2017/18 NHS STANDARD CONTRACT

FOR SEVERE AND COMPLEX OBESITY (Adults)

PARTICULARS, SCHEDULE 2 - THE SERVICES, A- SERVICE SPECIFICATIONS

Service Specification No.	A05/S/a
Service	Severe and Complex Obesity (Adults)
Commissioner Lead(s)	
Provider Lead	
Period	1st April 2017 – 31st March 2020 (with a potential to extend to 31st March 2022.
Date of Review	January 2020

1. Population Needs

1.1 National/local context and evidence base

Obesity and overweight are a global epidemic. The World Health Organisation (WHO) expects that approximately 2.3 billion adults worldwide will be overweight by 2015 and more than 700 million will be obese. 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). 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%. There has been a marked increase in the proportion (doubling) that are obese, a proportion that has gradually increased over the period from 13.2% in 1993 to 26.2% in 2010 for men and from 16.4% to 26.1% for women.

BMI Definition	BMI range (kg/m2)
Underweight	Under 18.5
Normal	18.5 to less than 25
Overweight	25 to less than 30
Obese	30 to less than 40
Obese I	30 to less than 35
Obese II	35 to less than 40
Morbidly obese/obese III/severe	40 and over
Overweight including obese	25 and over
Obese including morbidly obese	30 and over

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 (Department of Health).

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.

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 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). 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/m2 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 of ≥35 kg/m2. Other groups have been less well studied but bariatric surgery is reported to be cost effective against a wide range of co-morbidities.

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 also been shown to be a highly cost effective therapy that prevents the development of co-morbidities.

Bariatric surgery in the North West services will require that these patients fulfil the criteria within this specification. Selection criteria of patients for bariatric surgery should prevent perverse incentives for example patients should not become more eligible for surgery by increasing their body weight. Similarly the selection criteria should not forbid bariatric surgery for patients who have lost weight with non-surgical methods.

2. Scope

2.1 Aims and objectives of service

The main clinical aim of a Tier 4 specialised complex obesity service is to achieve a significant reduction in the burden of obesity-related co-morbidities, where all other services have been unable to achieve this. This will be achieved by facilitating a significant, and sustained, weight reduction in the patient.

The provider of a complex obesity service will, as part of a continuous pathway of care include the patient's GP (Primary Care); local (to the patient) services commissioned by local authority (LA) or clinical commissioning group (CCG) and local district general hospital/tertiary care based interventions which may include private sector providers (e.g. those commercial slimming clubs with scientific directors), deliver a service providing specialised care, including both non- surgical interventions and surgical and interventions, for patients who have been unable to achieve and/or maintain significant weight-loss. The service will be provided in a complete and reproducible pathway that meets the required standards of care and achieves expected outcomes whilst remaining within proper consideration of cost and resource.

Providers will have clinical protocols and programmes of care that deal with the patient journey through assessment, medical or surgical intervention, post-surgical care (where appropriate), discharge and long term follow up, including the transition back to a specialist weight management service local to the patient's home, as part of a life-long shared care arrangement of follow-up and surveillance.

Providers will be required to demonstrate that they have multi-disciplinary teams that can provide such assessments and that clinically appropriate referrals to other specialties for further consultation and clinical management will be made.

Whilst bariatric surgery is a last-line intervention, the provision of follow up for complications, nutritional and weight maintenance support for the patient remains a lifetime commitment for the patient.

We describe an ideal service for severe and complex obesity which includes bariatric surgery. Various elements of this pathway will have different commissioning pathways and responsibilities.

2.2 Service description/care pathway

The services provided will cover in secondary and/or tertiary clinical settings:

- Assessment and diagnosis of underlying causes of overweight and obesity where this cannot be identified or managed in primary care or community based medical obesity services. Including but not limited to rare genetic syndromes, endocrine disturbances and abnormalities.

- Assessment and treatment using non-surgical methods, or onward referral to other specialties, of those with complex disease states and/or comorbidities that cannot be managed adequately in either primary or secondary care.

