



# **Cynulliad Cenedlaethol Cymru** **The National Assembly for Wales**

## **Y Pwyllgor Iechyd a Gofal Cymdeithasol** **The Health and Social Care Committee**

**Dydd Iau, 13 Chwefror 2014**  
**Thursday, 13 February 2014**

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynndi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In

addition, a transcription of the simultaneous interpretation is included.

**Aelodau'r pwyllgor yn bresennol**  
**Committee members in attendance**

Rebecca Evans	Llafur Labour
Elin Jones	Plaid Cymru The Party of Wales
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

**Eraill yn bresennol**  
**Others in attendance**

Jonathan Barry	Llawfeddyg Ymgynghorol mewn Bariatreg Laparosgopig, Cymdeithas Llawfeddygaeth Gordewdra a Metabolaidd Prydain Consultant Laparoscopic Bariatric Surgeon, British Obesity and Metabolic Surgery Society
Scott Caplin	Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg Abertawe Bro Morgannwg University Health Board
Dr Dev Datta	Ymgynghorydd mewn Biocemeg a Meddygaeth Fetabolig, Cymdeithas Gastroenteroleg ac Endoscopi Cymru, Consultant in Biochemistry and Metabolic Medicine, Welsh Association of Gastroenterology and Endoscopy
Colin Ferguson	Cyfarwyddwr Materion Proffesiynol, Coleg Brenhinol y Llawfeddygon Director of Professional Affairs, Royal College of Surgeons
Dr Nadim Haboubi	Cadeirydd Fforwm Gordewdra Cenedlaethol Cymru a Meddyg Ymgynghorol mewn Meddygaeth Oedolion a Gastroenteroleg Chair, National Obesity Forum for Wales and Consultant Physician in Adult Medicine and Gastroenterology
Dr Jane Layzell	Ymgynghorydd mewn Meddygaeth Iechyd Cyhoeddus, Bwrdd Iechyd Lleol Aneurin Bevan Consultant in Public Health, Aneurin Bevan Local Health Board
Alison Shakeshaft	Cyfarwyddwr Therapiau, Bwrdd Iechyd Lleol Aneurin Bevan Director of Therapies, Aneurin Bevan Local Health Board
Dr Khesh Sidhu	Dirprwy Gyfarwyddwr Meddygol ac Ymgynghorydd mewn Meddygaeth Iechyd Cyhoeddus a Phwyllgor Gwasanaethau Iechyd Arbenigol Cymru Deputy Medical Director and Consultant in Public Health Medicine and Welsh Health Specialised Services Committee
Jan Smith	Cyfarwyddwr Gweithredol Therapiau a Gwyddorau Iechyd, Bwrdd Iechyd Lleol Aneurin Bevan Executive Director of Therapies and Health Science, Aneurin Bevan Local Health Board
Dr Suzanne Wood	Ymgynghorydd mewn Iechyd Cyhoeddus, Iechyd Cyhoeddus Cymru

Consultant in Public Health, Public Health Wales

**Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol  
National Assembly for Wales officials in attendance**

Chloe Davies	Dirprwy Glerc Deputy Clerk
Llinos Madeley	Clerc Clerk
Victoria Paris	Y Gwasanaeth Ymchwil Research Service

*Dechreuodd y cyfarfod am 09:38.  
The meeting began at 09:38.*

**Cyflwyniad, Ymddiheuriadau a Dirprwyon  
Introduction, Apologies and Substitutions**

[1] **David Rees:** Good morning, everyone. I am sorry to have kept you waiting for a little bit; we just had to get some technical information sorted out. I welcome you to this morning's session of the National Assembly's Health and Social Care Committee. We are in Swansea University this morning, and I thank Swansea University at the start for its kindness in offering us this opportunity.

[2] I will just cover some housekeeping. If you need translation, please use the equipment, which can also be used for amplification. There are no scheduled fire alarms, so if the fire alarm does go off, please follow the ushers. If you have any mobile phones and any electronic equipment that may interfere with the broadcasting, could you please turn them off? I know that some people sitting here have equipment that may be okay, but other equipment may interfere with the broadcasting. We have received apologies from Darren Millar, William Graham, Lynne Neagle and Leighton Andrews for this morning.

09:39

**Ymchwiliad i Argaeledd Gwasanaethau Bariatrig: Sesiwn Dystiolaeth 1  
Inquiry into the Availability of Bariatric Services: Evidence Session 1**

[3] **David Rees:** This morning's session is the first in our inquiry into the availability of bariatric services in Wales. We are pleased to welcome Dr Nadim Haboubi this morning.

[4] **Dr Haboubi:** Bore da. **Dr Haboubi:** Good morning.

