

Clinical Evidenced Based Intervention

Bariatric Surgery

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Version:	V2.0
Approved By:	Commissioning Committee
Date of Approval:	12 th December 2023
Date of Review:	December 2025 If the review date has exceeded, the published policy remains valid

Change and Approval History:

Version	Revision Description	Reviewer / Approval Group	Date of Review / Approval



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Appendix 1 – Complications after 90 days by type of primary obesity procedure



Policy: Bariatric Surgery

This policy outlines:

- The eligibility criteria for referral for bariatric surgery (tier 4 weight management service)
- When revision bariatric surgery will be funded
- Considerations for patients considering having bariatric surgery abroad.
 - NHS-funded (S2 route)
 - Privately funded.

1. Eligibility for Referral for Bariatric Surgery

This section is copied from the national EBI programme, available [here](#). Local amendments are stated in square brackets [].

Summary

There are a variety of surgical options available for promoting weight loss. These bariatric procedures include Roux-en-Y gastric bypass, one anastomosis (mini) gastric bypass, vertical sleeve gastrectomy and adjustable gastric banding. The specific type of procedure should be decided as part of a shared decision-making conversation between the patient and the surgeon, during which risks and possible outcomes are discussed.

Bariatric procedures aim to promote weight loss and improve other metabolic complications of obesity. This proposed guidance establishes criteria for referral of a patient to a bariatric surgical centre for consideration of performing a bariatric surgical procedure.

Recommendation

This guidance applies to those aged 18 years and over.

For patients with a BMI of 50 or more, surgery should be considered as a first-line treatment intervention. [Consideration of surgery as a first-line treatment for patients with a BMI of 50 or more should be undertaken by a tier 3 weight management service multidisciplinary team.]

Patients with a BMI less than 50 should be referred for consideration of bariatric surgery if they meet the following criteria:

- The patient has a BMI of 40 kg/m² or more, or between 35 kg/m² and 40 kg/m² with significant obesity-related complications likely to improve with weight loss (for example, type 2 diabetes, sleep apnoea or hypertension)



- OR
- The patient has a BMI of 30 kg/m² or more with type 2 diabetes of less than 10 years duration. This BMI threshold should be reduced to 27.5 kg/m² if the patient is of Asian family origin.

All patients being considered for bariatric surgery must also meet the following criteria:

- Appropriate non-surgical measures have been tried but the patient has not achieved or maintained adequate, clinically beneficial weight loss.
- AND
- The patient has been receiving or will receive intensive management in a tier 3 service or equivalent. For more information on tier 3 services, please refer to NHS England's report of the working group into joined up clinical pathways for obesity and The Royal College of Surgeon's Weight Assessment and Management Tier Services Commissioning Guide.
- AND
- The patient is otherwise fit for anaesthesia and surgery [as far as can reasonably be assessed in tier 3. The final assessment would be undertaken in tier 4]
- AND
- The patient commits to long-term follow-up.
- AND
- The patient and clinician have undertaken appropriate shared decision-making consultation regarding undergoing surgery including discussion of risks and benefits of surgical intervention.

After surgery, the host bariatric surgery unit should follow up with the patient for two years. Thereafter, responsibility for follow up should be handed over to the either the local nonsurgical Tier 3 service OR the patient's GP, who should conduct yearly appointments. These appointments should include weight measurement and a request for nutritional blood tests. See British Obesity & Metabolic Surgery Society (BOMSS) guidance for more details.

Please note that this guidance is intended as a standard threshold for access. However, if you/ your patient falls outside of these criteria, the option to apply for an Individual Funding Request is still available to you [where it can be demonstrated that there are clinically exceptional circumstances].



Rationale for recommendation

According to NICE guideline CG189 surgery for the treatment of obesity is recommended if specific criteria are met, relating to the patient's body mass index and the presence of obesity-related complications. This balances the risk of surgery with its potential positive long-term impact on the patient. When commissioned appropriately, obesity surgery is highly effective in promoting weight loss, and more importantly, reducing mortality and morbidity burden. It is also one of the most cost-effective treatments in the field of surgery. The penetrance of obesity surgery remains very low even though thousands of eligible patients stand to benefit from this life-saving intervention with the associated health benefits it provides.

