West Yorkshire and Harrogate
Health and Care Partnership

West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 1st October 2019	Agenda item: 50/19		
Report title:	Bariatric Surgery Implementation Update		
Joint Committee sponsor:	Helen Hirst		
Clinical Lead:	All clinical representatives		
Author:	Clare Smart Bradford District and Craven CCGs Lindsay Springall NHS Leeds CCG		
Presenter:	Michelle Turner Director of Quality and Nursing Bradford District and Craven CCGs		
Purpose of report:			
Decision		Comment	✓
Assurance			

Executive summary

This report provides an update on implementation at 'place' on the commissioning of surgery for severe and complex obesity. In March 2019, the Joint Committee received and agreed to adopt the new commissioning policy and a new service specification for bariatric surgery. The Joint Committee does not have delegated authority for decision making for bariatrics and the decision to commission more Tier 4 bariatric surgery needed to be taken by the individual CCGs which make up the Joint Committee. Joint Committee members agreed to recommend, to their respective CCGs, the aspiration to commission at the rate of 4% of the eligible population. Over time, the rate of 4% would bring all CCGs to the rate of the highest delivering CCG.

The *commissioning policy*, whilst new to the West Yorkshire and Harrogate CCGs, does not represent a significant or substantial change to the policy previously used by NHS England. The new *service specification* addressed the anticipated increase in bariatric surgery activity across West Yorkshire and Harrogate and was also brought to the Joint Committee for approval. To support the implementation of the new arrangements for bariatric surgery, the working group explored the best means to manage the contract between CCGs and the provider trusts for the provision of bariatric surgery. It was agreed that each lead commissioner would include the new service specification and commissioning policy in their main provider contracts to commence on 1st April 2019.

The Joint Committee members have previously supported the ambition that had led to the development of the policy and service specification, in that there is a strong clinical case to commission more bariatric surgery over the next 2 to 5 years.

As the commissioning policy does not represent a significant or substantial change to the policy previously used by NHS England, no patient or public engagement was required, or has been conducted. By having a standard, enhanced approach to bariatric surgery, we can remove any avoidable and unfair differences that currently exist across the region and ensure a level playing field in terms of access to this treatment. We recognise that communication with local people about this is important and we have developed briefing material to help CCGs ensure that their local populations, patients, clinical staff and other stakeholders have the information that they need.

The West Yorkshire Association of Acute Trusts have recently held a workshop on bariatric surgery. Following a request to declare intent in terms of 'standing still and maintaining current numbers' or 'growing capacity' to meet the regional demand, two centres wish to maintain and two centres to grow. This indicates that the future capacity needs for bariatric surgery are feasible.

Members identified a number of issues to take into account, including that each 'place' in West Yorkshire and Harrogate ICS would need to ensure that local assessment and treatment services were linked effectively to tier 4 surgical services. A checklist to monitor implementation has been completed by all CCGs. Achievement against the aspirational 4% eligibility target is appended.

Appendices

Appendix 1 WYCCGs_Bariatrics_Checklist

Appendix 2 WYCCGs_Bariatrics_achievement 1920

Recommendations and next steps

The Joint Committee of CCGs is asked:

1. **To note** the position at 'place' across the ICS.

Delivering outcomes:

Commissioning consistently:

- To improve the health of the population by providing preventative health and social care support through the health optimisation approach
- To save money and release money to be used elsewhere for health and social care
- To reduce difference and inconsistency in policies and the way that health and social care is delivered
- To reduce the feeling of a 'post-code lottery' across the region, where people have different experiences of health and social care depending on where they live

Impact assessment	
Clinical outcomes:	QEIA previously submitted and considered
Public involvement:	No new consultation
Finance:	Individual CCG position
Risk:	QEIA previously submitted and considered
Conflicts of interest:	None declared

Obesity Surgery Commissioning Policy for Adults

Position update on implementation – September 2019

In order to monitor implementation of the Obesity Surgery Commissioning Policy for Adults agreed for West Yorkshire and Harrogate at the Joint Committee in February 2019, a checklist has been developed and completed by each clinical commissioning group within the ICS. The completed checklists are attached as Appendix 1.

The key messages/themes are:

a. The new commissioning policy has been communicated across all tiers of service provision across the weight pathway across all CCGs.

b. Progress is being made in ensuring that those CCGs without a non-surgical Tier 3 MDT are progressing local arrangements with Tier 4 providers and/or alternative provision (Harrogate, Calderdale, Greater Huddersfield, North Kirklees and Wakefield).

c. Referral routes are in place into Tier 4 services, for patients with BMI > 50 or for patients with a BMI of 35+ where they have acquired type 2 diabetes within the previous 10 years requiring an expedited pathway to tier 4.

d. The new service specification for Tier 4, Bariatric Surgery has been included via contractual routes / is covered via contracts with providers, with all providers, providing post follow-up surgical care for 2 years.

e. CCG routine and non-routine commissioning procedures comply with the WY&H policy; with the exception of NHS Harrogate CCG and NHS Wakefield CCG

f. Tier 4 capacity expansion requirements are currently being considered by individual CCGs. Tier 4 activity, year to date is included within Appendix 2 for information.

The Joint Committee is asked

1. To note the position at ‘place’.

Appendix 1: Completed Checklists

NHS Bradford District and Craven CCGs

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
Implementation of the eligibility criteria: • The person will have longstanding obesity with a BMI of 40kg/m2 or more, or between 35 kg/m2 and 40kg/m2 (BMI over threshold for more than 2 years) in the presence of other significant diseases that could be improved with weight loss.	Are all providers providing weight management services, at Tiers 1-4 aware of the policy change within the CCG area?	**YES**		
• Surgery can also be considered for people of Asian family origin who have recent-onset type 2 diabetes at a lower BMI than other populations who have been reviewed by a Tier 3 service (or equivalent) and been referred for consideration.	Does the CCG have commissioned access to a Tier 3 specialised weight loss programme? If no tier 3 service then the Surgical Service is expected to assess patients using an MDT providing the equivalent of a Tier 3 assessment before then reviewing the patient at a Tier 4 MDT. This will need to include a Psychologist / Psychiatrist with an interest in obesity. **If a non-surgical Tier 3 MDT is not commissioned locally, it is expected that Tier 4 providers and the commissioner agree local contracting arrangements for this provision (service development) and/or access to other Tier 3 services.**	**YES**		
	Are Tier 3 services commissioned on a GP registered population or resident population	**YES**	**Commissioned on a GP**	