[5] **David Rees:** Bore da. **David Rees:** Good morning.

[6] Thank you for the written evidence that you have provided. I remind Members that the focus is on levels 3 and 4 of the obesity pathway. Therefore, please try to concentrate any questions that you have on those areas, although I accept that levels 1 and 2 have some input into that. If it is okay with you, Dr Haboubi, we will go straight into questions.

[7] **Dr Haboubi:** Please do.

[8] **David Rees:** I will start. The all-Wales obesity pathway, as you know, is the Welsh Government's approach to addressing obesity. What is your view of the progress of that pathway, and does it in any way need some changes at this point in time?

[9] **Dr Haboubi:** That is a very valid question, and it is extremely essential to start with a question like that on the obesity pathway. By the way, I was probably the only medical adviser on the pathway, and I wish there were more physicians or surgeons involved in the development of the pathway. The pathway is probably one of the best documents ever produced in the UK, not just in Wales. The pathway was launched by the Wales national obesity forum back in 2010. From the very first minute, we raised concerns that it was just going to be a document that would be shelved. It is an essential document, it is very important and it covers all aspects of obesity. Up to now, nothing has been done to implement and support that pathway. So, the concern that we raised initially that it would be a document that would be shelved is exactly what happened.

[10] **David Rees:** Thank you for that. In your view, is there an issue with all levels identified in the pathway, or is it more levels 3 and 4 that have issues to be concerned about?

[11] **Dr Haboubi:** I am going to be very honest. I am very passionate about it, because I have been involved in the management of obesity for about 13 or 14 years. So, when I talk to you, I talk from experience, and I am a physician. I think that the Welsh Government has got it wrong from the beginning, because obesity has two aspects. There is something called 'prevention' and there is something called 'management'. The task was given purely to sort it all out to public health. I can understand that public health is probably the best by far to prevent a disease. When you deal with people with complex and severe obesity, this is a clinical condition. They already have so many problems that need to be addressed. So, physicians and surgeons were excluded from dealing with the problem; the task was given just to public health. The pathway begins with level 1, which is prevention, and that is done in the community. Level 2 is about primary care and community care. Levels 3 and 4, which involve the royal colleges, physicians and surgeons, are actually about patients. So, we are talking about levels 1, 2, 3 and 4, and you have to separate them. I think that levels 1 and 2 should be public health concerns and levels 3 and 4 should involve the royal colleges, physicians and surgeons, because we are experts in dealing with not just obesity, but also with problems related to obesity. That is the problem, and that is why we have not moved an inch since that pathway was published and launched.

[12] **Gwyn R. Price:** Good morning. Do you believe that the development of a nationally agreed common access and service specification will ensure the provision of level 3 services across Wales? *[Interruption.]* Apologies for that, doctor; it was not me. *[Laughter.]*

[13] **David Rees:** Let us just check if everything is working again. We are just checking the technical advice that everything is okay.

[14] **Gwyn R. Price:** As I said, apologies for that. Do you believe that the development of a nationally agreed common access and service specification will ensure the provision of level 3 services across Wales?

[15] **Dr Haboubi:** Can you elaborate? Can you tell me what you mean by that? What are you trying to ask me?

[16] **Gwyn R. Price:** You are suggesting that the level 3 service is coming across Wales. You would like level 3—

09:45

[17] **Dr Haboubi:** It has to be. Level 3 does not exist, only when it is partly resourced as it was when I ran it for Aneurin Bevan Local Health Board. There should be a level 3 service in every single health board. In our opinion, that would have to be centrally commissioned,

because, if you leave it to health boards, no-one will put his hand in his pocket to get the money out. You produce a document and you have to enforce it. You have to make sure that health boards implement it, whether you or they have to provide the resources. Do not forget that obesity—and I am talking about complex obesity—is a chronic disease. The Americans have just got it right, because they have now defined obesity as a disease. We have not. Do you know why? If we define it as a disease, it is going to cost. Yes; hypertension, diabetes, arthritis et cetera—

[18] **Gwyn R. Price:** So, do you believe that bringing in a level 3 service would, in the long run, save money?

[19] **Dr Haboubi:** Of course, because eventually you will actually provide a service to treat obesity in these people. I do not think that there would be a single person with a BMI of 35 who does not have comorbidity. I do not believe it. I see these people. Their comorbidity is hidden. These people are full of illnesses; they are on so many medications. Naturally, you are going to improve their diabetes, their hypertension, their cholesterol et cetera. Some of them may actually require surgery, some of them do not require surgery and some of them do not want to have surgery. You have to have a level 3 service everywhere; otherwise, this crisis is going to escalate. It is a crisis.

[20] **David Rees:** May I ask a question?

