



THE MANAGEMENT OF MORBID OBESITY AND ACCESS TO BARIATRIC SURGERY

Aim

To report on the further work requested at the March 2010 Board meeting, specifically the proposed composition and capacity of the local Specialist Weight Management Team (SWMT) and the number of bariatric operations per annum to be included in the Service Level Agreement (SLA) with the North Tyneside bariatric service.

Background

A paper presented at the March 2010 Board meeting discussed the obesity trends, the increase in requests for bariatric surgery over the last six years, suggested criteria for surgery more stringent than those recommended by SIGN and NICE and the development of a local SWMT to implement the criteria. The aim was to match the increasing demand with limited supply and to select those who could benefit most from surgery.

The criteria and SWMT were agreed and further work was requested to specify the composition and capacity of the team and the number of operations to be specified in the SLA with the North Tyneside service. Both the SWMT and the SLA were to be delivered within the financial envelope agreed of £100,000 recurring per annum, which is included in the 2010/11 financial plan. The criteria agreed were:

- Body Mass Index (BMI) > 50 or 45-50 with co-morbidities
- Co-morbidities to be specified and to cover only serious conditions such as diabetes, severe arthritis and significant hypertension
- Evidence of loss of 5% body weight before referral or with the support of the local SWMT.

A small working group has taken this work forward, meeting twice, with representatives from the three Clinical Boards and the Commissioning Team. Members of this group also met with the North Tyneside bariatric service team and considered the recently published SIGN guideline on obesity (number 115).

Role and Composition of the SWMT

The Working Group considered four options for the role of the local SWMT as follows:

- A) Gatekeeper only** – assess for appropriateness of onward referral to bariatric service only.
- B) Gatekeeper plus** - more active pre-op assessment and longer term follow up after period of surgical team follow up.

C) Gatekeeper plus level 3 patient management – B above plus management of patients who have not succeeded with level 1 (primary care) and level 2 (Lifestyle Adviser Support Service, Community Dietetic service or Counterweight service) input, but are not clear candidates for surgery. Includes care pathway development and coordination

D) Obesity Managed Clinical Network – C above plus leadership role in coordinating and managing a local network across all 4 levels and auditing care pathways.

The March Board paper outlined a role for the local SWMT consistent with either option B or C. The composition of the team required to deliver these differing roles is outlined below:

Option	Discipline						
	Comm'g Team	ECR Panel	Dietetics	Psychology	Nursing	Admin	Other
A	x	x					
B			x	x	x	x	Support from Physician and MH services as necessary
C			x	x	x	x	As 2 and support from HI Physical Activity Specialist.
D			x	x	x	x	As 3 plus need for management and audit support, and health improvement and GP involvement.

The Working Group felt that option A could be delivered through the new ECR procedures with the Commissioning Team and ECR Panel, or alternatively referrals could go directly to the North Tyneside bariatric team. The remaining options involve a broader and an increasingly more specialist role and would need input from particular disciplines as shown and occasional support from others. The level of input required from the disciplines to deliver the roles under options B, C and D would be substantially different.

A brief options appraisal exercise looking at the pros and cons of the four options was conducted and Appendix 1 contains the results. The conclusion was that option C was likely to provide the most cost effective solution to the management of morbid obesity overall allowing the development of local expertise that would support better patient management at levels 1 and 2, be able to manage a significant case load at level 3 and deliver a more rigorous selection of patients for surgery (level 4).

Capacity and costs of the SWMT

The capacity needed within the local team to deliver the option C role will be dependent on the prevalence and incidence of obesity, the coordination and capacity within level 1 and 2 services, the willingness of patients to consider surgery and the referral behaviour of GPs, amongst other factors.

The March Board paper estimated that there were about 2,200 people with BMIs > 40 in Borders. Unfortunately, figures are not available for the number with BMIs > 50 and 45-50 with co-morbidities. However, if we assume that there may be around 1,000 and that around 50% would not consider more intensive support or surgery or would fail to attend, then we are left with approximately 500 as a potential backlog or prevalence, which the SWMT might need to manage. The team would also need to keep pace with the incidence of morbid obesity, i.e. new cases arising each year which the Board paper estimated as being approximately 27 per annum.

