

Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Policy for Bariatric Surgery in Adults

Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

1. Background

EA Title	Policy for Bariatric Surgery in Adults		
EA Author	David King	Team	
Date Started	4/7/2019	Date Completed	12/7/2019
EA Version	1	Reviewed by E&D	

What are the intended outcomes of this work? Include outline of objectives and function aims

Obesity is commonly defined as a Body Mass Index (BMI) of 30 kg/m² or greater (see Table 1). Individuals living with obesity are at greater risk of a variety of different health conditions. These include type 2 diabetes mellitus (T2DM), non-alcoholic fatty liver disease, hypertension, asthma, gastro-oesophageal reflux disease, depression and a variety of other conditions [1]. The risk of developing obesity-related co-morbidities increases as an individual's BMI increases [2].

Table 1.

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	40 and over

Source: NICE. Obesity: identification, assessment and management [1]

Epidemiology

Obesity is a global problem, estimated to have affected over six hundred million adults worldwide in 2014 [14]. In England, in both men and women, more than one in four adults are obese (28.2%) and 2.7% are classed as morbidly obese [15].

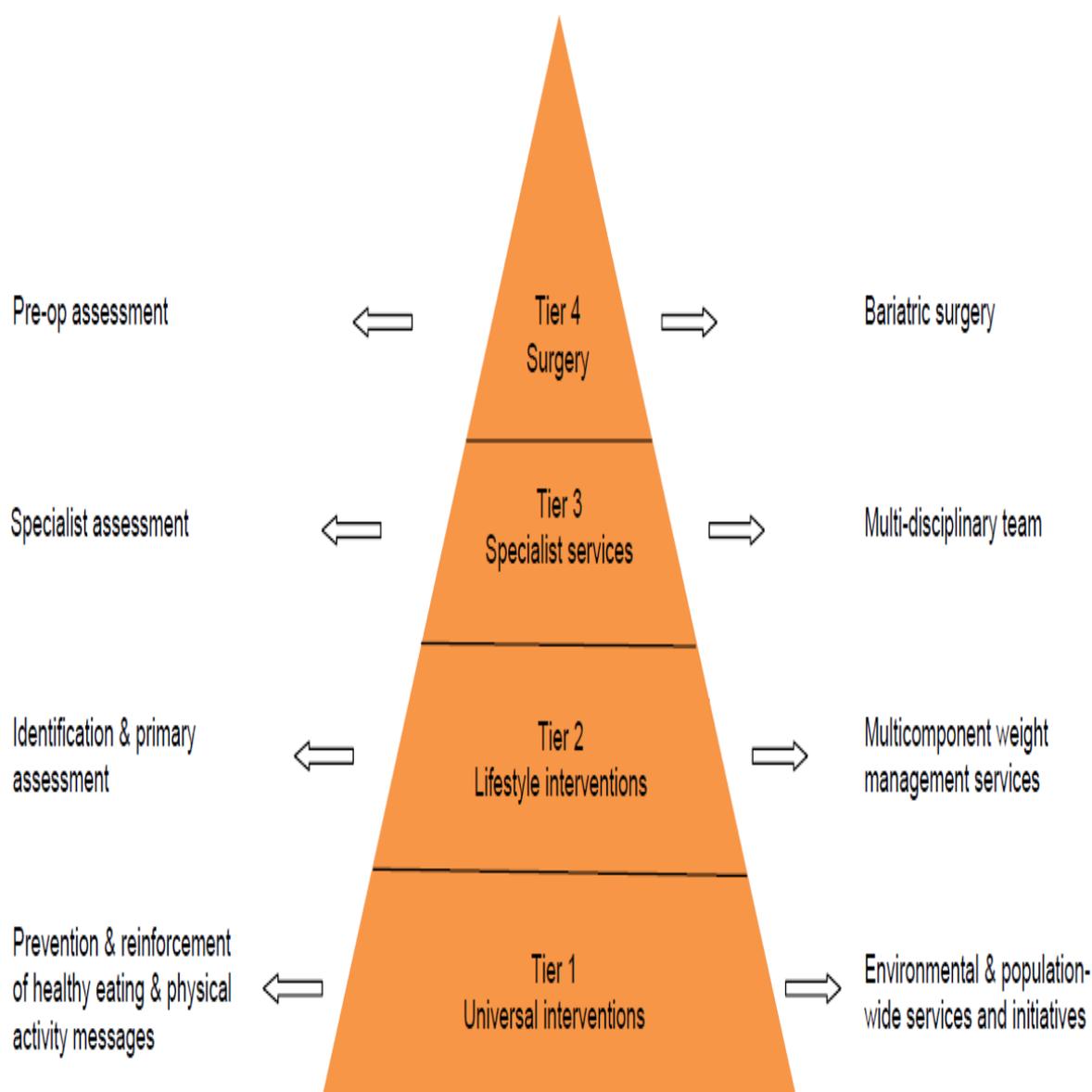
The prevalence of obesity in the UK rose between 1993 and 2014, the rate of increase began to slow in 2001 but the overall trend is still continuing to rise. According to the Health Survey for England, 61.7% of adults were overweight or obese in 2014, with more men being obese (65.3%) than women (58.1%) [16, 17]. Over the same time period, the prevalence of morbid obesity has also continued to climb, with a sharp rise in female prevalence between 2007 and 2011 (see Figure 4). Whilst the trend for males appears to have levelled off in recent years, the current level still represents a sizeable increase from that seen in the early 1990's. The number of people classed as obese in the UK is expected to increase by 11 million by 2030, with a likely corresponding increase in those with morbid obesity [18].

