NHS

South East Clinical Senate

South East
Clinical
senate

Best Practice Review of Clinical Pathways Identified as Areas of Uncertainty and Differing Opinion

DATE: August 2025

Email: england.clinicalsenatesec@nhs.net
Web: www.secsenate.nhs.uk

Contact details of the key personnel coordinating the review process

Chair: Paul Stevens

Head of Senate: Emily Steward

Email: Emily.Steward@nhs.net

South East Clinical Senate

Email: clinicalsenatesec@nhs.net

Web: https://secsenate.nhs.uk/

Foreword

Clinical Senates play a role in shaping healthcare services across their regions, providing independent clinical advice to commissioners on proposals for service reconfiguration and service change, but also looking at 'wicked' issues that have a clinical element. This work falls into the latter category.

The NHS 10-year health plan[1] aims to transform the NHS into a more digitally enabled, community-focused, and preventative healthcare system. This report exemplifies some of the key shifts of care described in the 10-year health plan in a review of seven clinical areas with an existing community focus. The clinical areas reviewed are linked by a desire and commitment from primary care and general practitioners, fully integrated with specialist services, to deliver high quality care across the South East region with equity of access and avoidance of harm.

The multi-professional review panel members were drawn from outside and across the South East region to provide an abundance of knowledge and expertise, both local and independent. It has been a real pleasure working with the panel and I want to thank them for their work and for the rich and stimulating discussions surrounding the problems and issues that beset the interface between hospital-based care and the community.

Paul Stevens

Chair South East Clinical Senate

---

[1] HM Government (2025) Fit For The Future 10 Year Health Plan for England. Available at: [Fit for the future: 10 Year Health Plan for England](). Accessed 7 August 2025.

Table of Contents

1. Introduction and Background

Integrated Care Systems (ICSs) are partnerships bringing together NHS organisations, local authorities and others to plan, commission and deliver the best health and care pathways for their population. As commissioners look at developing patient pathways, it is important to understand what best practice looks like. For certain clinical areas the conflicting opinions as to the optimum care may make it difficult for the system to come together to create appropriate pathways of care. For example, one stakeholder reported 3 different clinical guidelines about the monitoring of monoclonal gammopathy of undetermined significance (MGUS). Conflicting opinions as to optimum care and differing priorities may potentially adversely impact quality and equitable access to high quality care.

It is with this background that the South East Clinical Senate has been asked by the Medical Directors for Primary and Secondary Care Transformation, NHS England (NHSE) South East to review current practice in the South East region compared with best practice in certain clinical areas identified by Integrated Care Board (ICB) colleagues.

The following areas were identified as having a degree of uncertainty.

Clinical Area	**Uncertainties**
Direct oral anticoagulant (DOAC) management	Frequency and nature of monitoring plus minimum patient information required for safe prescribing.
Disease modifying anti-rheumatic drug (DMARD) monitoring	Frequency and nature of monitoring plus minimum patient information required for safe prescribing.
Monoclonal gammopathy of undetermined significance (MGUS) follow up and monitoring	Frequency and nature of monitoring required to check non-progression of clinical condition. Thresholds to trigger care escalation. Minimum patient information required.
Prostate specific antigen (PSA) monitoring	Frequency and nature of monitoring required to check non-progression of clinical condition. Thresholds to trigger care escalation. Minimum patient information required.
Post-bariatric surgery monitoring and management	Frequency and nature of monitoring and supplements required. Minimum patient information required.

Monitoring of eating disorders	Frequency and nature of monitoring and treatment required. Thresholds to trigger care escalation. Minimum patient information required.
Insertion and management of ring pessaries	Expertise required, frequency, triggers for action

2. Review Methodology

The Clinical Senate established an independent review team to consider the 7 clinical areas detailed above. All Local Medical Committee (LMC) Chairs and ICB clinical leads were contacted and invited to take part in or nominate a representative for this review. The senate review team membership is listed in appendix A. Great care was taken to avoid conflicts of interest, and all review team members were required to sign confidentiality and declaration of interest agreements.

The senate management team supplied a synopses document[2] for the clinical areas under review to panel members to highlight available literature, orientate and provide context for the review. The synopses document was circulated to panel Subject Matter Experts (SME) prior to being sent to all for an accuracy check. It was then circulated to the whole panel (TEAMS review day and desktop review participants).

A pre-meet was held on 4th June 2025 (via Microsoft TEAMS) for review team members. This served to discuss the Key Lines of Enquiry (KLOEs) listed in appendix B, to appraise review team members of the purpose of the review and to outline the critical friend nature and difference between this request and a clinical senate assurance review.

A full day virtual panel review meeting via MS TEAMS was held on 2nd July 2025. The agenda for the day is shown in appendix C.

To facilitate the greatest number of contributors those unable to attend the TEAMS panel review undertook a desktop review. The notes from both reviews were synthesised into a first draft which was circulated to all for comment on 17th July 2025.

---

[2] Available at: Clinical-Synopses-Clinical-Pathways-Identified-as-Areas-of-Uncertainty-and-Differing-Opinion-v.Final_.pdf Accessed 7 August 2025.

The final report was then prepared and sent to the Medical Directors for Primary and Secondary Care Transformation, NHSE South East and to the Regional Medical Director NHS England South East on 12th August 2025.

Owing to the timelines for this report chairman's action was taken regarding sign off. The final report and the terms of reference (ToR) will be discussed at the next senate council meeting and formal sign off minuted.

Scope

The scope of this review was focused on the South East region however it is recognised it may have wider applicability.

Developing commissioning recommendations for ICBs is out of the scope for this review however recommendations made are to inform review and development of clinical pathways of care.

3. Findings of the Senate Review Panel

The findings of the Senate review panel are structured against the three core areas the Senate was requested to focus on as set out in the ToR. These were:

- A review of the evidence with regards to best practice and current guidelines in respect of the above clinical areas.
- To ascertain the scale of benefit of best practice.
- Considering the above suggest recommendations for provision of these services to ensure best practice, equity of access and avoidance of harm.

In addition, for each clinical area the panel also considered:

- Is this a primary care pathway or not?
- If it is then what does the pathway entail?

The review KLOEs covered the following 6 areas:

- Clinical Area – feasibility, pathway structure, if any more evidence is needed
- Workforce – competencies, training, who can deliver the care
- Engagement – whether input from patients and staff is necessary for the pathway design
- Health inequalities – Core20Plus5, inequalities, patient choice and need
- Healthcare sustainability – considerations in pathway development

- Strategic – system learning

We have highlighted throughout the report where further evidence is awaited and/or exemplar guidelines have been provided from across the region. In all cases the discussion concludes with associated recommendations. It is important to note that these recommendations are not guideline recommendations, they are recommendations aimed at standardising best practice, equity of access and avoidance of harm in the clinical areas under consideration. A list of all recommendations can be found in appendix D however please note they should be read within the context and alongside evidence provided in the report narrative.

4. Key Recommendations

Clinical colleagues' commitment and determination to provide best practice was at the forefront of the discussions and the review panel were cognisant of the significant financial and operational pressures existing across the NHS. Commissioning of services was not within the panel's remit, however during the panel discussions it was not surprising that to completely disconnect funding flows from clinical pathway delivery presented a challenge. Where best practice was considered to require adaptation of existing patient pathways it will unavoidably encompass a combination of alteration to funding flows and doing things differently and the two are mutually reliant. This need has been articulated in the NHS 10-Year Health Plan as a requirement to facilitate local areas to build and expand their neighbourhood health services and realise the 'shift' from hospital to community.[1]

Person Centred Coordinated Care

The NHS 10-Year Health Plan promotes a neighbourhood health model (as locally as it can be, in a neighbourhood health centre, in a hospital if necessary) and provides a clear mandate for the NHS; the provision of a single, coordinated, patient orientated service with a delivery model able to provide continuous, accessible and integrated care.[1] Continually improving quality of care for people using services includes improving safety, effectiveness and experience and involves making better use of resources.[3] The Dash Report[4] highlights the need for strategic thinking and planning with regard to improving quality of care.

---

[3] The King's Fund (2017) Making the case for quality improvement: lessons for NHS boards and leaders. Available at: Making The Case For Quality Improvement | The King's Fund Accessed 7 August 2025.

[4] DHSC (2025) Review of patient safety across the health and care landscape. Available at: Review of patient safety across the health and care landscape Accessed 8 August 2025.

The desire to work together to provide system level patient centred coordinated care to ensure best practice, equity of access and the avoidance of harm shone through during this review. To facilitate this the panel recommend:

- Sharing of guidelines across the region to facilitate learning
- Aligning of standards across the region where possible to achieve consensus on guidance from different bodies, for example:
    - prostate specific antigen – prostate specific antigen thresholds used for decision making in National Institute for Health and Care Excellence (NICE) and Getting It Right First Time (GIRFT) guidance
    - different assays used in multiple labs
    - views of cancer alliances.
- Improved interconnectivity of information technology (IT) systems

Please also see pages 43-44 for further information and strategic and system learning recommendations.

Health Inequalities

When planning healthcare pathways the NHS has legal equality and health inequality duties and associated initiatives to fulfil, such as Core20PLUS5 (see health inequalities section pages 34-40 for more detail on these). To demonstrate meeting these requirements, an equalities and health impact assessment (EHIA) should be carried out during the development of each clinical pathway. Various guidance documents and templates are available and are not onerous. The aim is to identify groups that are at risk of disadvantage or further disadvantage and then look for solutions that are practicable, wherever possible.

Quality assurance

For some services delivered by multiple providers, such as general practice, embedding automatic digital performance reporting directly from clinical systems would enhance patient safety and facilitate resource management. Manual systems are time consuming and inaccurate. Some examples would be:

- frequency and completeness of MGUS patient monitoring
- % DOAC monitored (offered and completed)
- frequency and completeness of DMARD patient monitoring
- % PSA monitored (including testing rates in high risk patients)

5. Clinical Area

The panel concluded that for the clinical areas under consideration a primary care pathway is both feasible and practicable and is to be recommended but should not be considered as a standalone offer. To ensure best practice, equity of access and avoidance of harm the following factors were considered:

- the primary care pathway should be part of a system wide patient coordinated care pathway inclusive of patient self-management where appropriate (see healthcare sustainability section on pages 40-43)
- the pathway must have the right number of people correctly trained in the right place, with appropriate space and resources (see healthcare sustainability section on p40-43)
- there must be well delineated escalation routes into specialist services when required that are both reliable and responsible.

A key umbrella recommendation encompassing all these different clinical areas when provided by a primary care/general practice pathway is responsive, reliable and timely responses from secondary/tertiary care services when escalation is required. These should be transparently stated and publicly available.

Specific principles and recommendations for each clinical pathway are detailed below.

Direct Oral Anticoagulant (DOAC) management

The two main classes of oral anticoagulants are vitamin K antagonists and direct oral anticoagulants (DOACs). Vitamin K antagonists were the only oral anticoagulants available for several decades and warfarin was the most commonly used, with monitoring routinely done by dedicated services.

The increased use of DOACs and the associated monitoring has significantly increased GPs' workload and variations in local practice exist. The panel agreed a primary care pathway is feasible and practicable for initiation in non-valvular atrial fibrillation (AF), prophylaxis after venous thromboembolism (VTE) and pulmonary embolism (PE), and repeat prescribing after initiation in secondary care. Every panel member agreed diagnosis and treatment of PE and VTE requires a specialised service with rapid access to diagnostic investigations, however there are instances such as in cases of suspected lower limb VTE where clinical discretion is required and DOACs might need prescribing in primary care whilst awaiting diagnostic imaging.

The panel's view was that clarification of the pathway and follow up for VTE needs to be clearer. It was also agreed that access to diagnostics and subsequent reporting can be problematic. In order to gain a greater understanding and address this issue, Hampshire and Isle of Wight ICB are running a pilot in one of their hospitals where the General Practitioner (GP) has direct access to the ultrasound scan (USS). The NICE pathway suggests that an initial negative scan may need repeating a week later.[5] If the scan is negative then the patient is discharged from the radiology department rather than going back to have an assessment unless the GP specifies they would like the patient to be assessed. It is noted that some practices, for example all GP practices in Sussex, have direct access to USS for suspected DVT.

Initiation of DOACs

The panel agreed that where a clinician makes the decision that a DOAC is required it is the responsibility of that clinician to provide an initial prescription and communicate to those subsequently responsible for repeat prescribing in the pathway of care. For example, post operative prophylaxis prescribing of DOACs is the responsibility of the surgical team who can make the appropriate risk assessment in terms of the suitability of the individual patient taking into consideration their current clinical picture.

Patient safety: monitoring, call/recall services

People are prescribed DOACs for a variety of reasons and in significant numbers in every general practice. DOACs account for some of the most common significant drug related adverse effects, and all panel members expressed the importance of good prescribing skills, the ability to detect triggers for dose modification and access to appropriate training. Renal function monitoring and DOAC dosage adjustment was a concern shared by the panel for certain patients. A primary care pathway needs to link to a local haematology specialists for advice and guidance that needs to be reliable and responsive.

There is a Care Quality Commission (CQC) expectation to do a minimum of annual monitoring as part of drugs and medication monitoring. However, DOAC recall is extremely complicated when compared with recall for other conditions as many patients need monitoring more frequently than an annual check and this results in different times of recall for different cohorts of patients. This issue is compounded by different IT providers and subsequent interoperability issues making data analysis

---

[5] NICE (2023) Venous thromboembolic disease: diagnose, management and thrombophilia testing. Nice guidance NG158. Available at: Recommendations | Venous thromboembolic diseases: diagnosis, management and thrombophilia testing | Guidance | NICE Accessed 8 August 2025.

challenging. The panel observed that the current data captured suggests much monitoring is below accepted standards.

Owing to the IT system issues highlighted above and coding problems this is extremely time consuming with some practices employing cross referencing safeguards and checking patient cohorts by spreadsheet.

Patent information

Patient counselling and written information needs to be provided at initiation. This should include the potential risks and benefits of the prescribed medication, potential interactions with other medication and duration of treatment. For VTE patients there is not always clarity on the duration of therapy and who/how that decision was made, unless a patient review by a specialist in VTE is built into the pathway. Patients need to know to inform the GP, competent prescriber or pharmacist if they are taking a DOAC with every new initiation of another drug. Patient information needs to be provided in a variety of languages and formats.

Warfarin (and oral vitamin K antagonists)

There is variation across the region in responsibility of initiation (primary or secondary care) and different approaches to monitoring for this cohort of patients with some practices monitoring and some sending patients to the hospital. It was agreed that whoever does the prescribing should be doing the monitoring (or have access to the results of monitoring). In Sussex, for example, there are 3 different models for warfarin monitoring; hospital monitoring, GP monitoring and third party monitoring from a private pharmacy. Both the hospital model and the third party model are considerably more expensive than the GP model. The panel are agreed that monitoring of warfarin and (rarely) other oral vitamin K antagonists in a typically sized general practice is no longer cost effective due to the reduction in patient numbers and the widespread use of DOACs. To ensure safety with decreasing patient numbers some ICBs are introducing minimum thresholds, for example 20 patients, and encouraging practices to have a buddying arrangement.

Further evidence to be considered

- CKS | NICE
- DOACs (Direct Oral Anticoagulants) monitoring – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice
- 2021 European Heart Rhythm Association Practical Guide on the Use of Non-Vitamin K Antagonist Oral Anticoagulants in Patients with Atrial Fibrillation | EP Europace | Oxford Academic

Recommendations:

R1. Consistent pathway guidelines inclusive of initiation, monitoring and recall. This should be standardised across the whole region.

R2. An improved standard national patient information leaflet available in different languages and formats including online (the current NHS England leaflet is order only).[6] The leaflet should include risks and benefits, interactions with other drugs and monitoring frequency.

R3. Provision of interoperable IT systems to assist patient safety,[7] particularly with regard to recall of patients prescribed DOACs for monitoring and key drug interaction alerts for agents that have significant effects on DOAC pharmacodynamics. For example, Optimise Rx.

Disease modifying anti-rheumatic drug (DMARD) monitoring (non-biological DMARDs)

The treatment of autoimmune rheumatological disease, but also several other diseases, including certain skin, bowel, respiratory and neurological disorders, is increasingly reliant on disease modifying agents, both non-biologic and biologic (including targeted synthetic DMARDs). For the purposes of this document DMARDs explicitly refers to non-biologic disease modifying agents.