[Relevant] Patient information

There are a variety of minimally invasive surgical options to help weight loss (bariatric surgery) and improve health. These include Roux-en-Y gastric bypass, one anastomosis (mini) gastric bypass, vertical sleeve gastrectomy and adjustable gastric banding. NICE guideline CG189 states that surgery for obesity is an option if specific criteria are met, balancing the risk of surgery with the long-term benefits of alleviating ill health caused by obesity.

Evidence shows that when commissioned as recommended, surgery is highly effective in causing weight loss, reduces the long-term impact of poor health and reduces the risk of premature death from obesity-related conditions. Despite this, the UK has one of the lowest rates of bariatric surgery in the developed world.

We recommend using the BRAN principles (Benefits, Risks, Alternatives and do Nothing) when speaking with patients about this.

Further information on patient involvement in EBI can be found on the [AoMRC] EBI for patients section. [Available [here](#)]



2. Revision Bariatric Surgery for Complex Obesity

The following section is adapted from the [NHSE Guide for Clinical Commissioning Groups \(CCGs\): Clinical Guidance: Revision Surgery for Complex Obesity](#). This NHSE document was developed to support local commissioners when the responsibility for commissioning specialist Adult Severe and Complex Morbid Obesity services was devolved to Clinical Commissioning Groups from 1st April 2016. It is informed by NICE Guidance NG189 (2015) and describes revision obesity surgery, adds clarity to the commissioning issues and reasons behind the current demand for revision surgery. It also identifies the groups of patients commissioners should consider eligible for NHS funding.

Introduction

Best results from surgery are obtained when those patients who meet current guidelines, are well prepared, and the timing of surgery has been optimised within a specialist programme providing pre- and postoperative comprehensive care. This requires a multi-disciplinary weight management service that includes specialist dietetic counselling and education, psychological support, assessment and medical management by a suitably experienced clinician. Finally, the decision related to timing of surgery should include consideration of the co-morbidities of obesity which may be serious, severe and risk organ damage or even be life threatening. There are also instances when obesity surgery is requested to reduce weight rapidly prior to carrying out other major surgery (elective or urgent) that a patient may require.

Unprepared or inadequately prepared patients who are unable to engage and comply with a specialist weight management programme are more likely to have poorer outcomes from the surgical obesity procedure, such as weight loss below expected, weight regain, non-resolution/re-emergence of co-morbidities and on-going or emergent psychological morbidity. Hence it is critically important that access to such programmes is matched to a planned follow-up programme. Surgical management for any chronic disease has its limitations. The concept of failure and the need for revision surgery is well established and accepted in other disciplines such as orthopaedics where for example revision rates for hip arthroplasty are >7% at 5 years¹. The overall incidence of surgical revision after a primary obesity operation ranges from 5% (Biliary pancreatic diversion (BPD)) up to 50% (Laparoscopic gastric band (LAGB)) with intermediate rates for Roux-en-Y gastric bypass (RYGB) and laparoscopic sleeve gastrectomy (LSG). Indications for surgical revision are diverse and can be for weight loss failure or weight regain, re-emergence of co-morbidities as well as other parameters such surgical complications or a combination of these.

¹ Labek G, Thaler M, Janda W, Agreiter M, Stöckl B. Revision rates after total joint replacement: cumulative results from worldwide joint register datasets. J Bone Joint Surg Br 2011;93:293-7.



In some cases, the need for re-operation will be explicit because of a technical or post-surgical anatomical problem that clearly requires a further surgical procedure to correct. In other cases, the indication will be a perceived failure of the primary surgery to achieve expected weight loss outcomes and satisfactorily resolve preoperative co-morbidities. This is a more ambiguous area as there is no generally accepted definition of failure in terms of weight loss, weight regain, or inadequate resolution or re-emergence of co-morbidities. Issues that arise with the provision of revisional surgery, include the indications for a second operation, the effectiveness of revision procedures and the associated morbidity, mortality, and complication rates, the technical expertise of those performing complex revisions and the health service facilities and resource utilisation required for a second operation. Additionally, patients are increasingly presenting to the NHS with either failed operations or with complications following on from surgery carried out in the private sector within the UK or abroad. Such patients may not have previously met NHS England guidance pre-operatively, nor had adequate preparation or follow up.

