Pathway for management of severe obesity and/or Bariatric Surgery

In Primary Care
Patient asks GP for help with their weight.

<table>
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<th>GP assessment:</th>
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<td>1. Must have attempted Tier 2 Obesity services initially (LEAP/FAB/DHAL +/- Exercise on Prescription +/- Orlistat). If achieved, check</td>
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<td>2. Eligibility: BMI 40kg/m² or above, or 35 kg/m² with co-morbidity</td>
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<td>3. Motivation: Patients must engage with the Tier 3 clinic for 12 months before they can be referred for surgery. High level of motivation and willingness to work hard at changing lifestyle essential for success. If patient not ready to engage suggest delay referral until they are ready.</td>
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<td>4. Smoking: offer support to give up (smokers will not be offered surgery).</td>
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<td>5. Sleep apnoea: All patients must be screened using STOPBANG tool. Refer to Sleep clinic if score ≥ 5. Await outcome from sleep clinic before referring to bariatric clinic.</td>
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Once above achieved, GP refers patient to Primary Care Specialist Weight Management Clinic (NB. Blood tests required). Dietetic service invites the patient to ring to make an appointment.

Patient attends an assessment appointment. Bariatric Dietitian discusses:
- Weight history
- Dieting history
- Current eating patterns
- Motivation to change lifestyle
- Options for lifestyle improvement
- Action plan to include self-monitoring of progress

Patient attends regular appointments to review progress over 6 months.

6 months review: If patient is making good progress and wishes to be considered for surgery, Bariatric Dietitian:
- Screens for binge-eating, briefly assesses medication, medical history, psychiatric history, checks compliance with any Sleep Clinic advice, and refers to surgical MDT to discuss any concerns.
- Patient attends for a further 6 months to consolidate lifestyle improvements made. Must research surgical options available.
- After 12 months of regular engagement in Primary Care Specialist Obesity Clinic:
  - Bariatric Dietitian refers patient to Bariatric Surgeons LRI.

In UHL
Patient sees an Upper GI Surgeon to discuss surgical options, motivation to have surgery, risks and benefits of surgery and any further work-up required (may need to see anaesthetist).

Patient is listed for surgery

Patient attends a Pre-assessment clinic with Bariatric Nurse and follows a pre-operative diet for 1-2 weeks before surgery

SURGERY
Patient is seen on the ward and/or has telephone follow-up in first 2 weeks after surgery.

Patient attends an 8 week follow-up appointment with Bariatric Dietitian and Bariatric Nurse.

Patient attends for Dietetic follow-up at 6 months, 12 months and 2 years. (Blood tests are requested in advance of most follow-up appointments).

At 2 years patient is discharged back to GP. Annual blood testing strongly recommended.