	basis in line with LA arrangements?		**registered population basis**	
• The individual has recently engaged with a local specialised weight loss programme for a period specified locally. Engagement can be judged by attendance records and achievement of pre-set individualised targets (for example steady and sustained weight loss of 5-10%, or maintaining constant weight whilst stopping smoking). This period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months but may need to be longer to ensure people are properly optimised and prepared for surgery. • For patients with BMI > 50 or for patients with a BMI of 35+ where they have acquired type 2 diabetes within the previous 10 years an expedited pathway to tier 4 may be offered with consideration of the risk: benefit evaluation below. • Before referral to Tier 4 services, ideally the patient will have been assessed by a specialist obesity MDT and have had a psychological assessment and a full understanding of the risks and benefits of obesity surgery and the required lifelong lifestyle changes required after surgery. • The patient understands and commits to the need for long term follow-up. • The patient has been unable to lose clinically significant weight (i.e. enough to modify co-morbidities) during the period of previous interventions with a range of alternative	Does the CCG have written into contract of Tier 3 specialised weight loss programme the period of time for which patients should attend the Tier 3 service locally (6 month minimum period)? Is the Tier 3 provider able to track attendance/individualised targets? Is there a referral route into Tier 4 surgical services in place for patients requiring the expedited pathway? (these referrals do not need to be seen by a Tier 3 service) Has an increase in capacity been considered by the commissioner for Tier 4 surgery assessment and treatment? Does the CCG's commissioned Tier 3 specialised weight loss programme provide assessment by a specialist obesity MDT and have the expertise to provide a psychological assessment?	**YES** **YES** **YES** **Paper based** **YES** **YES**		

non-surgical measures. • The person is generally fit for anaesthesia and surgery as assessed by surgeon and anaesthetist.				
Surgical Assessment The final decision on whether an operation is indicated should be made by the surgical (Tier 4) MDT based on an individual risk benefit. This will be informed by their own clinical assessment and information provided by primary care and by an appropriate specialist non-surgical (Tier 3) MDT. The expectation is that there will be a close liaison and overlap between the members of the non-surgical (Tier 3) and surgical (Tier 4) MDTs.	Have local Tier 4 Bariatric Surgery providers signed up to the deliver the new service specification and understand all requirements of them?	**YES**		
Surgical Follow-Up All patients should be followed up for a minimum of 2 years by specialist teams in line with NICE guidance, using an appropriate mixture of surgical and medical clinics to monitor the outcomes. This should be in line with the intervals currently recommended by the British Obesity and Metabolic Surgery Society.	Has the CCG a pathway in place for patients who require medical input post two years following surgery?	**YES With surgical provider**		
Routinely commissioned procedures The following procedures are routinely commissioned: • gastric bands only if other means are not suitable and following MDT discussion of the post-operative risks • sleeve gastrectomy • Roux en Y gastric bypass. • Gastric balloon for patients with a BMI >60 or at high operative risk to stabilise weight	Do routinely commissioned procedures as documented within the West Yorkshire and Harrogate policy align with local CCG Individual Funding Request policy?	**YES**		

before a more intensive surgical procedure				
Not routinely commissioned (Individual Funding Requests only): **1) Requests for excess skin removal following surgery** This policy does not include routine approval for follow-up surgery for excess skin removal. These requests are still subject to Individual Funding Requests to local CCGs. **2) Revisions of bariatric procedures** All Elective surgical revisions of bariatric procedures will be subject to Prior approval by the relevant local CCG. Patients presenting with acute complications of their initial surgery requiring immediate emergency surgery will be treated on the basis of their clinical need and funded accordingly. The numbers of such procedures will be carefully monitored. Band revisions which are solely for weight gain will not be routinely commissioned. Where there is a clinical need (defined as assessment by bariatric surgeon as implant failure) with or without weight gain, an Individual Funding Request should be made unless the clinical need is urgent (requires operation within the next 7 days). Where the procedure was originally conducted in the private sector then the band should only be reinserted or adjusted by an NHS surgeon where there is a clinical need – this will require prior approval except for urgent cases (requiring operation within the next 7 days). **3) single-anastomosis duoeno-ileal bypass with**	Do not routinely commissioned procedures as documented within the West Yorkshire and Harrogate policy align with local CCG Individual Funding Request policy?	**YES**		

sleeve gastrectomy (in line with NICE IPG569.) https://www.nice.org.uk/guidance/ipg569/chapter/1-Recommendations (accessed 1/11/17) **4) Duodenal–jejunal bypass sleeve (DJBS)** (in line with NICE IPG 471) https://www.nice.org.uk/guidance/ipg471/chapter/1-Recommendations (accessed 1/11/17) **5) laparoscopic gastric plication** (in line with NICE IPG432) https://www.nice.org.uk/guidance/ipg432/chapter/1-Guidance accessed 1/11/17 **6) Mini gastric bypass** (still considered experimental within Yorkshire and Humber but for review in 2020**)** http://www.bomss.org.uk/wp-content/uploads/2014/09/BOMSS-MGB-position-statement-September-20141.pdf (accessed 1/11/17) **7) duodenal switch** – (considered experimental but may be a promising new treatment) In addition, any other bariatric surgery procedures not listed here will not be routinely commissioned. Where a clinician wishes to make a request for another device/procedure, an application for exceptional funding through the CCG Individual Funding Request (IFR) process should be made in the first instance. Where there are cohorts (usually more than 10 patients) who would benefit from another procedure, the next step would usually be a request for a business case to support the development of a commissioning policy for such procedures or devices.				