Monitoring and reviewing of patients prescribed DMARDs generated significant discussion on panel day, with safety and capacity challenges within general practice being cited as areas of concern. Management of DMARDs is complicated; patients are not always stable, there are a number of specialities involved and there are a wide range of medicines. Patients have reported not being able to book their own monitoring when the pathway indication for a monitoring test was clear, for example following an out of hours health event. Shared care protocol (SCP) agreements are lengthy (potentiating a risk that important information may get missed) and vary

---

[6] Specialist Pharmacy Service (2025) Accessing resources for patients on high risk medicines. Available at: Accessing resources for patients on high risk medicines – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice Accessed 8 August 2025.

[7] Armando LG, Miglio G, de Cosmo P, et al (2023). Clinical decision support systems to improve drug prescription and therapy optimisation in clinical practice: a scoping review. BMJ Health Care Inform 30:e100683.

between ICBs across the South East with different drugs included. This presents a problem for patients who move GPs.

The panel agreed there was a need for collaboration and consistency across the region and these patients are best managed through shared care with specialist services. Panel consensus was that the safest option for patients is for DMARDs to be initiated and adjusted by secondary or tertiary care specialist teams with monitoring and same dose prescribing happening in general practice. The panel supported shared care for patients requiring DMARDs who have been identified by specialist teams as stable. A reliable and responsive advice and guidance service also needs to be provided by secondary and tertiary care colleagues.

The capabilities and interoperability of technology to facilitate proactive register management was highlighted by the panel as an issue, with patient monitoring call/recall issues similar to that of DOACs above. The corollary example given was the absence of a hospital database for patients on valproate. The existence of such information would facilitate safe care (such as an efficient patient call/recall service) and also the shared care model. The COVID-19 pandemic was highlighted as accelerating this process for one Trust in the region.

Further evidence to be considered

- A practical guide to thiopurine prescribing and monitoring in IBD
- British Society of Gastroenterology guidelines for diagnosis and management of autoimmune hepatitis | Gut
- The revision of the British Society for Rheumatology guideline for the prescription and monitoring of non-biologic disease-modifying anti-rheumatic drugs is expected later this year.[8]

Recommendations:

R4. Hospital Trusts should have a database of patients for whom they have specialist responsibility for the relevant drugs and their own performance standards.

R5. South East region adoption of a nationally mandated shared care protocol that applies to everybody. The current national shared care protocol does not cover all drugs, and others are locally written shared

---

[8] Available at: Guidelines | British Society for Rheumatology Accessed 8 August 2025.

care agreements. Despite shared care protocols' length, national shared care protocols are all formatted the same, therefore it is known which section contains the responsibilities for the GP. If local shared care agreements are required, the formatting should mirror that of the national document.

R6. The need for minority specialities that prescribe DMARDs to be supported. This would support with communications, monitoring infrastructure and safe discharge for example. Currently larger users such as Rheumatology and Dermatology have their own infrastructure, shared care is less safe in other specialties that cannot justify or have the resource and organisation to do shared care monitoring and communication well.

R7. Recommended changes to SCP paperwork:

- **Place repeatable information' online which would make it less unwieldy plus easier to update with changes.**
- **SCP to move with the patient. Currently they do not follow patients when they move GPs, requiring GPs to request the information resent.**
- **Ultimately send the SCP electronically.**

R8. Consideration of timing of recall of patients using a patient's specific needs, medical history and risk factors as the primary drivers for recall decisions. The panel heard that some practices in the region are piloting bringing those most at need in for review during the summer months rather than a birth date recall, with subsequent less frequent patient deterioration in the winter months together with a reduction in hospital attendances.

R9. Triage the high risk complex reviews to GPs and low risk protocolised reviews to other healthcare professionals within primary care (nurse, pharmacists, paramedics).

R10. Empowering patients to take ownership of their health by involving them in the recall process and for those with multiple long term conditions coordinating recall for monitoring.

Monoclonal gammopathy of undetermined significance (MGUS)

Monoclonal Gammopathy of Undetermined Significance (MGUS) is a common, asymptomatic condition, the prevalence of which increases with age. About one in 30 people aged 50 years or older will have the condition, this rises to one in 20 people aged over 70 years, and nearly one in 10 people aged over 85 years. It is about 1.5 times more common in men than in women. The disorder also appears to be 2-3 times as common in patients of African descent as in Asians and Caucasians. MGUS may progress to Myeloma (or other lymphoproliferative disorders) at a rate of 0.5-1% of patients per annum, that risk of progression is lifelong and therefore once identified MGUS requires regular monitoring.

The panel were agreed that low risk patients (M protein ≤15 g/L) can be monitored in general practice every 3–4 months for the first year following identification and every 6–12 months thereafter if no disease progression is detected, with clear guidance and accessible support from the specialist haematology service if required.

Patient safety: monitoring, call/recall services

Monitoring of the condition is lifelong. Funding resource issues exist in both primary and secondary care which present service delivery challenges and resultant variance in approach across the region. These patients represent a significant number, an estimate for Sussex was given at 4,500-5,000. Audit data is suggestive of insufficient monitoring of patients, only 19% of patients with a diagnosis of MGUS receiving annual monitoring.

Provision of a patient tailored response service engenders significant work for the specialist team. Guidelines are complicated therefore training and familiarisation of clinicians involved in delivering that care is very important. For example, interpretation of paraprotein results. There was recognition that training for primary care colleagues from specialist teams with case scenarios would be helpful.

There are similar challenges to the recall of patients in this area as for DOACs and DMARDs, it requires a register recall system and for this to be effective patient coding needs to be accurate and aligned to where the patient is receiving care (primary or secondary care).

The panel discussed patient initiated follow up and patient access to their records to enable them to take responsibility for their care. There are a number of challenges and considerations here which are explored in the healthcare inequalities section on pages 34-40 and in the South East Clinical Senate report on patient access to their healthcare records.[9]

Further evidence to be considered

Evidence is awaited from 2 trials, the Iceland Screens, Treats, or Prevents Multiple Myeloma (iStopMM)[10] and the PROMISE Study: A Nationwide Project for Predicting the Progression of Developing Myeloma in a High-Risk Screened Population.[11]

It is hoped these trials will define the patients who need monitoring for years and patients who are unlikely to progress and then can be ‘de-escalated’ from the monitoring regime. This will have a significant impact on financial resources and importantly give some reassurance to patients who understandably may find the whole process anxiety inducing.

Recommendations:

R11. Laboratory based audit across the region to determine the percentage of patients with known MGUS receiving annual monitoring and the completeness of that monitoring (full blood count, serum creatinine and calcium and protein electrophoresis for paraprotein).

R12. Implement a simple standardised region-wide protocol for primary care follow up of low risk MGUS incorporating timely and responsive secondary care advice and guidance when required together with clear guidance for appropriate de-escalation of monitoring.

R13. Case-based MGUS monitoring and referral education sessions from local haematology services

R14. Consider introduction of serum free light chains to obviate urine Bence Jones protein testing

---

[9] Available at: South-East-Clinical-Senate-Patient-Access-to-Healthcare-Records-Report.pdf Accessed 4 August 2025.

[10] Available at: iStopMM | International Myeloma Foundation Accessed 8 August 2025.

[11] National Library of Medicine. Clinical trials.gov. Predicting Progression of Developing Myeloma in a High-Risk Screened Population (PROMISE). Available online at: Researcher View | Predicting Progression of Developing Myeloma in a High-Risk Screened Population (PROMISE) | ClinicalTrials.gov Accessed 4 August 2025.

Prostate Specific Antigen (PSA)

Prostate cancer is the most common solid cancer in men. Roughly 50,000 new cases are diagnosed each year in England and Wales and we know from the National Prostate Cancer Audit that 16.4% of men diagnosed with prostate cancer in England between 1st January 2015 and 31st December 2019 had metastatic disease at diagnosis. Metastatic disease was strongly linked to deprivation and also varied by region.[12] Those in the most deprived areas were 29% more likely to have metastatic disease at diagnosis compared to those in the least deprived. People with a family history of prostate cancer in a first degree relative are 2-4 times more likely to develop the disease and people of Black ethnicity have double the risk of those of White ethnicity. Men with mutations of BReast CAncer gene 1 (BRCA1) and BReast CAncer gene 2 (BRCA2) are at risk of earlier and more aggressive prostate cancer (BRCA genes normally produce proteins that help repair damaged DNA).

This is an area where evidence and consensus on best practice patient pathways are evolving and the panel expressed caution with regards to how a primary care pathway may be structured. It was noted during the panel discussion that the advice and guidance regarding PSA threshold values for initial referral differs in different consensus documents (GIRFT[13] and NICE).[14] Prior to the 2024 GIRFT publication NICE recommended clinicians used age-related thresholds for men with lower urinary tract symptoms, or a single threshold for those concerned about prostate cancer risk. A survey of cancer alliances had highlighted that PSA thresholds for referral were variable dependent on individual cancer alliances. The 2024 GIRFT Urology document sets national guidance with room for regional variation and clinical opinion. The current nuances in thresholds for PSA, the question of Digital Rectal Examination (DRE) offering additional value to decision making, different laboratory assays for testing and the use and availability of PSA density as a diagnostic tool combine to make pathway decision making in this area challenging.

The panel discussed the monitoring and follow up of different groups of patients who have **not been** diagnosed with prostate cancer:

---

[12] Healthcare Quality Improvement Partnership (2022) Patient and Tumour Characteristics Associated with Metastatic Prostate Cancer at Diagnosis in England. NPCA: Short Report 2022. Available at: NPCA_Short-report-2022_Final-08.09.22.pdf. Accessed 8 August 2025.

[13] NHSE (2024) Towards Better Diagnosis and Management of Suspected Prostate Cancer. Available at: GIRFT-Urology-Towards-Better-Diagnosis-Management-of-Suspected-Prostate-Cancer-FINAL-V1-April-2024-1.pdf Accessed 8 August 2025.

[14] NICE (2029) Prostate cancer: diagnosis and management. Nice guideline NG131. Available at: Recommendations | Prostate cancer: diagnosis and management | Guidance | NICE
Accessed 8 August 2025

- **The low risk patient requesting a PSA and/or those with a negative PSA.** An appropriately resourced primary care pathway is feasible and practicable. Avoidance of health anxiety is important and this group would need time allocated for appropriate pre and post-test health counselling.[15]
- **Patients with an elevated PSA** referral to secondary care for further testing is required.
- **The high risk patient with a negative PSA and/or a negative biopsy.** Testing in this group will assist earlier diagnosis. However, there are differences in local pathways and this group presents increasing numbers. The way care is currently organised does not reflect the current evidence presenting challenges for a primary care pathway. This may be an area for a shared care pathway. When a patient is discharged, clear PSA thresholds and follow up should be set by the secondary care specialist team.

Recommendations:

R15. A single agreed pathway approach across the South East would be beneficial, particularly for high risk patients. In addition, for all patients the balance of testing in asymptomatic men as opposed to symptomatic men needs to be clear.

R16. Clinicians should note that clinically relevant thresholds may depend on the specific PSA assay and that ideally the same assay is applied over time for better clinical decision making. Ideally within one cancer network the same PSA assay should be used.

R17. PSA thresholds for referral of men for investigation and diagnosis of prostate cancer and PSA thresholds for re-referral of men with diagnosed prostate cancer undergoing primary care monitoring should follow national guidance and be standardised across the region.

R18. For men who have undergone prostate ultrasound and/or Magnetic Resonance Imaging (MRI) the PSA density threshold can be used to guide referral for prostate biopsy. A commonly used threshold is 0.15 ng/mL/cm^3.[11]

---

[15] Office for Health Improvement and Disparities (2024) Advising men without symptoms of prostate disease who ask about the PSA test. Available at: [Advising men without symptoms of prostate disease who ask about the PSA test - GOV.UK](https://www.gov.uk) Accessed 8 August 2025.

R19. Forward planning is required to ensure availability of resources, such as MRI scanning, to meet increasing demand in this area. This should include an assessment of current inefficiencies, for example inappropriate referral for prostate MRI and missed appointments.

R20. There is a reluctance from men to be tested. While initiatives such as testing offers at football matches were welcomed these need to be discussed and coordinated with local general practices who experience a huge surge in patient enquiries and follow up as a result.

R21. Transgender women and people who do not identify as men but have a prostate need to feel welcome and supported by healthcare services. This means having safe and clear routes of access and care that takes a tailored approach and appreciates what matters to the patient.[16]

Post Bariatric Surgery

After bariatric surgery unidentified nutritional deficiencies can occur and cause long-term harm (such as Wernicke's encephalopathy, peripheral neuropathy, anaemia, osteoporosis or night blindness) or death. It is therefore important for people who have had bariatric surgery to have lifelong nutritional monitoring and appropriate nutritional supplementation.

NICE guidance[17] promotes a shared care (primary and secondary care) model post 2-year follow-up, however the panel verbalised challenges with this ambition in practice. There was panel consensus that following the initial 2-year follow up provided by the secondary or tertiary care centre who has carried out the surgery these patients are suitable for monitoring in general practice and if not possible for individual GP practices, then a practice buddying or Primary Care Network (PCN) arrangement is to be encouraged.

However, the safety of these patients was a concern and there are important considerations to facilitate monitoring in primary care and realise a true shared care pathway. These being:

- **Ready access to specialist services.** Secondary care must be responsive to escalation requests. The panel heard that too often there are delays or

---

[16] Available at: Resources for Professionals - OUTpatients Accessed 30 July 2025.
[17] NICE (2025) Overweight and obesity management. Nice Guideline NG 246. Available at: Overview | Overweight and obesity management | Guidance | NICE Accessed 8 August 2025.

inadequate prioritisation with requests for secondary care opinion. Such delays have the potential to compromise patient safety for example through drug absorption and biometric change. When the need arises GPs should be able to get the patient into secondary care with expediency.

- **Patients who access bariatric surgery privately, particularly abroad.** The 2-year post-operative follow up by secondary care for patients who have had private care abroad is variable. This variability places a huge demand on primary care services. Within one ICB in the region local surgery figures showed 1,500 patients while GP systems highlighted more than 4 times as many patients. Although not all the region's ICBs had run the data there was panel agreement that the true number of patients having had surgery would be far in excess of local Trust surgery and/or registry figures. However, it was acknowledged this may change with the advent of the anti-obesity drugs (acknowledging these drugs will present new issues for care providers not within the remit of this review). Another area of concern regarding patients accessing surgery privately and abroad was pre-operative counselling and lack of patient information, both potentially associated with much higher incidence of complications and poor outcomes. Scheduled follow-up support is positively associated with weight loss results, and therefore private surgery that does not include follow-up support would run the risk of poor-outcomes, weight regain or potential nutritional deficiencies.

Postoperative Follow-Up and Weight Loss

A study utilising the Bariatric Outcomes Longitudinal Database (BOLD) found that patients who adhered to scheduled postoperative follow-up visits (at 3, 6, and 12 months) experienced significantly greater weight loss. Specifically, those with complete follow-up had higher rates of excess weight loss (≥50%) and total weight loss (≥30%) compared to those who missed visits.[18] Research from Cleveland Clinic Abu Dhabi highlighted that increased visits with surgical teams, dietitians, and primary care providers post-surgery were positively associated with greater total weight loss at 12 months. This underscores the importance of comprehensive postoperative care in achieving optimal weight loss outcomes.[19] A further study published in Surgery for Obesity and Related Diseases demonstrated that patients

---

[18] Spaniolas K, Kasten KR, Celio A, Burruss MB, Pories WJ. (2026) Postoperative Follow-up After Bariatric Surgery: Effect on Weight Loss. Obes Surg. Apr;26(4):900-3. doi: 10.1007/s11695-016-2059-6. PMID: 26757922.

[19] Tat C, Barajas-Gamboa JS, Lee-St. John T et al. (2021) Impact of Patient Follow-Up with a Multidisciplinary Team After Bariatric Surgery in a Middle Eastern Academic Medical Center. Bariatric Surgical Practice and Patient CareVol. 16, No. 3 Published on line 9 September 2021. Available from: https://www.liebertpub.com/doi/10.1089/bari.2020.0139 Accessed 8 August 2025.

who attended all scheduled follow-up appointments after laparoscopic gastric bypass had significantly greater long-term weight loss (74% excess weight loss) compared to those who missed appointments (61% for those with 1-year follow-up and 56% for those lost to follow-up before 1 year).[20]

Patients accessing bariatric services overseas and those accessing obesity drugs privately present a significant challenge for NHS services and a potential patient safety risk. It was highlighted during the panel discussion that overseas/private patients who find themselves unable to access NHS bariatric surgery follow-up care may present with avoidable complications such as reduced muscle mass. There is also the risk that these patients may not be eligible for hospital bariatric clinics as their Body Mass Index (BMI) no longer meets the threshold. Conversely there is evidence to suggest that patients who go abroad are more likely to experience weight gain problems 4-6 years post-surgery as they have not had access to pre-operative psychological and nutritional support and advice. This will have a potential patient wellbeing and NHS resource attached (both clinical and financial).

