East Suffolk and North Essex NHS Foundation Trust

Improving patient access and safety during Obesity treatment initiation through provision of Psychology throughout patient journey

Osamah Niaz
Consultant Bariatric Surgeon

Authors: Daniela Alves, Hywel Room, Chiara Vari, Caroline McArthur, Cleverly Fong, Gabriella Miller, Morgan Serres, Felicty Burden, Rebecca Drane, Osamah Niaz, Vigyan Jain, Laura Falvey, Claudia Ashton

Background

Wide variability and low consistency in how Psychology is delivered across obesity services in the UK

AN UNCLEAR ROLE

MDTs often view Psychology as a pre-surgery check to assess contraindications.

Psychologists see the role of Psychology as building relationships and identifying support needs.

A MISMATCH WITH PATIENTS

51% of patients report they could not access psychology when needed.

Post-operative support is consistently rated a key priority.

NO SHARED STANDARD

High variability between services has made it difficult for psychologists and bariatric/obesity teams to agree consistent standards of care.

Without a shared framework, psychology resources are not allocated according to clinical need.

Based on a UK survey of MDT members, psychologists and patients. Ratcliffe D, Banting E. What is the role of psychology in bariatric surgery? A survey of the differing views of psychologists, the multidisciplinary team, and patients in the UK. Clinical Obesity. 2023;13(6):e12612. https://doi.org/10.1111/cob.12612

The Framework: Complexity × Readiness

Clinical Complexity — psychiatric history, psychosocial needs • **Readiness for Treatment** — functioning, engagement, capacity to adhere

	LOWER READINESS	HIGHER READINESS
HIGHER COMPLEXITY	Intensive psychological input. Focus on stabilisation before treatment decisions progress.	Complex needs, but engaged and stable. Structured support integrated alongside treatment.
LOWER COMPLEXITY	Brief, targeted intervention to build engagement and readiness for treatment.	Minimal/no input needed. Proceed on the standard pathway, with psychology available if required.

Complexity and readiness are assessed independently, then combined to guide proportionate psychological input at each stage.

Results: Interventions Delivered

N = 50 patients with complete data

1. TREATMENT PREFERENCE

GLP-1 / OMM	**62% (n=31)**
MBS (surgery)	**38% (n=19)**

2. READINESS FOR TREATMENT

High readiness	**62% (n=31)**
Medium readiness	**26% (n=13)**
Low readiness	**12% (n=6)**

3. CLINICAL COMPLEXITY

Medium complexity	**60% (n=30)**
Low complexity	**26% (n=13)**
High complexity	**14% (n=7)**

4. PSYCHOLOGICAL SUPPORT DELIVERED

Medium-readiness support (1:1 or group)	**10 (20%)**
GLP-1 psychological intervention	**5 (10%)**
Post-MBS psychology support	**7 (14%)**

The framework facilitated identification of psychological support needs and allocation of proportionate psychological interventions across the treatment pathway.

Towards Proportionate, Equitable Psychology Input

SHIFTS AWAY FROM GATEKEEPING

Towards formulation-led psychological care that is proportionate to clinical need.

INTEGRATES PSYCHOLOGY THROUGHOUT

As a resource across the whole pathway, not just a pre-operative checkpoint.

Thank You

Osamah.Niaz@esneft.nhs.uk