NHS Calderdale

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
Implementation of the eligibility criteria: • The person will have longstanding obesity with a BMI of 40kg/m2 or more, or between 35 kg/m2 and 40kg/m2 (BMI over threshold for more than 2 years) in the presence of other significant diseases that could be improved with weight loss. • Surgery can also be considered for people of Asian family origin who have recent-onset type 2 diabetes at a lower BMI than other populations who have been reviewed by a Tier 3 service (or equivalent) and been referred for consideration.	Are all providers providing weight management services, at Tiers 1-4 aware of the policy change within the CCG area? Does the CCG have commissioned access to a Tier 3 specialised weight loss programme? If no tier 3 service then the Surgical Service is expected to assess patients using an MDT providing the equivalent of a Tier 3 assessment before then reviewing the patient at a Tier 4 MDT. This will need to include a Psychologist / Psychiatrist with an interest in obesity. **If a non-surgical Tier 3 MDT is not commissioned locally, it is expected that Tier 4 providers and the commissioner agree local contracting arrangements for this provision (service development) and/or access to other Tier 3 services.**	**YES** **NO**	**The previous tier 4 service spec shared with CHFT was based on the national spec; so very few changes to adopt the new WY&H spec.** **CHFT have agreed to provide a non-surgical MDT weight management pathway within the T4 provision.**	**April 2019**

• The individual has recently engaged with a local specialised weight loss programme for a period specified locally. Engagement can be judged by attendance records and achievement of pre-set individualised targets (for example steady and sustained weight loss of 5-10%, or maintaining constant weight whilst stopping smoking). This period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months but may need to be longer to ensure people are properly optimised and prepared for surgery.	Does the CCG have written into contract of Tier 3 specialised weight loss programme the period of time for which patients should attend the Tier 3 service locally (6 month minimum period)? Is the Tier 3 provider able to track attendance/individualised targets?	**N/A** **N/A**	**Calderdale does not commission a separate tier 3 service; see above.**	
• For patients with BMI > 50 or for patients with a BMI of 35+ where they have acquired type 2 diabetes within the previous 10 years an expedited pathway to tier 4 may be offered with consideration of the risk: benefit evaluation below.	Is a referral route into Tier 4 surgical services in place for patients requiring the expedited pathway? (these referrals do not need to be seen by a Tier 3 service)	**Y**	**In place already**	**April 2019**
• Before referral to Tier 4 services, ideally the patient will have been assessed by a specialist obesity MDT and have had a psychological assessment and a full understanding of the risks and benefits of obesity surgery and the required lifelong lifestyle changes required after surgery. • The patient understands and commits to the need for long term follow-up. • The patient has been unable to lose clinically significant weight (i.e. enough to modify co-	Has an increase in capacity been considered by the commissioner for Tier 4 surgery assessment and treatment? Does the CCG's commissioned Tier 3 specialised weight loss programme provide assessment by a specialist obesity MDT and have the expertise to provide a psychological assessment?	**Y** **N/A**	**Contracting aware**	**April 2019**

morbidities) during the period of previous interventions with a range of alternative non-surgical measures. • The person is generally fit for anaesthesia and surgery as assessed by surgeon and anaesthetist.				
Surgical Assessment The final decision on whether an operation is indicated should be made by the surgical (Tier 4) MDT based on an individual risk benefit. This will be informed by their own clinical assessment and information provided by primary care and by an appropriate specialist non-surgical (Tier 3) MDT. The expectation is that there will be a close liaison and overlap between the members of the non-surgical (Tier 3) and surgical (Tier 4) MDTs.	Have local Tier 4 Bariatric Surgery providers signed up to the deliver the new service specification and understand all requirements of them?	**Y**	**CHFT already working to the national service spec**	**April 2019**
Surgical Follow-Up All patients should be followed up for a minimum of 2 years by specialist teams in line with NICE guidance, using an appropriate mixture of surgical and medical clinics to monitor the outcomes. This should be in line with the intervals currently recommended by the British Obesity and Metabolic Surgery Society.	Has the CCG a pathway in place for patients who require medical input post two years following surgery?	**Y**	**Post-operative care is a key component of CHFT Bariatric service**	
Routinely commissioned procedures The following procedures are routinely commissioned: • gastric bands only if other means are not	Do routinely commissioned procedures as documented within the West Yorkshire and Harrogate policy align with local CCG Individual Funding Request policy?	**Y**		

suitable and following MDT discussion of the post-operative risks • sleeve gastrectomy • Roux en Y gastric bypass. • Gastric balloon for patients with a BMI >60 or at high operative risk to stabilise weight before a more intensive surgical procedure				
Not routinely commissioned (Individual Funding Requests only): **1) Requests for excess skin removal following surgery** This policy does not include routine approval for follow-up surgery for excess skin removal. These requests are still subject to Individual Funding Requests to local CCGs. **2) Revisions of bariatric procedures** All Elective surgical revisions of bariatric procedures will be subject to Prior approval by the relevant local CCG. Patients presenting with acute complications of their initial surgery requiring immediate emergency surgery will be treated on the basis of their clinical need and funded accordingly. The numbers of such procedures will be carefully monitored. Band revisions which are solely for weight gain will	Do not routinely commissioned procedures as documented within the West Yorkshire and Harrogate policy align with local CCG Individual Funding Request policy?	Y Y		

not be routinely commissioned. Where there is a clinical need (defined as assessment by bariatric surgeon as implant failure) with or without weight gain, an Individual Funding Request should be made unless the clinical need is urgent (requires operation within the next 7 days). Where the procedure was originally conducted in the private sector then the band should only be reinserted or adjusted by an NHS surgeon where there is a clinical need – this will require prior approval except for urgent cases (requiring operation within the next 7 days). 3) **single-anastomosis duoeno-ileal bypass with sleeve gastrectomy** (in line with NICE IPG569.) https://www.nice.org.uk/guidance/ipg569/chapter/1-Recommendations (accessed 1/11/17) 4) **Duodenal–jejunal bypass sleeve (DJBS)** (in line with NICE IPG 471) https://www.nice.org.uk/guidance/ipg471/chapter/1-Recommendations (accessed 1/11/17) 5) **laparoscopic gastric plication** (in line with NICE IPG432) https://www.nice.org.uk/guidance/ipg432/chapter/1-Guidance accessed 1/11/17 6) **Mini gastric bypass** (still considered experimental within Yorkshire and Humber but for review in 2020**)** http://www.bomss.org.uk/wp-		**Y** **Y** **Y** **Y**		

content/uploads/2014/09/BOMSS-MGB-position-statement-September-20141.pdf (accessed 1/11/17) **7) duodenal switch** – (considered experimental but may be a promising new treatment) In addition, any other bariatric surgery procedures not listed here will not be routinely commissioned. Where a clinician wishes to make a request for another device/procedure, an application for exceptional funding through the CCG Individual Funding Request (IFR) process should be made in the first instance. Where there are cohorts (usually more than 10 patients) who would benefit from another procedure, the next step would usually be a request for a business case to support the development of a commissioning policy for such procedures or devices.		**N**		