Current NHS commissioning arrangements require that all patients are initially assessed by a full multidisciplinary team (MDT) prior to surgery and undertake formal follow up for up to 24 months post operation. Surgical patients are required to meet recommended criteria and guidance.

Definition of and Indications for Revision Surgery

The need for revision surgery may be required due to either one or a combination of the following factors:

1. Surgical complications including technical problems arising from the original obesity surgical procedure. These may present as severe gastrointestinal symptoms such as reflux, nausea, vomiting, dysphagia or inability to tolerate solid foods.
2. Medical complications of the primary procedure including profound macro- and micronutrient deficiencies; anaemia, malnutrition and metabolic abnormalities such as disabling intractable hypoglycaemia.
3. The failure of the primary operation to provide adequate, stable and durable weight loss with adequate resolution of weight related comorbidities, or to address significant weight regain, frequently with re-emergence of preoperative comorbidities.

Revision surgery is therefore an additional attempt to maintain or secure further improvements in weight loss, improvement, or resolution of obesity-related comorbidities, and gains in quality of life. Although at present there is no consensus of what constitutes adequate weight loss nor significant weight gain (apart from procedure specific average expected excess weight loss at 1 and 2 years or regain to \geq pre op morbid obesity levels) it is recognised that in some cases revision bariatric surgery is an appropriate strategy for optimal management of the lifelong chronic disease of obesity. Some higher risk



patients may have a second bariatric operation as a planned staged procedure according to a risk reduction strategy and they are not considered in this document beyond noting that at present there is insufficient evidence regarding planned one step procedures or phased or two step procedures or indeed the optimal duration between the two stages. It is also recognised that 'servicing' reoperations are needed for gastric band surgery over time.

The following are NOT considered revision surgery for the purpose of this policy:

1. Early re-operation i.e., surgery within 90 days of the index obesity surgical procedure. This should be regarded as a complication of the primary surgical procedure and will be the responsibility of the provider undertaking the primary bariatric operation.
2. Those patients who are undergoing planned phased or two-step procedures as agreed at the time of the initial MDT accepting the patient for surgery.

Revision surgery is clinically indicated to treat complications arising > 90 days after the index obesity procedure.

A revision procedure is considered clinically necessary when there is documentation of a secondary surgical complication related to the original obesity operation or there is evidence of medical complications of obesity surgery (see Appendix A).

Failure of weight reduction and/or resolution of severe comorbidities

Repeat surgery for failure of a primary obesity procedure may be due to failure to achieve sufficient or expected weight loss; and may be accompanied by failure of co-morbidities to resolve e.g., diabetes, obstructive sleep apnoea. However, there is a lack of consensus on the definition of inadequate weight loss, and when revision surgery would be justified on this basis. Long-term studies of obesity surgery show a gradual tendency, sometimes even as early (within/soon after) 1–2 years to regain weight that was lost in the first few months after the operation or a failure to attain the expected average percentage of excess weight loss². There may also be a failure of co-morbidities to either resolve fully/partially or there may be a re-emergence with time or weight regain. It should be noted that comorbidity resolution does not always occur, especially for blood pressure, but also for obstructive sleep apnoea³ and type 2 diabetes where there has been a long preoperative duration (> 5 years) or severity (requirement for insulin; poor glycaemic control)⁴. In addition to weight loss and co-morbidities, a further classification

² Sjöström L et al. Bariatric surgery and long-term cardiovascular events. JAMA 2012; 307:56-65.

³ Dixon JB et al. Surgical vs Conventional Therapy for Weight Loss Treatment of Obstructive Sleep Apnea: A Randomized Controlled Trial. JAMA 2012;308:-:1142-1149

⁴ Arterburn DE et al A Multisite Study of Long-term Remission and Relapse of Type 2 Diabetes Mellitus Following Gastric Bypass. Obesity Surgery 2013 epub



of failure might be patient symptoms e.g. intractable reflux symptoms, breathlessness, musculoskeletal pain and poor quality of life etc. Following surgery, patients will be expected to have engaged and have been compliant with an appropriate follow up programme. This post-operative period should have included a prescribed behavioural, nutritional and exercise programme which will have been administered, assessed and supervised by a physician. There will have been regular monitoring and recording of the clinical progress, weight, nutritional status, co-morbidities, surgical complications as well as engagement with the programme.

