The person is generally fit for anaesthesia and surgery.
- The person commits to the need for long-term lifestyle modification and follow-up.

Other types of procedures (e.g. gastric plication, intragastric balloon, and biliopancreatic diversion with duodenal switch) are not routinely funded and will need prior approval through the CSU.

CCGs should commission specialist bariatric surgery in the context of a care pathway including prevention and non-surgical interventions. Priority should be given to the provision of effective, coordinated weight loss management support including combined access to specialist diet advice, exercise advice/referral scheme, pharmacological support and counselling. Whilst patients experiencing surgical complications from previous bariatric surgery would be considered automatically for further surgical interventions, patients with weight re-gain alone would not.

### Supporting Information

#### Background

- Amongst both men and women in England, 25% of adults are obese (i.e. they have a BMI of 30 kg/m<sup>2</sup> or more). It is estimated that approximately 400,000 adults across the SHIP8 CCG area are obese.
- There were over 18,000 bariatric operations across UK & Ireland between 2011-13; 76% of these were funded by the NHS [1].
- The majority of procedures were performed laparoscopically rather than open.

#### Notes:

*Whilst the panel recognised the considered expert advice of NICE in their recommendation, the panel also had a duty to prioritise spending of a finite resource locally and made a decision which it felt gave the most equitable and effective use of investment. This policy may be reviewed in the light of new evidence or guidance from NICE.*

*Exceptional circumstances may be considered where there is evidence of significant health impairment and there is also evidence of the intervention improving health status.*

- The three most common types of procedures in the UK include<sup>1</sup>:
  - Roux-en-Y gastric bypass (52%)
  - Sleeve gastrectomy (21%)
  - Adjustable gastric banding (22%)
- Other types of procedures are rarely performed (e.g. gastric plication, intragastric balloon, and biliopancreatic diversion with duodenal switch).

### The Search

- There was a large volume of evidence, including the recent Cochrane Review[1], the 2009 Health Technology Assessment[2], the 2014 Second Registry Report of the UK National Bariatric Surgery Registry[3], and multiple randomised controlled trials (RCTs).
- The available evidence does not allow for a clear answer to whether there is variable clinical or cost effectiveness between the main types of bariatric procedures.
  - The studies either included participant selection criteria that did not match the bariatric surgery patient eligibility criteria in the NICE clinical guideline, or they did not specify whether patients had previously gone through lifestyle or Tier 3 (or equivalent) interventions in multi-disciplinary teams.
  - There was limited reported of outcomes such as quality of life, resolution of obesity related comorbidities (other than type 2 diabetes) or longer term outcomes.
  - All identified economic evaluations were weak due to limited long-term follow-up data and significant heterogeneity between the studies.

### Findings

- Clinical effectiveness:
  - Both sleeve gastrectomy and Roux-en-Y gastric bypass procedures were more effective than the adjustable gastric band in terms of greater weight or BMI loss.
- Safety:
  - The adjustable gastric band was safer than the sleeve gastrectomy and Roux-en-Y gastric bypass, with no apparent difference between sleeve gastrectomy and Roux-en-Y.
- Cost-effectiveness:
  - All procedures are highly cost-effective, with reported incremental cost effectiveness ratios being significantly lower than the £20,000 per quality-adjusted life year (QALY) ceiling. There is evidence that bariatric surgery is most cost-effective in patients who are obese with an obesity related comorbidity, particularly T2DM.
- BMI threshold:
  - There is no good quality evidence to support a higher BMI threshold regarding clinical effectiveness, but some weak evidence suggests that bariatric surgery may be more cost effective in patients with a higher BMI due to a greater capacity to benefit.
- Ongoing research:
  - Local specialist providers are involved in an NIHR funded RCT and are currently recruiting patients to help compare the clinical and cost effectiveness of the three most commonly performed procedures.

### References

1. Colquitt JL, Pickett K, Loveman E, Frampton GK. Surgery for weight loss in adults. Cochrane Database of Systematic Reviews 2014, Issue 8. Art. No.: CD003641. DOI: 10.1002/14651858.CD003641.pub4.
2. Picot J, Jones J, Colquitt JL, 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 Technology Assessment (Winchester, England). 2009;13(41):1.
3. United Kingdom National Bariatric Surgery Registry. Second register report. 2014. Available at: <http://nbsr.co.uk/2014-report/>; accessed 27<sup>th</sup> January 2016.

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