NHS Greater Huddersfield CCG and NHS North Kirklees CCG

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
Implementation of the eligibility criteria: • The person will have longstanding obesity with a BMI of 40kg/m2 or more, or between 35 kg/m2 and 40kg/m2 (BMI over threshold for more than 2 years) in the presence of other significant diseases that could be improved with weight loss.	Are all providers providing weight management services, at Tiers 1-4 aware of the policy change within the CCG area?	**Y**		**April 2019**
• Surgery can also be considered for people of Asian family origin who have recent-onset type 2 diabetes at a lower BMI than other populations who have been reviewed by a Tier 3 service (or equivalent) and been referred for consideration.	Does the CCG have commissioned access to a Tier 3 specialised weight loss programme? If no tier 3 service then the Surgical Service is expected to assess patients using an MDT providing the equivalent of a Tier 3 assessment before then reviewing the patient at a Tier 4 MDT. This will need to include a Psychologist / Psychiatrist with an interest in obesity. **If a non-surgical Tier 3 MDT is not commissioned locally, it is expected that Tier 4 providers and the commissioner agree local contracting arrangements for this provision (service development) and/or access to other Tier 3 services.**	**N**	**CHFT have agreed to provide a Kirklees Weight management pathway that would provide elements of T3 within the T4 MDT assessment. Pathway can be rolled out once confirmation is received from MYHT as to whether they are also prepared to provide this service. The confirmation from MYHT is being sought by Wakefield CCG colleagues**	**TBC**

• The individual has recently engaged with a local specialised weight loss programme for a period specified locally. Engagement can be judged by attendance records and achievement of pre-set individualised targets (for example steady and sustained weight loss of 5-10%, or maintaining constant weight whilst stopping smoking). This period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months but may need to be longer to ensure people are properly optimised and prepared for surgery.	Does the CCG have written into contract of Tier 3 specialised weight loss programme the period of time for which patients should attend the Tier 3 service locally (6 month minimum period)? Is the Tier 3 provider able to track attendance/individualised targets?	**N** **TBC**	**Adult Wellness will provide weight management support to Kirklees residents. Confirmation needs to be sought from Council that this service (due for implementation September 2019) will support the pathway to T4 Bariatric surgery.** **Confirmation will be required from Adult Wellness colleagues around monitoring of attendance/targets/period of time**	**Sept 2019** **Sept 2019**
• For patients with BMI > 50 or for patients with a BMI of 35+ where they have acquired type 2 diabetes within the previous 10 years an expedited pathway to tier 4 may be offered with consideration of the risk: benefit evaluation below.	Is a referral route into Tier 4 surgical services in place for patients requiring the expedited pathway? (these referrals do not need to be seen by a Tier 3 service)	**Y**	**The current referral route for Kirklees patients to T4 surgical services is via IFR. Referral between Adult Wellness and T4 Bariatric surgery is still to be confirmed**	**June 2019**
• Before referral to Tier 4 services, ideally the patient will have been assessed by a specialist obesity MDT and have had a psychological assessment and a full understanding of the risks and benefits of obesity surgery and the required lifelong	Has an increase in capacity been considered by the commissioner for Tier 4 surgery assessment and treatment?	**Y**	**SMT paper 11th April 2019 set out the implication of 4% eligible patients**	**April 2019**

lifestyle changes required after surgery. • The patient understands and commits to the need for long term follow-up. • The patient has been unable to lose clinically significant weight (i.e. enough to modify co-morbidities) during the period of previous interventions with a range of alternative non-surgical measures. • The person is generally fit for anaesthesia and surgery as assessed by surgeon and anaesthetist.	Does the CCG's commissioned Tier 3 specialised weight loss programme provide assessment by a specialist obesity MDT and have the expertise to provide a psychological assessment?	**N**	**The current IFR referral route provides eligible patients with a T4 MDT assessment. The proposed Kirklees weight management pathway provides these elements of T3 within our T4 service.**	**June 2019**
Surgical Assessment The final decision on whether an operation is indicated should be made by the surgical (Tier 4) MDT based on an individual risk benefit. This will be informed by their own clinical assessment and information provided by primary care and by an appropriate specialist non-surgical (Tier 3) MDT. The expectation is that there will be a close liaison and overlap between the members of the non-surgical (Tier 3) and surgical (Tier 4) MDTs.	Have local Tier 4 Bariatric Surgery providers signed up to the deliver the new service specification and understand all requirements of them?	**Y and TBC**	**CHFT have indicated they intend to become a bariatric centre. MYHT have also indicated they want to undertake additional activity, but are in discussions with Wakefield CCG around the new service specification**	**June 2019**
Surgical Follow-Up All patients should be followed up for a minimum of 2 years by specialist teams in line with NICE guidance, using an appropriate mixture of surgical and medical clinics to monitor the outcomes. This should be in line	Has the CCG a pathway in place for patients who require medical input post two years following surgery?	**Y**	**Post-operative care is a key component of CHFT Bariatric service**	**June 2019**

with the intervals currently recommended by the British Obesity and Metabolic Surgery Society.				
Routinely commissioned procedures The following procedures are routinely commissioned: • gastric bands only if other means are not suitable and following MDT discussion of the post-operative risks • sleeve gastrectomy • Roux en Y gastric bypass. • Gastric balloon for patients with a BMI >60 or at high operative risk to stabilise weight before a more intensive surgical procedure	Do routinely commissioned procedures as documented within the West Yorkshire and Harrogate policy align with local CCG Individual Funding Request policy?	**Y**		**June 2019**
Not routinely commissioned (Individual Funding Requests only): .	Do not routinely commissioned procedures as documented within the West Yorkshire and Harrogate policy align with local CCG Individual Funding Request policy?	**Y to all**		**June 2019**

