National Assembly for Wales
Health and Social Care Committee

Inquiry into the availability of bariatric service

Evidence from Hywel Dda University Health Board – ABS 19

Hywel Dda University Health Board Response to the Inquiry into the Availability of Bariatric Services in Wales

Thank you for the opportunity to comment on the Inquiry into the availability of Bariatric Services in Wales. Hywel Dda University Health Board provides health services to a population 372,320 people living in the counties of Pembrokeshire, Carmarthenshire and Ceredigion who need emergency and scheduled hospital treatment and mental health care, as well as care are in their own homes, through Community Clinics and Primary Care settings.

Within the Health Board area the level of overweight and obesity in adults is 57% and obesity is 22% (Welsh Health Survey, 2012). This is in line with the Welsh average and is increasing over time. Rates of childhood obesity, again, are in line with the Welsh average but there are areas of the Health Board where the rates in girls are statistically, significantly higher than the Welsh average. Both adult and child obesity are more prevalent in our most deprived areas.

The following provides our considered response to the key issues for consideration.

1. ***The effectiveness of specialist services at level 3 and 4 of All Wales Obesity Pathway in tackling the rising numbers of overweight and obese people in Wales***

1.1 The All Wales Obesity Pathway (AWOP) describes services to be delivered at each level of the pathway from population level interventions at level 1, to Specialised Bariatric Surgery at level 4, the numbers accessing services decreasing as services target those with the most complex needs as they progress up the Pathway. The aim of level 3 and 4 services therefore, is to achieve weight loss with individuals who present with already, very complex obesity related physiological and psychological health needs in order to manage their obesity related co-morbidities and reduce their health risks. Achieving weight reduction, even at modest levels, has been shown to result in a reduced incidence of obesity related chronic conditions and to improve the management of such conditions.

1.2 Interventions at levels 1 and 2 of the pathway focus on preventing overweight and obesity from rising further and preventing individuals from needing to access more specialised services at levels 3 and 4 of the Pathway. The focus at this level is on population health improvement rather than on individual care. The current trajectory in obesity prevalence means that the demand for level 3 and 4 services will continue to increase for many years despite preventative efforts.

1.3 Currently, due to the restricted availability of Bariatric Surgery, the focus is on those with most complex co-morbidities / higher Body Mass Index (BMI). Further Investment in Bariatric Services should enable those at a lower levels of complexity / BMI to be treated, bringing more individuals into a lower BMI category with corresponding reduction in health risk factors. This, however, would need to

be considered alongside the equitable provision of level 3 - gateway services (section 2.3).

1.4 The Multi Disciplinary Team (MDT) post operative care of people undergoing bariatric surgery needs to be included in any future service plans to ensure that people who have undergone surgery have the appropriate long term monitoring by suitably trained professionals. Additionally, those accessing level 3 services will need long term, sustained support that enables them to address some of factors that led to their initial weight gain. Many of those factors, described in the Foresight report (2007), as being within the 'obesity system' are beyond the remit of Specialist Clinical Services, but the long term effectiveness of these specialist services will depend on the provision of interventions to support sustained weight management in the community, such as the built environment, social networks, or access to affordable healthy food - delivered at levels 1 and 2 of the pathway.

1.5 Consideration should be given to the increased complexity and costs associated with providing services in Health Board areas that serve very sparsely populated, rural communities, where provision and availability of services at all levels of the Pathway have to be designed so as not to disadvantage those who live in isolated communities, live in deprived circumstance, those who rely on public transport, and / or those whose first language is not English.

1.6 It should also be noted that centres do have evidence of successful interventions supporting delivery of the AWOP, however, within Wales the delivery of the Pathway has received none of the resources required to deliver at the scale required to demonstrate the population health impact required.

2. The eligibility criteria of patients and the availability of obesity surgery and specialist weight management services across Wales

2.1 Hywel Dda University Health Board patients access NHS Bariatric Surgery at the Welsh Institute of Metabolic and Obesity Surgery (WIMOS), Morriston Hospital. The eligibility criteria for Specialist Bariatric Services are stipulated on the Welsh Health Specialised Services Committee website. These criteria serve as accepted guidance to the Multi Disciplinary Team (MDT) at Morriston and patient suitability is a clinical decision made by the MDT.