- These will include:

    - Treatment for those using non-surgical modalities where conventional treatment has failed in primary or secondary care;
    - Treatment for those where drug therapy is being considered for a person with a BMI more than 50 kg/m2;
    - Specialist interventions (such as a very-low-calorie diet for extended periods),
    - Pre-operative preparation, surgical intervention and immediate post-operative follow-up.
    - Life-long post-operative follow-up and specialist surveillance, in conjunction with community based medical obesity services, and primary care.

The Tier 4 Multi-Disciplinary Team (MDT)

All patients referred into Tier 4 services will be assessed by the Tier 4 MDT. The Tier 4 provider will have two pathways of care available for each patient; non-surgical and surgical. These pathways will be sequential, not parallel.

At referral the Tier 4 non-surgical MDT will determine whether a patient has progressed through appropriate local community based Tier 3 services and if not will reject the referral.

The non-surgical team will assess the patient to determine:

- the cause of obesity,
- the presence and severity of co-morbidities,
- to stratify/score risk (Obesity Surgery Mortality Risk Score (OS-MRS) (see annex 2)),
- to evaluate the modalities of weight loss that have been explored,
- to detect other diseases and
- to optimise their medical condition.

The non-surgical MDT will include, as a minimum;

- Bariatric dietitian
- Bariatric physician
- Bariatric specialist nurse
- Psychotherapist / psychologist / psychiatrist - with an interest in obesity
- Other relevant medical specialist for referral and consultation e.g. endocrinologist/diabetologist/cardiologist/anaesthetist (unless already in the non-surgical MDT).

Following assessment, patients will be reviewed by a combined non-surgical and surgical Tier 4 MDT to consider the optimal therapy for individual patients. Only if the team feels that the patient fulfils the surgical selection criteria will they be referred onward to the bariatric surgery team. The commissioner expectation is that the MDT stage of the pathway will normally take at least 6 months.
If non-surgical therapies requiring tier 4 interventions are considered optimal the non-surgical team will recommend, and provide treatment with a view to discharging back to the Tier 3 as clinically appropriate.

Depending on local arrangements, the surgical Tier 4 MDT will undertake the counselling and preparation of patients assessed as appropriate for bariatric surgery.

The Tier 4 MDT will work, in conjunction with local commissioners and providers, within integrated care pathways and shared care protocols to ensure patients are receiving appropriate pre- and post- operative care and long term follow-up regardless of location.

The provider will be able to offer support to the patients through a designated contact person and in the form of a clear and comprehensive information pack in appropriate formats to comply with equality and diversity legislation.

Surgery

The specialist surgical MDT should include as a minimum:

- Bariatric surgeon
- Bariatric dietitian
- Specialist anaesthetist
- *Relevant medical specialist with an interest in obesity e.g. endocrinologist/diabetologist
- *Psychotherapist / Psychologist / Psychiatrist with an interest in obesity
- *Ideally on site access to other relevant medical specialists for the diagnosis and management of co-morbidities.

*not necessary if part of the non-surgical MDT

(This list is not exhaustive and the MDT should have access to/include the most appropriate group of health care professionals required to make a comprehensive and appropriate decision).

The surgical MDT will be supported by a radiologist and radiographer with a special interest in obesity. Patients will also have access to physiotherapy and occupational health professionals to assess and manage their levels of physical activity.

Specialised complex obesity services will deliver primary bariatric surgery for all patients deemed clinically appropriate, and within the criteria defined in the commissioning policy.

The bariatric surgery MDT will satisfy itself that:

- bariatric surgery is in accordance with relevant guidelines
- there are no specific clinical or psychological contraindications to this type of surgery
- the individual is aged 18 years or above.
- the patient has engaged with non-surgical Tier3/4 Services.
- the anaesthetic and other peri-operative risks have been appropriately minimised

- the patient has engaged in appropriate support or education groups/schemes to understand the benefits and risks of the intended surgical procedure. This should be provided by the Tier 4 service, following referral, should the patient be assessed by the MDT as having not engaged prior to referral. However the expectation is clearly that the patient has accessed services prior to referral to Tier 4.
- the patient is likely to engage in the follow up programme that is required after any bariatric surgical procedure to ensure:
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  - safety of the patient,
  - best clinical outcome is obtained and then maintained.
  - change in eating behaviour
  - change in physical behaviour
  - change in health promoting lifestyle

- The overall risk: benefit evaluation favours bariatric surgery.
- The MDT will meet physically (not virtually) and minutes will be recorded of the patient management decisions.