NHS Harrogate CCG

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
Implementation of the eligibility criteria: • The person will have longstanding obesity with a BMI of 40kg/m2 or more, or between 35 kg/m2 and 40kg/m2 (BMI over threshold for more than 2 years) in the presence of other significant diseases that could be improved with weight loss. • Surgery can also be considered for people of Asian family origin who have recent-onset type 2 diabetes at a lower BMI than other populations who have been reviewed by a Tier 3 service (or equivalent) and been referred for consideration.	Are all providers providing weight management services, at Tiers 1-4 aware of the policy change within the CCG area? Does the CCG have commissioned access to a Tier 3 specialised weight loss programme? If no tier 3 service then the Surgical Service is expected to assess patients using an MDT providing the equivalent of a Tier 3 assessment before then reviewing the patient at a Tier 4 MDT. This will need to include a Psychologist / Psychiatrist with an interest in obesity. **If a non-surgical Tier 3 MDT is not commissioned locally, it is expected that Tier 4 providers and the commissioner agree local contracting arrangements for this provision (service development) and/or access to other Tier 3 services.** Are Tier 3 services commissioned on a GP registered population or resident population	**Y** **N** **Y** **N**	**Policy forwarded to tier 2 service. Awaiting tier 2 response from fit4life to confirm they are aware.** **We are in discussions with York and South Tees hospital about the provision of tier 3 services; we are planning to align this with Scarborough and Ryedale CCG as part of the merging we are currently undergoing.** **As above, we are currently in discussions**	

• The individual has recently engaged with a local specialised weight loss programme for a period specified locally. Engagement can be judged by attendance records and achievement of pre-set individualised targets (for example steady and sustained weight loss of 5-10%, or maintaining constant weight whilst stopping smoking). This period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months but may need to be longer to ensure people are properly optimised and prepared for surgery. • For patients with BMI > 50 or for patients with a BMI of 35+ where they have acquired type 2 diabetes within the previous 10 years an expedited pathway to tier 4 may be offered with consideration of the risk: benefit evaluation below. • Before referral to Tier 4 services, ideally the patient will have been assessed by a specialist obesity MDT and have had a psychological assessment and a full understanding of the risks and benefits of obesity surgery and the required lifelong lifestyle changes required after surgery. • The patient understands and commits to the need for long term follow-up.	basis in line with LA arrangements? Does the CCG have written into contract of Tier 3 specialised weight loss programme the period of time for which patients should attend the Tier 3 service locally (6 month minimum period)? Is the Tier 3 provider able to track attendance/individualised targets? Is a referral route into Tier 4 surgical services in place for patients requiring the expedited pathway? (these referrals do not need to be seen by a Tier 3 service) Has an increase in capacity been considered by the commissioner for Tier 4 surgery assessment and treatment? Does the CCG's commissioned Tier 3 specialised weight loss programme provide assessment by a specialist obesity MDT and have the expertise to provide a psychological assessment?	**N** **N** **Y** **Y** **N**	**We are currently in the process of identifying a tier 3 service provider, we will ensure this is written into the contract at the time of writing** **We will ensure that the tier 3 provider is able to track attendance/individualised targets.** **At present, all our referrals to tier 4 go through IFR** **Report is currently being written to ensure awareness of 4% eligibility and potential consequences of this** **We currently do not commission tier 3 and we are in discussions with York and South Tees hospitals around providing this.**	

• The patient has been unable to lose clinically significant weight (i.e. enough to modify co-morbidities) during the period of previous interventions with a range of alternative non-surgical measures. • The person is generally fit for anaesthesia and surgery as assessed by surgeon and anaesthetist.				
Surgical Assessment The final decision on whether an operation is indicated should be made by the surgical (Tier 4) MDT based on an individual risk benefit. This will be informed by their own clinical assessment and information provided by primary care and by an appropriate specialist non-surgical (Tier 3) MDT. The expectation is that there will be a close liaison and overlap between the members of the non-surgical (Tier 3) and surgical (Tier 4) MDTs.	Have local Tier 4 Bariatric Surgery providers signed up to the deliver the new service specification and understand all requirements of them?	**Y**	**Our local bariatric tier 4 surgery providers is LTHT**	
Surgical Follow-Up All patients should be followed up for a minimum of 2 years by specialist teams in line with NICE guidance, using an appropriate mixture of surgical and medical clinics to monitor the outcomes. This should be in line with the intervals currently recommended by the British Obesity and Metabolic Surgery Society.	Has the CCG a pathway in place for patients who require medical input post two years following surgery?	**Y**		

Routinely commissioned procedures The following procedures are routinely commissioned: • gastric bands only if other means are not suitable and following MDT discussion of the post-operative risks • sleeve gastrectomy • Roux en Y gastric bypass. • Gastric balloon for patients with a BMI >60 or at high operative risk to stabilise weight before a more intensive surgical procedure	Do routinely commissioned procedures as documented within the West Yorkshire and Harrogate policy align with local CCG Individual Funding Request policy?	**N**	**Not yet routinely commissioned.** **Any bariatric surgery request is referred through IFR. The criteria for exceptionality are:** • **patients with BMI 50+ or BMI 45-49.9 with more than 2 significant co-morbidities[1] (one of which should be diabetes)** **AND** • **completed 12 weeks Tier 2 weight management services (or can demonstrate equivalence)**	
Not routinely commissioned (Individual Funding Requests only)	Do not routinely commissioned procedures as documented within the West Yorkshire and Harrogate policy align with local CCG Individual Funding Request policy?	**Y to all**		

[1] Significant comorbidities should include, but are not limited to: Diabetes; poorly controlled hypertension (>2 medications); osteoarthritis of a weight bearing joint causing severe pain which is not controlled by conservative measures; sleep apnoea requiring treatment with CPAP