Obesity has a bidirectional relationship with mental health and disordered eating and although not within the scope of this review there was panel discussion regarding the safety, such as anorexia-like symptoms and primary care resource implications of patients accessing obesity drugs privately. Not all GPs are informed by private pharmacies when patients have been started on these drugs and when they are there is a resultant increase in administrative and clinical workload. There was also concern expressed regarding the unintended consequences of patients not seeking medical advice prior to initiating medication, such as unplanned pregnancies and gynaecological cancers in patients who have not declared anti-obesity drug use and are co-committed on Hormone Replacement Therapy (HRT) or contraception.

Recommendations:

R22. Patient follow up 2-years post bariatric surgery is appropriate for shared care. However, the panel discussion highlighted that there is currently no consistency in practice. It is recommended all those involved in delivery of this pathway to work together to ensure patient safety, see appendix E, Sussex ICB Post Bariatric Surgery Follow-up Locally Commissioned Service.

---

[20] Gould JC, Beverstein G, Reinhardt S, Garren MJ (2007). Impact of routine and long-term follow-up on weight loss after laparoscopic gastric bypass. Surgery for Obesity and Related Diseases 3:627 – 630.

R23. Following discharge to primary care for monitoring a clear, responsible and reliable escalation pathway where primary care can seek advice from the secondary care bariatric team is required. This could be via email but crucially there needs to include an opportunity to have a conversation without making a referral. It would be helpful for specific timeframes to be made publicly available on Trust websites which would enable transparency for patients. Response times should not include 'holding' emails.

R24. Guys and St Thomas' Trust (GSTT) has Commissioning for Quality and Innovation frameworks (CQUINs) in place for advice and guidance requests and the adoption of these for all secondary care bariatric services is recommended.

R25. A risk awareness approach is required. The inability for some overseas/private patients to access NHS services post-surgery carries a risk for the health and wellbeing of the patient and longer-term resource implications for the health service. Principally these patients do need monitoring and there is a need for something to be established that healthcare teams can provide.

R26. South East region wide patient information would assist in realising the above recommendations. Patient information should include:

- **Pre-operative information about access to NHS services in the immediate 2 years post-surgery for patients going abroad.**
- **The importance of pre-operative psychological and nutritional advice and support for patients considering surgery overseas.**
- **The lifelong consequences of bariatric surgery.**
- **Which supplements are available over the counter and do not require a prescription**

R27. Information on private care would benefit from policy support as inconsistencies are likely. It should be understood that funding for private surgery whether at home or abroad must include the 2 year follow up period post-surgery.

R28. Post-bariatric surgery education for primary care/GP practices from local bariatric services to promote awareness of potential problems will both provide an understanding of monitoring and help establish

links for when escalation is required and exactly who to escalate to locally.

Eating Disorders

Eating disorders are serious mental health conditions, which affect people irrespective of age, ethnicity, social class and geography.[21] The defining feature of an eating disorder is a substantial disturbance in eating or eating related behaviour, with various behavioural disturbances associated with each disorder.[22] Types of eating disorders include:

- **Anorexia nervosa** — low body weight due to restriction of food intake or persistent behaviour which interferes with weight gain and intense fear of gaining weight.
- **Bulimia nervosa** — recurrent episodes of binge eating followed by compensatory behaviour such as self-induced vomiting, laxative abuse, or excessive exercise.
- **Binge eating disorder** — recurrent episodes of binge eating in the absence of compensatory behaviours.
- **Atypical eating disorders (otherwise known as other specified feeding or eating disorder; OSFED)** — closely resemble anorexia nervosa, bulimia nervosa, and/or binge eating but do not meet the precise diagnostic criteria.
- **Avoidant / restrictive food intake disorder (ARFID)** – restriction of food intake for reasons other than beliefs about weight or body shape e.g. negative feelings over smell, taste or texture of certain foods.[23]

There was debate surrounding the types of patients to be monitored in primary care and also whether or not a primary care/general practice pathway is appropriate for this highly vulnerable group of patients. Where primary care/general practice are part of the pathway a shared care format with clear guidance and clear criteria for escalation and referral is required. The panel agreed that specialist training with continuity of care is required for patients already diagnosed as low risk by a specialist.

A primary care pathway is feasible for initial identification, assessment (mental health and physical health) and referral to a specialist eating disorders service. Also, for annual review follow up of low risk patients only (see risk stratification discussion

---

[21] Beat Eating Disorders. Types of Eating Disorder. Available at: Types of Eating Disorder. Accessed 8 August 2025.

[22] Attia E and Walsh T. (2025) 'Eating Disorders A Review.' *JAMA*. 33(14):1242-1252.

[23] NHS. Overview - Eating Disorders. Available at: Overview – Eating disorders - NHS. Accessed 8 August.

below). However ongoing physical health monitoring should sit with specialist eating disorders teams once they have accepted the referral. The specialist service must be integrated and not delineate physical issues such as electrocardiogram (ECG), weight and electrolyte monitoring from psychological issues as this creates communication gaps and potential patient safety issues. There was also debate around the extent of primary care monitoring for patients discharged from secondary care. Responsiveness is key to be able to step up into and step down from specialist care.

It is recognised that NICE supports a shared care pathway,[24] a PCN or community based service with specialist input. However, it was acknowledged by the panel that this is problematic, with question marks over timely access to specialist secondary care services.

Risk Stratification

Eating disorders are complex mental health conditions with potentially life threatening consequences. Patients frequently fail to volunteer appropriate clinical information and a consistent therapeutic relationship is an essential part of managing this. With some patients, there is the risk of iatrogenic harm due to their care seeking behaviour, for example engaging in a potentially harmful behaviour to ensure continued engagement with a health professional. Decisions regarding risk need to be taken regarding the whole clinical picture and context for each patient and this ideally involves senior experienced psychiatric/psychological support.

The panel discussed the Medical Emergencies in Eating Disorders (MEED)[25] and Kings College London (KCL)[26] risk assessment models. With one ICB offering an adapted version of these (see appendix F). An additional model shared on panel day was One Gloucestershire's pathway.[27] These models assist in categorising the patient into a risk group and subsequently primary, secondary or shared care. Some panel members felt with clear guidance low and moderate risk patients can be managed in primary care. However, others felt that primary care had no role in moderate risk patients given the complexities already mentioned, and transferring responsibility would likely result in worse outcomes. For patients managed in primary

---

[24] NICE (2020) Eating disorders :recognition and treatment. Nice guideline NG69 Available at: Overview | Eating disorders: recognition and treatment | Guidance | NICE Accessed 8 August 2025.
[25] Available at: Medical Emergencies in Eating Disorders – Guidance on recognition and management Accessed 8 August 2025.
[26] Available at: Microsoft Word - GUIDE FOR MEDICAL RISK ASSESSMENT December 2012.doc Accessed 8 August 2025.
[27] Available at: Eating disorders G-care Clinical Topic Pathway UPDATED 270225.docx Accessed 14 July 2025.

care, as with all the other clinical areas of this review, it is important to have access to a safe, consistent and responsive secondary care specialist service.

It is equally important to remember that managing physical health checks by protocol can result in low risk patients receiving unnecessary physical observations and blood tests as most people with an eating disorder are not at acute significant physical risk from their illness. Risk can be high even if blood tests are not unduly abnormal and this could give the false impression of safety. Primary care staff are not trained to manage the intricacies of clinical conversations with this patient cohort who may interpret what are intended as well intentioned comments as negative or critical. The majority of primary care staff that in practice would have to interact with these patients could not justify the training resource required.

When looking at red/amber/green risk codes clinical findings can be ambiguous. It is possible to have someone who is at the same BMI level as anyone else in the community and not at any major risk, similarly you can have a patient with a BMI at 15.1 (above 15.0 and therefore in the green low risk code) however this person is not equivalent to a healthy person in the community. Similarly with weight loss, you have people who could be losing 450 grams a week who are in the ‘green’ category but they are still losing weight consistently.

There was an appreciation among panel members that care needs to be approached from a system perspective; to have an NHS response, not just primary or secondary care. If all low and moderate risk patients are seen in primary care this creates space for high risk patients in oversubscribed secondary care services. If eating disorder services are overwhelmed by ‘green’ patients, there will not be sufficient capacity for the sicker ‘amber’ and ‘red’ patients; a situation affecting both patient safety and access. For eating disorders community-based outreach teams may be a solution.

An additional consideration with regards this client group is the significant resource required for GPs in university/college areas.

Recommendations:

R29. Primary care monitoring is probably not suitable for any other than the lowest risk patients but at all stages of care for this client group a clear, responsible and reliable escalation pathway into secondary care is critical. Responsiveness is key to enable step up and step down care.

R30. Where physical monitoring takes place in general practice there must be clear criteria for escalation and delineation between escalation for physical health reasons versus mental health.

R31. Risk stratification models require careful understanding and reflection for the individual patient. Continuity of carer and personalised care is of high importance.

R32. A system wide approach is required for this vulnerable client group to ensure safe and consistent pathways that enable low risk patients to be monitored in primary care.

R33. A properly trained and committed service within the community provided through, for example, a primary care network, rather than services provided by individual general practices should be considered.

R34. People with eating disorders who are being supported by more than one service have a care plan that explains how the services will work together to support them.[28]

Pelvic organ prolapse - insertion and management of ring pessaries

Pelvic organ prolapse is common affecting 1 in 10 women over the age of 50 years with 20–40% of these women experiencing prolapse symptoms that may be bothersome and affect their quality of life.[29] Although mild prolapse is often symptom free, symptoms such as a heaviness or a dragging sensation in the pelvis worsening throughout the day, bladder and bowel symptoms and discomfort during sexual intercourse increase with severity.[30]

A very effective way of managing pelvic organ prolapse symptoms is through use of a vaginal support pessary. A pessary is a plastic or silicone device that fits inside the vagina to help support the pelvic organs. They are suitable for most people and a

---

[28] NICE (2018) Eating disorders. Quality standard QS175. Available at: Overview | Eating disorders | Quality standards | NICE Accessed 4 August 2025.
[29] Pelvic Obstetric and Gynaecological Physiotherapy and United Kingdom Continence Society (2021) 'UK Clinical Guideline for best practice in the use of vaginal pessaries for pelvic organ prolapse.' Available at: uk_pessary_guideline_final_april21.pdf. Accessed 8 August 2025.
[30] Royal College of Obstetricians and Gynaecologists (2022) Pelvic organ prolapse. Available at: Pelvic organ prolapse | RCOG. Accessed 8 August 2025.

doctor or specialist nurse will advise of the type and size needed with ring pessaries being the most commonly used.[29]

However, pessaries are only a small part of first line pelvic floor dysfunction management. Best practice requires consideration of the whole pathway including prescriptions of topical oestrogen if women have prolapse and genitourinary symptoms and signs associated with menopause[31], and referral to pelvic health physiotherapists. The importance of the Multidisciplinary Team (MDT) and in particular pelvic health physiotherapists was highlighted as critical for the structure of this pathway. Referral to see a pelvic health physiotherapist for pelvic floor muscle exercises needs to be included.

A primary care pathway with speciality support (urogynaecology clinics in secondary care) for more complex cases is recommended. However, for routine prolapse and pessary assessment, fitting and review, and to reduce use of specialist appointments for routine care this service should sit within primary care (General Practice, Primary Care Networks (PCNs), Women health Hubs).

Key to providing the service are appropriately trained, accredited and experienced clinicians supported by urogynaecological services under a shared care arrangement for ongoing training and escalation of more complex cases. The particular problems with retained pessaries causing serious pelvic floor ulceration and the follow up of mentally frail patients who might move out of an area with an established subspeciality primary care service on new care home placement were highlighted.

There was discussion around who should initiate a pessary and vaginal and pelvic assessment. A woman can present with a vaginal prolapse secondary to other gynaecological problems, which can include both benign and (rarely) malignant pathology. Accurate assessment and diagnosis, including exclusion of other gynaecological pathology presenting as prolapse, is essential.[30] Whilst GPs have the ability to assess for pathology, there was acknowledgement that this is a multidisciplinary approach to care, and having the experience to obtain a holistic history and examination requires training and understanding of this area.

The panel considered the gold standard guideline for pessary use for prolapse is the 2021 guideline hosted by the Pelvic Obstetric and Gynaecological Physiotherapy.[28] The pathway needs to be designed to empower patients to self-manage pessary insertion when and where this is possible and there is a desire by the patient to do so.

---

[31] NICE (2019) Urinary incontinence and pelvic organ prolapse in women: management. Nice guidance NG123. Available at: Urinary incontinence and pelvic organ prolapse in women: management Accessed 8 August 2025.

Women's Health Hubs (WHHs) were introduced as part of the Women's Health Strategy for England.[32] Owing to the non-recurrent national funding received many pilots have not progressed into embedded services however there are examples of those that have and who are reporting excellent outcomes, such as the Guildford and Waverley Community Gynaecology Service, the North West London Gynaecology Collaborative and the North East London Women's Health Hub. The panel heard how WHHs support and facilitate the skills and training of the MDT, promote collaborative relationships between primary and secondary care colleagues and assist with patient flow/secondary care wait times.

Considerations for transgender women and transgender men

Patients who have had a vaginoplasty may experience a prolapse but this is likely to be rare. Transgender men who have not had gender reassignment surgery and therefore have female anatomy may also experience a prolapse. Healthcare providers will need to be aware that transgender men may experience the same symptoms as cisgender women and therefore need to have knowledge about transgender health and use appropriate language. If there is no hormone therapy or gender affirmation surgery, then anatomically this client group should not be treated any differently from a gender assigned at birth female in terms of appropriateness for consideration of a pessary. Hormone therapy may lead to tissue and natal organ changes that may not support the use of a pessary. WHHs would not be appropriate for people who do not identify as female.

Further evidence:

Long-term continuations rate of ring pessary use for symptomatic pelvic organ prolapse.

Recommendations:

R35. Adopting a 'hub' approach seems most feasible and practical for primary care:

- **WHHs are a holistic and practicable way to provide care to this group of women but the right people need to be in place with the right training and competencies.**
- **GP hubs are also possible by training and employing people to offer pessary fitting and review clinics. This could involve having external people, such as allied health professionals (AHP) and**

---

[32] Department of Health and Social Care. (2022) Policy paper: Women's Health Strategy for England. Available online at: Women's Health Strategy for England - GOV.UK Accessed 4 August 2025.

advanced care practitioners (ACP) to support outreach clinics from specialist services if appropriate.

Both of the above need development of an agreed pathway for onward referral into secondary care when appropriate.

R36. Establishment of a database of women who have had pessaries fitted and recall and register system of patients with pessaries needs to be a practice standard. Practices should keep a register and perform annual register validation to mitigate against loss of contact with patients with pessaries and the resulting complications. As with other areas recall of patients is hindered by inadequate IT systems.

R37. Consideration of ringfenced funding for pelvic health physiotherapist roles in the management of pessaries would be helpful. Nationally, wait times for routine pelvic health physiotherapy are incredibly high (over one year in parts of Sussex) therefore it is not appropriate for these patients to be referred into the current secondary care service provision. Placing the pelvic health physiotherapist role either as first contact practitioner or as advanced practice roles in primary care would help facilitate timely consultation.

R38. Transgender men and people who do not identify as women but may have pelvic organ prolapse need to feel welcome and supported by healthcare services. This means having safe and clear routes of access and care that takes a tailored approach and appreciates what matters to the patient.[16]

Workforce

Workforce continues to be a challenge for the NHS. The NHS Long Term Workforce plan LTWP[33] made the case for a more strategic approach to workforce planning and proposed actions to be taken locally, regionally, and nationally to address current and future challenges. The recently published NHS 10-Year Health Plan reconfirms the healthcare workforce need to be fit for the future, adapting to the dynamic nature of health and care delivery.[1] Discussions on panel day reflected these ambitions.

---

[33] NHSE (2023) NHS Long Term Workforce Plan. Available at: NHS Long Term Workforce Plan Accessed 4 August 2025.

The panel was unanimous in its recognition and support of the importance for ongoing high-quality training for staff in all the clinical areas. This was in relation to the whole MDT inclusive of administrative staff. While the panel felt that many of the core skills existed as part of healthcare professional training, extended and specialist roles for nurses and allied health professionals and revision of knowledge and skills for all to deliver the best care was welcomed. It was expressed that local training from secondary care specialist teams is highly valued, particularly when including case-based discussion, and has the added benefit of promoting professional relationships which in turn facilitate communication and collaboration.

Where specific skills and knowledge were thought by the panel to be required for the clinical areas under review they have been listed as recommendations below.