According to forecasts produced by the World Health Organisation, 31% of men and 30% of women will be obese by 2020, rising to 36% and 33% respectively by 2030 [19].

National Guidance

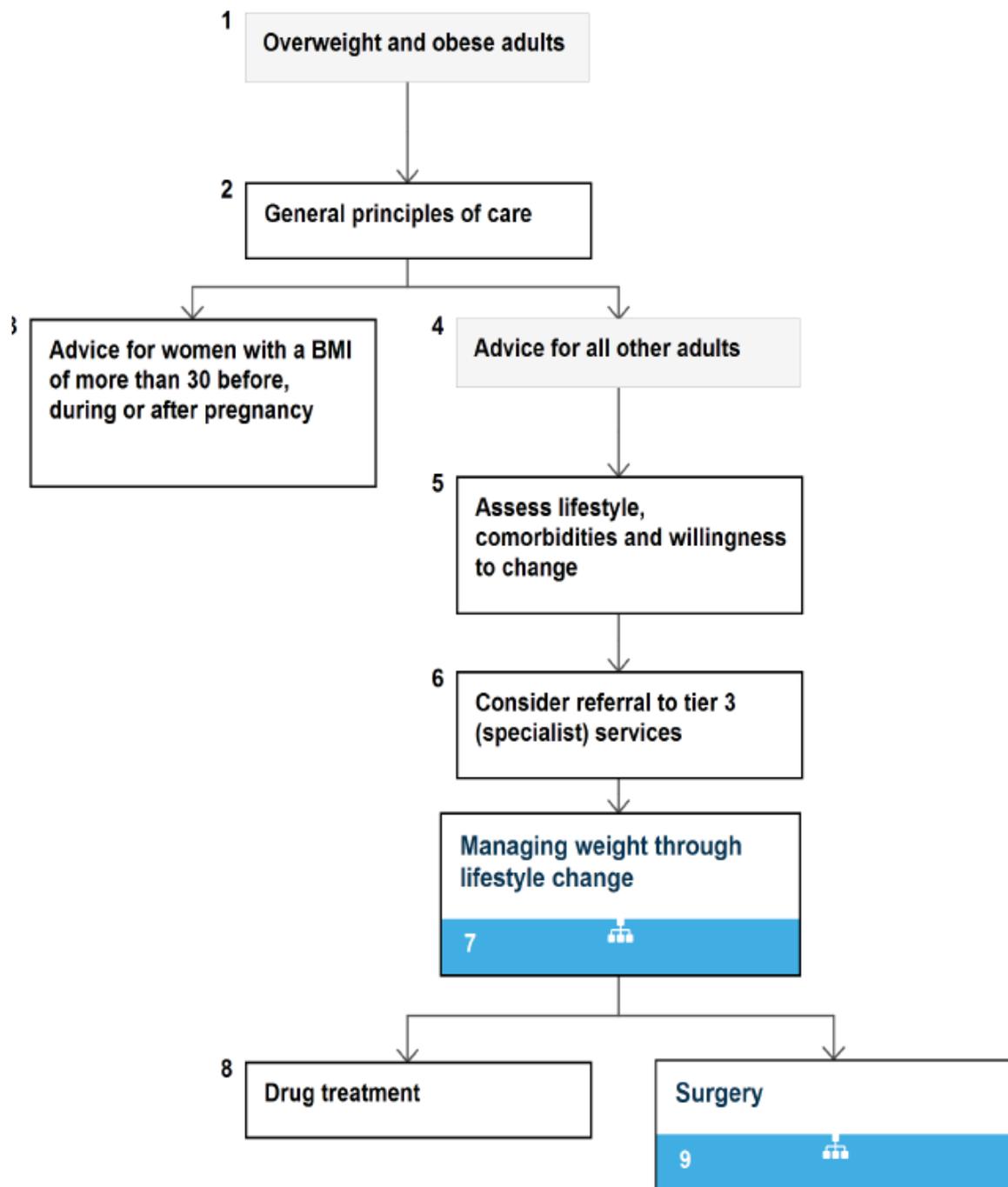
In England, obesity is managed through a tiered system (Figure 1), ranging from preventive population-based health promotion strategies (Tier 1) and lifestyle interventions (including diet, exercise, and behavioural) in primary care settings (Tier 2), through to more intensive specialist services provided by multi-disciplinary teams (tier 3) and bariatric surgery (tier 4) [3].

Figure 1: Tiered management of obesity



In November 2014, NICE published clinical guidance on the identification, assessment and management of obesity (NICE clinical guideline 189). [1]. The proposed NICE pathway is outlined below in Figure 2.

Figure 2: NICE pathway for overweight and obese adults



Co-Morbidities

The health issues associated with being overweight or obese include type 2 diabetes mellitus, cardiovascular disease and musculoskeletal disorders amongst others. People aged 35 to 59 with a BMI measurement of between 40 kg/m² and 50 kg/m² are five times more likely to die from ischaemic heart disease than those with a BMI of 22.5 kg/m² to 25 kg/m².