NHS Leeds CCG

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
Implementation of the eligibility criteria: • The person will have longstanding obesity with a BMI of 40kg/m2 or more, or between 35 kg/m2 and 40kg/m2 (BMI over threshold for more than 2 years) in the presence of other significant diseases that could be improved with weight loss. • Surgery can also be considered for people of Asian family origin who have recent-onset type 2 diabetes at a lower BMI than other populations who have been reviewed by a Tier 3 service (or equivalent) and been referred for consideration.	Are all providers providing weight management services, at Tiers 1-4 aware of the policy change within the CCG area? Does the CCG have commissioned access to a Tier 3 specialised weight loss programme? If no tier 3 service then the Surgical Service is expected to assess patients using an MDT providing the equivalent of a Tier 3 assessment before then reviewing the patient at a Tier 4 MDT. This will need to include a Psychologist / Psychiatrist with an interest in obesity. **If a non-surgical Tier 3 MDT is not commissioned locally, it is expected that Tier 4 providers and the commissioner agree local contracting arrangements for this provision (service development) and/or access to other Tier 3 services.** Are Tier 3 services commissioned on a GP registered population or resident population	**Y** **Y**	**Discussed with providers at weight management workshop in May 2019 – agreed pathway/formal launch in late 2019** **Tier 3 commissioned on a GP registered population basis**	**April 2019**

• The individual has recently engaged with a local specialised weight loss programme for a period specified locally. Engagement can be judged by attendance records and achievement of pre-set individualised targets (for example steady and sustained weight loss of 5-10%, or maintaining constant weight whilst stopping smoking). This period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months but may need to be longer to ensure people are properly optimised and prepared for surgery. • For patients with BMI > 50 or for patients with a BMI of 35+ where they have acquired type 2 diabetes within the previous 10 years an expedited pathway to tier 4 may be offered with consideration of the risk: benefit evaluation below. • Before referral to Tier 4 services, ideally the patient will have been assessed by a specialist obesity MDT and have had a psychological assessment and a full understanding of the risks and benefits of obesity surgery and the required lifelong lifestyle changes required after surgery. • The patient understands and commits to the need for long term follow-up.	basis in line with LA arrangements? Does the CCG have written into contract of Tier 3 specialised weight loss programme the period of time for which patients should attend the Tier 3 service locally (6 month minimum period)? Is the Tier 3 provider able to track attendance/individualised targets? Is a referral route into Tier 4 surgical services in place for patients requiring the expedited pathway? (these referrals do not need to be seen by a Tier 3 service) Has an increase in capacity been considered by the commissioner for Tier 4 surgery assessment and treatment? Does the CCG's commissioned Tier 3 specialised weight loss programme provide assessment by a specialist obesity MDT and have the expertise to provide a psychological assessment?	**Y** **Y** **Y** **Y** **Y**		**April 2019** **April 2019** **April 2019** **April 2019**

• The patient has been unable to lose clinically significant weight (i.e. enough to modify co-morbidities) during the period of previous interventions with a range of alternative non-surgical measures. • The person is generally fit for anaesthesia and surgery as assessed by surgeon and anaesthetist.				
Surgical Assessment The final decision on whether an operation is indicated should be made by the surgical (Tier 4) MDT based on an individual risk benefit. This will be informed by their own clinical assessment and information provided by primary care and by an appropriate specialist non-surgical (Tier 3) MDT. The expectation is that there will be a close liaison and overlap between the members of the non-surgical (Tier 3) and surgical (Tier 4) MDTs.	Have local Tier 4 Bariatric Surgery providers signed up to the deliver the new service specification and understand all requirements of them?	**Y**	**LTHT have seen the specification and understand requirements. Included within 19/20 contract documentation. Meeting scheduled for October 2019 with LTHT Bariatric Team to review activity/waiting times.**	**April 2019**
Surgical Follow-Up All patients should be followed up for a minimum of 2 years by specialist teams in line with NICE guidance, using an appropriate mixture of surgical and medical clinics to monitor the outcomes. This should be in line with the intervals currently recommended by the British Obesity and Metabolic Surgery Society.	Has the CCG a pathway in place for patients who require medical input post two years following surgery?	**Y**		
Routinely commissioned procedures				

The following procedures are routinely commissioned: • gastric bands only if other means are not suitable and following MDT discussion of the post-operative risks • sleeve gastrectomy • Roux en Y gastric bypass. • Gastric balloon for patients with a BMI >60 or at high operative risk to stabilise weight before a more intensive surgical procedure	Do routinely commissioned procedures as documented within the West Yorkshire and Harrogate policy align with local CCG Individual Funding Request policy?	**Y**		**April 2019**
Not routinely commissioned (Individual Funding Requests only):	Do not routinely commissioned procedures as documented within the West Yorkshire and Harrogate policy align with local CCG Individual Funding Request policy?	**Y to all procedures included**		**April 2019**

NHS Wakefield CCG

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
Implementation of the eligibility criteria: • The person will have longstanding obesity with a BMI of 40kg/m2 or more, or between 35 kg/m2 and 40kg/m2 (BMI over threshold for more than 2 years) in the presence of other significant diseases that could be improved with weight loss.	Are all providers providing weight management services, at Tiers 1-4 aware of the policy change within the CCG area?	**Y**		**NHS Wakefield CCG, Wakefield LA & MYHT colleagues were engaged & involved in the review & development of the draft WY&H policy & specification & aware of the content of the Joint Committee Paper & recommendations to approve policy & specification from 1/4/19.** **Patients referred to Tier 3 services require bloods for assessment by consultant. This will potentially have a cost implication for GPs as higher numbers of patients will be referred. Wakefield Aspire Health Referral form is remaining the same for now, bloods for patients with BMI 35-40 will be requested on a needs basis. To be reviewed after 6 months** **Weight management services are commissioned via Wakefield Local Authority.** **Commissioned services attend Multidisciplinary Team (MDT) meetings on a monthly basis;**

