Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

PROPOSED REGIONAL OBESITY MANAGEMENT SERVICE FOR NORTHERN IRELAND

Consultation Document

November 2023

CONTENTS

FOREWORD: PERMANENT SECRETARY

Obesity is one of the most significant public health issues facing the population of Northern Ireland today. Having obesity can reduce life expectancy by up to 9 years, can increase the risk of a range of health conditions including heart disease, stroke and type II diabetes, and can have a significant detrimental impact on mental health. However, it is possible, through appropriate weight management programmes and interventions, to significantly reduce the risk of health conditions associated with obesity. It is for that reason that the Department of Health is launching this public consultation on the development of a Regional Obesity Management Service (ROMS) in Northern Ireland.

Supporting and enabling people to improve their health and wellbeing is a key priority for the Department of Health. Not only will this help to make the population of Northern Ireland healthier, which will improve wellbeing and ensure better quality of life for our residents; but it will also help to reduce demand on our health and social care services, which are coming under increasing and sustained pressure.

Whilst there are already some resources in place to support individuals with obesity, it is recognised that for many people a more intensive clinical intervention may be required to support weight management. The Department of Health has recently launched a public consultation on a new strategic framework to tackle obesity: '*Healthy Futures: A Strategic Framework to Prevent the Harm caused by Obesity, and Improve Diets and Levels of Physical Activity in Northern Ireland'.* The previous strategy, "A Fitter Future for All" (2021), was purely focussed on prevention and early intervention. During the co-production of Healthy Futures, the message from those with lived experience of obesity was clear: it is not possible to completely separate prevention from treatment and other specialist services. Individuals may require specialist support and help from highly skilled professionals to be able to manage their weight.

In other parts of the UK this specialist support, which may include the provision of weight loss medication and bariatric, or weight loss, surgery, is provided via specialist obesity management services. In Northern Ireland, these services have not traditionally been commissioned and are therefore not currently available within the health service.

It is for that reason that the Department is exploring options for the establishment of a prototype ROMS for Northern Ireland. The ROMS would form part of a new approach to weight management, aligning with recommendations set out by the National Institute of Clinical Excellence (NICE). It would provide a means for people living with obesity in NI to access treatment and specialist support that is not currently available to them, and would bring us into line with our counterparts in the rest of the UK.

This consultation seeks views on a proposal for a new ROMS which would aim to enhance health and wellbeing in Northern Ireland by focusing on the provision of speciality clinical support, in community and hospital based settings, to address obesity. The development of a ROMS would be complementary to the key priorities and actions set out in the Healthy Futures consultation, and I am delighted that we are in a position to take both these consultations forward in parallel.

As with any new service, it will of course be subject to resource availability and Ministerial approval. However, we are keen to take this consultation forward as a first step in this journey, so that we are in a better position to move quickly and decisively when the time is right. This is your opportunity to share your views on whether you see this as an important future service development, and what you see as the important elements of that service. And it is our opportunity to listen to you, take note, and prepare for the next stage.

All responses to this consultation will be considered and analysed and will form the basis of our advice to a new Health Minister, when the Executive is restored. We are keen to hear from all those who have an interest in obesity management, whether that be from lived experience, or due to professional interest. Please send us your views, comments and suggestions so that we can take them into account as we develop plans for a new obesity management service for the people of Northern Ireland.

Peter May

Permanent Secretary, Department of Health

SECTION 1: INTRODUCTION

1. The Department of Health would welcome your views on its plans to introduce a prototype Regional Obesity Management Service (ROMS) in Northern Ireland, as set out in this consultation document.

BACKGROUND TO THE CONSULTATION

2. In 2019 the Department of Health initiated a process to develop a prototype ROMS. A Task and Finish (T&F) Group was established and tasked with taking this work forward, with the Department's intention to consult in early 2020. However, the advent of the pandemic, and the challenges experienced by health and social care in its aftermath, paused this work for a period of time. However, the Department, feels the time is now right to seek public opinion on a proposed way forward for specialist obesity management services in NI.

3. A range of stakeholders were involved in the initial development work in 2019. This included clinical representation on the T&F Group across a range of professions (including endocrinology, psychology, dietetics, surgery and clinical biochemistry). In addition, the Department worked with the Patient Client Council to engage with a group of individuals with lived experience. Further engagement with stakeholders has taken place in 2023 during the preparation of this consultation paper.

IMPACT ASSESSMENTS

4. In accordance with the relevant statutory requirements, the following impact assessment screening documents have been prepared and are available on the Department's website for consideration during this consultation:
    - Draft Equality Screening, Disability Duties and Human Rights Assessment;
    - Draft Rural Needs Impact Assessment;
    - Draft Data Protection Impact Assessment screening.

5. This proposal has also been screened out as regards applicability of Article 2 of the Windsor Framework.

HOW TO RESPOND TO THE CONSULTATION

6. We are keen to hear from all those with an interest in the development of treatment options for people living with obesity.

7. The consultation will run for 12 weeks from 24 November 2023 to 16 February 2024. All information relating to the consultation is available on the Department's website.

8. You can respond to the consultation online by accessing the Northern Ireland Government Citizen Space website and completing the online survey there.

9. We would prefer responses using Citizen Space, however, if you wish to send an email or hard copy of your response, please send it to:

Department of Health
ROMS Team
Annex 3
Castle Buildings
Stormont
Belfast
BT4 3SQ
ROMS@health-ni.gov.uk

10. A full set of consultation questions are provided in Annex A to this consultation document.

11. When you reply, it would be very useful if you could confirm whether you are replying as an individual in a professional or private capacity, or submitting an official response on behalf of an organisation. If you are replying on behalf of an organisation, please include:

- your name;
- the name of your organisation; and
- an e-mail address.