Between the same groups, the risk of dying from stroke was 6.5 times higher and the risk of dying from diabetes was 22.5 times higher. Vascular risk factors also exhibit a strong relationship with BMI; both systolic and diastolic blood pressure increases with BMI [20]. The prevalence of diabetes amongst those with normal weight was around 1.5%, compared to 15% in the severely obese [20].

On its own, BMI is a strong predictor of mortality and is strongly associated with diabetes for which sex-specific prevalence may rise more than five-fold from baseline across the BMI range. Table 3 shows a simplified version of the relationship between BMI and health risk.

Table 3: Co-Morbidity Risk by BMI Classification

Classification	BMI (kg/m ²)	Risk of Obesity Related Co-Morbidities
Underweight	<18.5	Low risk (but risk of other clinical problems increased)
Normal Range	18.50 – 24.99	Average risk
Overweight	≥25.0	Increased risk
Obese	≥30.0	Medium to high risk
Morbidly Obese	≥40.0	Very high risk

Non-Surgical Interventions

Non-surgical interventions for obesity consist of a wide variety of measures which may be used in varying combinations as part of a multi-component pathway. Generally, this comprises dietary intake, physical activity levels and behaviour change and may also include pharmacological interventions [25]. These should be clinically led and involve multi-disciplinary assessment [13].