The typical patient gradually gains weight after surgery – there is a need to distinguish what can be expected from the natural history and what is due to nonengagement with a healthy lifestyle and prescribed follow-up plan.

Weight loss failure – patient factors

Some patients manifestly fail to maintain weight loss due to non-engagement with a comprehensive and high quality post-operative programme. Some consider that stretching of a stomach pouch formed by a previous gastric band/bypass/sleeve gastrectomy due to the patient's persistent poor dietary behaviour, should not constitute a surgical complication and the appropriate modality of treatment for these patients is not surgical. However, if the procedure has failed to address the patients desire to eat, inability to control portion or meal size, consideration can be given to revision surgery if it is thought that such revisional surgery would address these needs. There may be grounds to consider surgery on the basis of exceptionality through the IFR process.

Weight loss failure – operation factors

Where there has been poor patient preparation and selection for primary obesity surgery in accordance with the NHS recommended pre surgical pathway or lack of adequate follow-up, it could be regarded that failure to lose weight does not merit further surgery. It is recommended that these individuals should be considered for reengagement with a specialist non-surgical service for the appropriate interventions, before being reconsidered for a revision procedure. It is recognised that there may be biological factors which make some patients more likely to fail to lose weight or to regain weight but there are no current biomarkers that can be used to define this subgroup of patients.

Risks of Revision Bariatric Surgery

Revision surgery is more complex and technically more challenging than the primary obesity surgery and is associated with higher levels of both peri-operative risk and complication rates to the patient⁵. This will require high

⁵ Hallowell PT et al. Should bariatric revisional surgery be avoided secondary to increased morbidity and mortality? Am J Surg 2009; 197:391-6.



volume specialist units with greater subspecialty surgical skills and appropriate facilities to optimise results.

The evidence appears to suggest that a second obesity operation confers a greater risk of adverse outcomes such as peri-operative complications, conversion from a laparoscopic to an open procedure, longer lengths of hospital stay, higher intensive care unit utilisation and increased re-admissions than a primary obesity operation. Reasons for the higher morbidity appear to be technical and operative complexity, more technically complex procedures, decreased quality of tissues, presence of adhesions etc. Major complications include a reported higher frequency of leaks, surgical-site infections, intra-abdominal abscesses etc. As the complexity of the revision procedure and number of prior surgeries increases, so does the perioperative morbidity. Previous fundoplication operations represent the highest risk group. It follows that, for patient safety reasons, revision surgery should be performed in a high volume, tertiary referral obesity centre (Tier 4 bariatric medical and surgical service) with advanced investigative, endoscopic and surgical skills and obesity medical and revision surgery subspecialty expertise.

National and local context

In England, there are approximately 6000-7,000 bariatric surgery operations performed per year.^{6,7} In addition, it is estimated that up to 5000 procedures per year are performed for residents of England within the private sector mainly in the UK but also overseas⁸.

A proportion of these cases will progress to a second procedure. It is currently considered (on the basis of United States data) that the overall incidence of surgical revision after a primary obesity operation range between 5-50 percent. The lowest rate of revision is associated with duodenal switch at 5%. For gastric bypass it is 10- 20%. For gastric banding it is the highest at up to 50%⁹ although some centres record a lower rate of 15% for laparoscopic adjustable gastric band (LAGB) revision¹⁰.

The revision rate per primary procedure in England is unknown. However, based on data from the National Bariatric Surgery Registry, between 2012 and 2022, on average 10.5% of NHS bariatric surgery operations were revision operations (including planned second stage procedures)⁷. Similarly, data from the National Obesity Audit demonstrates 10.5% of patients who had

⁶ National Obesity Audit <https://digital.nhs.uk/data-and-information/publications/statistical/national-obesity-audit/bariatric-surgical-procedures-21-22-final-and-q1-q2-22-23-provisional> BI dashboard [Accessed 29/11/2023]

⁷ National Bariatric Surgery Registry. Introduction 2022. <https://nbsr.e-dendrite.com/> [Accessed 29/11/23]

⁸ [NHSE Guide for Clinical Commissioning Groups \(CCGs\): Clinical Guidance: Revision Surgery for Complex Obesity](#).