12. If you have any queries or wish to request a copy of the ROMS consultation document in an alternative format, please contact the Department using the following email address to make your request: ROMS@health-ni.gov.uk.

13. The consultation will close **at 5pm on Friday 16 February 2024**. Following the close of the consultation, we will consider the responses received and publish a report summarising the consultation findings on the Department's website.

PRIVACY, CONFIDENTIALITY AND ACCESS TO CONSULTATION

14. For this consultation, we may publish all responses except for those where the respondent indicates that they are an individual acting in a private capacity (e.g. a member of the public). All responses from organisations and individuals responding in a professional capacity will be published. We will remove email addresses and telephone numbers from these responses; but apart from this, we will publish them in full. For more information about what we do with personal data please see our consultation privacy notice webpage.

15. Your response, and all other responses to this consultation, may also be disclosed on request in accordance with the Freedom of Information Act 2000 (FOIA) and the Environmental Information Regulations 2004 (EIR); however all disclosures will be in line with the requirements of the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (UK GDPR) (EU) 2016/679.

16. If you want the information that you provide to be treated as confidential it would be helpful if you could explain to us why you regard the information you have provided as confidential, so that this may be considered if the Department should receive a request for the information under the FOIA or EIR.

OBESITY STRATEGY CONSULTATION

17. The Department is also currently consulting on a new strategic framework to tackle obesity, "Healthy Futures". Details on this consultation, and how to respond, can be found on the Department's website.

SECTION 2: MAKING THE CASE FOR OBESITY MANAGEMENT SERVICES IN NI

AIM

18. The Department of Health is taking forward plans to introduce a ROMS in Northern Ireland. It is intended that this will include the provision of both preventative measures and active multidisciplinary weight loss strategies, including, where appropriate, bariatric surgery (weight loss surgery)[1].

19. The overriding strategic objective of ROMS for severe and complex obesity is to achieve a significant risk reduction in the burden of obesity-related co-morbidities among the group of patients targeted in the service. It is intended that this will be achieved by facilitating significant and sustained weight reduction in the individuals and improvement in their long-term health. This will initially be introduced as a prototype model for a period of two years, and it is intended that, during that period, 100 bariatric surgeries will be delivered per annum as well as the prescribing of GLP-1 agonists[2] (weight loss medication).

20. The Department of Health has been working with a range of Health and Social Care (HSC) professionals from across HSC Trusts, the former Health & Social Care Board (HSCB), the Public Health Agency (PHA) and the Patient Client Council (PCC), to develop this prototype ROMS model for Northern Ireland. We now want to explain our proposals and to hear what you, as service users and people with lived experience, think, and take your views and experiences into account to ensure that services deliver the very best quality care for patients.

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[1] Bariatric surgery, also referred to as weight loss surgery and metabolic surgery, is a treatment option for people with severe obesity. The most common bariatric surgery procedures performed in the UK and worldwide are the gastric bypass and the sleeve gastrectomy. They work mainly by altering signals that come from the gut, which in turn control appetite, a person's interest in food, taste and blood sugar. These changes in gut signals overcome/ trick the body's fat defense mechanisms that normally make sustained weight loss difficult. Bariatric and Metabolic Surgery (bomss.org)

[2] Glucagon-like peptide-1 (GLP-1) agonists (also known as GLP-1 receptor agonists, incretin mimetics, or GLP-1 analogs) represent a class of medications used to treat type 2 diabetes mellitus and, in some cases, obesity.

WHAT ARE OBESITY MANAGEMENT SERVICES?

21. In recent years obesity management in other jurisdictions has followed a four-tiered approach, as outlined as follows:

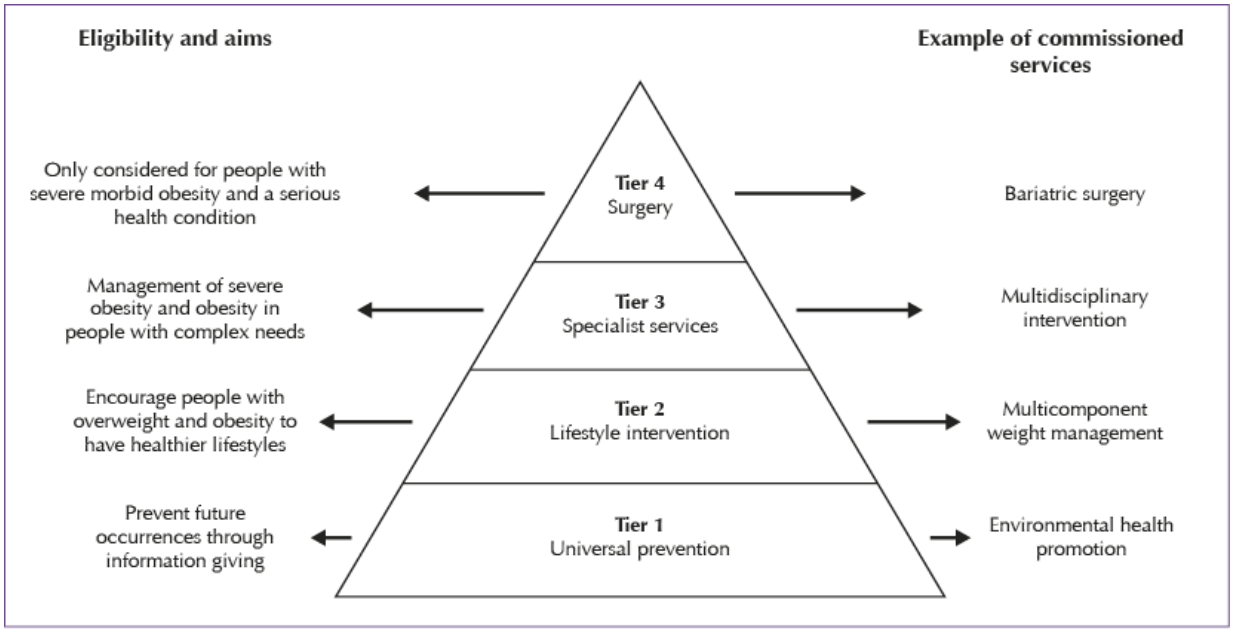

Figure 1. The UK Obesity Care Pathway (Department of Health, 2013).

a. Tier 1 - universal services such as health promotion, encouraging all individuals to exercise and maintain a healthy weight; identify those whose weight is outside healthy range and provide general support and information.
b. Tier 2 - lifestyle interventions including advice and support for weight loss within a community setting. This includes for example, referrals to commercial weight loss classes.
c. Tier 3 - administered in a community setting, providing support in obesity care led by a specialist multi-disciplinary team including obesity physicians; psychological therapists; dieticians; community pharmacists; and exercise specialists. This includes education on physical activity, improving eating behaviour, exploring behavioural change around food, and where appropriate commencement of supervised very-low-calorie diets or prescription of specific medications licensed for weight loss (GLP-1 agonists) in a specialist multidisciplinary setting.
d. Tier 4 - bariatric (or obesity) surgery, for example gastric by-pass or vertical sleeve gastrectomy. This may be an option for some patients who have not responded to non-surgical interventions despite support at the other tiers. For this group of

patients, the only prospect of regaining health and an improved quality of life is through a surgical procedure. Patients are referred for bariatric surgery where comprehensive assessment will already have taken place and it has been decided by a multidisciplinary clinical team that surgery is a viable option for the treatment of obesity. This ensures that those progressing to surgery have had appropriate pre-assessment to ensure that they are in a category where the potential benefits outweigh the known risks of surgery and also that candidates are ready for surgery.

22. This tier model, which has already been implemented in England and has been operating for a number of years, also suffers from some limitations. These have been acknowledged by the National Institute of Clinical Excellence (NICE), which provides national guidance and advice to all UK Health bodies to improve overall health. Clinical Guideline (CG) 189[3] provides clinical guidance on the identification, assessment and management of obesity; this has recently been updated to reflect the current evidence on bariatric surgery, and NICE is currently reviewing the entire obesity management guidelines for children and adults.

23. Considering that obesity affects at least 1 in 5 people in the UK, it is not possible to treat these patients in secondary care (in a hospital setting). This approach has worsened health inequalities in England, as the patients who seek referral to secondary care usually come from high socioeconomic and educational backgrounds. The limited availability of secondary care resources has also created a bottleneck in waiting lists, with many patients waiting approximately 2 years for treatment. New treatments for obesity such as GLP-1 agonists now provide effective pharmaceutical options, and a new, innovative and evidence based approach that enables the population of Northern Ireland to benefit from NICE recommended treatments is required.

ARE THESE SERVICES CURRENTLY PROVIDED IN NORTHERN IRELAND?

24. A number of Tier 1 or universal programmes and initiatives are currently provided in Northern Ireland by the Department of Health, the Public Health Agency, the Food Standards Agency NI, and other healthcare partners to help tackle the growing problem

[3] NICE Clinical Guideline (CG) 189 *"Obesity: identification, assessment and management. Published date: 27 November 2014, updated 26 July 2023."*

of obesity. However, whilst individuals here are able to access advice and support groups privately to assist with weight loss, there are currently no formal Tier 2 or 3 services in Northern Ireland to support those living with overweight or obesity and wish to access these services. The lack of these services means that patients are currently unable to avail of new weight loss treatments approved by NICE, as they must be initiated and managed by a specialist weight management service.

25. Additionally, Tier 4 services (weight loss or bariatric surgery) are currently not routinely commissioned by the Department of Health either within or outside of Northern Ireland. As with other services which are not routinely commissioned in Northern Ireland, referrals can be considered as part of the Extra Contractual Referral (ECR) process[4], however this is something that is done on the basis of clinical need and is not used for routine weight loss.

26. In the development of this prototype model, we have taken into consideration key elements of the tier model described above. Further detail on the proposed service for NI on which we are consulting is provided at Section 3 of this document.

WHY DO WE NEED A REGIONAL OBESITY MANAGEMENT SERVICE?

27. Obesity is one of the most significant public health issues facing Northern Ireland today. The development of obesity is complex and related to many different factors, many of which are outside a person's control. For example, biology (genetics, hormones), behaviour and psychological factors, as well as societal, cultural and environmental factors all strongly influence the development of obesity.

28. Having obesity can reduce life expectancy by up to 10 years, equivalent to the effect of lifelong smoking[5] and it can also increase the risk of a range of health problems including: heart disease and stroke; type 2 diabetes; several cancers (including postmenopausal breast cancer); arthritis of hips and knees; mental health conditions such as depression, sleep apnoea and complications in pregnancy.