The tier 3 service should be provided via a multidisciplinary team containing a bariatric physician, dietitian, specialist nurse, clinical psychologist and a liaison psychiatry professional. In addition to this there should also be access to a physical therapist.

Non-surgical weight-management interventions (also known as 'Lifestyle Interventions') are commonly split into four categories:

1. Behavioural interventions
2. Physical activity

3. Behaviour change
4. Pharmacological interventions.

Interventions should be seen as multicomponent and incorporate combinations of the interventions described below.

Behavioural interventions

Behavioural interventions are provided with the support of an appropriately trained professional and include various strategies for adults which are incorporated as appropriate. These include (but are not limited to) self-monitoring of behaviour and progress, stimulus control, goal setting, ensuring social support is available, cognitive restructuring (modifying thoughts), reinforcement of changes and providing strategies for dealing with weight regain [1].

Physical Activity

Encouragement should be given to increase levels of physical activity, regardless of whether this will lead to weight-loss. This is due to the general fitness improvements it can bring and the associated reduced risk of cardiovascular disease and type 2 diabetes. This may comprise of 45-60 minutes of moderate-intensity exercise per day, increasing to 60-90 minutes for those who have already lost weight to prevent regaining of excess weight. Suitable activities include brisk walking, gardening, cycling, supervised exercise programmes, swimming, stair-climbing etc [1].

Dietary

Dietary interventions should not be unduly restrictive but should be tailored to individual food preferences and also be nutritionally balanced. As with physical activity, dietary improvements should be encouraged for reasons other than weight loss alone due to the associated health benefits which a balanced diet can bring. The primary requirement for a dietary intervention however is to reduce energy intake to a point below energy expenditure by approximately 600 kcal/day or by reducing fat content. This should be partnered with expert support and intensive follow-up. Low (800-1600 kcal/day) and very low (800 kcal/day or less) calorie diets should be used with some degree of caution due to issues around nutritional completeness [1].

Pharmacological Interventions

Pharmacological interventions should only be considered after behavioural, physical and dietary interventions have been started and evaluated. This applies especially to those service-users who have not achieved their target weight loss or have plateaued. It may also be utilised to maintain weight-loss as opposed to continuing weight loss [1]. Orlistat is the only pharmacological treatment for obesity currently recommended by NICE. This medication is a lipase inhibitor which works through preventing approximately a third of consumed fat from being absorbed, However, in addition to the well-documented side effects, there are potential issues related to the heightened risk of kidney problems [26].

Bariatric Surgery

Bariatric surgery includes a group of procedures that promote weight loss. They are usually performed laparoscopically, with decreased time in hospital and a shorter recovery time compared to open procedures. In the UK and Ireland, there were over 18,000 bariatric surgery operations in the three financial years ending 2011, 2012, and 2013; 95.4% of all primary operations were performed laparoscopically over this period [22]. More recently, minimally invasive surgical techniques also include robotic procedures, though their feasibility and safety are debated. Bariatric surgery may be categorised under three headings: restrictive; malabsorptive and combined procedures.

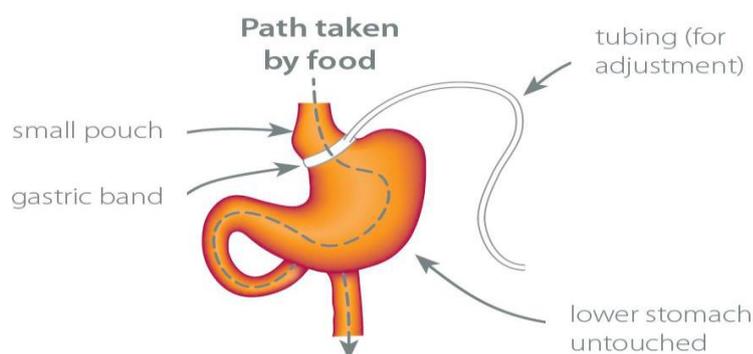
Restrictive procedures

Restrictive procedures, described below, lead to a fixed or adjustable reduction in the size of the upper gastrointestinal tract.