The Working Group examined the capacity that would be needed to deliver the assessments of new patients referred, intensive support and treatment of some after assessment, and follow up after surgery. Initially the emphasis is likely to be on assessing the backlog of patients and as this is reduced, more clinical time will be available to support the increasing numbers needing treatment and post-operative follow up. This demand and capacity analysis was done making two different sets of assumptions about the number of assessments, patients needing treatment, and the number of follow up appointments that would be required per annum. Appendix 2 shows the assumptions and the results. Between 0.6 and 0.7 Whole Time Equivalents (WTE) of clinical time seems to be needed.

Additional capacity would be required for training and support of staff at levels 1 and 2, development and management of the care pathway, liaison with the surgical team, and education and CPD activities. In all approximately 1 WTE of clinical staffing seems to be required. Some administrator input would be needed also. The following is therefore recommended as a reasonable team capacity to deliver the SWMT role and provide the multi-disciplinary input and skills needed, gross costs are also identified:

Specialist Nurse (band 7)	2 days/week	16,290
Dietitian (band 7)	2 days/week	16,290
Psychologist (band 8a)	1 day/week	10,340
Administrator (band 4)	1 day/week	4,775
Total	1.2 WTE	£47,695

There may be a need for a small non-recurring resource for equipment but this can be managed within the first year allocation given slippage and part year funding of the posts above.

For comparison the cost of option B, with the treatment costs in Appendix 2 and associated administrator time removed, would be between £10-20,000 less.

Number of bariatric operations and Service Level Agreement

The local SWMT would undertake the initial assessment against the locally agreed criteria and the surgical assessment would concentrate more on an explanation of the

recommended procedure, side effects and implications for life long dietary control and follow up, and the assessment of surgical and anaesthetic risk before surgery.

Post-operative follow up within the first year is at 6 weeks, 3, 6 and then 12 months after surgery. It is expected that the surgical team will hand over the follow up to the local SWMT after the 12 month visit, but as experience of the local team develops this could occur earlier, within the first year, with an adjustment to the SLA costs.

The latest tariffs from the North Tyneside bariatric service are:

2010/11 tariff	£
Balloon Insertion - elective inpatient	2,599
Removal of Balloon - elective daycase	756
Gastric Banding - elective inpatient	5,573
Gastric Bypass - elective inpatient	10,540
Sleeve Gastrectomy	10,535
Outpatient - new referral inc. Endocrine tests	361
Outpatient - new referral exc. Endocrine Tests	288
Outpatient review	153
Outpatient review including banding adjustment	241

One pre-operative assessment and four post-operative follow up appointments would be needed for each patient, costing approximately £1000. The type of operation is selected for each individual patient and costs are significantly different. An analysis of the Borders patients seen by the North Tyneside service so far suggest that gastric bypass is the most common operation with occasional balloon insertions, with the average cost being £9,400. This gives a total cost of £10,400 per patient and the funding available, after the SWMT costs, would support approximately five operations per annum in the initial SLA.

Summary

This paper reports on the further work undertaken to recommend the role, composition and capacity of the Specialist Weight Management Team approved at the SPC in March (option C on page 2 recommended and capacity outlined on page 3); the number of bariatric operations to be included within the Service Level Agreement with the North Tyneside bariatric service (recommendation is 5 per annum); and all within the financial envelope of £100,000 recurring included in the financial plan.

Recommendation

The Board is asked to **approve** :

- the recommendations on the role, composition and capacity of the local SWMT
- the number of bariatric operations to be specified per annum in the SLA with the North Tyneside bariatric service
- project and line management arrangements for the SWMT.