[4] Transfer for treatment by the Strategic Planning and Performance Group - DOH/HSCNI Strategic Planning and Performance Group (SPPG)
[5] https://www.ox.ac.uk/news/2009-03-18-moderate-obesity-takes-years-life-expectancy

29. People living with obesity regularly face stigma and discrimination in society; research in healthcare shows that people living with obesity are likely to face delays in diagnosis. Experiencing stigma and discrimination based on body size/shape can worsen a person with obesity's mental and physical health and often leads to disengagement with healthcare services, which can lead to worsening health outcomes.

30. In addition to the risk of a myriad of health problems clearly directly associated with obesity, there is also a significant financial impact on Health and Social care services. The total direct and indirect costs to Health and Social Care in NI of overweight and obesity in 2015/16 were estimated at around £457 million. This is a significant increase from the 2009/10 estimate of £268 million. It is likely that such costs are even greater in 2023.

SECTION 3: PROPOSED NEW REGIONAL OBESITY MANAGEMENT SERVICES FOR NI – A PROTOTYPE MODEL

HOW CAN ACCESS TO CARE BE INCREASED?

31. Based on the lessons learned from the implementation of the tiered system in England and the long experience of treating the sister disease of type 2 diabetes, we are proposing the establishment of a **clinical treatment pathway** aimed at increasing access to care, whilst at the same time prioritising those patients who stand to benefit the most. This treatment pathway would complement existing public health measures to prevent and manage the disease of obesity. Further detail on the pathway is set out below.

OBESITY MANAGEMENT IN PRIMARY CARE

32. Patients living with obesity will be identified by their primary care team and be referred to the local multidisciplinary obesity management service. This could consist of or have access to a general practitioner, nurse, dietitian, psychologist, general practice pharmacist, community pharmacist, health coach/social prescriber, occupational therapy and physical activity specialist. These multidisciplinary teams already exist in primary care but have not yet been set up or trained to treat and manage obesity effectively. This model is used for many other chronic conditions such as type 2 diabetes, cardiovascular disease, respiratory disease and cancer.

33. Following assessment by all members of the team, the patient's needs would be identified and the appropriate treatment offered. This could include nutritional, physical activity, occupational, psychological and pharmacological therapies. These services will be designed and resourced to provide lifelong treatment for obesity, as they do for any other chronic condition. Evidence from Randomised Controlled Trials (RCTs) has demonstrated that this is feasible and cost-effective.

OBESITY MANAGEMENT IN SECONDARY CARE

34. A key element of the ROMS model is access to a specialist multi-disciplinary weight management service[6]. There would be a subgroup of patients who would either not respond to treatments in primary care or would have complex needs that could only be addressed through a shared-care model. Such a model would involve input of a specialist multidisciplinary team in secondary care. These could consist of or have access to: a physician; dietitian; surgeon; anaesthetist; psychologist and endoscopist. These would be in addition to specialist representatives from the other disciplines already mentioned in the primary care service. The aim of this service would be to intensify or modify treatment to address the complex needs of the patient. This could include more advanced pharmacotherapy, endoscopic interventions and bariatric surgery.

35. Depending on the patient's response, they could either remain under shared-care or be discharged back to primary care. Figure 2 below provides an overview of the clinical treatment pathway.

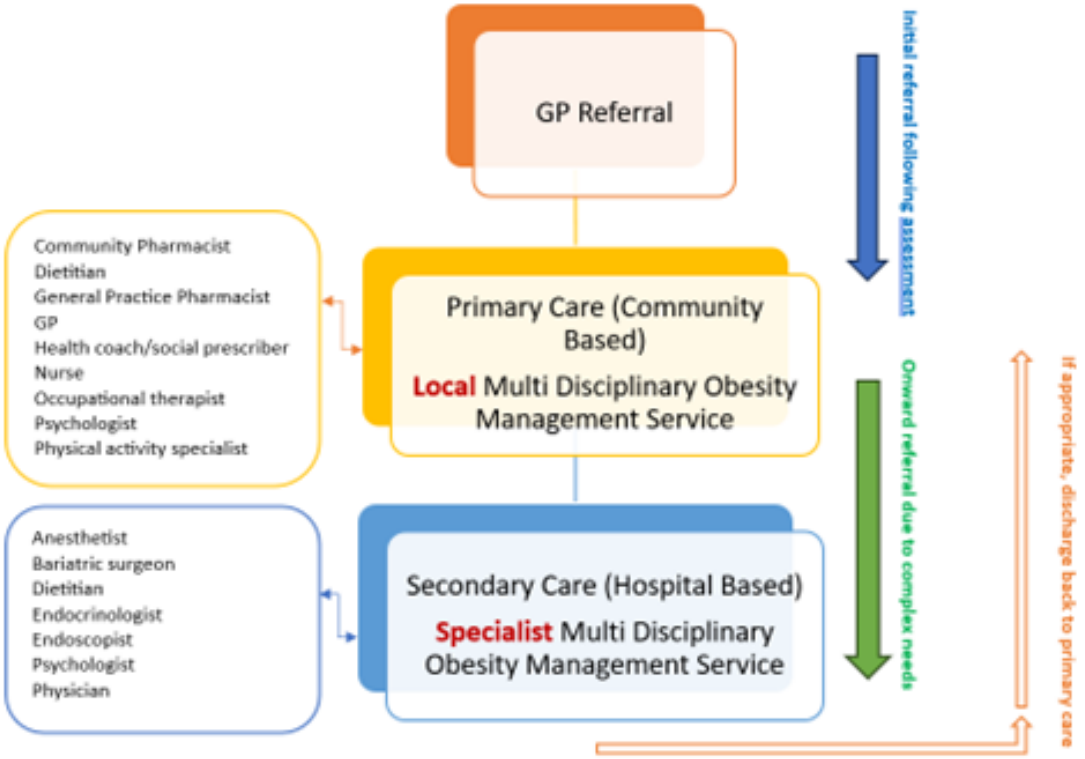

Figure 2: Clinical Treatment Pathway for ROMS

[6] *A specialist primary, community or secondary care based multi-disciplinary team offering a combination of surgical, dietetic, pharmacological and psychological obesity management interventions (NICE CG 189, 2023)*