Adjustable gastric banding (AGB)

This procedure places an adjustable silicone band around the upper stomach, creating a small pouch above the band and a narrowing between the pouch and main part of the stomach below it (Figure 6). This restricts the amount of food that can be eaten and reduces hunger sensations by pressing on the surface of the stomach. The band may be tightened or loosened by injecting or removing saline through a portal under the skin that is connected to the band. The procedure is reversible and relatively non-invasive. AGB has replaced the older restrictive gastropasty (horizontal, vertical, and banded) procedures that are no longer performed in the UK due to poorer performance. Gastric banding made up 22.3% of all bariatric surgery operations in the UK between 2011 and 2013 [22, 23, 24].

Figure 6: Diagrammatic representation of a gastric band in place



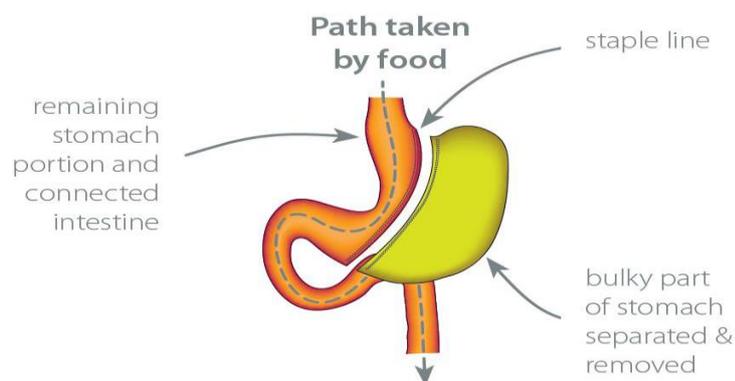
Source: National Bariatric Surgery Register. NSBR Second Registry Report. 2014 [22]

Sleeve gastrectomy (SG)

This procedure divides the stomach vertically to reduce its size by seventy-five percent, whilst keeping the stomach function and digestion unaltered by leaving the pyloric valve

intact (see Figure 7). The procedure is not reversible but is relatively quick to perform and is one of the most commonly performed restrictive procedures. It was initially used as the first of a two-part procedure for patients at high risk from bariatric surgery, followed by a conversion to either a Roux-en-Y gastric bypass or a duodenal switch (see below). However, as some patients achieve significant weight loss with the sleeve gastrectomy alone, it is now also used as a stand-alone procedure. In some patients, the procedure may be followed by a duodenojejunal bypass, which involves bypassing the first part of the small intestine, resulting in food moving directly to the latter part of the small intestine, thereby reducing absorption of calories. SG made up 20.8% of all bariatric surgery operations in the UK between 2011 and 2013 [22]. A further 12 (0.07%) SG procedures were performed in combination with a biliopancreatic diversion with duodenal switch

Figure 7: The basics of a sleeve gastrectomy procedure



Source: National Bariatric Surgery Register. NSBR Second Registry Report. 2014 [22]

Intragastric balloon (IGB)

Intragastric balloon procedures involve placing a silicon balloon endoscopically to float freely inside the stomach, thereby reducing the volume of the stomach, leading to an earlier sensation of satiety. It is typically used either in patients who are at least 40% of their optimal weight, or in morbidly obese patients for whom surgery is high risk. IGB made up 2.1% of all bariatric surgery operations in the UK between 2011 and 2013 [22].