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
• Surgery can also be considered for people of Asian family origin who have recent-onset type 2 diabetes at a lower BMI than other populations who have been reviewed by a Tier 3 service (or equivalent) and been referred for consideration.	Does the CCG have commissioned access to a Tier 3 specialised weight loss programme? If no tier 3 service then the Surgical Service is expected to assess patients using an MDT providing the equivalent of a Tier 3 assessment before then reviewing the patient at a Tier 4 MDT. This will need to include a Psychologist / Psychiatrist with an interest in obesity. **If a non-surgical Tier 3 MDT is not commissioned locally, it is expected that Tier 4 providers and the commissioner agree local contracting arrangements for this provision (service development) and/or access to other Tier 3 services.** Are Tier 3 services commissioned on a GP registered population or resident population basis in line with LA arrangements?	**Y**		**this includes the clinical specialist for MDT, dietician and psychologist and LA Case Manager/Leader.** **The clinical specialist is responsible for referral to Tier 4 services.** **Wakefield Council commissions on a resident population basis.** **A public health needs gap analysis was completed in July 2018 & has informed discussion between Wakefield LA & Wakefield CCG commissioners.** **As a result Wakefield LA weight management commissioners service are actively liaising with providers of the relevant cross boundary weight management services so that referrals for Wakefield GP registered patients who are not Wakefield resident receive access to weight management services in a timely way.**
• The individual has recently engaged with a local specialised weight loss programme for	Does the CCG have written into contract of Tier 3 specialised weight loss programme the	**N**	**Due to contracts being separated into three lots**	

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
a period specified locally. Engagement can be judged by attendance records and achievement of pre-set individualised targets (for example steady and sustained weight loss of 5-10%, or maintaining constant weight whilst stopping smoking). This period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months but may need to be longer to ensure people are properly optimised and prepared for surgery.	period of time for which patients should attend the Tier 3 service locally (6 month minimum period)?		**(clinical specialist, dietician and psychologist) it is not written into the individual contracts that the patients attend for a minimum 6 months.** **The pathway takes a minimum of 6 months, except in exceptional circumstances as part of expedited pathway.** **<u>The Pathway</u>** **Patients attend an initial clinical specialist appointment, followed by up to the equivalent of dietetics and possible psychologist appointments.** **3 months post programme completion, patient attends a follow up appointment with Wakefield Council Case Management Team** **Eligible patients attend a final appointment with the clinical specialist for onward referral to Tier 4**	
• For patients with BMI > 50 or for patients with a BMI of 35+ where they have acquired type 2 diabetes within the previous 10 years an expedited pathway to tier 4 may be offered with consideration of the risk: benefit evaluation below.	Is the Tier 3 provider able to track attendance/individualised targets?	**Y**		**Wakefield Council tracks attendance and individualised targets. MDT formally assesses and reviews patients that are of concern.**
• Before referral to Tier 4 services, ideally the patient will have been assessed by a	Is a referral route into Tier 4 surgical services	**Y**		**Wakefield Council reviews all incoming referrals from GPs**

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
specialist obesity MDT and have had a psychological assessment and a full understanding of the risks and benefits of obesity surgery and the required lifelong lifestyle changes required after surgery. • The patient understands and commits to the need for long term follow-up. • The patient has been unable to lose clinically significant weight (i.e. enough to modify co-morbidities) during the period of previous interventions with a range of alternative non-surgical measures. • The person is generally fit for anaesthesia and surgery as assessed by surgeon and anaesthetist.	in place for patients requiring the expedited pathway? (these referrals do not need to be seen by a Tier 3 service) Has an increase in capacity been considered by the commissioner for Tier 4 surgery assessment and treatment?	**Y**		**and health professionals.** **From 1 April 2019** **In the case of an expedited pathway, Wakefield Council and or providers will refer patients to MDT. MDT will review all evidence including clinical need, patient history, adherence, commitment and readiness for change.** **Please note that patients are discussed individually and not all will go straight to Tier 4 if for example it is felt that the patient is not suitable and/or does not meet the criteria.** **Clinical lead will have the final decision with regards to agreed pathway for individual patients.** **MDT Terms of reference are reviewed on an annual basis but given the changes to the bariatric policy, review will take following issue of final policy, potentially MDT June 2019.** **Exact volumes of business within Tier 3 are difficult to predict and the Council will need to review on a quarterly basis and feedback any**

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
	Does the CCG's commissioned Tier 3 specialised weight loss programme provide assessment by a specialist obesity MDT and have the expertise to provide a psychological assessment?	**Y**		**concerns to the CCG.** **Yes, MDT is part of the Tier 3 pathway, a psychologist is a commissioned lot. Patients can be referred/recommended by MDT for psychological support; however, not all patients are identified as needing support.**
Surgical Assessment The final decision on whether an operation is indicated should be made by the surgical (Tier 4) MDT based on an individual risk benefit. This will be	Have local Tier 4 Bariatric Surgery providers signed up to the deliver the new service specification and understand all requirements	**Y and TBC**	**CHFT have indicated they intention to become a bariatric centre. MYHT**	

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
informed by their own clinical assessment and information provided by primary care and by an appropriate specialist non-surgical (Tier 3) MDT. The expectation is that there will be a close liaison and overlap between the members of the non-surgical (Tier 3) and surgical (Tier 4) MDTs.	of them?		**have also indicated they want to undertake additional activity, but are in discussions with Wakefield CCG around the new service specification** **MYHT and CHFT have agreed to work collaboratively across the footprint of both organisations to provide additional capacity. Discussions are concluding regarding the implementation of a formal MDT meeting between both organisations. This will provide a formal audit trail of clinical decision making in regards to surgical suitability and outcomes evaluation**	
Surgical Follow-Up All patients should be followed up for a minimum of 2 years by specialist teams in line with NICE guidance, using an appropriate mixture of surgical and medical clinics to monitor the outcomes. This should be in line	Has the CCG a pathway in place for patients who require medical input post two years following surgery?	**Y**		**Post-operative care is a key component of CHFT Bariatric service** **It is fully acknowledged that the surgical intervention is a**

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
with the intervals currently recommended by the British Obesity and Metabolic Surgery Society.				**small element of a complex weight management service and pathway. For this reason, post operative follow up and continued support is fully recognised within the MYHT pathway, however, opportunities for greater shared care pathways and collaborative management are evident and will be progressed through the Joint Planned Care Group in the future**
Routinely commissioned procedures The following procedures are routinely commissioned: • gastric bands only if other means are not suitable and following MDT discussion of the post-operative risks • sleeve gastrectomy • Roux en Y gastric bypass. • Gastric balloon for patients with a BMI >60 or at high operative risk to stabilise weight before a more intensive surgical procedure	Do routinely commissioned procedures as documented within the West Yorkshire and Harrogate policy align with local CCG Individual Funding Request policy?	**Y**		**The WYH policy has been integrated and adopted within the Wakefield CCG Commissioning policy, published on the CCG website in July 2019**
Not routinely commissioned (Individual Funding	Do not routinely commissioned procedures as	**Y**		**Abdominoplasty is included**