36. Bariatric surgery is an important element in the long-term management of obesity. It is fundamental that this procedure is performed on the right patient, at the right time for that patient. It is also important that it is performed by the right professional in the right place of treatment. It is therefore essential that individual people would have an appropriate period of self-management and weight management advice and support by specialist professionals before surgery.

37. For those requiring surgical intervention, to ensure suitability for surgery, patients need a thorough medical investigation to ensure there are no underlying medical causes of their obesity. All patients should also have a psychological assessment to ensure they are suitable for surgery and able to comply with the post-operative lifestyle change required. Following bariatric surgery, it is recommended that patients remain under shared-care for 2 years before being discharged back to the obesity management service in primary care for life long follow-up.

38. Some patients who are seen by the specialist obesity management service may decide that they do not wish to progress to bariatric surgery immediately and would prefer a period of intensive support to achieve weight loss. This service should be able to offer this and not merely be a surgical assessment service – although that is a core part of their role. All patients referred for bariatric surgery should have an assessment by the specialist obesity management service and if appropriate a period of management in the service.

39. This specialist help is extremely important in helping patients understand the underlying issues that can cause weight gain and promote a lifestyle based approach in which people are encouraged and supported to make small sustainable changes. Often, patients who have access to this service would be able to successfully lose and maintain a healthy weight, improving health-related outcomes, however, for a proportion of patients, significant weight loss to improve health-related outcomes is not achieved and surgery may be the only option.

WHO WILL BE ABLE TO ACCESS THIS SERVICE?

40. All patients with the disease of obesity (defined as having a BMI over 30, in addition to assessment using appropriate obesity staging systems[7]) with any obesity related complication should have access to this service. However, the available evidence suggests the need is greater for specific obesity-related complications or the needs of the subpopulations with obesity are large and unmet. For this reason, prioritisation of specific patient subpopulations may be necessary. These include for example, people living with a BMI ≥35 (or as appropriate for their ethnic background) with:

I. Type 2 diabetes mellitus (even with BMI ≥30 or appropriate for their ethnic background);
II. Cardiovascular disease (e.g. ischaemic heart disease, heart failure, atrial fibrillation/flutter);
III. Obesity-related chronic kidney disease, especially people on the waiting for transplantation;
IV. Non-alcoholic steatohepatitis;
V. Severe osteoarthritis, especially people on the waiting list for joint replacement surgery;
VI. Obesity-related infertility, especially for women seeking in vitro fertilization;
VII. Obstructive sleep apnoea;
VIII. Idiopathic intracranial hypertension.

The above list is not exhaustive. Specific access criteria will be developed prior to commencement of the service in accordance with best practice.

41. As this will be a new service running as a prototype for two years initially, we propose initially restricting access to bariatric surgery until the services are fully bedded in. This may mean the criteria to access bariatric surgery will be slightly different from those set out above, and will be based on a number of broad factors in line with clinical guidelines. This might include for example, an individual's BMI, co-morbidities, and suitability for surgery. After this first phase, the prototype service would undergo an evaluation and at that stage, if the service and treatment pathway is fully developed and functioning

[7] *Obesity Staging Systems are systems used for obesity classification to provide clinically relevant insight into health-related risks for individuals.*

well, the access criteria may be widened to allow a greater pool of people to access this element of the service.

WHERE WILL THE SERVICE BE LOCATED?

42. It is proposed that primary care based obesity management teams would be delivered within the community at a local level, while the specialist multi-disciplinary obesity management teams based in secondary care would be available in two locations in NI. It may also be possible to access some appointments remotely if deemed clinically appropriate.

43. It is also proposed that the bariatric surgery teams would initially be based at one location in Northern Ireland, with the potential to develop a second surgical site depending on the success of the prototype, and subject to availability of resources.

44. There are a number of reasons for this. There is a small pool of specialist surgeons in Northern Ireland who are trained in bariatric surgery, and it is intended that two surgeons would be present for each surgery initially. Taking this, and wider workforce issues into account, we believe that in order to deliver bariatric surgery as safely and efficiently as possible, the surgical service should be delivered at one location initially. We would also need to take account of the capacity and capability of existing hospital sites to deliver a new service, and this would need to be considered when deciding where the surgical service would be located. Availability and training needs of theatre and other support staff must also be considered.

45. It is recognised that this would mean individuals may have to travel further to access the services they need, however, we believe that this is the best approach to ensure bariatric surgery services can be established safely, with a view to growing the service at a later stage.

WHEN WILL THE SERVICE BE AVAILABLE?

46. Subject to the outcome of this public consultation, we would aim to establish the service as soon as resources allow. It is recognised that the HSC is under significant financial pressure and continues to have to prioritise rebuilding services and tackling existing waiting lists over the establishment of new services. However, the Department believes

that it is opportune to take forward this consultation on a prototype ROMS in conjunction with the ongoing consultation on the new Obesity Strategy. This will ensure the Department is fully prepared to take forward the development of this service as soon as the necessary resources are made available.