Gastric plication (or gastric imbrication)

A newer procedure that reduces the stomach volume by folding the stomach into itself and stitching it to create a narrow tube shape, similar to that of SG, but without removing any stomach tissue (Figure 6). The Registry report does not present the exact number or proportion of all November 2017 bariatric surgery operations that involve gastric plication. However, it is less than the 2.1% procedures labelled as 'other' in the Registry report [22].

Malabsorptive procedures

Malabsorptive procedures bypass a section of the intestine, with less physical restriction of food intake.

Biliopancreatic diversion (without duodenal switch)

This procedure is typically no longer performed in the UK due to risk of postgastrectomy syndrome (including, for example, dumping syndrome, bile reflux, diarrhoea). It involved portions of the stomach being removed through a horizontal gastrectomy (a restrictive procedure), with the small remaining pouch being connected to the final section of the small intestine. This is now replaced with the biliopancreatic diversion with duodenal switch (BDDS) procedure, which may be classed as a combined procedure (see group 3 below).

Jejunioileal bypass (JIB)

This procedure is no longer performed in the UK, where a significant part of the small intestine was detached and set to the side.

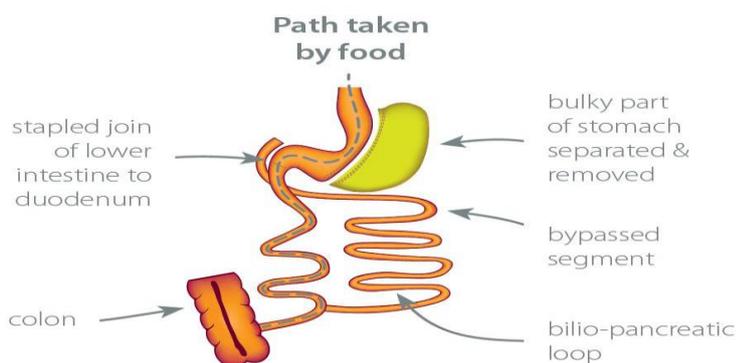
Combined procedures

Combined procedures include both restrictive and malabsorptive components.

Biliopancreatic diversion with duodenal switch (BDDS)

Biliopancreatic diversion with duodenal switch involves an initial restrictive vertical gastrectomy, followed by the malabsorptive component which re-routes a long portion of the small intestine, creating two separate pathways and one common channel (Figure 8). The shorter of the two pathways, the digestive loop, takes food from the stomach to the common channel. The longer pathway, the biliopancreatic loop, carries bile from the liver to the common channel. This procedure reduces the amount of time the body has to capture calories from food in the small intestine, and selectively limits the absorption of fat. The procedure is partially reversible, but there were only 19 BDDS procedures (0.1%), together with a further 12 procedures combined with SG in the UK between 2011 and 2013 [22].

Figure 8: Biliopancreatic diversion with duodenal switch



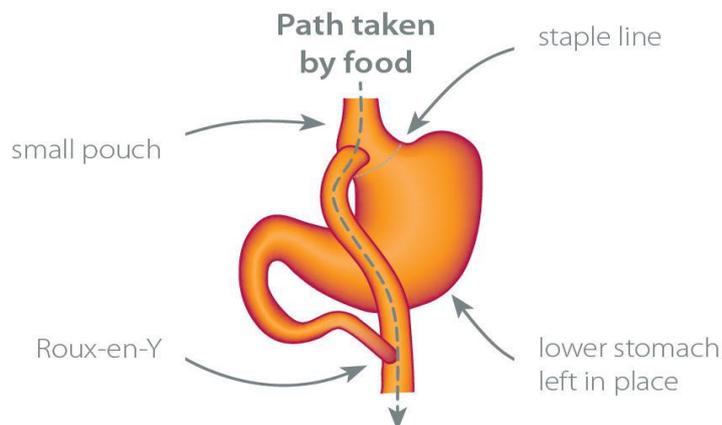
Source: National Bariatric Surgery Register. NSBR Second Registry Report. 2014 [22]

Roux-en-Y gastric bypass (RYGB)

Roux-en-Y gastric bypass has replaced the older banded gastric bypass, and involves creating a small pouch from the stomach which remains attached to the oesophagus at

one end, and connected to a section of the small intestine at the other end, thereby bypassing the remaining stomach and the initial loop of small intestine (Figure 9). This procedure reduces intestinal absorption. Adaptations of the procedure have been used to increase malabsorption and increase weight loss. The procedure is technically reversible. Roux en Y gastric bypass comprises 52.1% of bariatric surgery in the United Kingdom [22].