Specialised complex obesity services will be able to provide the full range of routine bariatric procedures, including laparoscopic and open procedures and revision procedures (a national policy for revision procedures will be developed in 2013). Providers will not restrict practice to one single method of operation.

It is expected that laparoscopic surgery will be the normal operating method used.

Specialised severe and complex obesity Services will be able to provide 24-hour emergency management of post-surgical complications, including the availability of 24-hour consultant bariatric surgeon cover or joint cover with upper GI surgeons. In some models of care the surgical bariatric service is part of the wider general surgery division and is clinically integrated with the upper GI surgical service. The critical factor is rapid access to bariatric surgery advice and attendance. Services will also have appropriate on-site arrangements for critical care of the morbidly obese together with suitably trained and qualified staff to support this area.

In order to allow for progression of Specialised Complex Obesity Services, it is anticipated that there will be a need for two levels of service in the future (Units and Centres of Excellence - see International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) guidelines appendix 2 - units correspond to Institutions in IFSO). These levels will work as a clinical network between themselves as part of the wider obesity care pathway, and cover the full range of surgical procedures and case complexity, education and training of post graduates and less experienced bariatric surgeons as well as multi-disciplinary training of other professionals (e.g. psychologists, dietitians etc.) with an interest in severe and complex obesity and bariatric surgery.

However, at present, bariatric units will have a minimum of 2 consultant surgeons. Each surgeon will perform at least 50 procedures per annum and the provider unit will perform a minimum of 100 procedures per annum. Units will carry out all types of surgical procedure but will be restricted to an upper BMI/Weight and complexity limit. Thresholds will be agreed in conjunction with the Commissioner and the Clinical network.

The surgeons in the multidisciplinary team should have undertaken a relevant supervised training programme and have specialist experience in bariatric surgery (see International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) guidelines – appendix 2).

Specialised complex obesity services will submit data on all patients treated to the National Bariatric Surgery Registry, using their standard protocols for data compliance.

Patients must be appropriately supported. Support will vary between units, but it is essential that specialist dietetics as well as nursing is provided, due to the specific issues that this work presents. Therefore a mix of specialism should be provided to match local requirements which will typically be ~1.5 wte per 100 patients with arrangements for annual leave.

Non-surgical management

There will need to be pathways for the management of:

- patients who require preparative therapy prior to bariatric surgery
- patients who have been assessed and found to be unsuitable for bariatric surgery but require Tier 4 specialist input.

These patients may need to be managed within the non-surgical MDT as described above for a period of up to 2 years. Where appropriate refer back to tier 3 or primary care

Patient Support

The Tier 4 provider will be able to offer support to the patients through a designated contact person and in the form of a clear and comprehensive information pack in appropriate formats to comply with equality and diversity legislation.

The provider will set up and maintain patient support groups and also to sign post patients to other patient support groups facilitated by different organisations or charities. Such groups are a vital source of peer support, advice and information for patients. They may also be able, depending on their stage of development, to form an advocacy role, either at group or individual level, or as agents for change or service development.

Follow Up

The provision of after-care and weight management support for the patient remains a lifetime commitment. Structured, systematic and team based follow up should be organised by the Tier 4 provider for up to 2 years after surgery. Lifelong specialist follow up is also advocated via local services (GP and Tier 3).

Tier 4 structured, systematic and team based follow up for 2 years post-surgery should be organised to include:

- monitoring nutritional intake (including protein and vitamins) and mineral deficiencies
- monitoring comorbidities
- medication review
- dietary and nutritional assessment, advise and support
- physical activity and support
- psychological support tailored to the individual
- information about professionally led or peer support groups.