HOW MUCH WILL THIS NEW SERVICE COST?

47. It is intended that the surgical service will initially be delivered from one location for secondary care (hospital based) services, however, it is planned that further centres would be created as the service develops in later years.

48. Indicative recurrent costs for the service, including treatment in both primary and secondary care, are set out below:

- Year 1: £1-2m
- Year 2: £2-2.5m
- Year 3: £2-4m
- Year 4 onwards: £2-5m

49. The above costs will very much be dependent on the access criteria, set in line with clinical guidelines, and the number of surgical centres in operation.

50. The lower recurrent figures in the early years of service delivery are based on the initial establishment of one surgical centre within the prototype model. This will require tighter access criteria initially as the new service model is embedded, and to manage available capacity.

51. It is then expected that numbers of patients accessing the service will increase in later years (year 3 onwards), at which point the model may be expanded to establish another surgical centre. At that stage, with more available capacity and the service more fully developed, it may also be possible to widen access criteria.

52. It is important to note that the figures outlined above are high level and indicative at this stage, and will be subject to availability of resources. A more robust costing exercise will be undertaken if a decision is taken to implement a service.

SECTION 4: WHAT HAPPENS NEXT?

53. We are keen to hear from you, so that we can take account of any views that will help us reach a decision. Following the close of the consultation, the Department will consider the responses and evaluate whether any changes should be made to the proposed prototype service model. A report summarising the consultation will be published on the Department's website. The Department will continue to engage with stakeholders following the consultation and as this work progresses.

54. If you have any questions or queries relating to this consultation exercise, please contact the Department via email at: ROMS@health-ni.gov.uk.

55. Please note the consultation will close at **5pm on Friday 16 February 2024**. If you submit your response after this date, the Department cannot guarantee that it will be considered.

56. A list of consultation questions is provided in Annex A.

ANNEX A

CONSULTATION QUESTIONNAIRE

(a word version of this consultation questionnaire is available on the Department's website: https://www.health-ni.gov.uk/consultations/proposed-regional-obesity-management-service-roms-northern-ireland)

PERSONAL DETAILS		
Name		
Email address		
Are you responding on behalf of an organisation?		**Yes/No** *(delete as applicable)*
Organisation *(if applicable)*		
Please indicate in which capacity you are responding to this consultation: *(please tick)*		
☐ Medical Professional ☐ HSC worker ☐ Member of the public ☐ Person with lived experience		
The Department may publish responses to this consultation, except those from individuals responding in a private capacity. Your response may also be disclosed on request in accordance with the Freedom of Information Act 2000 (FOIA) and the Environmental Information Regulations 2004 (EIR). If you wish your response to remain confidential, it would be helpful if you could indicate your reasons for this. **Would you prefer your response to remain confidential?** *(If so, please tick)* ☐ Yes		
Please explain the reason for your request:		
CONSULTATION QUESTIONS		
Q1: To what extent do you support or oppose this proposal for the establishment of a Regional Obesity Management Service?		
Strongly support / tend to support / neither support nor oppose / tend to oppose / strongly oppose *(please delete as appropriate)*		
Please add any further comments you may have:		
Q2: Do you agree with the principle that bariatric surgery should be carried out on a single site where it can be delivered safely and sustained?		

Strongly agree / tend to agree / neither agree or disagree / tend to disagree / strongly disagree *(please delete as appropriate)*
Please add any further comments you may have:
Q3: At which hospital site do you think a bariatric surgical service should be provided? *(please select one option)*
☐ Belfast Trust Hospitals (Royal Victoria, Belfast City, Mater) ☐ Craigavon Hospital ☐ Daisy Hill Hospital ☐ Altnagelvin Hospital ☐ South West Acute Hospital ☐ Antrim Area Hospital ☐ Ulster Hospital *Please note: location of service will primarily be based on available capacity*
Q4: Do you agree that specialist obesity management services (MDTs in secondary care) should be located in two locations in Northern Ireland?
Strongly agree / tend to agree / neither agree nor disagree / tend to disagree / strongly disagree *(please delete as appropriate)*
Please add any further comments you may have:
Q5: At which 2 hospital sites do you think a secondary care MDT specialist obesity management service should be located? *(please tick 2 options)*
☐ Belfast Trust Hospitals (Royal Victoria, Belfast City, Mater) ☐ Craigavon Hospital ☐ Daisy Hill Hospital ☐ Altnagelvin Hospital ☐ South West Acute Hospital ☐ Antrim Area Hospital ☐ Ulster Hospital *Please note: location of service will primarily be based on available capacity*
Q6: Would you be prepared to travel to another Trust for regular appointments with an obesity management MDT? *(please tick)*
☐ Yes ☐ No
Please add any further comments you may have:
Q7: Would you be prepared to attend obesity management appointments on a remote basis (for example, via Zoom, Microsoft Teams, via telephone) rather than face-to-face? *(please tick)*
☐ Yes ☐ No
Please add any further comments you may have:

Q8: Having read the consultation document do you agree that the service should initially be limited to those who would be expected to achieve the greatest health gain?
Fully Agree / Mostly Agree / Neither Agree nor Disagree / Mostly Disagree / Fully Disagree *(please delete as applicable)*
Please add any further comments you may have:
Q9: Is there any one key element/aspect which you feel is missing from the proposed service model?
If so, please provide further information if appropriate:
Q10: Do you have any further thoughts or comments which may be relevant to this consultation?
Please outline below:
Q11: Given the current pressure on resources in the Health Service, and having read this consultation document, do you feel there is merit in investing in this type of service? ☐ Yes ☐ No
Please add any further comments you may have:
IMPACT ASSESSMENT/SCREENINGS – QUESTIONS
Q12: Do you agree with the outcome of the Impact Assessment/screenings?
Fully Agree / Mostly Agree / Neither Agree nor Disagree / Mostly Disagree / Fully Disagree *(please delete as applicable)*
Please add any further comments you may have:

ANNEX B

GLOSSARY OF TERMS

Bariatric Surgery	Also called weight-loss or metabolic surgery and is sometimes used as a treatment for people who have obesity. It can lead to significant weight loss and help improve many weight related conditions. It is a major operation.
Cardiovascular disease	A general term for conditions affecting the heart or blood vessels. It is usually associated with a build-up of fatty deposits inside the arteries and an increased risk of blood clots.
Clinical Guideline	Recommendations on how to diagnose and treat medical conditions.
Clinical treatment pathway	A set of recommendations and/or flowchart which maps out each stage of a patient's treatment journey.
Co-morbidities	When a person has more than one disease or condition at the same time.
Endoscopist	A doctor who views the inside of a person's body without performing major surgery. An endoscopist uses an endoscope (a thin, flexible tube with a light and camera at the end) to do this.
Gastric bypass	An operation in which surgical staples are used to create a small pouch at the top of the stomach. The pouch is then connected to your small intestine, missing out the rest of the stomach. This means it takes less food to make you feel full and you absorb fewer calories from the food you eat.
GLP-1 agonists	Medicines used to treat type 2 diabetes and, in some cases, obesity.
Idiopathic intracranial hypertension	A build up of pressure around the brain. It can cause severe headaches and problems with your vision.
In Vitro Fertilization (IVF)	One of several techniques available to help people with fertility problems have a baby. During IVF, an egg is removed from a woman's ovaries and fertilized with sperm in a laboratory. The embryo is then returned to the woman's womb to grow.

Multidisciplinary team	A group of health and care staff who are members of different professions that work together to make decisions regarding the treatment of individual patients and service users.
Non-alcoholic steatohepatitis	The term for a range of conditions caused by a build-up of fat in the liver. It is usually seen in people who are overweight or obese.
Obstructive sleep apnoea	A relatively common condition where the walls of the throat relax and narrow during sleep, interrupting normal breathing.
Osteoarthritis	A condition that causes joints to become painful and stiff. It is the most common type of arthritis in the UK.
Pharmacotherapy	Medical treatment that utilises one or more pharmaceutical drugs to improve on-going symptoms (symptomatic relief), treat the underlying condition, or act as a prevention for other diseases.
Primary Care	The first point of contact in the healthcare system. This includes general practice, community pharmacy, dental and optometry (eye health) services.
Prototype	A new way of delivering care. It is used to test how well the new service will work, its safety and effectiveness, before further expansion or development.
Psychological Assessment	The process of evaluating a person's mental health and behavioural function to arrive at a diagnosis and guide treatment.
Randomised Controlled Trials	Studies in which a number of similar people are randomly assigned to two or more groups to test a specific drug, treatment or other intervention.
Secondary Care	Sometimes referred to as hospital and community care. It is usually care that is provided beyond that received in primary care. Secondary care can either be planned (elective) care or urgent and emergency care.
Subpopulations	A specific group of individuals with common patient characteristics that is the target of an intervention or policy recommendation.

Type 2 diabetes mellitus	An illness which causes the level of sugar in the blood to become high and is often linked to having overweight or being inactive.
Vertical sleeve gastrectomy	An operation in which a large part of the stomach is removed so it is much smaller than it was before. This means you cannot eat as much as before surgery, and you'll feel fuller for longer.

ANNEX C

OBESITY STATISTICS

All data sourced from Health Survey Northern Ireland trend tables[8].

Adult Data

Adult respondents aged 16+.

All Adults (BMI – all weight categories)

All	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020
Underweight	3%	2%	2%	1%	2%	1%	2%	2%	2%	1%
Normal weight	38%	36%	36%	37%	37%	38%	36%	34%	37%	33%
Overweight	36%	38%	38%	38%	36%	35%	35%	38%	37%	38%
Obesity	22%	22%	23%	22%	22%	24%	24%	24%	23%	24%
Obesity class III[9]	2%	2%	2%	2%	3%	2%	3%	3%	2%	3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

By Gender

Males	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020
Underweight	2%	1%	1%	1%	1%	1%	1%	1%	1%	1%
Normal weight	31%	30%	30%	31%	33%	34%	32%	26%	31%	28%
Overweight	44%	43%	43%	43%	40%	37%	38%	46%	42%	43%
Obesity	22%	24%	24%	23%	24%	26%	26%	24%	24%	26%
Obesity class III	1%	2%	2%	2%	2%	2%	3%	2%	2%	2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

[8] https://www.health-ni.gov.uk/publications/tables-health-survey-northern-ireland

[9] *BMI >40kg/m2*

Females	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020
Underweight	3%	2%	2%	1%	3%	2%	2%	2%	2%	2%
Normal weight	44%	42%	41%	43%	41%	41%	41%	42%	42%	38%
Overweight	29%	34%	32%	33%	33%	32%	33%	30%	32%	33%
Obesity	21%	20%	22%	20%	20%	22%	22%	23%	21%	23%
Obesity class III	3%	3%	3%	3%	3%	2%	3%	3%	3%	4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Obesity in Adults (BMI): By Age Group and Gender