Figure 9: Diagrammatic representation of a Roux-en-Y gastric bypass procedure



A key aim of this policy is to increase capacity and reduce waiting times for patients most in need of surgery, as set out in the criteria.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

Eligibility Criteria: Restricted

Patients eligible for surgery must have the following:

- BMI of $>35\text{kg/m}^2$
AND
Type 2 diabetes mellitus which has been diagnosed within the last 10 years.
- OR
- BMI of $>50\text{kg/m}^2$

The choice of surgery must be undertaken by a specialist bariatric surgeon following a shared decision making discussion with the patient:

- Listen to patients and respond to their concerns and preferences.
- Give patients the information they want or need in a way they can understand.
- Respect patients' right to reach decisions with the doctor about their treatment and care.
- Support patients in caring for themselves to improve and maintain their health.

This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Activity data 2018/19

	BSOL	Sandwell
Number of Procedures	116	61

It is not possible to tell definitively from the data if any of the above procedures would not have been undertaken based on this policy however it is believed that these procedures undertaken represent patients who would receive bariatric surgery under this policy.

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications

Work ing Grou ps	Clini cal Exp erts
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Guidance

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<p>3. Impact and Evidence:</p>
<p>In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.</p>
<p>Age: Describe age related impact and evidence. This can include safeguarding, consent and welfare issues:</p> <p>Age range data is not available for the profile of patients requesting the procedure. Some link may be identified between obesity and reduced mobility.</p> <p>As the treatment has been restricted, those who meet the criteria will be able to access treatment, who are the group who are deemed to benefit most. For patients not eligible alternative less invasive options are available to help reduce their BMI.</p>
<p>Disability: Describe disability related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/ learning disabilities, cognitive impairments:</p> <p>As with age obesity is itself a life limiting condition and is commonly found as a co morbidity with other conditions. It has not been shown the restricting this treatment will impact on this group negatively since those who would benefit most can access surgery and for others alternative approaches are better.</p> <p>It is noted that exercise may be more difficult / impossible for patients with some conditions which reduce mobility. In such case the approach would give due regard to reasonable adjustments.</p>
<p>Gender reassignment (including transgender): Describe any impact and evidence on transgender people. This can include issues such as privacy of data and harassment:</p>

3. Impact and Evidence:
<p style="text-align: center;">No impact identified</p>
<p>Marriage and civil partnership: Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part-time working, and caring responsibilities:</p> <p style="text-align: center;">No impact identified</p>
<p>Pregnancy and maternity: Describe any impact and evidence on pregnancy and maternity. This can include working arrangements, part-time working, and caring responsibilities:</p> <p style="text-align: center;">No impact identified on the basis of available data, a link may be made between pregnancy and increased weight during and post birth.</p>
<p>Race: Describe race related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures, and language barriers:</p> <p style="text-align: center;">No impact identified</p>
<p>Religion or belief: Describe any religion, belief or no belief impact and evidence. This can include dietary needs, consent and end of life issues:</p> <p style="text-align: center;">No impact identified</p>
<p>Sex: Describe any impact and evidence on men and women. This could include access to services and employment:</p> <p style="text-align: center;">No impact identified</p>
<p>Sexual orientation: Describe any impact and evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers:</p> <p style="text-align: center;">No impact identified</p>
<p>Carers: Describe any impact and evidence on part-time working, shift-patterns, general caring responsibilities:</p> <p style="text-align: center;">No impact identified</p>