[21] **Dr Haboubi:** Please do.

[22] **David Rees:** The level 3 service that has been identified has to be in each health board, in each health area, and the level 3 service clearly requires, therefore, a management team to look at the management of it.

[23] **Dr Haboubi:** It has to be multidisciplinary and well-structured.

[24] **David Rees:** In other conditions we are being advised, in certain areas, that specialist centres are more effective. Is it that we should have specialist centres—and have more than just one—or is it that the health board should have a level 3 service team?

[25] **Dr Haboubi:** Is it logical, when my clinic is in Ebbw Vale, that I have people coming from Haverfordwest or from Rhayader? That is not logical, is it? They are not coming here just to be given antibiotics. These people have to be interviewed. They have to talk about their obesity, food et cetera. It is a personal problem. You have to be engaged with these people. Therefore, you have to respect their locality. You cannot just take them for one or two visits; there has to be a series of several consultations and so on over a period of months or even years. For example, I was at a meeting not long ago at the Royal College of Physicians in London and learned that some obesity centres in America actually follow up patients indefinitely.

[26] **Rebecca Evans:** You say in your paper that you have queried whether level 3 services should be funded from the Welsh Health Specialised Services Committee, and that that would potentially deliver a more robust clinical service. What are the barriers to that happening? Is it just Government will?

[27] **Dr Haboubi:** In 2009, our health board—and there is only one unit providing a level 3 service—wanted to shut that unit. Do you know why? It was because it would save £15,000 per annum. It was not shut for political reasons. The Assembly Member for Blaenau Gwent then was involved and had written to Edwina Hart because patients had complained that this was a service that needed to improve and escalate. Edwina Hart had then written to the health board. So, we are talking about the fact that you have to have a service like this everywhere.

Your question is in relation to who should fund it.

[28] **Rebecca Evans:** Tell us how it should be funded.

[29] **Dr Haboubi:** I say that obesity is a chronic disease; therefore, it should be funded by the NHS. Now, it is up to the Welsh Government whether it wants to—. If you want to enforce it, I think that it should be centrally funded. If you leave it to every single health board to sort it out themselves, they will have to cut corners and they will implement a level 3 service that is fairly suboptimum. It costs less. I think that there should be a well-structured level 3 service agreed upon, uniform in every single health board, so that at least they compete with each other and then you will see where the centres of excellence are, why the people in Powys are doing better than the people in Blaenau Gwent, et cetera.

[30] **Rebecca Evans:** Could I ask you to tell us a bit more about your own work in terms of—you mentioned Haverfordwest—from how far afield people come to your service and what the waiting lists are like?

[31] **Dr Haboubi:** Awful, the waiting list is awful. I am ashamed of it, but I am also proud of it. The reason why is because there is nobody else. We have had referrals from Gloucester, England, Hereford, and Bristol, but not anymore. We simply cannot see them anymore. The reason why we have so many referrals and such a long waiting list is because there is nobody else and these people are desperate. They have all tried everything, such as the commercial organisations. They have lost weight before and have put it back again. It is a complex condition. They need experts. They need a team—not Nadim Haboubi, no; they need a team of psychologists and expert dieticians. They are not any dieticians; you have to have a bariatric dietician. You have to have a bariatric nurse. It is an extremely complex issue. You need to develop some training programmes and so on for all these professionals. Shut me up, if I talk too much. [*Laughter.*]

[32] **Rebecca Evans:** May I ask one more question?

[33] **David Rees:** Yes, go on.

[34] **Rebecca Evans:** You mention the importance of the team. We hear a lot about recruitment difficulties in certain specialisms and fields in Wales.

[35] **Dr Haboubi:** Surgeons, did you say?

[36] **Rebecca Evans:** No, I said recruitment difficulties. Do you have recruitment difficulties in your field?

[37] **Dr Haboubi:** Well, I run a clinic. I am not a full-time obesity physician. I am an obesity physician, but I run just one session. I was not appointed an obesity physician. This was something that I developed later on because of my interest in nutrition. If you are asking me, ‘Is it difficult to recruit people?’, no, of course it is not. What we need to establish is that there is such a need. We are, in the Royal College of Physicians and the national obesity forum, trying very hard and increasing awareness among our colleagues, mainly health professionals. The colleges and the surgeons well before us have developed a sub-speciality, which is bariatric surgery. We are developing, in the Royal College of Physicians, a specialty called the bariatric physician or obesity physician. So, there is a need. I do not think that recruitment is a big issue. If you establish the need, you will easily fulfil the need.

[38] **David Rees:** May I expand on that? Clearly, you have identified the need, and you say that recruitment is not possibly an issue. However, at the present time, are there sufficiently skilled and qualified individuals able to take on posts now, or are we looking at

trying to make sure that there are training opportunities and programmes in place so that we can develop those individuals?

