NORTH BRISTOL CENTRE FOR WEIGHT LOSS, METABOLIC AND BARIATRIC SURGERY

ANNUAL REPORT

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INTRODUCTION:

2014 Has been a momentous year for North Bristol NHS Trust and the Weight Loss, Metabolic and Bariatric Surgery service. The service was established in 2003 and has grown into one of the largest units in the South West due to the work of Sally Norton, Justin Morgan, Andrew Johnson, Faith Brown and Sharon Bates. In May 2014 Frenchay and Southmead hospitals merged with services being brought under one roof at Southmead. The Brunel building is recognised as one of the most advanced hospital designs in Europe and is the new standard of a modern NHS hospital.

We have taken the opportunity of the move to redesign and rename the service to reflect the current thinking around weight loss. We feel that it is important to be clear that we offer a range of non-surgical methods of weight loss via our Tier 3 pathway incorporating specialist medical, dietetic and psychological care and only following this are patients put forward for bariatric surgery if appropriate. It is becoming increasingly clear that surgery has beneficial effects not just on weight but also on a number of conditions associated with obesity. The metabolic effects of surgery, especially its impact on diabetes, are becoming better understood and the provision of metabolic bariatric (sometimes known as diabesity) surgery is reflected in the unit name.

We have rewritten our pathways and standard operating procedures to clarify the progress of patients from referral to the Tier 3 service, through surgery and post-operative follow up. We are commissioned to provide follow up for a maximum of two years after surgery at which time the patients care will be transferred back to primary care. We are able to continue their follow up after this time as long as additional funding has been established or in an emergency or urgent setting. These pathways are published on our website.

The MDT has been restructured and now meets every week. The team discusses all new referrals as well as complicated post-operative issues. Letters to the patient and GP are generated at this meeting and patients are listed for surgery at this time if appropriate.

We offer all types of bariatric procedure including Roux-en-Y Gastric Bypass, Sleeve Gastrectomy, Gastric Band and revision operations. They are performed laparoscopically in

our state-of–the-art theatres and we are currently performing proportionately more bypass and sleeve procedures which is a change from our previous practice. We also offer intra-gastric balloon insertion as a temporary measure for rapid weight loss usually as a bridge to a definitive procedure in high risk individuals.

- National changes

There have been significant changes with regard to the provision of weight loss services throughout the UK over the last 12 months. There are a vast number of individuals that would benefit from intensive weight management services, but the challenge we face is to provide this equitably across the UK within the financial constraints of the NHS. It is clear however that investment in weight management and bariatric surgery ultimately reduces the financial burden on the NHS (and country as a whole) as patients are healthier, more productive and live longer.

There has been an update in NICE guidance on referral to weight management services with evidence suggesting benefit from earlier referral of patients with type 2 diabetes and those of Asian origin at a lighter weight. There have also been recommendations from a widely consulted document about the provision of Tier 3 non-surgical weight management services firmly advocating this provision and the requirement for full assessment within a structured service before consideration for surgery. Well prepared patients are more likely to do better post-operatively and an effective Tier 3 service is therefore essential in achieving excellent outcomes.

The second National Bariatric Surgical Registry (NBSR) report was published in September. This prospectively gathered data from 18000 operations between 2010 and 2013 and continues to show advances in the safety and effectiveness of surgery despite the fact that we are operating on a group of patients that are heavier with a higher number of comorbidities than previously. Overall mortality has fallen to 0.07% with an average length of hospital stay of just 2.7 days. It provides clear evidence that bariatric surgery radically improves health for patients with severe and complex obesity. Submission of data to NBSR is now a condition for NHS commissioning of surgery and we comply with this.

2014 was also the second year for the publication of surgeon specific outcome data and NBT surgeons fall within the expected ranges for numbers of procedures performed, hospital stay and outcomes and there have been no outlying centres identified. This will continue in the future with an annual report published via NHS Choices and the NBSR websites.

There remain huge challenges nationally, not least a proposal for Tier 4 services to be commissioned by local CCGs rather than NHS England and suggested changes in the tariffs for surgery. We are committed to working with the commissioners to allow equitable access for weight loss services within these constraints to avoid the postcode lottery that has been present in the past.

- Local changes

Bristol, North Somerset and South Gloucestershire (BNSSG) CCGs have not commissioned a Tier 3 weight loss service to date, although at NBT we have provided this in an 'unofficial' capacity. All patients referred are seen by a consultant endocrinologist, counselling psychologist and specialist dietician. There have been some issues with regard to the structure of this service although we hope that this will improve in the near future.

BNSSG CCGs have submitted a business case for the provision of a formal Tier 3 service and we are in dialogue to help with this goal. We are sure that this would be a great step forward in the management of these complex patients allowing for well prepared and focussed patients progressing towards their weight loss goals and surgery. We see this Tier 3 service as being structured and time limited with clear endpoints which will allow for accurate outcome data collection, a well organised funding stream and clarity for primary care physicians in understanding what to expect from our service.