DOAC

The competencies required to deliver this pathway include safe prescribing and on-going monitoring and dosing. In primary care DOACs can be initiated by GPs and nurses or pharmacists if within their scope. Pharmacy teams in primary care are ideally placed to undertake on-going DOAC reviews, monitoring and dose adjustment.

Recommendations:

R39. Workforce training is required to ensure baseline tests are undertaken for safe initiation and on-going prescription.

R40. Knowledge of where DOACs should not be used is a requirement (warfarin and low molecular weight heparins may still be needed for some patients).

R41. Knowledge/access to check for drug interactions is a requirement.

R42. Knowledge of the dose of DOAC for the given indication and the criteria for 'normal dose' or 'reduced dose' is required.

DMARD

It is necessary to review blood results as a continuum. The SCP paperwork associated challenges and recommendations were noted on p14 of this report.

PELVIC ORGAN PROLAPSE

Competencies required to deliver best practice are those set out in the UK clinical guidelines for best practice in the use of vaginal pessaries for pelvic organ prolapse.[34]

R43. Some nurses and physiotherapists are already trained; some are not but would be appropriate to fit pessaries with the right training. Training more nurses and physiotherapists would help to alleviate GP services.

6. Engagement

Clinical

It is well documented that for patient safety, staff wellbeing and a positive workplace culture, staff need to feel in control and belong to a cohesive team.[35] [36] [37]

Recommendations:

R44. Increased inclusion of hospital based specialists in these types of reviews.

R45. A system wide approach. This would involve ICB teams working together and the whole MDT to be involved in patient pathway design at the earliest possible stage.

R46. Region wide ICB collaboration and sharing of best practice.

R47. Attention to workplace culture. Development of supportive relationships between primary and secondary care colleagues to facilitate safe care.

---

[34] Available at: logbook_editable_1.pdf Accessed 8 August 2025.

[35] West, M and Coia, D (2019) Caring for doctors caring for patients. Available at: caring-for-doctors-caring-for-patients_pdf-80706341.pdf Accessed 8 August 2025.

[36] The King's Fund (2020) The courage of compassion. Supporting nurses and midwives to deliver high-quality care. Available at: The courage of compassion: Supporting nurses and midwives to deliver high-quality care Accessed 8 August 2025.

[37] Available at: NHS England » The Promise Accessed 8 August 2025.

Patients and the Public

Putting people at the heart of service change is about commissioners and providers making choices about what is right for the NHS, taking due account of the needs and choices of patients and their families and carers.

Due to extenuating circumstances patient and public representation on panel day was not possible however patent and public senate council members have reviewed and provided feedback on this report. The senate management team acknowledge this is an area which needs to be strengthened in future discussions of the clinical areas of this review.

This review highlighted areas where through working with patients, their families and the public patient information could be strengthened. These have been discussed under the separate clinical areas and health inequalities sections of this report.

Recommendations:

R48. Further patient and public panel views are required for all clinical pathways reviewed.

R49. ICBs to prioritise working with patients, families and carers to codesign and develop clinical pathways.

R50. To ensure holistic care it is essential that service users contributing their views span all geographies and demographic groups, including the 9 protected characteristics.

For further information on co-production and patient pathway transformation please see the South East Clinical Senates report, ‘Putting people at the heart of service change’.[38] This report provides many valuable and informative cases of co-production in action and what has been achieved as a consequence of enabling people with lived experience to be equitable team members.

---

[38] Available at: Putting-people-at-the-heart-of-service-change-report-v.-Final-.pdf Accessed 4 August 2025.

7. Health Inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. They arise because of the conditions in which we are born, grow, live, work and age. These conditions influence how we think, feel and act and can impact both our physical and mental health and wellbeing.

Within this wider context, healthcare inequalities are about the access people have to health services and their experience and outcomes.

Some factors that may affect a person's access and experience include:

- availability of services in their local area
- service opening times
- access to transport
- access to childcare
- language (spoken and written)
- literacy
- poor experiences in the past
- misinformation
- fear.[39] [40]

Reducing Inequalities

When planning healthcare pathways the NHS, including ICBs, have two separate duties.

All public authorities are required to have due regard to the aims of the Public Sector Equality Duty (PSED) of the Equality Act 2010 in exercising their functions, such as when making decisions and when setting policies. NHS Commissioners have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (the National Health Service Act 2006 as amended by the Health and Social Care Act 2012).[41]

---

[39] Available at: NHS England » What are healthcare inequalities? Accessed 8 August 2025.
[40] The King's Fund (2022) What are health inequalities? Available at: What Are Health Inequalities? | The King's Fund Accessed on 8 August 2025.
[41] Available at: NHS England » Equality and health inequalities legal duties Accessed on 8 August 2025.

Clinical pathways should also include the Core20PLUS5 and associated initiatives (for both adults and children)[42] [43] and the NHS 5 health inequalities strategic priorities.

- Restoring NHS services inclusively
- Mitigating against digital exclusion
- Ensuring data are complete and timely (for example ethnicity recording and other long term conditions
- Accelerating prevention programmes
- Strengthening leadership and accountability (for example, having a named strategic lead for health inequalities for locally enhanced services in an area)[44]

Examples of plus groups include carers, the homeless, people with poor general and health literacy, people involved with the criminal justice system, refugees and asylum seekers.[45] [46] It is important to remember that many of these people have protected characteristics and that people can be experiencing multiple layers of disadvantage and be members of more than one plus group.

The NHS has also published the Inclusion Health Framework to help systems to plan, develop and improve health services to meet the needs of people in inclusion groups. Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.

To demonstrate meeting these requirements, an equalities and health impact assessment (EHIA) should be carried out during the development of each clinical pathway[47]. Various guidance documents and templates[48] are available and it does

---

[42] Available at: NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities Accessed on 8 August 2025.
[43] Available at: NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people Accessed on 8 August 2025.
[44] NHSE (2021) 2021/22 priorities and operational planning guidance: Implementation guidance. Available at: Report template - NHSI website Accessed on 8 August 2025.

[45] Available at: NHS England » Inclusion health groups Accessed 8 August 2025.
[46] Available at: NHS England » A national framework for NHS – action on inclusion health Accessed 8 August 2025.
[47] Available at: Health Equity Assessment Tool (HEAT) - GOV.UK Accessed 8 August 2025.
[48] Available at: NHS England » NHS England: Equality and Health Inequalities Impact Assessment (EHIA) Accessed 8 August 2025.

not need to be onerous. The aim is to identify groups that are at risk of disadvantage or further disadvantage and then look for solutions that are practicable, if possible.

Below are some examples for the clinical areas under review:

- Prostate cancer - those who are more deprived are more likely to have metastatic disease at diagnosis. Black men and those with BRCA gene mutations have a higher risk of prostate cancer.
- Pelvic organ prolapse - client group are female and often older, may be issues of cognitive impairment.
- Bariatric surgery - people with a learning disability or severe mental health are more at risk of living with overweight or obesity and may require additional support for some interventions.
- For all pathways - older people may need specific consideration in the guideline as they may require additional support for some interventions.

The principles of shared decision making and personalised care should be built into the development and implementation of all clinical pathways. For example, the panel heard the lack of a 3 month supply of DMARD medication is affecting poorer patients, patients with reduced mobility and those vulnerable by being on immunomodulators. This has resulted in patients running out (reduced adherence) and/or not being able to afford monthly prescriptions.

Digital Inclusion Needs

This is affected by access issues (infrastructure issues or poverty) and then digital literacy. We heard on panel day an example of a patient who needed to be in work to have internet access. Some groups with protected characteristics and/or from inclusion groups will be more affected than the general population.[49] [50] [51] The Government's ambition of making the NHS App the digital front door to the health service and managing online healthcare as easy as online banking[52] is welcome. Nevertheless, the NHS App will only work for some.

---

[49] Available at: Digital Inclusion Action Plan: First Steps - GOV.UK Accessed 8 August 2025.
[50] Available at: NHS England » Inclusive digital healthcare: a framework for NHS action on digital inclusion Accessed 8 August 2025.
[51] Available at: A resource for addressing belief and trust barriers to using digital health services | Good Things Foundation Accessed 8 August 2025.
[52] Available at: Managing healthcare easy as online banking with revamped NHS App - GOV.UK Accessed 4 August 2025.

Joined Up Care

Reducing health inequalities is embedded in a population health management (PHM) approach. A PHM approach improves population health through data-driven planning, to understand the needs of a population and to target the delivery of proactive care to those individuals with increased health risk and poorer outcomes.[53] NHS England is creating the infrastructure to facilitate this in primary care,[52] [54] [55] for example using the Johns Hopkins Adjusted Clinical Groups System population segmentation model to identify individuals at higher risk.[56] This could also be supplemented by people on multiple disease registers if not included in the outputs.

People on multiple disease registers present a higher level of complexity for clinicians to navigate and manage. This is especially true for people with multiple long-term conditions, frailty, cognitive impairment (for example people with learning disabilities or dementia), other members of high risk groups who have difficulty accessing care and/or at higher risk of health conditions (for example members of inclusion health groups) or people with severe and enduring mental health illness and people in care homes.

Patient Safety

There are safeguarding considerations for people who are identified at risk and for whatever reason may have greater difficulty complying with registers and appointments. A fail-safe system should be developed with learning from serious incidents and other incidents. This could be across ICBs (see population health management above and joining up people on risk registers). Call/recall systems are a high area of risk that needs to be managed.

Recommendations:

R51. To improve equity of access, regional variation in services needs to be reduced.

---

[53] Available at: NHS England » Population health management Accessed 4 August 2025.
[54] Available at: Network Contract DES Contract specification 2025/26 – PCN requirements Accessed 10 July 2025.
[55] Available at: PowerPoint Presentation Accessed 4 August 2025.
[56] Available at: NHS England » Transforming care through modern general practice and population segmentation Accessed 8 August 2025.

R52. Complete an EHIA during the development of each clinical pathway. This is a nice framework for thinking about protected characteristics and different groups.

R53. Identification and management of high risk groups, for example in the population health management approaches may be helpful future mitigations. As part of the development process, teams should seek the views and comments from members of these communities. Use the learning from the COVID-19 pandemic initiatives and work with community leaders to raise awareness of conditions and actions needed. Such as PSA checking for Black men.

R54. Consider how these best practice pathways can be shared with prisons and immigration removal centres. Such pathways are more complex because of the interface with community services under challenging circumstances. These people should receive the same level of care as people in the community.

R55. There should be ongoing monitoring of health inequalities in the implementation and ongoing delivery of care pathways to ensure that health inequalities and digital inclusion are not widened. Any issues can then be identified early and mitigations put in place. Leadership and data are essential (see 5 strategic priorities above).

R56. Digital inclusion needs to be considered (see above).

R57. Communication and leaflets in a variety of different formats and languages are needed. Web based solutions are only an option for some.

R58. Systems to join up appointments for interventions for people with multiple conditions and on different disease registers.

R59. Improve access to services for those with reduced mobility/cognitive comprehension. For example, house bound patients, hospital transport is available but NHS transport service does not include getting to the GP.

R60. Develop a range of different models of care to improve access, such as practices buddying up to provide services. This could be

extended to look at services for people at high risk of developing a disease.

R61. A fail-safe system should be developed with learning from serious incidents and other incidents. This could be across ICBs.

R62. Care pathways need to be cognisant of intersectionality and the multiple aspects of a person's identity that can combine to make unique forms of discrimination and inequity.[57] Please see PSA page 21 and pelvic organ prolapse page 31 recommendations also.

For further information on health inequalities and patient pathway transformation see the South East Clinical Senates report, 'Health Inequalities within the southeast region through as service change lens'.[58] The aim of this report is to provide guidance to systems, it provides practice examples and signposts to further information and resources.

8. Healthcare Sustainability

Climate change is a health emergency, the impacts of which threaten the foundations of good health and of health systems to deliver high quality care.[59] Healthcare itself contributes approximately 4-5% of global greenhouse gas emissions,[60] and in response the NHS in England became the world's first health system to commit to reaching net zero carbon by 2045,[61] an ambition recently reinforced in the 10 Year Health Plan.[1]

Delivering low-carbon care requires a comprehensive approach in order to navigate the complexities and pressures on healthcare systems, but in turn promises to deliver efficiency and cost co-benefits, maintaining or improving patient care.

---

[57] Available at: Resources for Professionals - OUTpatients Accessed 4 August 2025.

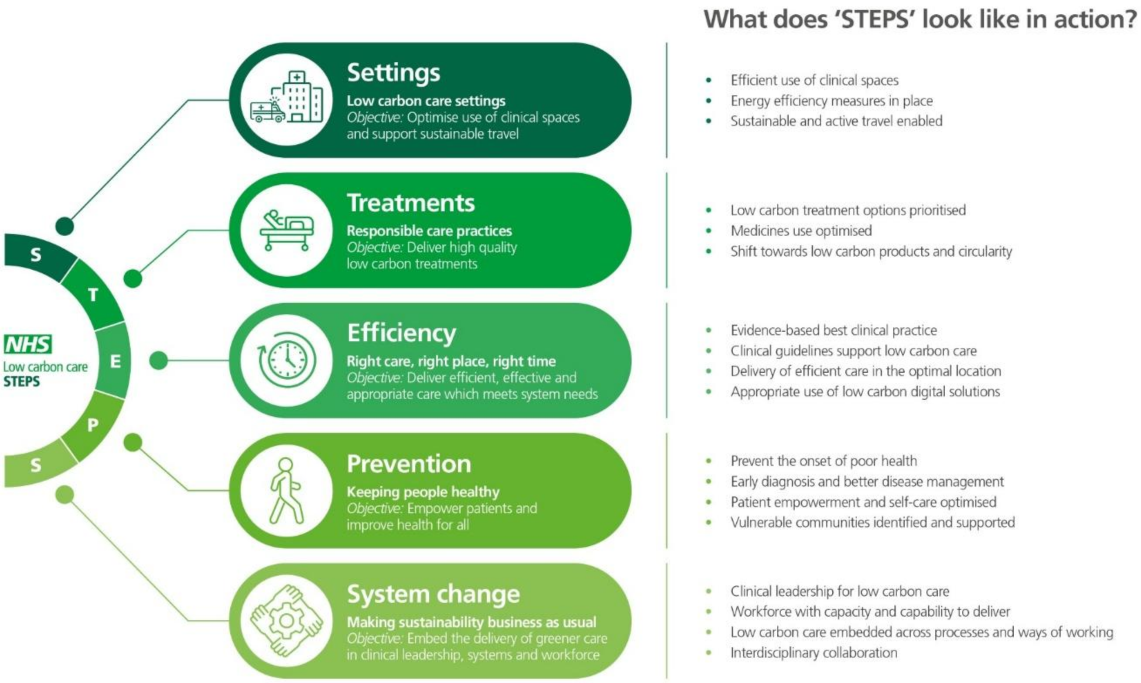
[58] Available at: Health-Inequalities-within-the-southeast-through-a-service-change-lens-v.Final_.pdf Accessed 4 August 2025.

[59] Romanello M, Di Napoli C, Green C et al. (2023) Available from: The 2023 report of the Lancet Countdown on health and climate change: the imperative for a health-centred response in a world facing irreversible harms - The Lancet *Lancet*; **402**: 2346–2394. Accessed 8 August 2025.

[60] ARUP (2019) Healthcare's climate footprint. Available at: https://www.arup.com/insights/healthcares-climate-footprint/ Accessed 8 August 2025.

[61] Available at: Greener NHS » Delivering a 'Net Zero' National Health Service Accessed 8 August 2025.

The low-carbon care STEPS framework in figure 1 can be used to support the delivery of low carbon care across all clinical healthcare services. The framework enables consideration of the whole patient pathway, encompassing the breadth of actions and opportunities and highlights the importance of joined-up, synergistic action.[62]



Settings
Low carbon care settings
Objective: Optimise use of clinical spaces and support sustainable travel

Treatments
Responsible care practices
Objective: Deliver high quality low carbon treatments

Efficiency
Right care, right place, right time
Objective: Deliver efficient, effective and appropriate care which meets system needs

Prevention
Keeping people healthy
Objective: Empower patients and improve health for all

System change
Making sustainability business as usual
Objective: Embed the delivery of greener care in clinical leadership, systems and workforce

What does 'STEPS' look like in action?