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
Requests only): **8) Requests for excess skin removal following surgery** This policy does not include routine approval for follow-up surgery for excess skin removal. These requests are still subject to Individual Funding Requests to local CCGs. **9) Revisions of bariatric procedures** All Elective surgical revisions of bariatric procedures will be subject to Prior approval by the relevant local CCG. Patients presenting with acute complications of their initial surgery requiring immediate emergency surgery will be treated on the basis of their clinical need and funded accordingly. The numbers of such procedures will be carefully monitored. Band revisions which are solely for weight gain will not be routinely commissioned. Where there is a clinical need (defined as assessment by bariatric surgeon as implant failure) with or without weight gain, an Individual Funding Request should be made unless the clinical need is urgent (requires operation within the next 7 days). Where the procedure was	documented within the West Yorkshire and Harrogate policy align with local CCG Individual Funding Request policy?			**within the Wakefield CCG commissioning policy and is not routinely commissioned. Patients requiring skin removal after excessive weight loss are subject to IFR processes**

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
originally conducted in the private sector then the band should only be reinserted or adjusted by an NHS surgeon where there is a clinical need – this will require prior approval except for urgent cases (requiring operation within the next 7 days). 10) **single-anastomosis duoeno-ileal bypass with sleeve gastrectomy** (in line with NICE IPG569.) https://www.nice.org.uk/guidance/ipg569/chapter/1-Recommendations (accessed 1/11/17) 11) **Duodenal–jejunal bypass sleeve (DJBS)** (in line with NICE IPG 471) https://www.nice.org.uk/guidance/ipg471/chapter/1-Recommendations (accessed 1/11/17) 12) **laparoscopic gastric plication** (in line with NICE IPG432) https://www.nice.org.uk/guidance/ipg432/chapter/1-Guidance accessed 1/11/17 13) **Mini gastric bypass** (still considered experimental within Yorkshire and Humber but for review in 2020**)** http://www.bomss.org.uk/wp-content/uploads/2014/09/BOMSS-MGB-position-statement-September-20141.pdf				

Key Changes	Implications for commissioners	CCG in state of readiness (Y/N)	If No, actions required to achieve state of readiness	Date actions completed/state of readiness achieved
(accessed 1/11/17) **14) duodenal switch** – (considered experimental but may be a promising new treatment) In addition, any other bariatric surgery procedures not listed here will not be routinely commissioned. Where a clinician wishes to make a request for another device/procedure, an application for exceptional funding through the CCG Individual Funding Request (IFR) process should be made in the first instance. Where there are cohorts (usually more than 10 patients) who would benefit from another procedure, the next step would usually be a request for a business case to support the development of a commissioning policy for such procedures or devices.				

Tier 4 Bariatric Surgery - West Yorkshire & Harrogate CCGs

50/19 Appendix 2

Achievement against the 4% eligibility target

CCG Name	18/19 Activity	18/19 Cost	4% eligibility target as per population for 19/20	4% eligibility target as at July 19	Activity as at July 19	Cost as at July 19	Activity Variance to target as at July 19	% Variance to target as at July 19
AIREDALE, WHARFEDALE AND CRAVEN CCG	11	£56,393	22	7	11	£66,887	4	57%
BRADFORD CITY CCG	7	£26,715	16	5	4	£30,336	-1	-20%
BRADFORD DISTRICTS CCG	22	£91,614	45	15	16	£85,923	1	7%
CALDERDALE CCG	15	£62,947	29	10	11	£64,668	1	10%
GREATER HUDDERSFIELD CCG	19	£95,655	34	11	4	£21,305	-7	-64%
HARROGATE AND RURAL DISTRICT CCG	6	£31,498	22	7	2	£12,094	-5	-71%
LEEDS CCG	47	£235,796	113	38	14	£41,901	-24	-63%
NORTH KIRKLEES CCG	11	£57,748	25	8	5	£15,249	-3	-38%
WAKEFIELD CCG	20	£86,287	49	16	10	£65,024	-6	-38%
							0	
Grand Total	**158**	**£744,653**	**355**	**117**	**77**	**£403,387**	**-40**	**-34%**

Tier 4 Bariatric Surgery - West Yorkshire & Harrogate CCGs

Activity by CCG & Provider

CCG Name	Provider Name	18/19 Activity	18/19 Cost	Activity as at July 19	Cost as at July 19
AIREDALE, WHARFEDALE AND CRAVEN CCG	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	9	£45,687	10	£58,472
	LEEDS TEACHING HOSPITALS NHS TRUST	2	£10,706	1	£8,415
BRADFORD CITY CCG	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	7	£26,715	4	£30,336
BRADFORD DISTRICTS CCG	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	20	£85,164	15	£80,427
	LEEDS TEACHING HOSPITALS NHS TRUST	1	£5,353	1	£5,496
	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	1	£1,097		
CALDERDALE CCG	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST			1	£2,233
	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	15	£62,947	10	£62,435
GREATER HUDDERSFIELD CCG	LEEDS TEACHING HOSPITALS NHS TRUST	1	£5,353		
	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	17	£84,211	3	£14,740
	MID YORKSHIRE HOSPITALS NHS TRUST	1	£6,091		
	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST			1	£6,565
HARROGATE AND RURAL DISTRICT CCG	YORK HOSPITALS NHS TRUST	5	£26,145	1	£6,597
	LEEDS TEACHING HOSPITALS NHS TRUST	1	£5,353	1	£5,496
LEEDS CCG	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	2	£7,142	1	£2,233
	LEEDS TEACHING HOSPITALS NHS TRUST	45	£228,654	13	£39,668
NORTH KIRKLEES CCG	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	2	£11,396	2	£8,499
	MID YORKSHIRE HOSPITALS NHS TRUST	9	£46,352	3	£6,750
WAKEFIELD CCG	LEEDS TEACHING HOSPITALS NHS TRUST	2	£2,447		
	MID YORKSHIRE HOSPITALS NHS TRUST	18	£83,840	10	£65,024
Grand Total		**158**	**£744,653**	**77**	**£403,386**