⁹ Kellogg TA. Revisional bariatric surgery. Surg Clin N Am 2011;91;1353-71.

¹⁰ O'Brien PE et al. Long-term outcomes after bariatric surgery: fifteen-year follow-up of adjustable gastric banding and a systematic review of the bariatric surgical literature. Ann Surg 2013; 257:87-94.



a bariatric surgical procedure between 2017/18 and 2019/20 had a revision surgical procedure⁶.

Within HWEICS, there were approximately 130-160 bariatric surgical procedures per year between 17/18 and 19/20, prior to a decrease in activity during COVID.⁶ The number of revision procedures is difficult to calculate due to the need to suppress low numbers in the data set, but appears lower than the national average.

Criteria for commissioning

Patients who had NHS Funded Primary Bariatric Surgery*

*This is on the basis that NHS Contract Providers are accredited and required to accept patients who meet recommended criteria and current specifications

Group 1: Patients presenting with a clinical history, symptoms and/or signs that suggest acute / acute on chronic / worsening medical and/or surgical complications - related to their primary obesity operation:

Patients must be triaged and treated immediately if classified as “**emergency**”.

Patients are triaged by an MDT and may be assessed as ‘**Clinically Urgent**’ if they are judged to have a subsequent risk of developing emergency complications if they remain untreated. This category will include patients with adverse anatomical complications of the primary surgery but exclude loss of restriction due to dilatations of the gastric pouch and/ or the gastro-jejunal junction.

This corrective surgery, or in rare cases reversal surgery, would be as per routine and considered as good clinical practice. Trusts (providers) should triage referral letters from GPs, hospital consultants on this basis.

Examples would include:

1. If there is a band complication i.e., slippage then the band can be repositioned/ replaced. Conversion can be considered if the criteria as stipulated in the recommended guidance on severe and complex morbid obesity are met, the patient is compliant, on regular follow up and MDT review agrees.
2. If there is a band erosion then band removal can be followed up by a bypass after 6 months if the criteria as stipulated in the recommended policy on severe and complex morbid obesity are met, the patient is on regular follow up, compliant and MDT review agrees.



3. If there is severe band intolerance with gastro-oesophageal reflux, esophageal dysmotility, or persistent vomiting then the same as 1, 2 above.

However, if recommended criteria are not met and/ or there has been poor response to primary bariatric surgery (insufficient weight loss or weight regain in the absence of surgical complication), then the ICB will only fund for band removal.

Medical emergencies might include profound macro and micronutrient deficiencies; anaemia; malnutrition and metabolic abnormalities such as disabling intractable hypoglycaemia: and intractable diarrhoea.

If a band is removed for one of the indications above, then the patients may be considered for conversion to another operation following thorough assessment and counselling regarding treatment options by a Tier 4 service. Ideally the patient should be required to attend the Tier 4 specialist weight management service for at least six months prior to revision surgery, during which period compliance, improvement in weight and co-morbidities is demonstrated.

Group 2: The patient has failed to achieve expected average weight loss targets for the primary obesity procedure performed or regained their pre-operative weight. This category will include patients who following a Gastric Bypass develop a dilated gastric pouch or gastro-jejunal anastomotic dilatation. This category will not include patients who have previously had vertical banded gastroplasty. These patients should not be offered further obesity surgery unless they fall within Group 3 below.

Group 3: The patient has multiple, severe and life-threatening co-morbidities which have persisted or re-emerged following primary obesity surgery despite strong evidence that the patient has both attended and engaged with the follow up programme and multidisciplinary assessment has determined and agreed:

- The co-morbidities are potentially life threatening or represent a significant risk to health and well-being that is both severe and serious (in the short to medium term)
- The presence of clear grounds of clinical exceptionality

Groups 2 and 3 will not be routinely funded. If the treating clinician feels strongly that there are clinically exceptional reasons that are relevant to a particular case such as technical failure or other special circumstances in patients who have complied with planned follow up, then an application for funding may be appropriate through the Individual Funding Request (IFR) panel.