Lifelong specialist follow up is advocated and providers should have arrangements in place to discharge patients to the local community Tier 3 based obesity service within 2 years. The patients GP will also provide additional support. Refer to gp

Long term follow up should use a shared care model of chronic disease management. It is the responsibility of the Tier 4 bariatric team to develop clear protocols for the required monitoring with local community (GP and Tier 2) based services to ensure they are aware of the patient's ongoing progress.

"Lost to follow up" across the whole pathway should be minimised and a robust mechanism should be in place for early identification of post-operative complications. Rapid access to the specialised complex obesity Tier 4 MDT will be available for assessment of complications and post-operative care will be available to manage complications as they occur including revision surgery in line with NHS policies. Failure to lose 'sufficient' weight is not deemed a complication.

2.3 Population covered

The service described in this specification is for patients ordinarily resident in the North West of England. Mersey/cheshire

Specifically, this service is for adults (aged 18 and over) with complex obesity requiring specialised interventions and management as outlined in this specification and in the Specialised Complex Obesity commissioning policy.

2.4 Any acceptance and exclusion criteria

Acceptance Criteria

Referrals will only be considered for patients who are adults (aged 18 and over) as a treatment option for people with morbid obesity providing the patient fulfils all of the criteria laid out in the commissioning policy www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/08/a05-p-a.pdf

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. 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. ?define

- There must be formalised Tier 4 Multidisciplinary Team led processes for the screening of co-morbidities and the detection of other significant diseases. These should include

  - identification, diagnosis, severity/complexity assessment, risk
  - Stratification/scoring and appropriate specialist referral for medical management. Such medical evaluation is mandatory prior to entering a surgical pathway.

- Morbid/severe obesity has been present for at least five years.

- The individual has recently received and complied with a local specialist tier 3 obesity service weight loss programme as set out in the NHS England commissioning policy and ?NICE guidance

Exclusions to this specification (based on NICE Guidance (CG43)): This specification does not cover:

- Patients with a BMI under 35 kg/m2. *
- People with recent onset Type 2 diabetes who have not gone through appropriate Tier 3 services and do not meet the surgical acceptance criteria;
- Children and adolescents up to and including 17 years and 11 months;
- Revision surgery;
- Routine follow-up after 2 years.

* There may be special clinical scenarios where urgent weight loss is required (prior to renal transplant or fertility treatment or cancer treatment or benign intracranial hypertension). These will arise from referral by another clinical MDT to a specialised complex obesity service. These patients may not have been through a Tier 3 service. However, if their clinical situation permits, they should undergo a minimum period of preparation, education and clinical optimisation in the Tier 4 non- surgical specialised weight management service. These will be treated as exceptional cases and accelerated through the individual funding processes. IFR panel?

2.5 Interdependencies with other services

Facilities:

Providers of complex obesity services will be able to demonstrate that they have suitably equipped facilities and appropriately trained specialist staff to provide assessment; pre-operative; operative; and post-operative care for patients. Ideally, facilities for the complex obesity service will be separate from those for other patients in order to maintain the focus of the service on the special needs of the patients. However, irrespective of whether there are dedicated facilities, providers will ensure that privacy and dignity of patients is maintained at all times.

Consideration will be given to the services being delivered on the ground floor of the provider. Where this is not possible the commissioner will seek written assurances regarding access to lifts, including compliance with current legislation; emergency protocols for the event of power failure or rapid evacuation of patients in relation to other emergencies. Where this is not possible, the commissioner will seek written assurance regarding the physical structure of the relevant building and its load-bearing capabilities.

The service should have a physical environment that meets the needs of patient attending the service: toilet seats, grab rails, shower chairs, commodes, chairs, beds, lifting equipment etc. will be suitable for use by patients who are morbidly obese. The provider will make appropriate beds and scales available for obese patients and ensure that suitable imaging equipment is available for obese patients.