[39] **Dr Haboubi:** All physicians—I am talking about physicians now—deal with a lot of problems that are related to obesity. There is definitely a need for some training, but, at the same time—. The Royal College of Physicians, for example, has established a training programme that is linked to a specialty within medicine, which is endocrinology and diabetes. That is going to be part of the curriculum. So, there will be not just cardiologists or gastroenterologists, there will be obesity physicians. It is happening in England. It is happening now in Wales as well. I am disappointed that not very many colleagues, among, for example, physicians—. There are plenty of dieticians who have a vast interest in managing obesity. We are very short on psychologists who have an interest in eating disorders—we are talking about Wales now. However, there is the national obesity forum and we are all working together now to increase awareness. We have to start initiating services and build them up and improve them. You have to start from somewhere. Experts will not descend on you from the sky, will they? I mean, they have to—.

[40] **David Rees:** No, I agree. Kirsty is next.

[41] **Kirsty Williams:** Dr Haboubi, you said that you are ashamed of your waiting lists. On average how long will a patient wait from a referral from their GP to access your clinic?

[42] **Dr Haboubi:** It used to be six months when we started. Now, it is two and a half years.

[43] **Kirsty Williams:** It is two and a half years.

[44] **Dr Haboubi:** Interestingly, a few days ago we were looking at the waiting list. We found out that five patients died waiting to see me. I am not saying that they died because of—. Obviously, it was from some comorbidities. So, this is serious. This is really serious. People are dying. The problem needs to be addressed. Who the hell is going to do that and when?

[45] **Kirsty Williams:** So, in terms of the patients who come to see you, obviously, previous interventions have not worked for them, by virtue of the fact that they are in your clinic. Is that because they have had access to NHS help previously and it simply has not worked for them, or are they coming to you having not had any intervention from levels 1 or 2 NHS services?

[46] **Dr Haboubi:** Level 1 has failed. There is no prevention. Prevention has not worked, has it? You know that very well. That is why we in Wales are the worst in the whole of the western world. In some areas in the western world, the epidemic has been halted or arrested, but not in Wales. We are still having this increase. Now, your question was how long—the waiting list in relation to—

[47] **Kirsty Williams:** I am interested in establishing whether people end up with you because there is no service below you—

[48] **Dr Haboubi:** Exactly, there is nothing.

[49] **Kirsty Williams:** Or is it because the service below you is—

[50] **Dr Haboubi:** No. There is nothing.

[51] **Kirsty Williams:** Okay. The option then for your patients is to potentially move on to

a level 4 service.

[52] **Dr Haboubi:** Yes.

[53] **Kirsty Williams:** Could you tell me how many people you have referred for level 4 services in the last year whom you have actually been able to acquire surgery for?

[54] **Dr Haboubi:** That is a very good question and an intelligent one. How many people have I referred? I have referred a lot; I cannot give you the number, but probably over 20. How many of them have had surgery? Maybe two or three—one from Powys, and I do not cover Powys. I am a Valleys man. [*Laughter.*]

[55] **Kirsty Williams:** Well, we are grateful for the Powys patients that you do see.

[56] **Dr Haboubi:** And the surgeon is here.

[57] **Kirsty Williams:** I know, and I know the patient.

[58] **David Rees:** That is why the question has been asked, then.

[59] **Kirsty Williams:** No, no. What I am interested in is what is preventing—. You know, you do not refer people because you think, 'Today, I will refer someone'. You refer people because you think that that is the right service for them. What are the barriers, then, that you face as a referring clinician to getting that service for your patients?

[60] **Dr Haboubi:** Poor resources. I refer to the Welsh Institute of Metabolic and Obesity Surgery, because it is the only centre there, but it is poorly resourced. The criteria are very rigid. The criteria are not set by WIMOS, but by the Welsh Health Specialised Services Committee. I do not know any surgeon on that committee; they are all in public health. The criteria are too rigid. You have to have a BMI of 50, you have to have severe—you are almost dead before you actually qualify. It is just impossible. Therefore, yes, there should be an expansion, not only in the number of surgeries that are provided, but the facilities that they have. They also have limited facilities. You need intensive treatment unit beds and a larger team. You need a well-resourced team. So, finance.

[61] **David Rees:** May I ask one question, before I ask Kirsty whether she has a supplementary question?

[62] **Dr Haboubi:** Please do.

[63] **David Rees:** The only place to which you refer patients is to Morriston, effectively—the level 4 unit in Wales.

[64] **Dr Haboubi:** That is right.

[65] **David Rees:** Okay. I just wanted to clarify that. Kirsty, did you want to come back in?