Patients who had Privately Funded Primary Bariatric Surgery

Some patients may have had their primary obesity surgery outside of NHS contracts at independent/private providers (abroad, or within the United Kingdom) but subsequently present at NHS facilities as clinical emergencies. The NHS has a duty of care for these patients and **will fund emergency and clinically urgent treatment on a similar basis as Group 1 patients.**

These patients may not have previously completed the recommended presurgical pathway or have met the NHS guidance for their primary obesity surgery and may not have been adequately followed up. These patients should be referred to the Tier 2 and/or 3 weight management services.

Any request for further (up to two years only) band filling and/or routine outpatient follow-up care (not associated with an acute, non-elective episode for these patients) will require the agreement of the ICB and will need to demonstrate that the patient has met recommended eligibility criteria for obesity surgery.

The patient's GP and Private Provider will therefore be required to collaborate to provide evidence on:

1. Weight Management Service attendance including Tier 3
2. Recommended criteria and Guidance fulfilment
3. Primary obesity operation
4. Follow-up attendance
5. Response to primary operation defined by progress with reduction of excess weight at 1 and 2 years including impact on co-morbidities.

If these factors are not completely fulfilled, patient must go through tier 2 and/or 3 weight management services in order to comply with recommended criteria.

Where patients have had privately funded bariatric surgery with no or inadequate follow up arrangements, and the patient has not met the eligibility criteria for NHS funded obesity surgery, HWEICB will not fund routine outpatient follow-up care. GPs, who are not bariatric specialists, should not be expected to provide this follow up. (See Considerations for Patients Having Bariatric Surgery Abroad and/or Privately)

Follow up Post Revision Bariatric Surgery

The ICB will routinely fund 2 years of follow up within the specialist service after revision obesity surgery.



Applications for Revision Bariatric Surgery

For revision surgery applications (other than emergency and clinically urgent procedures), if the patient meets the above requirements, the provider should be prepared to submit the following information to the ICB:

- Referral source and reason for application
- Previous obesity procedure and provider
- Fulfilment of recommended criteria and guidance, pre-op
- Classification of admission (urgent, emergency, planned, elective)
- Current procedure undertaken and indications.
- Discharge plan.
- Patient has engaged and complied with post-op follow-up.

Patient Pathway

Management of Failure and Patient Pathway

Current commissioning arrangement in England only prescribes a period of 2 years follow up by the specialist Tier 4 service. Patients who have had primary obesity surgery should be followed up for life within a specialist programme. At present, there is no guidance on the format of such subsequent follow up. However, appropriate professionally led lifelong follow up will allow early detection of complications and morbidities following weight loss surgery, including weight loss failure. Early detection may enable non-surgical interventions (e.g., intensified dietary advice and physical activity and supervision) to succeed in the first instance.

Initial assessment of failure should ideally be conducted within the local follow up service. If there is no appropriately constituted follow up service available that can meet the needs of these patients, then they should be referred to a specialist Obesity Centre with both medical and surgical bariatric (Tier 4 service) that can provide this service even if it is not at the original surgery centre. It should be mandatory for obesity surgery providers to develop these services to provide the complete patient pathway for continuity of care and long-term follow-up.

Before considering whether a particular individual is a candidate for a revision of the primary obesity operation, it is important to determine whether the operation failed the patient e.g., an anatomic /technical cause for the complication or weight regain or whether patient factors were responsible. The latter would include weight regain caused primarily as a result of patients' eating behaviour in relation to intake, dietary choices, large portion sizes, snacking, binge eating, alcohol consumption and lack of sufficient physical exercise or where there is a combination of reasons including poor follow-up and persistent psychosocial issues causing emotional eating. It is imperative that these issues be recognised, investigated, diagnosed and resolved before considering revision surgery or there will be repeated operative failure to provide weight loss or to control weight regain.



Failure must therefore be managed according to the cause(s) and revision patients triaged through an appropriately constituted specialist MDT. The need for revision should be based on the suspected cause underlying the patients' problems and requires careful preoperative work up. Clinical evaluation should include a detailed, surgical, medical, dietetic and psychological assessment with appropriate radiological and endoscopic investigations and imaging. There should also be a review of the previous clinical and operative reports, in addition to other documentation from members of the specialist weight management team, (psychologists, physicians or psychiatrists and dieticians).