3. Impact and Evidence:
<p>Other disadvantaged groups: Describe any impact and evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include lower socio-economic status, resident status (migrants, asylum seekers), homeless, looked after children, single parent households, victims of domestic abuse, victims of drugs / alcohol abuse: (This list is not exhaustive)</p> <p style="text-align: center;">No impact identified</p>

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	This condition could be linked to a health inequality due to the prevalence of obesity. As the surgical procedures remain available it is not anticipated that a health inequality will be made worse.
Is there any impact for groups or communities living in particular geographical areas?	Yes	A limited link between obesity and areas of high deprivation has been made.
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	Yes	The ability to access better diet quality and exercise may be reduced for those in low socio economic groups. Due regard to this will need to be given in supporting such patients.
How will you ensure the proposals reduce health inequalities?		

The intention of the policy is to support patients with very high BMI through a number of interventions with surgery being the final option.

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	Yes, this decision has been made in line with clinical recommendation and NICE guidance
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	No evidence of impact from this policy
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	No discrimination identified
	How will this affect a person's right to freedom of thought, conscience and religion?	N/A
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	Policy will be applied with due Regard to this consideration.
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	An individual can discuss the impact with their GP and has the option for an IFR request to be made
Right to Life	Will or could it affect someone's right to life? How?	No evidence of impact from this policy
Right to Liberty	Will or could someone be deprived of their liberty? How?	No evidence of impact from this policy

6. Social Value

Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?
Enable all people to have control over their lives and maximise their capabilities	None
Create fair employment and good work for all	None
Create and develop health and sustainable places and communities	None
Strengthen the role and impact of ill-health prevention	None

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	Protected Characteristic/ Group/ Community	Date

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us So we will):

As part of the process further targeted engagement is planned with representative groups from among Sandwell, Birmingham and Solihull Patients. In addition, it has been identified that patient and clinician information is key in ensuring that the harmonised treatment policies review delivers effective outcomes. To this end an information briefing sheets on each procedure will be developed to give more information on the procedure, eligibility criteria and signposting to further information sources, such as NHS Choices. These information sheets are also designed to help facilitate discussions between GPs and patients. Information briefing sheets have already been tested and uploaded onto the GP systems for the first 45 harmonised treatment policies for Birmingham and Solihull. Due regard will be given to both the accessible information standard and the potential need to translate such leaflets into relevant local languages.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

The restriction of this policy will have limited impact on those who would wish to receive the treatments, this must be balanced against the need to adhere to NICE guidelines and the clinical effectiveness evidence. The opportunity for any exceptional cases to be considered via IFR remains and will ensure treatment is available in an exceptional case.

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9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the recommendations and any changes to the proposal arising from the equality analysis.

Consideration will need to be given to what additional support patients from a low socio economic background will require and how due regard can be given to reasonable adjustments in approach for disabled persons.

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

This policy is not linked to a contract however, prospective providers remain bound by their contracts with the CCG.
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11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):
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N/A

12. Publication

How will you share the findings of the Equality Analysis?
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This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages. All Equality Analysis should be recommended for publication unless they are deemed to contain sensitive information.
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Publication on the CCG's website.

<p>Following approval all finalised Equality Analysis should be sent to the Communications and Engagement team for publication: bsol.comms@nhs.net</p>		
<p>13. Sign Off</p>		
<p>The Equality Analysis will need to go through a process of quality assurance by the Senior Manager for Equality and Diversity, Senior Manager for Assurance and Compliance or Equality and Human Rights Manager and signed-off by a delegated committee</p>		
	Name	Date
Quality Assured By:		
Which Committee will be considering the findings and signing off the EA?		
Minute number (to be inserted following presentation to committee)		

Please send to Balvinder Everitt or Michelle Dunne, Equality, Diversity and Inclusion for Quality Assurance.

Once you have committee sign off, please send to Caroline Higgs, Communications & Engagement Team for publication: bsol.comms@nhs.net