[66] **Kirsty Williams:** No, that is fine.

[67] **David Rees:** Rebecca is next.

[68] **Rebecca Evans:** I just wanted to ask, if someone waits two and a half years to see you, and then you decide that you would like to refer them for surgery, and, potentially, that referral is successful, how long the wait is then.



[69] **Dr Haboubi:** No, no. I do not—. Most of my patients are not referred for surgery. Do not forget that I am not a station from which to refer patients to surgery. I will try my best for them not to have surgery, but there are patients who desperately need surgery.

[70] **Rebecca Evans:** How long do they have to wait after you have referred them to have the surgery?

[71] **Dr Haboubi:** If they are accepted, it is a matter of months. It is not long. I am not qualified to answer this question, because it is for a surgeon to answer.

[72] **David Rees:** I suppose that the question is: from the point at which that they are referred to you to the point at which they receive surgery, what is the average wait?

[73] **Dr Haboubi:** I do something else, which is that I have two waiting lists—a routine one and an urgent one.

[74] **David Rees:** Right.

[75] **Dr Haboubi:** I see patients on the urgent waiting list within a month or two. Who are the urgent patients? I set some criteria—the young who have severe comorbidities, and so on. So, I do not refer patients just like that. I probably do not refer them until maybe a year after my team and I have tried. Some people lose weight, but they cannot lose any more.

10:00

[76] **David Rees:** Lindsay is next.

[77] **Lindsay Whittle:** Thank you, Chair. First of all, may I apologise to you as the Chair of the committee, the committee and our expert witness, Dr Haboubi, for being late? I have had a wonderful guided tour of many car parks in Swansea this morning—at least three. Dr Haboubi, I have heard you anyway at two separate conferences and I admire your frankness. Your honesty is sometimes almost brutal. I wanted to ask a question on the procedure following bariatric surgery, which is the procedure for removing excess skin. I notice in our papers today, Chair, that it says that these procedures are not routinely funded by the NHS, but, quite frankly, if I was a patient who had lost 20-plus stone with all of this excess skin, I still would not be feeling good about myself. I still would not. I think that that procedure should be available on the NHS, otherwise, quite frankly, if we are going to be as brutally frank as you, all that they are going to do is put that weight back on and eat again, and we are back to—

[78] **Dr Haboubi:** Thank you, sir. One of my patients is coming here on 12 March. She has lost about 80 to 90 kg, her BMI now is normal, and she had a BMI of 45. I have referred her twice for an apronectomy, which is the removal of excess skin, and she was declined. Do you know why? I will tell you why: it was because she did not have a fungal infection under the skin and she was not psychologically disturbed enough, but the woman is desperate. You would know her when she comes on 12 March. Of course, this has to be part and parcel of the NHS. There are patients who do not want to have surgery or to lose so much weight in case they have excess skin. What are they going to do with it? These people are young, okay? It scares them. So, either you have a comprehensive service or you forget it—send them somewhere else. We have people going to Belgium, the Netherlands or India. I think that that is embarrassing.

[79] **David Rees:** I think that that is a question we can ask about in other sessions.

[80] **Lindsay Whittle:** Okay, thank you. Well, the papers are here, so—

[81] **David Rees:** Gwyn is next.

[82] **Gwyn R. Price:** You are talking about a BMI of 50 and that, I assume, is what is in the guidelines now, but there is an opinion that it should be 40. Do you have an opinion on that or do you think that it is up and down and about who you see in front of you?

[83] **Dr Haboubi:** I think the NICE guidelines, which are a BMI of 35 with comorbidity, then 40, are probably the best guidelines, and they have to be applied. I know that, even in England—although NICE is not an English club, it is for the UK—there are still places where there are, and Jonathan Barry might elaborate on that, stricter guidelines than the NICE guidelines, because it depends on their resources. However, the NICE guidelines are probably the ones that we need to follow, because they are probably the most evidence-based guidelines available worldwide.

[84] **Gwyn R. Price:** Thank you.

[85] **David Rees:** Kirsty, do you have a question?

[86] **Kirsty Williams:** Dr Haboubi, because of the strictness of the guidelines to access bariatric surgery, I know of at least one constituent who is eating her way to get to that particular criterion, because, each time that she gets to the criterion, it is moved and, because of a whole range of psychological issues, her answer is, ‘Well, I’ll just eat my way to that next criterion in the hope that that will work.’ Is my constituent just a one-off, or is that a common phenomenon that you see, namely that people are actually getting more obese in a desperate attempt to access bariatric surgery?