Full Specialist MDT re-assessment

Patient re-assessment should be conducted by an MDT with a full range of expertise. Assessment should include:

- Medical and surgical assessment by specialist obesity physician and surgeon with appropriate knowledge, training and experience, based on large caseload of both primary and revision procedures.
- Dietetic assessment from an experienced obesity dietician, usually at senior grade
- Formal psychological assessment or case review by a psychologist experienced in obesity and obesity surgery.
- Analysis and documentation of reason(s) for failure, which may include the following:
 - Procedure Failure: There is documented evidence of procedure failure such as technical band complications, or persistent marginal ulcer. There is documented evidence of severe and disabling metabolic complications resulting from the original procedure such as malnutrition or intractable hypoglycaemia, or micronutrient deficiencies.
 - Patient Factors: Patient has failed to adhere to post – operative advice given by the Tier 4 obesity team based on dietary, nutritional or physical activity guidance or complied with regular attendance for follow up.
 - Service failure: The patient may have been failed by lack of service arrangements i.e., inadequate/absent specialist weight management programmes (Tier 3 and/or Tier 4) and/or follow up arrangements that have either not been prescribed or commissioned. The latter often happens in the private sector, where the focus is on the obesity operation and short-term follow up.

One or more of the above factors may co-exist in the same patient. Where possible there should be an agreement between the patient and MDT of the reason(s) for failure.



A comprehensive management plan should be drawn up for each patient which may involve some or all of the following components; further dietetic/psychological support, further clinical investigation /imaging, input from specialist teams such as gastroenterologists (e.g., for parenteral feeding), revision of the primary obesity procedure. Some patients will be deemed unsuitable for re-operation and may require further multidisciplinary specialist weight management by either tier 3 or nonsurgical tier 4.

Specialist Surgical Centre role

Patients should only undergo revision or re-operative surgery in appropriately experienced and centres, which may or may not be the original surgical centre, and by surgeons who have the appropriate level of experience for the type of revision surgery. For further details, please see the [NHSE Guide for Clinical Commissioning Groups \(CCGs\): Clinical Guidance: Revision Surgery for Complex Obesity](#) p.18.

3. Considerations for Patients Having Bariatric Surgery Abroad

NHS-funded

Patients who wish to have NHS-funded bariatric surgery abroad, via the S2 route, should ensure that they meet the eligibility criteria in this policy and are able to evidence this prior to incurring any costs. If in doubt, patients/GPs can confirm with the EBI and IFR team that criteria have been met in advance. There is a financial risk to patients if the ICB is not satisfied that criteria were met after costs have been incurred by the patient. Patients should also ensure that they have follow-up arrangements in place.

Privately-funded

Before approaching a private clinic or surgeon, patients should be encouraged to do as much research as possible into the different types of weight loss surgery and private providers.

Some patients consider having treatment abroad, where costs for private treatment can be cheaper and waiting lists shorter, but patients should weigh up any potential savings against the potential risks. Standards may not be as strict in clinics outside the UK, and aftercare is not always straightforward. Clinics in other countries may not provide adequate preparation or follow-up care, or it may not be the same standard as in the UK. Clinics may also provide incorrect advice about access to follow-up care on the NHS.

Appropriate follow up care after bariatric surgery is vital to maximise the chance of a safe and successful outcome. NICE and the British Obesity &



Metabolic Surgery Society specify that patients require a minimum of 2 years of specialist follow up post bariatric surgery, before lifelong support usually provided by the GP with access to specialists when required. The need for support and ongoing monitoring remains regardless of where the surgery is done.

Locally and nationally, GPs are increasingly being approached by patients who have had bariatric surgery abroad and are requesting post-operative monitoring by the GP. There may be no other follow-up plan in place, or the private specialist may provide a list of desired tests and reassurance that they will provide specialist advice to the GP.

GPs should be aware of the clinical need for adequate follow-up post bariatric surgery. However, GPs are not bariatric specialists, and the GMC is clear that doctors “must recognize and work within the limits of [their] competence.”