Age group	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020
16-24	12%	8%	16%	10%	12%	14%	17%	9%	13%	14%
25-34	16%	20%	20%	19%	20%	22%	20%	22%	20%	25%
35-44	26%	26%	24%	22%	24%	29%	27%	29%	25%	27%
45-54	29%	30%	34%	30%	30%	32%	34%	32%	30%	34%
55-64	31%	34%	31%	33%	33%	33%	36%	37%	34%	30%
65-74	30%	30%	27%	31%	32%	29%	32%	32%	28%	35%
75+	24%	17%	21%	22%	26%	25%	25%	24%	22%	27%
Total %	**23%**	**24%**	**25%**	**24%**	**25%**	**26%**	**27%**	**26%**	**25%**	**27%**

Males by Age group	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020
16-24	5%	7%	15%	10%	13%	17%	17%	7%	12%	12%
25-34	13%	21%	19%	19%	20%	19%	21%	26%	18%	21%
35-44	28%	28%	24%	25%	24%	33%	28%	30%	25%	30%
45-54	32%	30%	36%	31%	33%	34%	35%	31%	36%	35%
55-64	36%	37%	33%	38%	35%	35%	39%	39%	36%	32%
65-74	30%	28%	30%	31%	32%	31%	36%	32%	31%	38%
75+	21%	25%	27%	16%	31%	29%	27%	17%	26%	27%
Total %	**23%**	**25%**	**26%**	**24%**	**26%**	**28%**	**29%**	**27%**	**26%**	**28%**

Females by Age group	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020
16-24	18%	8%	17%	10%	11%	11%	16%	11%	15%	15%
25-34	19%	19%	22%	18%	20%	24%	19%	18%	22%	28%
35-44	24%	24%	24%	20%	23%	26%	25%	28%	25%	24%
45-54	26%	29%	32%	30%	28%	30%	33%	33%	25%	34%
55-64	25%	31%	29%	28%	30%	31%	32%	34%	33%	28%
65-74	30%	32%	25%	31%	33%	27%	28%	31%	26%	32%
75+	26%	13%	18%	26%	23%	23%	23%	28%	19%	27%
Total %	**23%**	**22%**	**24%**	**23%**	**24%**	**25%**	**25%**	**26%**	**24%**	**27%**

Obesity in Adults (BMI): By rural/urban

Urban / Rural	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020
Mixed Urban / Rural						19%	31%	27%	25%	24%
Rural	24%	25%	24%	25%	26%	28%	27%	26%	24%	26%
Urban	23%	23%	26%	23%	24%	27%	26%	26%	25%	28%
Total %	**23%**	**24%**	**25%**	**24%**	**25%**	**26%**	**27%**	**26%**	**25%**	**27%**

Children Data

Child respondents aged 2 – 15 years old. Figures here use the International (IOTF) Body Mass Index cut-offs for thinness, overweight and obesity in children[10].

All Children (IOTF BMI cut offs)

All	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020
Underweight	7%	5%	4%	5%	5%	7%	6%	6%	6%	5%
Normal weight	65%	65%	69%	70%	66%	68%	69%	68%	67%	69%

[10] https://www.worldobesity.org/about/about-obesity/obesity-classification

Overweight	19%	21%	19%	17%	21%	16%	17%	18%	19%	20%
Obesity	8%	10%	8%	7%	7%	9%	7%	9%	8%	6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

By Gender

Boys	**2010 / 2011**	**2011 / 2012**	**2012 / 2013**	**2013 / 2014**	**2014 / 2015**	**2015 / 2016**	**2016 / 2017**	**2017 / 2018**	**2018 / 2019**	**2019 / 2020**
Underweight	6%	4%	3%	4%	4%	6%	6%	5%	8%	7%
Normal weight	70%	67%	69%	73%	72%	70%	69%	67%	66%	69%
Overweight	17%	19%	20%	16%	18%	16%	17%	17%	17%	20%
Obesity	8%	10%	8%	7%	6%	8%	8%	11%	10%	5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Girls	**2010 / 2011**	**2011 / 2012**	**2012 / 2013**	**2013 / 2014**	**2014 / 2015**	**2015 / 2016**	**2016 / 2017**	**2017 / 2018**	**2018 / 2019**	**2019 / 2020**
Underweight	9%	6%	6%	6%	7%	8%	6%	6%	4%	4%
Normal weight	61%	62%	68%	67%	60%	66%	70%	69%	68%	70%
Overweight	22%	22%	19%	19%	24%	15%	18%	18%	21%	19%
Obesity	8%	10%	7%	8%	9%	10%	6%	7%	7%	7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

By Age Group

2 – 10 years old	**2010 / 2011**	**2011 / 2012**	**2012 / 2013**	**2013 / 2014**	**2014 / 2015**	**2015 / 2016**	**2016 / 2017**	**2017 / 2018**	**2018 / 2019**	**2019 / 2020**
Underweight	7%	4%	5%	6%	5%	8%	5%	5%	7%	5%
Normal weight	65%	61%	71%	68%	69%	67%	73%	70%	67%	70%
Overweight	17%	22%	19%	18%	17%	16%	15%	16%	17%	18%
Obesity	10%	12%	6%	7%	9%	9%	7%	8%	9%	7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

11 – 15 years old	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020
Underweight	7%	6%	4%	3%	7%	6%	7%	7%	5%	6%
Normal weight	66%	71%	64%	74%	62%	71%	63%	62%	67%	68%
Overweight	23%	18%	20%	16%	28%	14%	22%	20%	22%	22%
Obesity	4%	6%	11%	7%	4%	9%	7%	11%	6%	4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**