The surgical service should have demonstrable arrangements for:

- access to in-patient beds for post-operative recovery;
- access to critical care facilities 24 hours a day, to at least high dependency (HDU) Level 2, and located on the same site at which surgical procedures are undertaken;
- access to Intensive care unit (ITU) Level 3 facilities on sites where surgical procedures are undertaken that are available 24 hours a day. Where this is not the case providers will have robust plans and procedures in place for patient transfers to local ITU level 3 critical care facilities that are available 24 hours a day. Procedures will include details of arrangements that the provider has with the receiving hospital for clinical liaison hand-over during the patient transfer and post transfer/re-admittance to their surgical unit;
- access to suitably qualified doctor with sufficient training and experience in bariatric surgery 24 hours a day for advice and treatment as necessary;
- the emergency assessment and treatment of post-operative complications;
- provision for revision procedures following assessment of previous outcomes for primary bariatric surgery;
- the training and education of all staff involved in the care and management of morbidly obese patients.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

Core Standards: to be in place at commencement of the contract

- NICE Clinical Guideline 43: Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children
- Obesity: identification, assessment and management (CG189)
- National Bariatric Surgery Registry data standards and requirements http://hostn3.e-dendrite.com/csp/bariatric/FrontPages/nbsrfront.csp accessed 26 Aug 2012
- http://www.bomss.org.uk/pdf/Pages_from_NBSR_2010.pdf accessed 26 Aug 2012
- Safeguarding Adults: the Role of Health Service practitioners (Department of Health, 2011)
- British Obesity and Metabolic Surgery Society Commissioning Standards

- Association of Upper Gastro-intestinal Surgeons: Provision of Services (2011)
- International Federation for the Surgery of Obesity: Guidelines for Safety, Quality, and Excellence in Bariatric Surgery (2008) – see Appendix 2
- http://www.eac-bs.com/eacbs/en/4/58.htmlaccessed 26 Aug 2012.

4. Key Service Outcomes

Commissioning Data and minimum data sets

The Commissioners require data on the services in order to benchmark the service against this specification and provide assurance on service delivery and clinical outcomes, together with information required to monitor and manage the contractual agreement. This data will be provided through national and local information collection.

Providers shall comply with guidance relating to clinical coding as published by the NHS Classification Services and with the definitions of activity maintained under the NHS Data Model and Dictionary.

Providers shall collect and provide national datasets within the timescales set out in the relevant Information Centre guidance and all applicable Information Standards Notice(s) and submit coded data to SUS.

Providers shall ensure that all patients seen within the service are entered onto the National Bariatric Surgery Registry, and comply with the data requirements of the registry.

Procedure mix undertaken, primary surgical procedures, revision procedures. Total and by CCG.

Providers shall comply with all local information collection requirements as listed in this service specification and in the contractual agreement with the commissioner.

The outcome measures listed below will be derived from information collected at individual patient level. The outcome measures are to be collected for all patients.

Outcome Measures

For all patients referred to the Tier 4 bariatric surgery provider, there should be documentation of the patient's weight management history (engagement, attendance, duration, improvement in weight and co-morbidities) in specialised T3 weight management services and reasons for referral for bariatric surgery.

At least 90% of patients going for bariatric surgery should comply with all criteria as given in the Commissioning Policy document. Is this right or can it come out?

Co-morbidity improvement

Reduction in objective measures of identified co-morbidities, functional status improvement and lifestyle

To be monitored at 6-months, 12-months, 18-months and 24-months post- surgery. Split by co-morbidity, e.g. type 2 diabetes, sleep apnoea, hypertension, asthma etc. Functional improvement can be monitored by increase in exercise tolerance, mobility. Life- style factors include increase in physical exercise, reduction/cessation of smoking and excessive alcohol intake.

Weight Loss

Weight should be recorded at onset of engagement with T3 weight management programme. Weight should be recorded at the time of assessment at surgical MDT and post-surgery (WL) by surgical procedure. WL to be monitored at 6-months, 12-months, 18-months and 24- months' post- surgery.