- Efficient use of clinical spaces
- Energy efficiency measures in place
- Sustainable and active travel enabled

- Low carbon treatment options prioritised
- Medicines use optimised
- Shift towards low carbon products and circularity

- Evidence-based best clinical practice
- Clinical guidelines support low carbon care
- Delivery of efficient care in the optimal location
- Appropriate use of low carbon digital solutions

- Prevent the onset of poor health
- Early diagnosis and better disease management
- Patient empowerment and self-care optimised
- Vulnerable communities identified and supported

- Clinical leadership for low carbon care
- Workforce with capacity and capability to deliver
- Low carbon care embedded across processes and ways of working
- Interdisciplinary collaboration

Figure 1: Summary of the Low-Carbon Care STEPS framework, formed of five guiding principles for delivering high-quality, equitable, low-carbon care. This infographic outlines the key details for each of the five 'STEPS', including the objective of each one, and the core delivery actions required. While this framework is divided into five key areas for action, there is no requirement to consider or implement the principles in a linear or sequential manner.

Many recommendations in this report are already aligned with actions that can be taken to lower the carbon impact of healthcare delivery. The healthcare sustainability effects of these have been highlighted in the recommendations below.

---

[62] Hyde J, King E, John, J et al (2025) Perspectives on technology: All STEPS count - an integrated framework for net zero urological care. Available at: [Perspectives on technology: All STEPS count – an integrated framework for net zero urological care - Hyde - 2025 - BJU International - Wiley Online Library]() Accessed 8 August 2025.

Recommendations:

R63. Settings: Maximising the use of low-resource, energy efficient care settings for patient consultations and procedures where possible. The 'hub' approach as described in the pelvic organ prolapse section of this report is likely to have positive patient outcomes with additional climate mitigation co-benefits of reducing often longer-distance visits to more high intensive energy settings in secondary care.

R64. Settings: Embedding energy efficiency into infrastructure and improving energy efficiency through behaviour change, for example, ensuring that computing equipment is switched off when not in use. The behaviour change initiative 'Operation TLC' (Turn off equipment, Lights out, Control temperatures) saved 2200 tCO_2e and £0.5m in 1 year at one NHS trust,[63] [64] with projected annual reductions of £35m and 155 $ktCO_2e$ if implemented across all trusts nationally.

R65. Treatments: Applying sustainable procurement principles and shifting towards circularity utilising the five Rs (Reduce, Reuse, Repair, Remanufacture/Repurpose and Recycle), across the breadth of clinical services. This may include the reduction in unnecessary glove and couch roll use, considering reusable alternatives, for example vaginal speculum, and appropriate use of waste management systems across the clinical pathways, all of which have significant cost and carbon savings.

R66. Treatments: Identifying and prioritising low-carbon treatments and optimising medicines involves reviewing the practices, products and treatments used across clinical pathways, mentioned multiple times across this report.

R67. Efficiency: Streamlining care pathways to reduce unnecessary appointments, procedures (e.g. imaging and pathology testing), and follow ups through patient initiated follow ups, same-day or one-stop

---

[63] Major J, Puddy E (2020) *Sustainability: energy use and water consumption*. London: Royal College of Anaesthetists, 2020. Available at: https://www.rcoa.ac.uk/sites/default/files/documents/2021-12/Energy%20use%20and%20water%20consumption%20final.pdf Accessed 28 July.

[64] Limb M. (2013) Hospital trust cut energy bill by £100000 by switching off lights and closing doors. *BMJ* **346**: f2844 Hospital trust cut energy bill by £100 000 by switching off lights and closing doors | The BMJ Accessed 28 July.

appointments and with the right clinician are all excellent low-carbon care examples.

R68. Efficiency: Shifting care to community and home settings or using digital technologies to reduce patient travel and optimise care delivery where appropriate are further examples detailed in sections of the report of low-carbon care.

R69. Prevention: Promoting active lifestyles and low-carbon diets is an essential aspect of primary prevention to reduce the onset of poor health and resultant financial and carbon cost of healthcare interventions, but it has particular relevance to secondary prevention in all of the clinical pathways included in this report.

R70. Prevention: Early diagnosis, better disease management and empowering patients to manage their own health was detailed strongly across several sections of the report, which will in turn reduce healthcare visits and their associated emissions improving population health.

R71. System: A recognition that the application of low-carbon care requires clinical leadership supported by workforce who have had training in low-carbon care in order to embed sustainability into the operations, governance, standards and policies across the breadth of clinical pathways, evidenced by strong organisational green plans.

Further evidence

Carbon emissions from clinical activities by speciality in secondary and tertiary care in England: an exploratory cross-sectional analysis of routine administrative data - ScienceDirect

Perspectives on technology: All STEPS count – an integrated framework for net zero urological care - Hyde - BJU International - Wiley Online Library

Getting It Right First Time (GIRFT) - Greener NHS Knowledge Hub - Futures

For further information on healthcare sustainability and patient pathway transformation see the South East Clinical Senates report, ‘Embedding healthcare sustainability in major service change’.[65] The aim of this report is to provide guidance

---

[65] Available at: Embedding-sustainability-in-service-change-final-report.pdf Accessed 4 August 2025.

to systems; it provides key questions for systems to ask themselves and examples of good practice.

9. Strategic and System Learning

The panel day for this review was long and varied with a rich and valuable discussion. All present appreciated the opportunity to discuss the issues and the learning that resulted.

Regional variation

It is clear there is regional variation and the mechanisms to standardise pathways to ensure equity of access to best practice would be welcomed by the panel. We have made a key recommendation about patient centred coordinated care at the beginning of this report on page 9. Overall this can be summarised by adopting a ‘do it once and do it right’ ambition.

Demand management

R72. For cancer and other diseases, if a celebrity is diagnosed or died, better preparation for primary care and testing is needed to mitigate overloading the system. It would be beneficial in these instances to coordinate with other stakeholders, for example, Cancer Alliances.

R73. National communication to establish patient and public expectation. For example, as new drugs and technology become available.

R74. National communication with patient written and digital communication to include warnings and when a patient needs to contact their healthcare provider.

COVID-19

The continued learning from the COVID-19 pandemic is listed below.

R75. During the pandemic not all women were able to have the pessary changed every 6-months. Pessary changes could be extended to 9

months in certain cases. For example, for women not experiencing vaginal bleeding or offensive discharge.

R76. Contingency planning in the event of any disruption to services/access. For example, supporting patients to self-manage where possible and appropriate to do so.

R77. Ensure remote access review is built into pathways as standard.

10. Conclusion

This review of clinical pathways identified as areas of uncertainty and differing opinion was conducted just prior to publication of the NHS 10-year health plan which pledged to introduce a neighbourhood health service to ‘bring care into local communities, convene professionals into patient-centred teams and end fragmentation’.[1] The 10-year health plan[1] also highlighted inequalities in access to care and inequitable outcomes, particularly in rural or coastal areas and in areas of high deprivation, all of which are highly prevalent in the South East region.

The seven clinical areas reviewed are all examples of pathways of care that are already being delivered in local communities across much of the South East. The recommendations we have made in this report are aimed at standardising best practice, equity of access and avoidance of harm. Each of the pathways rely on true integration of care, sharing of information between GP practices, primary care and secondary care; together with responsive, easily accessible specialist care and support when required. Innovative use of information technology support for patient recall and patient self-management wherever possible are universal requirements. Critically treatment and monitoring recall information should follow patients as they move between healthcare providers and prompt appropriate actions. Delivery of care must adhere to the principles of patient need and patient choice, recognising that the nature of some of the clinical areas, such as eating disorders and insertion and management of ring pessaries, may require a networked solution.

Certain clinical areas reviewed in the report, such as PSA testing and post-bariatric surgery monitoring, are highly topical and link to key health priorities. Prostate cancer is a major issue in terms of numbers of people affected. The identification of those benefiting from PSA testing in the future will link to the NHS Genomics Medicine Service that is proposed to integrate genomic testing for pharmacogenomic profiles into the NHS over-40s Health Check.[66] Bariatric surgery is one treatment modality for obesity and links to proposals to end the obesity epidemic. Post-bariatric surgery monitoring forms part of the comprehensive weight management services proposed to be delivered through Neighbourhood Health Centres.

Crucially, given the lead time for the training of professionals in new or extended roles, this means that undergraduate training, apprenticeships, postgraduate training, research and continuous professional development must be considered for all members of the multi-professional health and care workforce. Key challenges facing ICBs and providers undergoing reconfiguration in terms of workforce are addressed in our allied report 'Teaching, Training and Research: Workforce considerations for major service change'.[67]

For all clinical areas clearly articulated and understandable patient information, available in different formats and languages, that is standardised and applicable across the region should be a prerequisite. For example, the national PSA testing and prostate cancer advice for men without symptoms of prostate disease.[68]

Safe working practices are integral to high quality patient care. Where best practice requires adaptation of existing patient pathways and doing things differently identification of the skills requirements and workforce planning needs to be ahead of the service need. The NHS 10-year health plan advocates for 'consistent, joint funding to those services which are essential to deliver in a fully integrated way' and for 'NHS funding flows increasingly sensitive to patient voice, choice and feedback'.[1]

The remit of this review excluded making recommendations for commissioning of services, but it is clearly impossible to disconnect funding flows from clinical pathway delivery and the two are mutually reliant. A year ago, GPs in England had begun to take collective action, essentially pushing back on unfunded work. The successful delivery of the seven clinical pathways considered in this review, and that of many more besides, relies on money increasingly following patients through their life course, as promised in the 10-year health plan.

Clinical Senate recommendations are not mandatory but reflect the considered opinion of a group of independently acting clinicians and others after reviewing the

---

[66] Available at: https://www.nhs.uk/tests-and-treatments/nhs-health-check/ Accessed 8 August 2025.
[67] Available at: 090124-Teaching-Training-and-Research_Worforce-Considerations-for-Major-Service-Change-Final.pdf Accessed 8 August 2025.
[68] Office for Health Improvement and Disparities (2024). PSA testing and prostate cancer: advice for men without symptoms of prostate disease. Available at: https://www.gov.uk/government/publications/prostate-specific-antigen-testing-description-in-brief/psa-testing-and-prostate-cancer-advice-for-men-without-symptoms-of-prostate-disease-aged-50-and-over Accessed 8 August 2025.

material shared with them within the timescales required. It is hoped that the range of recommendations in this report will help to improve the quality of care and access to that care for the population of the South East region.

Appendix A - South East Clinical Senate Review Group membership for Expert Panel Review day

Name	Roles
Bruce Allan	Clinical Director Primary Care Sussex
Jacqueline Anderson	Medical Director Surrey and Sussex LMC
Victoria Asfour	Consultant Urogynaecologist
Claire Brown	Clinical Specialist Pelvic Health Physiotherapist and Pre-Doctoral Research Fellow
Sam Clark-Stone	Chair of the British Society of Eating Disorders. Mental Health Nurse, Eating Disorders Service at Gloucestershire Health & Care NHS Foundation Trust
Chrissie Clayton	Senior Medical Director Sussex LMC
Isabella D'Almeida	Professional Lead Perinatal Pelvic Health Service - Sussex LMNS
Zaid Hirmiz	Hampshire and Isle of Wight deputy CMO
Joanna Hollington	Principal Dietitian and Dietetic Lead for Bariatrics at Guys and St Thomas NHS Foundation Trust
Jack Jacobs	Kent LMC Medical Director
Michael Jenkinson	Consultant Physician and Medical Examiner
Sashi Kommu	Consultant Pelvic Cancer Urological Surgeon and Honorary Professor of Urology & Cancer Biology at the School of Biosciences, University of Kent and The East Kent Hospitals University NHS Foundation Trust
Jackie Mcglynn	GP and Frimley ICB Clinical Lead Urgent Care, Pain, Stroke and Gynaecology
Donna Meers	Clinical Lead Pelvic Health Physiotherapist at Maidstone and Tunbridge Wells
Patience Okorie	GP and Clinical Director Children and Maternity Services/ Population Health , NHS Sussex
Ashwani Peshen	Deputy CMO for Kent and Medway

Catherine Roughley	Consultant Haematologist
Fiona Rees	Consultant Pharmacist - Gastroenterology
Matt Smith	Consultant in Public Health, Specialised Commissioning and Health & Justice lead. Public Health Directorate, NHS England, South East Region
Jade Stacey	NICE implementation consultant (London and South East Region)
Sarah Steely	GP and Shadow Director of PCN for Care Collaborative. Clinical Lead for Diabetes at Surrey Heartlands Integrated Care System
Alison Warren	Consultant Pharmacist Cardiology
Karen Wilkinson	Uro-Oncology Clinical Nurse Specialist, University College London Hospital
Paul Vinson	West Sussex LMC Chair
Senate Management Team	Paul Stevens, Chair of South East Clinical Senate Sally Smith, Vice Chair of South East Clinical Senate Emily Steward, Head of South East Clinical Senate

South East Clinical Senate Review Group membership (Clinical Synopses and Desktop Reviewers)

Name	Roles
Lorraine Albon	Consultant Physician, Western Sussex Hospitals Foundation Trust (Lead Bariatric Physician). BOMSS member
Raj Bajwa	GP and Clinical lead for research and innovation in Buckinghamshire, Oxfordshire and Berkshire
Helen Barnes	Clinical Lead, Guildford & Waverley Community Gynaecology Service. GP Lead for Women's Health, Guildford & Waverley Alliance
Steve Bourne	Patient and Public Partner
Ritchie Chalmers	Deputy CMO for Secondary Care in Kent and Medway ICB
Jessie Frost	Strategy Manager, Net Zero Clinical Transformation, Greener NHS, NHSE
Karen Garratt	Colposcopy and Urogynae Nurse Specialist
Gaurav Gupta	Kent LMC Chair
Ruchika Gupta	GP and Clinical Director Long Term Planning Delivery, Surrey Heartlands ICB
Jin Lindsay	Consultant Haematologist. Haemato-Oncology, Kent &Canterbury Hospital
Sarah Markham	Patient and Public Partner
Louise Mercer	Co-chair British Society for Rheumatology. Consultant Rheumatologist at Stockport NHS Foundation Trust
Faz Pakarian	Consultant Gynaecologist and Urogynaecologist

Appendix B – Key Lines of Enquiry (KLOEs)

Clinical Area

- Is a primary care pathway feasible?
- Is a primary care pathway practicable?
- How would such a pathway best be structured?
- Should a primary care pathway be recommended? If not, what does the pathway need to look like to deliver best practice and equity of access to care?
- Is there any further clinical evidence that needs to be considered?
- What future needs for this patient group should be reflected in the pathway?
- What is the key patient information required for the pathway?
- Are there illustrative patient stories that can be used?
- Is there commissioning in place to support this area already - nationally, or locally (any area)? And if so, what can we learn from this?
- Any gaps or other feedback?

Workforce

- What are the competencies required to deliver the pathway?
- Do the required competencies require new skills and workforce training before delivery?
- Which members of the workforce are required to deliver the pathway and does this involve integrated multidisciplinary input?
- Any gaps or other feedback?

Engagement

- Are there special considerations for engagement about the pathway design with patients?
- Are there special considerations for engagement about the pathway design with staff?
- Any gaps or other feedback?

Health Inequalities

- Does the pathway meet the requirements of Core20Plus5?

- Is the pathway consistent with patient need and patient choice? Are there any inequities to consider?
- What health inequalities need to be addressed to ensure access and quality outcomes for the most vulnerable?
- Any gaps or other feedback?

Healthcare sustainability

- What should be considered when developing best practice pathways in terms of healthcare sustainability?
- Any other gaps or other feedback?

Strategic

- What barriers and enablers should be considered for standardising pathways?
- Is there relevant system learning from COVID-19 to be taken into account as part of the plans?
- Any gaps or other feedback?

Appendix C - Agenda for Panel Day

Item	Time	Item
1.	10:00	Welcome and introductions
2.	10:10	Monitoring of eating disorders
3.	11:00	Post-bariatric surgery monitoring and management
	11:50	**Comfort Break**
4.	12:00	Pelvic organ prolapse - insertion and management of ring pessaries
5.	12:50	Prostate specific antigen (PSA) monitoring
	13:40	**Lunch**
6.	14:10	Direct oral anticoagulant (DOAC) management
7.	15:00	Disease modifying anti-rheumatic drug (DMARD) monitoring (non-biological DMARDs)
8.	15:50	Monoclonal gammopathy of undetermined significance (MGUS) follow up and monitoring
9.	16:40	Any final thoughts and reflections
	17:00	**Meeting Close**

Appendix D – Recommendations

Please note it is intended these be read within the context and alongside evidence provided in the report narrative.