2.2 Across Wales, there are currently 128 cases allocated for bariatric cases per annum (2013 / 14), an increase from 80 cases per annum in the previous financial year. This increase follow from the 'Review of Bariatric Surgery Provision and Access Criteria in the Context of the All Wales Obesity Pathway 'conducted by WHSSC in 2013.

2.3 More recently, Cardiff and Vale Local Public Health Team have led a piece of work at an all-Wales level to develop a Nationally agreed Common Access Policy and Service Specification for level 3 services by Spring 2014. On publication of this Policy, consideration will need to be given to how this is funded across Wales.

2.4 NICE Guidance specifies that anyone with a BMI over 40 or over 35 with co-morbidities is eligible for Bariatric Surgery (NICE, 2006). However with 23% of the population of Wales (Welsh Health Survey, 2012) being obese, the NHS is not currently resourced to be able to meet this potential demand. The Obesity Pathway specifies (in line with NICE guidance and NCEPOD report mentioned

above), that individuals must have been through services at level 3 of the Obesity Pathway before they are eligible to be referred for Bariatric Surgery. Therefore, it is necessary to increase capacity at level 3 of the Pathway to deliver evidence based and equitable access to level 3 services across Wales, prior to, or alongside, increasing capacity at level 4 (Bariatric Surgery). The aim of this would be to minimise the numbers needing to go on to have Bariatric Surgery, improve the appropriateness of referrals for Bariatric Surgery and maximising outcomes and provision of long term follow up care as appropriate.

3. How services are evaluated and measured including in terms of delivering value for money?

3.1 Hywel Dda University Health Board has a robust Evaluation Framework to measure the effectiveness of services delivered at tier 3 as service provision is rolled out. This is being shared across Wales as part of the Public Health Wales led work (detailed above) to support an evidenced based, equitable approach.

3.2 In addition to clinical outcomes immediately post interventions, Health Boards should consider the wider impact that weight management interventions have on NHS resources. For example, clients achieving weight loss would expect to have an improvement in the management of their chronic conditions, a reduction in medication costs, a reduction in the number of health professional contacts or unscheduled admissions, a reduction in the need for some types of surgery, for example, Orthopaedic Surgery and a reduction in length of stay (NICE, 2006).

3.3 We believe that in relation to Bariatric Surgery it should be common practice for the cost benefits of clients who undergo procedures to be regularly reviewed. Clarity in relation to who is monitoring effectiveness and value for money of services should be considered and may benefit from support at an All Wales level (alongside level 3 service evaluation if resources to deliver are made available).

4 The levels of investment currently allocated to provide bariatric surgery in Wales

4.1 As previously highlighted current resource is insufficient to meet need. However, it is important to consider the need to increase and improve access across all levels of the AWOP. Appropriately resourced and equitable services need to be in place at all levels of the Pathway to maximise efficiency and outcomes.

4.2 Any review of costs at level 4 need to consider the inclusion of Plastic Surgery costs for patients who have successfully lost weight and have excess skin that needs removing. This Surgery is not currently available in Wales and has a significant impact on an individual's physical and psychological well being.

5 The availability of obesity surgery and specialist weight management services across Wales

5.1 Previous reports (WHSCC Review of Bariatric Surgery Provision and Access Criteria in the Context of the All Wales Obesity Pathway, January 2013) have highlighted that access varies across Wales depending on Health Board area. Similarly, level 3 services are not provided across all Health Board areas in Wales - the subject of on-going led by Cardiff and Vale Public Health Team to develop a nationally agreed common access policy and service specification for level 3 services by spring 2014.

6. Final comments

6.1 The Foresight Report (2007) argues that to be able to halt the obesity epidemic, a systemic approach is required which tackles a wide range of factors in an integrated way. It is important that we retain sight of this evidence as we move forward to address this challenge in Wales and do not fall in to the trap of only investing in certain parts of the Obesity Pathway, when in reality all parts of the Pathway are inter-dependent. We favour an approach that looks at the Pathway in its totality and recognises that whilst investment in services at level 3 and 4 of the Pathway will help reduce the burden of obesity in our current population, it is investment at level 1 and 2 that will bring about population level reduction in prevalence of obesity and its associated co-morbidities in the medium to longer term. Coordination of effort across Health Board geographies would reduce potential for duplication of effort at a time when resources are stretched and ensure a coordinated approach to evidence gathering, implementation and evaluation.

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