Policy/Strategy Implications	If approved the recommendations will help to develop a more strategic and managed response to obesity
Consultation	The Working Group included representatives from the three Clinical Boards. The North Tyneside bariatric service was consulted about the skills and disciplines required in a local SWMT. Discussions with colleagues in medicine (diabetes), psychiatry and health improvement about the occasional specialist input to the SWMT's work have been held with positive, supportive responses.
Consultation with Professional Committees	No formal consultation with Committees but wide professional input as outlined above.
Risk Assessment	<p>There is a risk of budgetary overspend given the prevalence of morbid obesity and trends. However, the option recommended minimises this and is the best to effectively match demand and supply.</p> <p>There is considerable risk to the health of the Borders population, and therefore future demand on services if this topic is not addressed vigorously. There is also a reputational risk if NHS Borders does not develop and implement a clear policy on the management of morbid obesity and bariatric surgery.</p>
Compliance with Board Policy requirements on Equality and Diversity	Not formally assessed but no compliance problems anticipated.
Resource/Staffing Implications	Resource implications are £100,000 per annum and this figure is included in financial plans. Staffing implications are as outlined on page 3.

Approved by

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Options Appraisal for SWMT

Option	Pros	Cons
1	No cost for SWMT More operations possible.	Difficult decision making due to lack of specialist clinical assessment. Less ability to identify those who can benefit most. No coordination of pathway. No development of local expertise. Lack of patient choice. Higher cost in SLA per patient since no local team pre-op ass't & follow up. Less liaison with surgical team. Potential for long waiting times, could breach 18 week RTT target. Uncertain lines of accountability. Potential for more complaints Not compliant with SIGN 115.
2	Better patient selection and benefit realisation than option 1. Cost per patient in SLA lower (some pre-op and post-op care delivered locally). Reassurance that lifestyle changes tried. Development of local expertise. Some ability to match demand with supply.	Patient dis-satisfaction – advice but no specialist support. No coordination of pathway. Some potential for long waiting times & breaching 18 week RTT target. Clinical responsibility uncertain. Better compliance with SIGN 115 than option 1. Funds used for SWMT not available for surgery.
3	Better patient selection than options 1 & 2. Lower cost per patient in SLA. Greater development of local expertise. Greater ability to match demand with supply – less risk of long waiting times. Patients better informed and managed – lower risk of complaints and dis-satisfaction. Less emphasis on surgery – greater choice of evidence based options. Better local knowledge of needs and coordination of pathway. Dedicated team to liaise with surgical team. Single point of contact for clinicians and patients queries and support. SIGN 115 compliant.	Higher cost of local SWMT needed to deliver capacity. Less funding available for operations.
4	As for option 3 above but even better coordination across the pathway and proactive auditing and continuous improvement.	Local SWMT and Network support likely to take majority of recurring funding. Little funding available for operations and level 4 work. Greater risk of overspend via ECR route.

Demand and Capacity Analysis

The two analyses below use differing assumptions about numbers of patients undergoing assessment and treatment, and different numbers of follow up appointments each year.

Analysis 1

Assumptions: 240 assessment p.a. x 2 hrs/assessment.
 50 patients in treatment: 40 in groups, 5 groups p.a. x 8 pts/group x 2 hrs/session x 8 weeks; 10 1to1 therapy, 1 hr/session x 8 weeks.

50 patients needing follow up x 4 appointments p.a. x 1 hr/session.

Function	Patients p.a. (patient groups p.a.)	Hours per session (no.sessions/treatment)	Total clinical hours	Days (6 clinical hours/day)	WTE (42 working weeks p.a.)
Assessment	240	2	480	80	0.38
Treatment – group	40 (5)	2 (8)	80	13	0.06
Treatment – 1 to 1	10	1 (8)	80	13	0.06
Follow up	50	1 (4)	200	33	0.16
Total	340		840	139	0.66

Analysis 2

Assumptions: 150 assessment p.a. x 2 hrs/assessment.
 100 patients in treatment: 80 in groups, 10 groups p.a. x 8 pts/group x 2 hrs/session x 8 weeks; 20 1to1 therapy, 1 hr/session x 8 wks

50 patients needing follow up x 2 appointments p.a. x 1 hr/session.

Function	Patients p.a. (patient groups p.a.)	Hours per session (no.sessions/treatment)	Total clinical hours	Days (6 sessions/day)	WTE (42 working weeks p.a.)
Assessment	150	2	300	50	0.25
Treatment – group	80 (10)	2 (8)	160	27	0.13
Treatment – 1 to 1	20	1 (8)	160	27	0.13
Follow up	50	1 (2)	100	17	0.1
Total	300		720	121	0.61