Number Ref.	**Recommendations**
Key Recommendations p9-10	
Are made under the following headings: • **Person centred coordinated care** • **Health inequalities** • **Quality assurance**	
Direct Oral Anticoagulant (DOAC) management (pages 10-13)	
R1.	Consistent pathway guidelines inclusive of initiation, monitoring and recall. This should be standardised across the whole region.
R2.	An improved standard national patient information leaflet available in different languages and formats including online (the current NHS England leaflet is order only).[6] The leaflet should include risks and benefits, interactions with other drugs and monitoring frequency.
R3.	Provision of interoperable IT systems to assist patient safety,[7] particularly with regard to recall of patients prescribed DOACs for monitoring and key drug interaction alerts for agents that have significant effects on DOAC pharmacodynamics. For example, Optimise Rx.
Disease modifying anti-rheumatic drug (DMARD) monitoring (non-biological DMARDs) (pages 13-15)	
R4.	Hospital Trusts should have a database of patients for whom they have specialist responsibility for the relevant drugs and their own performance standards.
R5.	South East region adoption of a nationally mandated shared care protocol that applies to everybody. The current national shared care protocol does not cover all drugs, and others are locally written shared care agreements. Despite shared care protocols' length,

	national shared care protocols are all formatted the same, therefore it is known which section contains the responsibilities for the GP. If local shared care agreements are required the formatting should mirror that of the national document.
R6.	The need for minority specialities that prescribe DMARDs to be supported. This would support with communications, monitoring infrastructure and safe discharge for example. Currently larger users such as Rheumatology and Dermatology have their own infrastructure, shared care is less safe in other specialties that cannot justify or have the resource and organisation to do shared care monitoring and communication well.
R7.	Recommended changes to SCP paperwork: • Place repeatable information' online which would make it less unwieldy plus easier to update with changes. • SCP to move with the patient. Currently they do not follow patients when they move GPs, requiring GPs to request the information resent. • Ultimately send the SCP electronically.
R8.	Consideration of timing of recall of patients using a patient's specific needs, medical history and risk factors as the primary drivers for recall decisions. The panel heard that some practices in the region are piloting bringing those most at need in for review during the summer months rather than a birth date recall, with subsequent less frequent patient deterioration in the winter months together with a reduction in hospital attendances.
R9.	Triage the high risk complex reviews to GPs and low risk protocolised reviews to other healthcare professionals within primary care (nurse, pharmacists, paramedics).
R10.	Empowering patients to take ownership of their health by involving them in the recall process and for those with multiple long term conditions coordinating recall for monitoring.
Monoclonal gammopathy of undetermined significance (MGUS) (apges 16-17)	
R11.	Laboratory based audit across the region to determine the percentage of patients with known MGUS receiving annual monitoring and the completeness of that monitoring (full blood

	count, serum creatinine and calcium and protein electrophoresis for paraprotein).
R12.	Implement a simple standardised region-wide protocol for primary care follow up of low risk MGUS incorporating timely and responsive secondary care advice and guidance when required together with clear guidance for appropriate de-escalation of monitoring.
R13.	Case-based MGUS monitoring and referral education sessions from local haematology services.
R14.	Consider introduction of serum free light chains to obviate urine Bence Jones protein testing.
Prostate Specific Antigen (PSA) (pages 17-20)	
R15.	A single agreed pathway approach across the South East would be beneficial, particularly for high risk patients. In addition, for all patients the balance of testing in asymptomatic men as opposed to symptomatic men needs to be clear.
R16.	Clinicians should note that clinically relevant thresholds may depend on the specific PSA assay and that ideally the same assay is applied over time for better clinical decision making. Ideally within one cancer network the same PSA assay should be used.
R17.	PSA thresholds for referral of men for investigation and diagnosis of prostate cancer and PSA thresholds for re-referral of men with diagnosed prostate cancer undergoing primary care monitoring should follow national guidance and be standardised across the region.
R18.	For men who have undergone prostate ultrasound and/or Magnetic Resonance Imaging (MRI) the PSA density threshold can be used to guide referral for prostate biopsy. A commonly used threshold is 0.15 ng/mL/cm^3.[11]
R19.	Forward planning is required to ensure availability of resources, such as MRI scanning, to meet increasing demand in this area. This should include an assessment of current inefficiencies, for example inappropriate referral for prostate MRI and missed appointments.
R20.	There is a reluctance from men to be tested. While initiatives such as testing offers at football matches were welcomed these need to be discussed and coordinated with local general practices who

	experience a huge surge in patient enquiries and follow up as a result.
R21.	Transgender women and people who do not identify as men but have a prostate need to feel welcome and supported by healthcare services. This means having safe and clear routes of access and care that takes a tailored approach and appreciates what matters to the patient.[16]
Post Bariatric Surgery (Pages 20-23)	
R22.	Patient follow up 2-years post bariatric surgery is appropriate for shared care. However, the panel discussion highlighted that there is currently no consistency in practice. It is recommended all those involved in delivery of this pathway to work together to ensure patient safety, see appendix E, Sussex ICB Post Bariatric Surgery Follow-up Locally Commissioned Service.
R23.	Following discharge to primary care for monitoring a clear, responsible and reliable escalation pathway where primary care can seek advice from the secondary care bariatric team is required. This could be via email but crucially there needs to include an opportunity to have a conversation without making a referral. It would be helpful for specific timeframes to be made publicly available on Trust websites which would enable transparency for patients. Response times should not include 'holding' emails.
R24.	Guys and St Thomas' Trust (GSTT) has Commissioning for Quality and Innovation frameworks (CQUINs) in place for advice and guidance requests and the adoption of these for all secondary care bariatric services is recommended.
R25.	A risk awareness approach is required. The inability for some overseas/private patients to access NHS services post-surgery carries a risk for the health and wellbeing of the patient and longer-term resource implications for the health service. Principally these patients do need monitoring and there is a need for something to be established that healthcare teams can provide.
R26.	South East region wide patient information would assist in realising the above recommendations. Patient information should include: • Pre-operative information about access to NHS services in the immediate 2 years post-surgery for patients going abroad.

	- The importance of pre-operative psychological and nutritional advice and support for patients considering surgery overseas. - The lifelong consequences of bariatric surgery. - Which supplements are available over the counter and do not require a prescription.
R27.	Information on private care would benefit from policy support as inconsistencies are likely. It should be understood that funding for private surgery whether at home or abroad must include the 2 year follow up period post-surgery.
R28.	Post-bariatric surgery education for primary care/GP practices from local bariatric services to promote awareness of potential problems will both provide an understanding of monitoring and help establish links for when escalation is required and exactly who to escalate to locally.
Eating Disorders (pages 23-27)	
R29.	Primary care monitoring is probably not suitable for any other than the lowest risk patients but at all stages of care for this client group a clear, responsible and reliable escalation pathway into secondary care is critical. Responsiveness is key to enable step up and step down care.
R30.	Where physical monitoring takes place in general practice there must be clear criteria for escalation and delineation between escalation for physical health reasons versus mental health.
R31.	Risk stratification models require careful understanding and reflection for the individual patient. Continuity of carer and personalised care is of high importance.
R32.	A system wide approach is required for this vulnerable client group to ensure safe and consistent pathways that enable low risk patients to be monitored in primary care.
R33.	A properly trained and committed service within the community provided through, for example, a primary care network, rather than services provided by individual general practices should be considered.

R34.	People with eating disorders who are being supported by more than one service have a care plan that explains how the services will work together to support them.[28]
Pelvic organ prolapse - insertion and management of ring pessaries (pages 27-30)	
R35.	Adopting a 'hub' approach seems most feasible and practical for primary care: • WHHs are a holistic and practicable way to provide care to this group of women but the right people need to be in place with the right training and competencies. • GP hubs are also possible by training and employing people to offer pessary fitting and review clinics. This could involve having external people, such as allied health professionals (AHP) and advanced care practitioners (ACP) to support outreach clinics from specialist services if appropriate. Both of the above need development of an agreed pathway for onward referral into secondary care when appropriate.
R36.	Establishment of a database of women who have had pessaries fitted and recall and register system of patients with pessaries needs to be a practice standard. Practices should keep a register and perform annual register validation to mitigate against loss of contact with patients with pessaries and the resulting complications. As with other areas recall of patients is hindered by inadequate IT systems.
R37.	Consideration of ringfenced funding for pelvic health physiotherapist roles in the management of pessaries would be helpful. Nationally, wait times for routine pelvic health physiotherapy are incredibly high (over one year in parts of Sussex) therefore it is not appropriate for these patients to be referred into the current secondary care service provision. Placing the pelvic health physiotherapist role either as first contact practitioner or as advanced practice roles in primary care would help facilitate timely consultation.
R38.	Transgender men and people who do not identify as women but may have pelvic organ prolapse need to feel welcome and supported by healthcare services. This means having safe and

	clear routes of access and care that takes a tailored approach and appreciates what matters to the patient.[16]
Workforce (pages 30-31)	
Where specific skills and knowledge were thought by the panel to be required for the clinical areas under review they have been listed as recommendations below.	
DOAC	
R39.	Workforce training is required to ensure baseline tests are undertaken for safe initiation and on-going prescription.
R40.	Knowledge of where DOACs should not be used is a requirement (warfarin and low molecular weight heparins may still be needed for some patients).
R41.	Knowledge/ access to check for drug interactions is a requirement.
R42.	Knowledge of the dose of DOAC for the given indication and the criteria for ‘normal dose’ or ‘reduced dose’ is required.
Pelvic organ prolapse	
R43.	Some nurses and physiotherapists are already trained, some are not but would be appropriate to fit pessaries with the right training. Training more nurses and physiotherapists would help to alleviate GP services.
Engagement (pages 32-33)	
Clinical	
R44.	Increased inclusion of hospital based specialists in these types of reviews.
R45.	A system wide approach. This would involve ICB teams working together and the whole MDT to be involved in patient pathway design at the earliest possible stage.
R46.	Region wide ICB collaboration and sharing of best practice.
R47.	Attention to workplace culture. Development of supportive relationships between primary and secondary care colleagues to facilitate safe care.

Patient and the public	
R48.	Further patient and public panel views are required for all clinical pathways reviewed.
R49.	ICBs to prioritise working with patients, families and carers to codesign and develop clinical pathways.
R50.	To ensure holistic care it is essential that service users contributing their views span all geographies and demographic groups, including the 9 protected characteristics.
Health Inequalities (pages 33-38)	
R51.	To improve equity of access, regional variation in services needs to be reduced.
R52.	Complete an EHIA during the development of each clinical pathway. This is a nice framework for thinking about protected characteristics and different groups.
R53.	Identification and management of high risk groups, for example in the population health management approaches may be helpful future mitigations. As part of the development process, teams should seek the views and comments from members of these communities. Use the learning from the COVID-19 pandemic initiatives and work with community leaders to raise awareness of conditions and actions needed. Such as PSA checking for Black men.
R54.	Consider how these best practice pathways can be shared with prisons and immigration removal centres. Such pathways are more complex because of the interface with community services under challenging circumstances. These people should receive the same level of care as people in the community.
R55.	There should be ongoing monitoring of health inequalities in the implementation and ongoing delivery of care pathways to ensure that health inequalities and digital inclusion are not widened. Any issues can then be identified early and mitigations put in place. Leadership and data are essential.
R56.	Digital inclusion needs to be considered.

R57.	Communication and leaflets in a variety of different formats and languages are needed. Web based solutions are only an option for some.
R58.	Systems to join up appointments for interventions for people with multiple conditions and on different disease registers.
R59.	Improve access to services for those with reduced mobility/cognitive comprehension. For example, house bound patients, hospital transport is available but NHS transport service does not include getting to the GP.
R60.	Develop a range of different models of care to improve access, such as practices buddying up to provide services. This could be extended to look at services for people at high risk of developing a disease.
R61.	A fail-safe system should be developed with learning from serious incidents and other incidents. This could be across ICBs.
R62.	Care pathways need to be cognisant of intersectionality and the multiple aspects of a person's identity that can combine to make unique forms of discrimination and inequity.[57] Please see PSA page 21 and pelvic organ prolapse page 31 recommendations also.
Healthcare Sustainability (pages 39-43)	
R63.	Settings: Maximising the use of low-resource, energy efficient care settings for patient consultations and procedures where possible. The 'hub' approach as described in the pelvic organ prolapse section of this report is likely to have positive patient outcomes with additional climate mitigation co-benefits of reducing often longer-distance visits to more high intensive energy settings in secondary care.
R64.	Settings: Embedding energy efficiency into infrastructure and improving energy efficiency through behaviour change, for example, ensuring that computing equipment is switched off when not in use. The behaviour change initiative 'Operation TLC' (Turn off equipment, Lights out, Control temperatures) saved 2200 tCO_2e and £0.5m in 1 year at one NHS trust,[63, 64] with projected annual reductions of £35m and 155 $ktCO_2e$ if implemented across all trusts nationally.

R65.	Treatments: Applying sustainable procurement principles and shifting towards circularity utilising the five Rs (Reduce, Reuse, Repair, Remanufacture / Repurpose and Recycle), across the breadth of clinical services. This may include the reduction in unnecessary glove and couch roll use, considering reusable alternatives e.g. vaginal speculum, and appropriate use of waste management systems across the clinical pathways, all of which have significant cost and carbon savings.
R66.	Treatments: Identifying and prioritising low-carbon treatments and optimising medicines involves reviewing the practices, products and treatments used across clinical pathways, mentioned multiple times across this report.
R67.	Efficiency: Streamlining care pathways to reduce unnecessary appointments, procedures (e.g. imaging and pathology testing), and follow ups through patient initiated follow ups, same-day or one-stop appointments and with the right clinician are all excellent low-carbon care examples.
R68.	Efficiency: Shifting care to community and home settings or using digital technologies to reduce patient travel and optimise care delivery where appropriate are further examples detailed in sections of the report of low-carbon care.
R69.	Prevention: Promoting active lifestyles and low-carbon diets is an essential aspect of primary prevention to reduce the onset of poor health and resultant financial and carbon cost of healthcare interventions, but it has particular relevance to secondary prevention in all of the clinical pathways included in this report.
R70.	Prevention: Early diagnosis, better disease management and empowering patients to manage their own health was detailed strongly across several sections of the report, which will in turn reduce healthcare visits and their associated emissions improving population health.
R71.	System: A recognition that the application of low-carbon care requires clinical leadership supported by workforce who have had training in low-carbon care in order to embed sustainability into the operations, governance, standards and policies across the breadth of clinical pathways, evidenced by strong organisational green plans.

Strategic and System learning (pages 42-43)	
Regional variation	
Overall this can be summarised by adopting a ‘do it once and do it right’ ambition.	
Demand Management	
R72.	For cancer and other diseases, if a celebrity is diagnosed or died, better preparation for primary care and testing is needed to mitigate overloading the system. It would be beneficial in these instances to coordinate with other stakeholders, for example, Cancer Alliances.
R73.	National communication to establish patient and public expectation. For example, as new drugs and technology become available.
R74.	National communication with patient written and digital communication to include warnings and when a patient needs to contact their healthcare provider.
COVID-19	
R75.	During the pandemic not all women were able to have the pessary changed every 6-months. Pessary changes could be extended to 9 months in certain cases.
R76.	Contingency planning in the event of any disruption to services/access. For example, supporting patients to self-manage where possible and appropriate to do so.
R77.	Ensure remote access review is built into pathways as standard.

Appendix E – Sussex Post Bariatric Surgery Follow-up Locally Commissioned Service

1. Population Needs

National/local context and evidence base

All practices are expected to provide essential and those additional services they are contracted to provide to all their registered patients. This Locally Commissioned Service (LCS) specification for Post Bariatric Surgery Monitoring outlines the more specialised services to be provided. No part of this specification by commission, omission or implication defines or redefines essential or additional services. This service must be provided in a way that ensures it is equitable in respect of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

After bariatric surgery, unidentified nutritional deficiencies can occur and cause long-term harm (such as Wernicke's encephalopathy, peripheral neuropathy, anaemia, osteoporosis or night blindness) or death. It is therefore important for people who have had bariatric surgery to have lifelong nutritional monitoring and appropriate nutritional supplementation.

NICE Quality Standard 127: Obesity: Clinical assessment and management recommends that people discharged from bariatric surgery service follow-up are offered monitoring of nutritional status at least once a year.

UK NHS specialist bariatric services provide post-operative follow up for a minimum period of two years as part of a ‘single episode of care’. After this, stable patients are suitable to be monitored by General Practice as recommended by NICE CG 189: Obesity: identification, assessment and management and the British Obesity and Metabolic Society.

A 2023 retrospective review at University Hospitals Sussex Foundation Trust of post-bariatric surgery patients discharged from Tier 4 services found significant inconsistencies in GP led monitoring of annual bloods for this cohort of patients. Low nutritional markers were common and robust annual testing was below standard and seemingly declining year on year (year 1: 40%, year 2: 24%). Hypovitaminosis D was the commonest finding, followed by low vitamin B12, folate and iron.

After discharge from bariatric surgery service follow up, all people should be offered at least annual monitoring of nutritional status, and appropriate supplementation according to need. General practitioners should liaise, where appropriate, with local bariatric teams about patient-specific nutritional deficiencies and necessary treatment.