Weight Loss for patients clinically unsuitable for surgery also to be monitored at 6-months, 12-months, 18-months and 24-months post intervention.

100% **data submission to National Bariatric Surgery Registry**: all procedures carried out will be entered into the NBSR as per Dendrite data entry criteria.

Percentage (%) of patients lost to follow-up: 6-months; 12-months; 24-months. It is the responsibility of the bariatric provider to ensure follow up to 2 years. There is an expectation of <1% of patients will be lost to follow-up.

Percentage of patients treated within 18-weeks; will be within current NHS waiting times standards and no patient will wait in excess of 52 weeks. (Please be aware that this does not mean surgery within 18-weeks of referral, first definitive treatment might be any non-surgical intervention deemed clinically necessary).

Patient access will be managed in line with the latest NHS waiting list management guidance; this may be subject to random audit by commissioners.

Mental health measure?

Morbidity and Mortality

Post-operative complications (rate, type, onset time): leak rate, early obstruction, deep vein thrombosis, pulmonary embolism, chest infection, bleeding or other.

In-hospital mortality rates: classified by operation type, BMI group and surgical risk score (separate data to be recorded for revision procedures).

Post-discharge mortality rate: All deaths that occur post-discharge, reporting at 30days, 6-months and 12-months following primary or revision surgery.

Surgical complications requiring HDU/ITU: Recorded admissions post operatively into ITU/HDU (reason for admission, duration of stay).

Morbidity and mortality rates will be benchmarked against other Tier 4 services by commissioners.

ANNEX 1 TO SERVICE SPECIFICATION:

IFSO Guidelines for Safety, Quality, and Excellence in Bariatric Surgery:
http://www.eac-bs.com/site/index.php/sqe-guidelines

ANNEX 2 TO SERVICE SPECIFICATION:

Person specifications of specialists comprising multi-disciplinary team (MDT)

Bariatric Surgeons

The surgeons in the multidisciplinary team must hold GMC (General Medical Council) registration, be on the specialist register for general surgery and have undertaken a relevant supervised training programme and have specialist experience in bariatric surgery. See IFSO guidelines appendix 2. They should be members of The British Obesity & Metabolic Surgery Society (BOMMS).

Bariatric Physicians

The physicians in the multidisciplinary team should hold GMC registration, be on the specialist register and have undertaken a relevant supervised training programme and have specialist experience in bariatric medicine. Formal training in obesity is a component of the training requirement for diabetes & endocrinology and metabolic medicine.

Primary Care Bariatric Specialists

The primary care specialists in the community based multidisciplinary team should hold GMC registration, be on the GP register and be a member of SCOPE and/or be a GP with a special interest in obesity. They should have undertaken a relevant supervised training programme.

Dietitians

All dietitians should be HPC (Health profession Council) registered and have undergone appropriate training in the management of obesity. Junior dietitians should have the support of a senior colleague with appropriate experience. Training should include both an understanding of psychological factors and readiness to change and motivational interviewing and counselling skills. They should be a member of BOMMS.

Psychologists

All psychologists should have HPC registration and be chartered with British Psychological Society. Psychologists should be sufficiently experienced in weight loss surgery, mental health and disordered eating behaviour. Ability to conduct an assessment to establish the individual's ability to implement necessary health behaviour changes for weight loss post-surgery through therapeutic approaches such as Motivational Interviewing and Stages of Changes. Experienced in identifying the individual emotional, cognitive and behavioural factors that may influence weight loss and be able to provide individual recommendations to improve weight loss and QoL outcomes. Ability to make recommendations for more complex patients that potentially may require psychological intervention pre and/or post-surgery for anxiety, depression and binge-eating. Able to train other health professionals in facilitation of health behaviour change.

Specialist nurses

All nurses should hold state registration, have undergone appropriate training within their specialist field and attended an obesity training course. Nurses involved in obesity management should have attended an obesity training course.

ANNEX 3: PUBLIC HEALTH – EXPECTED BALANCE OF PROCEDURES