According to the Medical Defense Union (MDU), a UK medical professional indemnity provider, even where the specialist abroad is willing to provide advice, a UK-based GP would be open to criticism by relying on advice from a specialist based overseas. As the provider is based in another country, they are not subject to the same regulatory requirements as doctors in the UK and work to different guidelines. It may be difficult for the GP to assure themselves of the specialists’ qualifications and expertise. There may also be language barriers that would make shared care inappropriate and unsafe.¹¹ Lists of blood tests requested by some overseas providers and seen by HWEICB have differed from those recommended in the UK by BOMSS¹². This creates uncertainty around which tests should be ordered to minimize clinical risk to the patient. The MDU further state that a GP, without the support of a UK-based bariatric specialist could struggle to justify why they took on monitoring for a complex patient if something went wrong.¹¹

HWE GPs should therefore not be undertaking routine post-operative follow-up and monitoring for bariatric surgery undertaken abroad.

Patients who would have been eligible for bariatric surgery in the UK, but chose to have their surgery privately abroad, will be funded for routine specialist follow up. This is in line with guidance that “The NHS should continue to provide free of charge all care that the patient would have been entitled to had he or she not chosen to have additional private care.”¹³

Patients who would not have been eligible for bariatric surgery in the UK must self-fund their routine specialist follow up and monitoring. The

¹¹ MDU. Monitoring a patient after bariatric surgery abroad. Autumn 2022. Available online <https://mdujournal.themdu.com/issue-archive/autumn-2022/monitoring-a-patient-after-bariatric-surgery-abroad> [Accessed 30/11/2023]

¹² BOMSS Guidelines <https://onlinelibrary.wiley.com/doi/full/10.1111/obr.13087>

¹³ DoH. Guidance on NHS patients who wish to pay for additional private care 2009 <https://assets.publishing.service.gov.uk/media/5a74ccb340f0b61df4778971/patients-add-priv-care.pdf>



private provider should normally deal with non-emergency complications resulting from the private element of care¹³. However, the NHS retains a duty of care and would provide emergency and clinically urgent care.

Longer-term (after 2 years) non-specialist follow-up and monitoring by primary care may be provided at the discretion of the GP.

Post-Surgery Vitamin and Mineral Supplements

Lifelong multivitamin and mineral supplements are necessary after bariatric surgery. The HWE ICB guidance on prescribing and providing patient advice regarding appropriate supplements can be found at

<https://www.hweclinicalguidance.nhs.uk/prescribing-guidance>

Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed as per the ICB policy.



Appendix 1: Complications after 90 days by type of primary obesity procedure

Gastric bypass complications after 90 days for complications of the primary obesity procedure

- Marginal ulceration (dyspepsia, bleeding, perforation)
- Anastomotic stenoses
- Gastro-gastric fistula formation
- Enteric fistula formation (rare)
- Obstruction (adhesions or internal hernias)
- Small bowel intussusception
- Chronic abdominal pain (often merits diagnostic laparoscopy)
- Staple or suture line leak can occur after 90 days and is likely to result in intraabdominal Abscess formation requiring drainage.

Band malfunction requiring further operation after 90 days.

- Band slippage
- Gastric pouch enlargement
- Band erosion
- Band or port site infection
- Tube disconnection
- Band unbuckling
- Band intolerance
- Severe reflux oesophagitis

Sleeve gastrectomy complications requiring further operation after 90 days:

- Severe gastro-oesophageal reflux
- Staple line leak can occur after 90 days and is likely to result in intra-abdominal abscess formation requiring drainage or fistula formation.
- Late stricture formation

Duodenal switch (with sleeve gastrectomy)

Rarely performed in UK but late complications include:

- Anastomotic leaks
- Strictures
- Obstruction
- Protein-calorie malnutrition
- Sleeve gastrectomy complications

Revision for medical complications of primary obesity procedures:

- Severe adverse and intractable symptoms e.g., dysphagia functional disorders e.g., dumping syndrome.
- Persistent vomiting



- Disabling post prandial hypoglycaemia
- Protein and fat malnutrition
- Diarrhoea
- Intestinal failure
- Severe anaemia
- Bacterial overgrowth
- Recalcitrant hypocalcaemia (with associated hyperparathyroidism)
- Other micronutrient/nutritional deficiencies
- Severe weight loss (undesirably low BMI)
- Recurrent nephrolithiasis
- Note: in elderly patients BMI may poorly reflect lean body mass and mask sarcopaenia (so-called sarcopaenic obesity)

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