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Implementation of national body contouring surgery guidelines following massive weight loss: A national cross-sectional survey of commissioning in England☆

Jonathan A. Dunne*, Justin C.R. Wormald, Reshma Ghedia, Mark Soldin

Department of Plastic and Reconstructive Surgery, St George's Hospital, Blackshaw Rd, Tooting, London, SW17 0QT, United Kingdom

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Summary *Introduction:* National guidelines for commissioning of body contouring surgery (BCS) following massive weight loss (MWL) in England were published in 2014. Nearly three-quarters of patients who have MWL seek BCS; however, access is known to vary according to the region. The aim of national guidelines was to standardise access. The purpose of this study was to determine implementation of the national guidelines by clinical commissioning groups (CCGs) in England.

Materials and methods: A cross-sectional, web-based survey was sent to all CCG chairs in England.

Results: Of 211 potential respondents, 108 completed the survey or provided funding guidelines (response rate = 52%). Eight CCGs (7%) had implemented the guidelines. A total of 69 CCGs were aware of the new guidelines (64%), and 66 CCGs stated that they fund BCS after MWL (61%). A total of 81 CCGs (75%) identified local funding guidelines, while 15 CCGs (14%) cited individual funding requests (IFRs) as the means of accessing funding.

To improve patient access to BCS; 58 of 65 respondents (89%) stated cost-effectiveness, whereas 56 of 75 respondents (75%) thought patient-reported outcome measures were key.

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* Corresponding author.
E-mail address: Jonathan.a.dunne@gmail.com (J.A. Dunne).

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Qualitative data to improve access included an integrated pathway from bariatric surgery to BCS, an improved evidence base and greater CCG finances. One CCG stated that it cannot afford to fund cosmetic procedures.
Conclusions: The purpose of national guidelines was to simplify the pathway to BCS after MWL and create fair distribution of funds across the country to needy patients; however, their uptake has been poor. Access to funding for BCS across England varies according to the location.

Introduction

Prevalence of obesity in the United Kingdom has risen 2-fold over the past 20 years, and in 2012, a quarter of the population were obese (body mass index (BMI) $\geq$ 30 kg/m^2).[1] Updated National Institute for Health and Clinical Excellence (NICE) guidelines for obesity published in 2014 advocate earlier assessment for bariatric surgery, including those with BMI of 30—34.9 kg/m^2 who have recent onset type 2 diabetes.[2] This may increase the bariatric surgery case load that has already risen 20-fold from 2000 to 2010.[1]

Massive weight loss (MWL) constitutes a reduction of 50% or greater of a person's excess weight, calculated from an ideal body weight. The resultant reduction in size leads to redundant skin, which may cause functional, psychological and social morbidity. Body contouring surgery (BCS) in this patient group is reconstructive surgery, and not a cosmetic procedure, and >70% of patients with MWL seek reconstructive BCS to improve their quality of life.[3,4]

Functional issues following MWL include impaired mobility due to redundant skin, preventing exercise and the establishment of an active lifestyle. Skin ulceration and infection may develop, requiring long-term wound management with dressings and antibiotic treatment.[5] It is known that a quarter of patients with obesity suffer from psychological disorders,[6] which may be exacerbated by skin redundancy and associated body image issues. Social factors and improved societal integration are further reasons why patients want BCS, and improved quality-of-life parameters have been demonstrated in the short- and medium-term after surgery.[7,8]

BCS was formerly funded by the primary care trusts (PCTs) and is now commissioned by clinical commissioning groups (CCGs). Variation in access of BCS had previously been established,[9] with different local guidelines and funding of procedures. To address the postcode lottery and standardise referral pathways, the Royal College of Surgeons of England and the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) produced NICE—accredited national commissioning guidelines for BCS in March 2014.[10]

The aim of this study was to determine uptake of the guidelines by CCGs in England.

Materials and methods

Chairman of all 211 CCGs were contacted by email in January 2015 to complete an online survey on commissioning of BCS after MWL and/or provide funding guidelines (Appendix 1). Where a response provided the guidance for a collaboration of CCGs, it was representative of all CCGs. Further rounds of invitations were sent to non-responders in March 2015 and June 2015. The structured survey addressed awareness and implementation of the guidelines; methods of funding for procedures and cases performed; restricting factors to access including qualitative data. Data were collated and analysed with Microsoft Excel v12.2.5.

Results

All 211 CCGs in England were surveyed and a total of 108 responses (52%) were received. Of the 108 that responded, 69 CCGs were aware of the new funding guidelines and 39 were not aware (36%) of them (Figure 1). Only 8 CCGs had implemented the new guidelines (7%). A total of 66 CCGs reported provision of funding for BCS following MWL (61%), compared to 42 CCGs that do not provide funding (39%).

Local funding guidelines had been identified by 81 CCGs (75%) as a potential source of funding for BCS, which should be available on their website. Fifteen CCGs cited individual funding requests (IFRs) as the mainstay of funding acquisition. Only 2 CCGs stated how many cases were approved in the past year (7 cases in total), including abdominoplasty, apronectomy and mastopexy. One of these CCGs commissioned 3 of 66 referrals (4.5%).

In terms of outcome measures, cost-effectiveness appeared to be the most important consideration following BCS (58 of 65 respondents, 89%), with patient-