- Referral Criteria

Criteria for referral for Tier 3 weight management clinic and Tier 4 bariatric surgery assessment is based on the updated NICE guidance (CG 189, Nov 2014) and is outlined below. There have been some changes to the previous recommendations.

Bariatric Surgery is a treatment option for people with obesity if all of the following criteria are fulfilled

1. Any person with BMI >40 kg/m^2 or person with BMI 35-40 kg/m^2 who has other significant disease that could be improved if they lost weight (e.g. type 2 diabetes, hypertension, dyslipidaemia, obstructive sleep apnoea, Benign Intracranial Hypertension etc.)
2. All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss
3. The person has been receiving or will receive intensive management in a Tier 3 service
4. The person is generally fit for anaesthesia and surgery
5. The person commits to the need for long term follow up
6. Bariatric surgery is the option of choice (instead of lifestyle interventions or drug treatment) for adults with a BMI of > 50 kg/m^2 when other interventions have not been effective
7. Patients with a BMI >35 kg/m^2 who have recent-onset type 2 diabetes should be offered an expedited assessment for bariatric surgery as long as they are also receiving or will receive assessment in a Tier 3 service
8. Consider an assessment for bariatric surgery for people with BMI 30-35 kg/m^2 who have recent onset type 2 diabetes as long as they are also receiving or will receive assessment in a Tier 3 service
9. Consider an assessment for bariatric surgery for people of Asian family origin who have recent onset type 2 diabetes at a lower BMI than other populations as long as they are also receiving or will receive assessment in a Tier 3 service

There is strong evidence that once a patient is morbidly obese they cannot lose enough weight to prevent premature death without surgery. Yo-yo dieting is common as morbidly patients struggle to maintain weight loss due to changes in signalling hormones.

There remains a mis-perception from some members of the public and health professionals that the mechanisms behind obesity are down to poor lifestyle choices driven by willpower and that surgery is an expensive method of devolving responsibility for poor behaviour. There is also a feeling that surgery is high risk and should only be used in extreme cases. It is incumbent on us therefore to educate and explain the complexities behind the mechanisms of obesity as well as the safety and cost effectiveness of surgery (both clinically and financially). This requires regular educational events for members of the public and health professionals which we are engaged in.

STAFFING AND PERSONNEL

There have been some significant changes in the make-up of our group over the past 12 months and we believe that we have a strong, dynamic and motivated team. We said goodbye to a number of our team and we are extremely grateful to all of them, many of whom have been present since the service first started. Sharon Bates, Sharon Tovey, Faith Brown and Justin Morgan have all moved on to different challenges.

Sally Norton took a six month sabbatical at the end of 2014 and James Hewes has taken over as lead clinician for the service. We welcome another surgeon to our team. Alan Osborne was appointed to the consultant team in January 2015. He has a great deal of bariatric experience having completed a fellowship in Taunton and a locum consultant position in Sussex. He has been on the council of BOMSS as the trainee representative, was awarded the Hunterian Professorship in 2012 and was on the committee for revising the recent NICE guidance. He is an excellent surgeon and we are very fortunate to have him on board.

Andrew Johnson continues as the lead endocrinologist and diabetologist for the service. Kathryn Lonnen was appointed consultant endocrinologist in September from her locum position. She will carry on with her work in Wiltshire Tier 3 and we aim to use much of her excellent work from setting up this service in helping establish the BNSSG Tier 3 clinic.

Dafydd Wilson-Evans joined in September as the bariatric practitioner. He has a great deal of experience in bariatrics, dietetics and diabetes, having been involved in the diabetic research team until appointed. He has been trained in performing gastric band adjustments. Dafydd is our first port of call for patients, is easily accessible and is invaluable in coordinating care.

Rachel Burns continues as our specialist dietitian and is involved in the restructuring of the Tier 3 and 4 services. We welcomed Emma Kewin back from Maternity leave in February to recommence her psychology work. Emma Lishman stepped into her shoes to cover the leave and will continue in the Wiltshire service – although she will alsol be on maternity leave soon!

Mike Darby remains as lead bariatric radiologist and runs a weekly fluoroscopic gastric band adjustment clinic. The specialist Anaesthetists (Mark Pyke, Jill Homewood and Steve Tolchard) have been working hard in our pre-operative assessment process to identify and manage high risk patients and facilitate shortened hospital stays. Maria George is now the lead bariatric theatre nurse.

We are supported by a strong managerial team including Niall Prosser and Carolyn Roper, and as ever the hardest working members of the team are our coordinators Pauline Clifford and Diane Smith.

ACTIVITY:

2014 has seen an increase in activity on previous years. This is in line with other units and may be explained by higher numbers of referrals due to changes in commissioning and NICE guidance.

- Referrals

The service has experienced increased numbers of referrals. Between Apr 2014 – Mar 2015, 232 patients were listed for surgery following review in the Tier 4 service, compared with approximately 180 the previous year. Of these, 121 patients have undergone a procedure with 111 on the waiting list.