Those discharged from NHS Sussex bariatric surgery service will have a clear plan regarding supplementation and annual monitoring requirements. This will include monitoring arrangements, common nutritional deficiencies and their treatment, as well as responsibilities of the specialist, the GP and the patient. Where there are problems, GPs will have rapid access (Advice and guidance or referral) to Tier 4 services.

It is estimated that there may be approximately 9,000 in Sussex with a history of bariatric surgery.

The provision of post bariatric surgery monitoring does not form part of the GMS Contract.

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

Domain 1	**Preventing people from dying prematurely**	**x**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**x**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**x**
Domain 4	**Ensuring people have a positive experience of care**	**x**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**x**

2.2 Local defined outcomes

1. A reduction in specialist interventions required after bariatric surgery

    1. Admissions
    2. Intravenous iron infusions

2. Prompt identification of nutritional issues

3. Avoidance of sequelae related to nutritional deficiency, such as metabolic bone disease, neuropathy and poor wound healing.

3. Scope

3.1 Aims and objectives of service

This service aims to provide an annual monitoring service for those who are more than two years post bariatric surgery and have been discharged from specialist care, to reduce the incidence of harm due to nutritional or metabolic deficiency.

3.2 Population covered and exclusions

Those eligible must be

1. registered with an NHS Sussex GP practice
2. more than 2 years post bariatric surgery
3. discharged from specialist care

Those who have had privately funded bariatric surgery in the UK or abroad should arrange follow-up monitoring privately for two years. Where there is the opportuniy to advise patients of this before surgery, this advice should be documented in their notes. Those considering surgery abroad may find the following guidance helpful BOMSS statement on going abroad for weight loss surgery.

After two years those who have had privately funded bariatric surgery become eligible for ongoing monitoring under this LCS.

At all times, GPs remain responsible for the essential GMS care of patients, including any NHS referral if appropriate, for any illness that might be a consequence of the bariatric surgery.

3.3 Addressing inequalities

NHS Sussex is committed to reducing health inequalities, particularly in Sussex’s most deprived communities and amongst population groups which have the poorest health outcomes.
This service must be provided in a way that ensures it is equitable for patients in respect of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

Additional resources: Translation and interpreting - NHS Sussex (ics.nhs.uk)

3.4 Service description/care pathway

Clinical staff delivering this service must be familiar with, and adhere to, the following guidance

4. NICE CG 189: Obesity: identification, assessment and management
5. NICE Quality Standard 127: Obesity: Clinical assessment and management
6. RCGP: Top-Ten-Tips-Bariatric-Surgery-Leaflet
7. BOMSS GP Hub

Practice Monitoring Register: Validation and Call-Recall

The practice must hold and maintain a register of those for whom the responsibility for offering post bariatric surgery annual monitoring lies with the practice.

Register Validation

Practices will be provided with a search for all those with a potential bariatric surgery code (see section 5).

At the onset of this service, and at least annually thereafter, the practice should review all patients on this search and add one of the following codes to indicate (for the purposes of this LCS) those for whom monitoring is the responsibility of the practice

History of bariatric surgical procedure H/O: bariatric operative procedure	608848006 768551000000107

Annual Call-recall

The practice must operate an annual call-recall service for all those on the practice monitoring register, offering,

8. Clinical review (see below) with a suitably trained clinician
    1. This would usually be a GP but could be a suitably trained independent practitioner. In view of the training and familiarity with guidelines required, the practice may wish to consider designating a lead clinician to carry out the clinical reviews.
    2. A face-to-face appointment should be offered to allow physical examination. However, a telephone or video consultation may be acceptable. Patient preference for the appointment type should be respected.
9. Blood testing in accordance with discharge recommendations or guidance

Follow-up and blood testing requirements vary depending on the type of bariatric surgery and whether there are any clinical concerns.

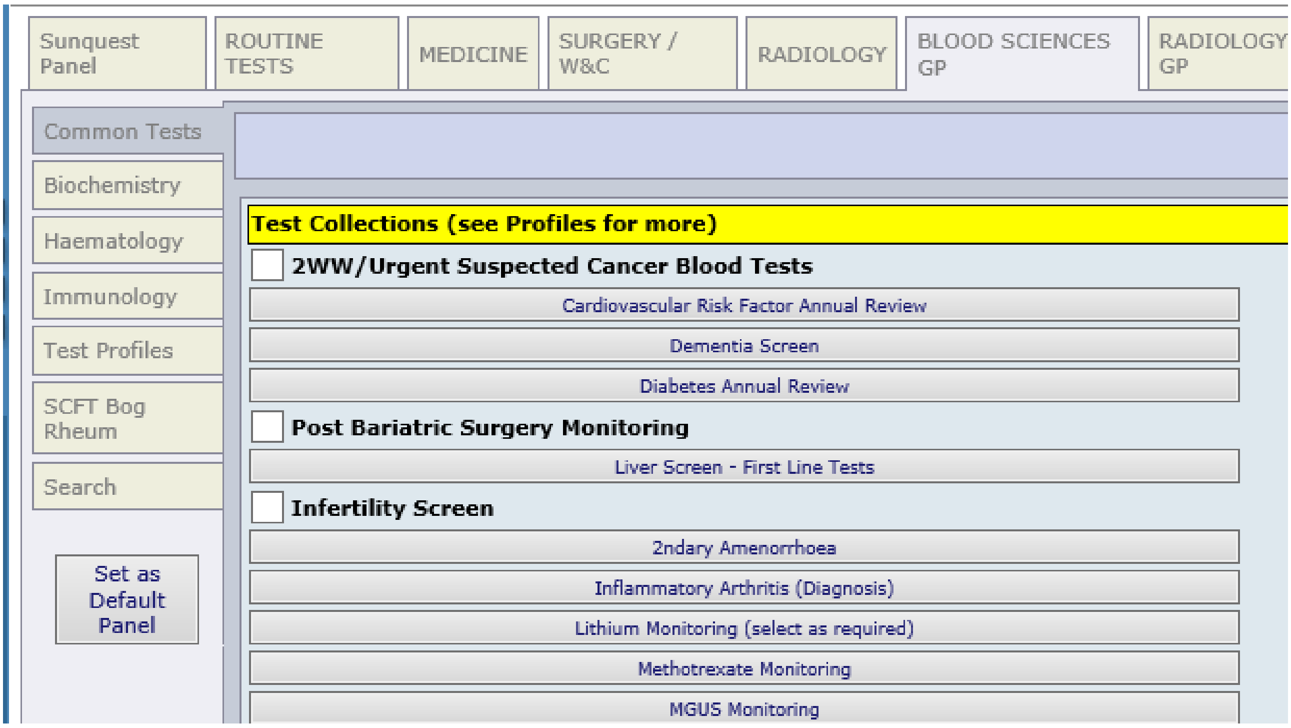
Blood testing

Recommended blood tests depend on the procedure, duration of follow-up and whether there are any clinical concerns. See tables below

PROCEDURE	DURATION OF FOLLOW UP	BLOOD TESTING
Gastric band	5y (7y post-surgery) After which, if no concerns, may be discharged to patient-initiated follow-up (PIFU)	“Standard” +/- Optional

Gastric sleeve Gastric bypass / Roux-en-y Duodenal switch	Lifelong	“Standard” set only if no clinical concerns +/- “Detailed” if clinical concerns +/- Optional

ICE Order-Comms will contain a diagnostic profile for ‘Post-Bariatric Surgery Monitoring’ as shown. Clinicians will then be guided to the appropriate tests



Summary of blood testing guidance

PROCEDURE	INVESTIGATIONS	OPTIONAL
Gastric band **Whether or not clinical concerns** or Gastric sleeve Gastric bypass / Roux-en-y Duodenal switch **No clinical concerns**	**“STANDARD PROFILE”** FBC Creat+Elecs ALT Adjusted Calcium Transferrin saturation Folate	B12 (but not if on parenteral B12) MMA HbA1c Lipids

Gastric sleeve Gastric bypass / Roux-en-y Duodenal switch **Clinical concerns**	**“DETAILED PROFILE”** Vitamins A, E, K, D Zinc Copper	B12 (not if on parenteral B12) MMA HbA1c Lipids

10. If, after clinical assessment, there are no concerns (diet good, weight stable, taking supplements), then only a ‘standard’ blood profile is required. Where there are any concerns regarding possible deficiencies (Gastric sleeve / Gastric bypass / Roux-en-y / Duodenal switch) then a ‘detailed’ profile should be requested.

11. Gastric banding does not cause malabsorption, and a detailed blood profile should not usually be required

1. Those in receipt of intramuscular B12 supplementation do not require B12 testing (so this is an optional request).

2. MMA may be of help in determining tissue deficiency of B12 for those on oral, or no, supplementation

3. Selenium deficiency is exceedingly rare and is not tested for unless specifically requested

4. Vitamin D should only be tested for if there are clinical concerns and is not recommended otherwise

5. Guidance on interpretation can be found in Appendix A

Organisation of Care

Practices are free to organise care as they see fit. Options are as follows,

1. Conduct the clinical review first, then organise blood testing according to whether there are any clinical concerns and/or optional requirements.
    1. Advantage: ensures only those tests required are performed, reducing the work of dealing with results. Mildly abnormal results are common in the detailed profile and, in the absence of symptoms, often do not need intervention (see Appendix A).
    2. Disadvantage: potentially a second consultation may be required to act on results (albeit for a minority)

2. Arrange a ‘standard’ profile of bloods first, then conduct the clinical review. Decide whether to do ‘detailed’ or ‘optional’ test profiles based on whether there are any clinical concerns or other issues

    1. Advantage: Abnormalities in the standard blood profile can be addressed in the clinical review
    2. Disadvantage: potentially a three-step process for some patients (albeit a minority)

3. Arrange a 'standard' profile of bloods for those with gastric banding, or a 'standard' and 'detailed' profile for those with other procedures, along with any optional requests. Then conduct the clinical review
    1. Advantage: Abnormalities can be addressed in the clinical review
    2. Disadvantage: Increases number of tests performed and the work involved dealing with results (which may be 'abnormal' but not clinically significant)

Practices may also wish to consider sending (by AccuRx for example) the BOMSS pre-consultation questionnaire for patients prior to the review appointment to help identify potential problems in advance.

Clinical review appointment

Clinicians providing review appointments should be familiar with the guidance above, in particular the BOMSS GP consultation guide for post-bariatric surgery annual reviews.

Practices should

4. ensure there is a final discharge letter with detailed follow up recommendations available from the bariatric surgical unit, and, if not, contact the unit to obtain one (where possible).
5. use the Ardens Bariatric Surgery template to record relevant aspects of the consultation.
6. be careful to avoid stigmatising language or blame for weight regain. Some weight regain is expected due to powerful biological drivers even with good adherence to dietary advice. The appointment should focus on the whole person and their experience, not just their weight.

The following should be covered in the review consultation

7. Date and type of procedure
8. Pre-surgical weight, lowest post-surgery weight, and current weight
9. Possible biological complications of surgery (abdominal pain, vomiting, 'dumping', post-bypass hypoglycaemia, excess skin)
10. Brief nutritional review including alcohol intake
11. Consider review of chronic obesity related comorbidities (such as Type 2 diabetes, hyperlipidaemia, hypothyroidism, obstructive sleep apnoea and blood pressure).
12. Review medications proactively. The pharmacodynamics and absorption of some medications may be affected by bariatric surgery, especially gastric bypass.
    1. Avoid NSAIDS or drugs that are gastric irritants.
    2. Oral contraceptives may not be fully absorbed so advise on contraception if appropriate.
    3. Further information is available in the BOMSS guidance on medications post-bariatric surgery for GPs.

13. Check recommended nutritional supplements (see full BOMSS nutritional guidance and BOMSS post-bariatric surgery nutritional guidance for GPs).
14. Consider psychological as well as physical problems (body dysmorphia, depression, anxiety, emotional eating, new addictive behaviour).
15. Discuss pre-conceptual planning if appropriate. 5mg of folic acid is usually recommended. If the patient intends to become pregnant or informs the GP that they are pregnant they will need review of multivitamins to avoid those with vitamin A in the retinol form. Forceval is usually a safe recommendation if pregnant. Follow current RCGP recommendations on managing women with BMI >30 kg/m² if appropriate. Make an urgent referral to consultant-led care if the patient becomes pregnant.

16. Red flag symptoms may require re-referral. More detailed guidance can be found here
    1. Infection at gastric band access port
    2. Sweating, dizziness, or fainting after eating or drinking
    3. Difficulty swallowing and/or vomiting
    4. Abdominal pain
    5. Heartburn/reflux/coughing at night
    6. Diarrhoea, or abdominal pain after eating or drinking.
    7. Confusion, eye problems, hair loss, pins and needles and a wide variety of other neurological disturbances. These can occur with vitamin and mineral deficiencies.

17. Excess skin may be an issue. Please note the constraints of NHS Sussex Clinical Funding Policies)

18. Weight re-gain
    1. This should be managed by appropriate dietary advice or support to develop healthy eating behaviours in the first instance.
    2. Re-referral or discussion with a specialist weight management service may be considered for those with weight gain back to the pre-surgical level

19. Excessive weight loss of >100% of excess body weight or symptoms of severely disordered eating. Consider referral to Eating Disorders Team, noting that BMI may not be a reliable indicator of risk due to the high starting weight and the weight of excess skin.

Coding

The following code should be used to indicate the clinical follow-up consultation and will generate payment under this LCS for patients on the practice post bariatric surgery monitoring register

Follow up obesity assessment	170795002

Summary of Practice Requirements

1. Familiarisation and compliance with relevant guidance
2. Validate and maintain practice monitoring register
3. Consider appointing lead clinician to provide reviews
4. Offer annual call-recall for review appointment and bloods as required
5. Annual quality assurance self-declaration

3.5 Audit and Quality Assurance

Practices may wish to assess service provision using the RCGP post bariatric monitoring audit tool (not a requirement of this LCS).

There are no performance indicators associated with this LCS

The following will be monitored for each practice for assurance purposes

1. Number on the practice monitoring register
2. Percentage having had a review in the previous 15 months

3.6 Interdependence with other services/providers

Where the practice needs advice specific regarding a post bariatric surgery problem, it should seek this from either the original specialist provider or, if this route is unavailable, from local specialist bariatric/metabolic services.

All LCSs, as they are list-based services, are offered to individual practices in the first instance. To ensure locally commissioned services (LCSs) are accessible to as many patients in Sussex as possible,

3. Practices may choose to put buddying arrangements in place, in agreement with another practice (or practices) where it is appropriate to do so
4. Practices may choose to deliver services at PCN level (with the agreement of the other practices in the PCN)

In each case, the practice delivering the service (or the lead practice if PCN based) should claim for the service delivered.

Practices may also subcontract locally commissioned services (LCSs) to GP federations, but this will require prior approval from the commissioner.

4. Applicable Service Standards

The Practice is responsible for ensuring that,

1. **Premises** used are registered with the Care Quality Commission (CQC) and the service is provided in a suitable setting
2. **Equipment** meets all criteria set out in national and local guidance and is maintained in line with manufacturer's guidance
3. **Training** meets all relevant criteria set out in national and local guidance
    4. **Serious Incidents** within this service are reported to NHS Sussex
    5. **Infection Control Guidance** is adhered to
    6. **Privacy and Dignity Guidance** are adhered to
    7. **Health and Safety** standards are met
    8. **Information Governance** standards are met
    9. **Safeguarding Adults, Children and Looked After Children Guidance** is adhered to including statutory training
    10. **Mental Capacity Act** - the Mental Capacity Act 2005 (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

4.1 Applicable national standards (e.g., NICE)

1. NICE CG 189: Obesity: identification, assessment and management
2. NICE Quality Standard 127: Obesity: Clinical assessment and management
3. RCGP: Top-Ten-Tips-Bariatric-Surgery-Leaflet
4. BOMSS GP Hub

4.1.1 Infection control

Practices must ensure that latest national infection control and prevention guidance is adhered to. Please follow current national guidance which includes, but not exclusive of the following:

1. Infection Prevention Society Guidance – National Guidance for England
2. Healthcare associated infections- Prevention and Control in Primary and Community Care – National Institute for Health and Care Excellence (NICE) [CG139]
3. Infection Prevention and Control Quality Standards – NICE [QS61]
4. Health and Social Care Act 2008: code of practice on the prevention and control of infections – Department of health and Social Care
5. Coronavirus Primary Care – National Health Service England and NHS Improvement
6. National Standards of Healthcare Cleanliness

Other resources and information can be found locally at NHS Sussex intranet page:
Infection prevention and control - NHS Sussex (ics.nhs.uk)

4.1.2 Chaperoning, privacy, and dignity

1. GMC guidance: Intimate examinations and chaperones
2. CQC guidance: Chaperones

4.1.3 Quality

Practices must comply with all the National Quality Requirements as set out in the NHS Standard Contract

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g., Royal Colleges)

1. BOMSS GP Hub

4.3 Applicable local standards

Not applicable

4.3.1 Quality Requirements

3. Significant Event incidents related to this service should be reported as SEAs (Significant Event Audit) and learning shared within the practice.