[87] **Dr Haboubi:** I cannot answer that question. I know that it has been publicised in the media that people are becoming more obese so that they can access surgery. I think that that is an exaggeration, to be honest. Obesity is far more complex than people becoming more obese so that surgery will be available for them. I really do not know the answer to that. No, I just do not think that it is the case that people eat more and more and become more and more obese until they qualify for surgery. I do not think so.

[88] By the way, a lot of my patients do not want to have surgery. There is a good number. Surgery is certainly not the treatment for obesity, but there are so many people who desperately need it.

[89] **Kirsty Williams:** In your paper you discuss good outcomes. We can create these level 3 services, but it will not do us any good unless the outcomes from the creation of those services are good. Could you tell us a little about your outcomes from your service?

[90] **Dr Haboubi:** Why do we take pride in what we are doing? We have published nationally and internationally our audits, and we do that every year. Our results have exceeded even the NICE guidelines because we are passionate. We are good. However, that is not enough, because we have a huge waiting list. Perhaps our results would be better if the pressure was less. You ask what we mean by good results. We are talking about a reduced number of medications. If you have an obese diabetic who is on insulin and no longer taking insulin, that is a hell of a— We are talking not just about cost. People who were waiting could also have had arthritis, hypertension, and their lipid profiles could have improved. We are talking not just about the quality of life but the comorbidity. I am not saying that these conditions, which are linked and associated with obesity, are disappearing but they are certainly diminishing.

[91] We mention outcomes by constant audit, and we are proud of it. It is available—you can just Google it on the internet, where you will find our published work, which is published in the European Congress of Obesity, or the International Congress on Obesity.

[92] **Kirsty Williams:** Do you provide solely an adult service, Dr Haboubi?

[93] **Dr Haboubi:** What?

[94] **Kirsty Williams:** Are you an adult-only service?

[95] **Dr Haboubi:** Yes; it is adult only.

[96] **Kirsty Williams:** So, forgive my ignorance, but what happens to children?

[97] **Dr Haboubi:** Nothing.

[98] **David Rees:** May I ask a question, because I think that Kirsty has highlighted a point perhaps where there is a great deal of stress and pressure upon your patients in particular? You have already highlighted that there is a low number of psychologists in this area. Are the aftercare and the support that people need after treatment sufficient?

[99] **Dr Haboubi:** It has to improve, obviously. It has to improve. We think that patients who have surgery at level 4, for example, should be followed up for two years, and that, after two years, should be followed up by the level 3 service. They have to come down to level 3 because there are so many complications. I think that one of my colleagues, Dev Datta, or one of the biochemists, will highlight that in future. However, these people need to be looked at and followed up. We are talking about surgery. It could be bypass surgery and they could be short on vitamins, supplements and so on. The follow-up will be with the dieticians, myself or a psychologist and so on. So, they need that follow-up.

[100] **David Rees:** You said that they should. Do they have that at the moment?

[101] **Dr Haboubi:** No.

[102] **David Rees:** So, after two years of the level 4 follow-up, there is no further follow-up.

[103] **Dr Haboubi:** No, there is nothing. There have been one or two mortality cases in Cardiff and the Vale, and we have also had two such cases, where people have had surgery elsewhere and no follow-up. Those people have died of vitamin deficiency. Can you imagine? This can be lethal. Do you know why? It is because there is no follow-up. These people have had surgery somewhere else.

[104] **David Rees:** Is that therefore an issue because their general practitioners are not following up, or is that an issue because they were done elsewhere and there was no information coming back? The question is about finding out why.

[105] **Dr Haboubi:** No, you need experts. If someone goes abroad and has surgery, you need to be followed up by an expert—someone who knows about nutrition, but it is also good as part of a team, not just the GP. The GP might just send haemoglobin and see whether the patient is anaemic or not. We are talking about micronutrients—things like zinc, selenium, copper and other little things. Only those who have an interest in the field would be aware of thiamine deficiency and the complexity of that—these deficiencies can kill.

[106] **David Rees:** So, this is a serious concern for individuals who go abroad for surgery

on their, probably, private pre-paid insurance. The consequences after the surgery are a serious issue.

[107] **Dr Haboubi:** I think that that needs to be addressed as well.

[108] **Lindsay Whittle:** Forgive me if it was covered earlier, but I want to ask you about close working with social services. I am aware of constituents who are having extensions built onto their homes in order that they can live totally downstairs. They cannot get upstairs because they are simply too obese. They are building extra bedrooms and larger bathrooms for these people. Surely that is not a good value-for-money exercise. Do you think that it would be better to put the money into psychological services, dieticians and all those other services?

[109] **Dr Haboubi:** Do you mean diverting resources from social services?

[110] **Lindsay Whittle:** Totally.

[111] **Dr Haboubi:** The answer is obviously 'yes', but any more resources are welcome wherever they come from.