- Operations (Apr 14 – Mar 15)

Procedure	**Numbers**
Insertion of intra gastric balloon	8
Removal of intra gastric balloon	3
Insertion of gastric band	10
Removal of gastric band	30
Revision of gastric band (unclipped, re-clipped)	6
Gastric Band, port/tubing adjustments	6
Sleeve Gastrectomy	40
Gastric Bypass	18

- Length of Stay

All gastric balloon and banding procedures are listed as day-case. New pathways aim to discharge inpatients following a sleeve gastrectomy or gastric bypass within 48 hours. The average length of stay between Nov 14 - Mar 15 was 1.9 nights which is less than the national average.

- Morbidity and Mortality (Sept 14 – Mar 15)

	Sleeve Gastrectomy		Gastric Bypass	
	≤30 days	**>30days**	**≤30 days**	**>30days**
Mortality	1	0	0	0
Morbidity	4	0	3	1

We experienced one death following sleeve gastrectomy two weeks post-operatively in a very high risk patient who was anticoagulated for previous pulmonary emboli and had a secondary intra-abdominal bleed.

Morbidities include 1 DVT, 1 suspected staple line leak post sleeve gastrectomy, 2 anastomotic ulcers post gastric bypass, 1 chest infection, 1 urinary retention and 1 episode of constipation requiring admission to ED. One sleeve gastrectomy had a stricture requiring endoscopic dilatations.

- Waiting times

Average wait for tier 3 assessment is more than 18 weeks. Tier 4 assessment wait is currently 8 weeks, and waiting time to operation is variable depending on the type and urgency of procedure. We are working to reduce these delays by increasing clinic and theatre availability and staffing levels.

COMPLIMENTS AND COMPLAINTS:

We are establishing an online qualitative patient feedback mechanism but have received positive feedback from a number of patients this year.

RESEARCH AND AUDIT PROJECTS:

Having launched the comprehensive new patient pathway for bariatric surgery last year we are auditing all our outcomes for one year against these criteria to ensure quality of care. This includes pain, wellbeing and length of stay as we move towards a 23-hour discharge after gastric bypass or sleeve gastrectomy. These results will be included in the annual report next year and presented in January 2016 at the annual national meeting for bariatric surgery in Cardiff.

We are involved in a number of other audit and research projects and are in the process of establishing links with Bristol University with an aim to be a contributing center to the largest upper GI randomized controlled trial in the country comparing the different bariatric operations (ByBand-Sleeve study). The team has also been asked to recruit to another NIHR national portfolio study into pregnancy after bariatric surgery as patients' fertility significantly increases with weight loss. While our research profile continued to grow the new NICE guidance presented research recommendations including the importance of diabetic surgery which needs to be considered. Surgical treatment of type 2 diabetes is one of the most cost-effective interventions ever assessed by NICE and newly diagnosed diabetics need to be considered for urgent surgical intervention under the new guidance. We aim to report our outcomes as this new service 'metabolic surgery' expands.

New oesophageal physiology equipment arrives in Spring 2015 giving patients the option of high resolution manometry and impedence pH studies which will help improve the assessment of complex cases. Oesophageal physiology after sleeve gastrectomy remains poorly described and the new equipment will allow us to present and debate this evidence and its effect on choice of surgery.

High risk patients now follow a separate pathway with clear discussion of the risks and benefits of surgery. The use of a bariatric bike for cardiopulmonary exercise testing is being evaluated to help determine individual risk profiles for surgery.

The team will also be presenting their revisional gastric banding surgery at the DDF meeting in the summer and will continue to contribute to national research over the next year.

PLANS FOR THE COMING YEAR:

2015 will be another exciting but consolidating year for NBT and the weight loss service. There have been a number of expected teething issues within the new trust following the move as many services have had to be altered and updated. In addition the pressure on all hospitals within the NHS has increased dramatically and this has put a strain on elective operating capacity due to non-availability of inpatient beds. We hope that with hard work and innovative thinking, solutions to these problems can be found and we can make strides towards reducing waiting times and speedy assessment and surgery.

We hope to be in a position to pilot the BNSSG Tier 3 service with a view to this being formally commissioned in 2015. We will be prospectively collecting outcome data on weight, comorbidity improvement and quality of life data during the process to ensure that our systems function well and are cost effective. Our pathways from referral to and discharge from the service will be regularly updated and available via the trust website to allow clarity for health professionals and patients on how to refer and what to expect from the team. We are also making strides towards being awarded center of excellence status.

Our long term aims are to establish a stand-alone bariatric surgical unit to allow for seamless throughput before, during and after surgery. This should increase our numbers of operations and reduce waiting times but would require further staff appointments. We are working towards a 23-hour post-operative stay model for all but the highest risk patients and almost all of our gastric band and balloon patients are now performed as day cases.

We remain committed to providing excellent streamlined care for all patients with obesity at NBT but welcome any feedback on how we can improve our service. Feel free to contact us at any time on the numbers provided.