4. Serious incidents related to this service must be reported to the NHS Sussex Patient Safety Team

5. GP practices should adopt and apply the Patient Safety Incident Response Framework (PSIRF) principles, as outlined in the NHS Sussex PSRIF Policy:
    1. Compassionate engagement and involvement of those affected
    2. A system-based approach to learning
    3. Considered and proportionate responses
    4. Supportive oversight focused on strengthening response systems and improvement

5. Practices should report patient safety events on the Learn from Patient Safety Events (LFPSE) service

6. Important, potentially recurrent, problems involving other providers should be submitted to PQIT (Provider Quality Improvement Tool)

7. Clinical Governance arrangements for this service are as set out in Schedule 5 of the NHS Standard Contract. In addition, the practice is required to evidence an effective system of clinical governance and put in place appropriate and effective arrangements for quality assurance, continuous quality improvement and risk management.

8. Where appropriate, patient satisfaction feedback about the service should be offered to all patients accessing this service and quality improvements should be made as an outcome of this feedback.

9. As part of the annual quality assurance process, the practice is required to make an annual quality assurance self- declaration that it has met the requirements of this LCS. A copy of the self-declaration form will be available on the NHS Sussex intranet. This may cover elements pertaining to the

1. Service specification
2. Service standards
3. Training
4. Audit standards

NHS Sussex is responsible for commissioning high quality, safe and effective care for the population of Sussex. It is vital that the organisation maintains good governance in the decisions it makes.

To ensure that NHS Sussex receives assurance that the services it commissions are provided according to specifications, and that practices fulfil the requirements within, an annual Quality Assurance Self-Declaration for LCSs has been developed whereby GP-practices are required to complete and return to NHS Sussex.

The Quality Assurance Self-Declaration was developed in collaboration with NHS Sussex Quality Team, and is aligned to the three main quality domains:

1. Patient safety
2. Patient experience
3. Clinical effectiveness

The annual Quality Assurance Self-Declaration for LCSs aims to provide GP practices with a system for identifying areas for improvement and a support mechanism to make those improvements.

The self-declaration will enable practices to identify areas requiring improvement and will enable NHS Sussex to focus on identifying possible areas requiring further development, training, and support.

Practices are required to submit the Quality Assurance Self-Declaration annually, and upon review, in conjunction with the Quality Team, feedback reports will be provided to primary care to encourage engagement and a culture for improvement.

Where forms have not been received by the required deadlines (as published with the annual QASD), NHS Sussex reserves the right to pause LCS payments to the practice pending receipt.

4.3.2 Equipment

4. The handling of consumables and associated activities (e.g., procurement, storage, prescribing, decontamination, and disposal of consumables) must be safe and in line with current legislation, licensing requirements, good practice, and any national guidelines

5. Equipment must meet all criteria set out in national and local guidance and be maintained in line with manufacturer's guidance

4.3.3 Safeguarding

Practices must have appropriate Safeguarding Policies, Procedures and Governance arrangements in place which comply and reflect the principles of the Pan Sussex Safeguarding Procedures (Children and Adults) and adhere to all Safeguarding and Looked After Children related Legislation. In addition, Practices must meet all regulatory safeguarding requirements (including CQC Regulation 13) and those as specified within the Sussex NHS Commissioners Primary Care Safeguarding Standards.

Mental Capacity guidance available on NHS Sussex intranet: Mental Capacity - NHS Sussex (ics.nhs.uk).

4.3.4 Medicines

Patients with no nutritional deficiencies may require nutritional supplements and must be advised that they will need to take vitamin and mineral supplements for life following bariatric surgery. The specific requirements and recommendations for these patients is outlined in the BOMSS Post-Bariatric Surgery Nutritional Guidance for GPs.

BOMSS recommends that multivitamin and mineral supplements contain a minimum of 400-800 micrograms of folic acid, 15mg of zinc and 2mg of copper. BOMSS also notes that there are wide range of multivitamin and mineral supplements available over the counter, and that their composition varies. Consequently, many over the counter supplements may need to be doubled to meet the recommended BOMSS dosage.

As per NHS England Policy Guidance: Conditions for Which Over the Counter (OTC) Items Should Not Be Routinely Prescribed in Primary Care primary care clinicians should remind patients that they are expected to purchase their vitamin and mineral supplements OTC.

Exceptions for prescriptions:
Prescriptions should only be issued when the patient has a medically diagnosed deficiency. In these cases, patients should receive appropriate clinical treatment.

Once the deficiency is resolved, the need for continued supplementation should be reviewed and patients should resume purchasing OTC preparations wherever appropriate.

Compliance with Local Guidance:
Practices should be familiar with and comply with national and local guidance and patient information

1. Sussex Formulary
2. UHS Sussex: Vitamin and Minerals for Life After Bariatric Surgery

3. BOMSS Post-Bariatric Surgery Nutritional Guidance for GPs

4.4 Training requirements

It is the practice's responsibility to ensure that all personnel involved in delivery of this LCS are familiar with the requirements and any relevant guidance.
Training should be recorded and made available as evidence if required. Practices should update training as per LCS speciality and specification.

Practice staff delivering any part of this LCS must be suitably trained and accredited. This can be achieved through

1. Self-directed learning
2. In house practice or PCN learning events
3. NHS Sussex educational events (where available)

Practices are expected to complete an annual self-declaration stating that all relevant staff and clinicians have been, or are planning to be, appropriately trained (see section 4.3.1).

The Sussex Training Hub (STH) will support training requirements for Locally Commissioned Services by providing, commissioning or sign-posting relevant education and training resources. Practices are not obliged to access training from STH and may obtain relevant training from other sources.

Training costs are provided to the practice as part of this specification (except where otherwise specified) as per section 6. It is the practice's responsibility to access and pay for appropriate training.

5. Coding, Records, Data Quality and Audit

5.1 Coding and business rules

Practices must submit claims and data submissions via the agreed NHS Sussex electronic payment and submissions portal (currently Apex Contract Manager).

‘Management information’ submissions must accompany all claims for payment via Apex Contract Manager.

Regarding the submissions’ portal,

1. No patient identifiable information is submitted.
2. Code-sets submitted are and will be absolutely limited to those described in this specification. No additional codes or data not specified in this LCS will be submitted or collected.
3. Practices must ensure that data is accurate before submission.
4. Data submitted via the electronic portal may be
    1. used to feedback to practices on their performance
    2. shared with other practices/PCNs

Practices must use the NHS Sussex approved code set as described in this specification

The practice monitoring register will consist of those with one of the following codes	
History of bariatric operative procedure	608848006
H/O bariatric operative procedure	768551000000107
AND one of the following codes	
Bariatric operative procedure	430715008
Laparoscopic bypass of stomach	708983005
Gastric bypass	442338001
Gastric bypass operation	11127003
Laparoscopic gastric bypass	708983005
Gastric sleeve	782550004
Endoscopic sleeve gastroplasty	870378000
Laparoscopic sleeve gastrectomy	427074001
Duodenal switch	426738005
Sleeve gastrectomy	87604009
History of sleeve gastrectomy	329281000119107
Roux-en-y gastric bypass / gastro-jejunostomy	173747005
OR	
Gastric band	470413006
Laparoscopic adjustable gastric band	414574004

Maintenance of gastric band	442261001
Vertical banded gastroplasty	30803004
Gastric band attached	413233009
Fluoroscopy guided endoscopic gastric banding	843581000000103
unless superseded by one of the following	
Removal of gastric band	426559000
History of removal of gastric banding device	10977641000119108
Payment will be made for any patient on the practice monitoring register who has the following code entered Follow up obesity assessment **subject to there not having been a claim paid in the preceding 9 months**	170795002

Where the practice feels it has provided activity that should reasonably be payable, but the payment is not processed automatically by Apex Contract Manager according to the business rules above, a manual claim with a brief explanation should be submitted to sxicb.sussex-lcs-claims@nhs.net for consideration.

5.2 Records

Adequate records must be maintained to provide an audit trail for post payment verification purposes.

It is recommended that practices use the Ardens ‘Bariatric Surgery’ data entry template

5.3 Audit and Data submission requirements

There are no specific audit requirements although it is recommended that practices consider auditing their service provision from time to time. The following guidance may help: RCGP post bariatric monitoring audit tool

The performance data (section 3.5) will be reported via Apex Contract Manager

6. Payment/Claiming

Practices will be paid as follows.

Practices should submit their claims, and payment will be made, as described in section 5.1.

For each post bariatric follow up review	£ xx.xx

Price is inclusive of training costs.

Practices whose claims are at variance with expectations may be asked to submit additional evidence to support past or future claims.

NHS Sussex reserves the right to check practice held information at any time to support post-payment verification.

Prices will be uplifted annually in negotiation with the LMC. Practices will be notified of any changes in price

Late or inaccurate claims

Where a practice is aware of any delay or inaccuracy in claims it should notify the primary care contracting team without undue delay.

5. Submissions must be made promptly to ensure timely payment. Where submissions pertaining to activity during any given quarter are not made before the end of the subsequent quarter,
    1. payment may be significantly delayed
    2. practices may be asked to give a reasonable explanation and provide supporting evidence for the claim

6. Where there are claims or data submissions that cannot be submitted using the electronic submissions portal, practices should contact sxicb.sussex-lcs-claims@nhs.net

Past overpayments will be recovered over a reasonable timeframe in agreement with the practice.

7. Termination

7.1 Termination

Unless otherwise notified, this Locally Commissioned Service terminates on 30.6.2028

The service may be terminated by either NHS Sussex or the Practice through the service of three months' notice.

NHS Sussex may require the practice to suspend the provision of the service immediately if it has reasonable grounds for believing that patient health or safety is at risk as a result of continuing provision of this service.

The LCS may be subject to review by NHS Sussex at any time during the term of the service. Breaches and terminations will be managed in accordance with the NHS Standard Contract.

APPENDIX A

Advice on managing abnormal results of nutritional screening (Dr Kate Shipman Feb 2025)

It is important to note that a nutritional (e.g. vitamin) deficiency requires three criteria before it is confirmed: a low concentration, specific symptoms of the deficiency, and resolution of symptoms on supplementation. Therefore, mild abnormalities with no symptoms of deficiency are not diagnostic of true micronutrient deficiency.

For a list of expected symptoms please see BOMSS post-bariatric surgery nutritional guidance for GPs

It is also important not to assume that there are no other secondary causes for the deficiencies. Therefore, be alert for new symptoms e.g. of Coeliac, bowel cancer etc as indicated by the blood test results and symptoms.

Iron deficiency

1. Consider secondary causes.
2. Iron supplementation is recommended routinely in a once daily oral format. If this is inadequate in the absence of secondary causes then consider parenteral treatments as per BSG guidance (Snook J, et al. Gut 2021;0:1–22).
3. Vitamin C does not improve iron absorption.

Folate and B12

- Additional supplementation (on top of regular multivitamin) may be indicated.
- Note MMA may be required to confirm the diagnosis if there are no symptoms of B12 deficiency and the result is unexpected. A high MMA supports the diagnosis of tissue deficiency.

Zinc

- Note zinc drops significantly in the acute phase so disregard results/do not test in people who are acutely ill or have a high rate of background inflammation.
- If mildly low, consider doubling the dose of daily supplement.
- If very low, high dose zinc supplements can be taken in addition but test copper and zinc at 3 months as zinc can prevent copper uptake in the gut (therefore avoid long term copper or zinc supplementation in isolation). The zinc/copper ratio in supplementation should be 8-15mg:1mg (minimum 2mg copper) in the multivitamins (i.e. the ratio must be ‘balanced’ long term).
- Note zinc can be found in dental fixatives so can be high (or copper low) in people with a high zinc exposure.

Copper

1. Note copper goes up in acute inflammation so disregard results/do not test in people who are acutely ill or have a high rate of background inflammation as you may mask deficiency.
2. If mildly low, consider doubling the dose of daily supplement. There are no good options for supplementing copper alone.
3. Note Wilson disease can be associated with low serum copper, but it is rare. If Wilson disease is suspected, consider 24-hour urine copper (looking for high urinary copper) as the first line screening test of choice.

More information can be found in:
O'Kane M, Parretti HM, Pinkney J, et al. British Obesity and Metabolic Surgery Society Guidelines on perioperative and postoperative biochemical monitoring and micronutrient replacement for patients undergoing bariatric surgery—2020 update. *Obesity Reviews*. 2020; 21:e13087.

Please note this document has been kindly shared by NHS Sussex ICB

Appendix F - Table from draft Hampshire and Isle of Wight ICB Primary Care Health Monitoring for Low/Moderate Risk (Blue/Green) Adult Eating Disorders Service

Table 1: Physical health monitoring risk assessment

Risk review guidance adapted from MEED and KCL Guidance.

Parameter	**Red** **(High Risk)**	**Amber** **(Alert to high concern)**	**Green** **(Mod risk)**	**Blue** **(Low risk)**
Medical History & Examination				
Weight loss/week for ≥2 weeks	>1kg	>0.5kg	<0.5kg	0Kg
BMI	<13	13-14.9	14.9-17.5	≥17.5
Disordered eating behaviours (In the context of an eating disorder)	Acute food refusal or estimated calorie intake <500kcal/day for >2 days			
Activity and exercise	High levels of dysfunctional exercise in the context of malnutrition (>2h/day)	Moderate levels of dysfunctional exercise in the context of malnutrition (>1hr/day)	Mild levels of/ or no dysfunctional exercise in the context of malnutrition	

			(<1 hour per day)	
Purging behaviours	Multiple daily episodes of vomiting and/ or laxative abuse	Regular (≥3 x per week) vomiting and/ or laxative abuse		
Self-harm and suicide risk (In the context of an eating disorder)	Self-poisoning, suicidal ideas with moderate to high risk of completed suicide	Cutting or similar behaviours, suicidal ideas with low risk of completed suicide		
Heart rate	<40	40-50	>50	
Cardiovascular health: Standing systolic blood pressure	<90mmHg with: Recurrent syncope and postural drop >20mmHg **OR** Increase in HR of > 30bpm	<90mmHg with: Occasional syncope **OR** Postural drop >15mmHg **OR** Increase in HR of up to 30bpm	Normal	Normal
Assessment of hydration status	Fluid refusal Severe dehydration (10%): ↓ Urine output Dry mouth Postural BP drop (as above) ↓ Skin turgor Sunken eyes Tachypnoea	Severe fluid restriction Moderate dehydration (5-10%): ↓ Urine output Dry mouth Postural BP drop (as above) Normal skin turgor Some tachypnoea Some tachycardia	Minimal fluid restriction Mild dehydration (< 5%): May have some dry mouth and concerns about risk of dehydration with negative fluid balance	-

	Tachycardia	Peripheral oedema		
Other clinical state	Life-threatening medical condition Significant alcohol consumption	Non-life-threatening physical compromise, e.g. mild haematemesis, pressure sores		
Temperature	<35.5°C tympanic OR 35.0°C axillary	<36°C	>36°C	
Muscular Function: SUSS Test	Unable to sit up from lying flat or to get up from squat at all or only by using upper limbs to help (Score 0 or 1)	Unable to sit up or stand from squat without noticeable difficulty (Score 2)	Able to sit up from lying flat and stand from squat with no difficulty (Score 3)	-
Investigations				
ECG: where indicated corrected QTc	>450ms (female) >430ms (male) Any other significant ECG abnormality	>450ms (female) > 430ms (male) **AND** No other ECG abnormality **AND** Taking medication known to prolong QTc interval	<450ms (female) <430ms (male)	
Biochemical Abnormalities	Hypophosphataemia & falling phosphate	Hypokalaemia (< 3.0mmol/L)		-

	Hypokalaemia (<2.5mmol/L) Hypoalbuminaemia Hypoglycaemia (random glucose <3mmol/L) Hyponatraemia Hypocalcaemia Transaminases > 3 x normal range In patients with diabetes: HbA1c >86mmol/L	Consider rate of change in electrolytes. If concerns about electrolytes, please seek advice from AEDS hub		
Haematology	Low white cell count <2.0 Low haemoglobin <10g/dL	Low white cell Count <4.0 Low haemoglobin <110g/dL		

Please note this table is from a draft document kindly shared by NHS Hampshire and Isle of Wight ICB.