[112] **Lindsay Whittle:** Do the LHBs work closely with social services on this issue?

[113] **Dr Haboubi:** We are trying to establish some services in Aneurin Bevan. One group of people we are excluding from treatment—excluding from treatment because we do not have the resources—are those who are housebound. If you cannot get out of your house, forget it; that is it—you are finished.

[114] **David Rees:** Is there any occasion when you or members of your team have made house visits?

[115] **Dr Haboubi:** No. I cannot go.

[116] **David Rees:** Are there any other Members with questions? I know that we started late, but we have just gone beyond our time.

[117] **Rebecca Evans:** May I just ask one question? Do you feel that GPs are referring to you in a timely manner or are they referring to you too late almost for the individual? Do they refer when the condition has got worse than it needs to be?

[118] **Dr Haboubi:** You are right. I think it varies. Some general practitioners are far more engaged with the patient. We call them patients because they are patients. So, some refer them in good time. Some of them just have no interest whatsoever or they refuse. The problem is that we cannot see self-referrals. That might happen in the private sector but not in the NHS. So, a patient has to be referred. Sometimes, the patient uses different means such as going to the practice nurses or dieticians in the community to get a referral from there. However, in general, it is very variable. It depends on the practices, to be honest. We get fantastic service from Blaenau Gwent because they are aware of us because we are local. I cannot speak about other parts.

[119] **David Rees:** Thank you, Dr Haboubi. Before we finish, is there any one specific recommendation you think we need to address in our report and our views on this? Keep it to one.

[120] **Dr Haboubi:** I really feel that levels 3 and 4 have to be addressed totally, genuinely and honestly by the politicians. You have the influence; we are just health officials. If you do

not truly address this process, then we will have a major problem in Wales. I think that it is sad that Wales is second to the US in terms of the epidemic and prevalence of obesity. It is sad that the problem is still escalating. It needs a genuine and honest addressing, and I think that you should really involve the experts in this. Up to now, we have just been left aside. You need to provide resources. Otherwise—

[121] **David Rees:** Just to confirm, the resources are in two different sections because, clearly, there is a need to address why people become obese in the first instance—that is the preventive approach—and there is the need to address your side of it with the level 3 management.

[122] **Dr Haboubi:** Yes, that is exactly it. They are two separate things. You are absolutely right. You have got to prevent it from childhood; you have got to address kids. You have got to prevent obesity. You have got to prevent those people who are of normal weight becoming overweight and those who are overweight becoming obese.

10:15

[123] The trouble is the question of what ‘overweight’ means. The average BMI in a UK adult now is 27.8, so most of us are overweight, actually. That cancer is progressive. Those who have a BMI of 50 had a BMI of 45 before. They had a BMI of 40, and 35, and maybe 30. You must stop that progression, but who does that? It is not public health when you have a BMI of 40 or 45, as you really have to have the experts—the surgeons and physicians, and the team.

[124] **David Rees:** Thank you very much for your evidence. I wonder if it would be possible for you to provide the figures—you were not quite clear on the figures as to the number of people who you have referred, and the number of people who have received surgery as a consequence of that. Would it be possible to write to us with that clarification?

[125] **Dr Haboubi:** Of course.

[126] **David Rees:** That would be very helpful. Thank you very much for that session. You will receive a copy of the transcript to check for factual accuracy.

[127] We will move on straight away, if that is okay. I welcome Elin Jones, who indicated that she would be late this morning.

10:16

## **Ymchwiliad i Argaeledd Gwasanaethau Bariatrig: Sesiwn Dystiolaeth 2 Inquiry into the Availability of Bariatric Services: Evidence Session 2**

[128] **David Rees:** I welcome Jonathan Barry, who is a consultant laparoscopic bariatric surgeon at Morriston Hospital; Mr Colin Ferguson, director of professional affairs for the Royal College of Surgeons; and Dr Dev Datta, consultant in biochemistry and metabolic medicine at Llandough hospital. I thank you again for your written evidence for the committee. We are tight on time, so if it is okay, we will go straight into questions. As my colleagues are very quiet at this point in time, I will ask your views on the obesity pathway. We have heard Dr Haboubi’s very strong view that it is right but not fully implemented. Do you have similar views in terms of how you see it working at this point in time?

[129] **Mr Barry:** From my own point of view, I share Dr Haboubi’s sentiments. In principle, the pathway is sound, but we are not making progress quickly enough. I know we

are discussing tier 4 here, and it is paramount and imperative that we have a tier 3 service in every LHB. I, as a level 4 surgeon, cannot stress enough the importance of a proper tier 3 service. It would improve the quality of referrals to our unit, and, as you alluded to in the last session, after two years, these patients will then go back into their own locality and, therefore, you have to have an effective tier 3 service there in order to follow these patients up. Dr Haboubi mentioned patients who are not being followed up, and I have personal experience of patients coming to harm, and indeed dying, through lack of appropriate support.

[130] **Kirsty Williams:** Dr Haboubi gave us a taste of the number of people that he refers through to your service, and the number of people who are actually able to pass the criteria and receive that service. The consistent theme running through all the evidence that we have had is the disconnect between what NICE guidelines are, and then what WHSSC says that it is going to do—or what it does—and what WHSSC has been told by the Minister. Fair play to the Minister, he last year said what should happen. Could you explain for the record what those differences are?

[131] **Mr Barry:** There is a disconnect between the NICE criteria. We will not have a fair and equitable access to bariatric surgery without implementing NICE criteria. We use the DUBASCO tool, which is purely a rationing tool that we have implemented solely to satisfy the fact that we can only operate on 67 patients in Wales for a population of 3,000. I think WHSCC has put in place progression. Last summer, at our National Obesity Forum meeting, we discussed the current implementation, and that we were going to move things forward, but, unfortunately, there has been some inertia here. We have not moved forward, certainly in the last year. As I say, the DUBASCO tool is fine from a rationing point of view, but it is not a clinical tool. However, it does satisfy the case where we have limited resource.

[132] **Dr Datta:** I echo Mr Barry's comments, and also Dr Haboubi's comments. One of the really important things in terms of deciding whether people are appropriate for medical and surgeons interventions is not just body mass index, which is a crude tool. A lot of what I am involved in doing deals with the medical problems as a result of obesity. There are multiple analogies that you can draw, but it is really important, as we have already mentioned this morning, to separate these medical and surgical interventions for treatment of obesity from interventions to prevent obesity among the public. It is a bit like saying, 'We'll do something about cigarette packaging' to a patient coming to see me tomorrow afternoon with lung cancer. It is a completely different matter. If there were NICE guidelines—which we have for obesity—being implemented in various places in England for cancer services but were not on offer in Wales for things like cancer or heart disease, there would be an outcry. However, because it is obesity, which is emotive and which is perceived among the medical and lay fraternity as being self-inflicted, there is no opportunity to offer people interventions that are proven to improve health. Instead, when I see an individual who has sleep apnoea and diabetes, I offer them very expensive chronic interventions, which is just fiddling around the edges, as opposed to dealing with the underlying problem. This is a major issue, it is a poor use of resources and we are doing a disservice to our patients.

[133] **Mr Ferguson:** I think that we are all in complete agreement about the fundamentals here, but there is clearly a huge gulf between the scale of the problem before us and the potential for provision of service at the moment. Even with the WHSCC's intentions, we are still a million miles away from having an effective service for these patients. As has been said, bariatric surgery has a very strong evidence base. NICE says that it is level 1, which is the strongest evidence base. It is not only evidence in terms of its efficacy but also its cost-effectiveness. It is not only just in terms of cost-effectiveness, but it is also a cost-saver in the medium term. This fits in very well with what the Minister has been talking about in terms of a new strategy for medicine in Wales, namely that we should be doing things that are cost-effective and which will save us money in the medium term. It seems like a no-brainer to us that we should be investing heavily in services for morbid obesity.

[134] **Kirsty Williams:** Is it because of a lack of political will? If the answer is so obvious, what do you think the barriers have been for moving this forward?

[135] **Mr Ferguson:** One of the differences between the Welsh health service and the English health service is the lack of a commissioning process. One of the advantages of a commissioning process is that you can put standards in there. In Wales, given that we do not have a commissioning process, we have to go in to persuade individual health boards that this is the correct thing to do and a good way to invest resources. That is a much more labour-intensive and less highly tuned process. So, that is one of the issues.

[136] It is just such a big problem that it has been put in the 'too difficult' box to a large extent, and people are shying away from addressing it. They do not realise that by not addressing it, they are wasting resource.

[137] **Gwyn R. Price:** Good morning, everybody. Dr Haboubi said that local health boards needed to get level 3 services all the way. He also said that level 1 was a waste of time. However, all evidence says that prevention is better than cure. Do you have a comment on that?

[138] **Mr Barry:** Level 3 and level 4 are great on an individual level, but on a population level we need to be looking at prevention. Somebody in the last panel session mentioned the problem of childhood obesity in Wales. We have 4.2% of adolescents being overweight or obese. Up until three years ago, we had the third highest rate of adolescent obesity in the world. Ninety per cent of children born in 2007 will be obese by 2050. This is a huge problem. We have to address the issue of level 1 and level 2, but that is outside of my job in level 4. However, it has to be stressed.

[139] **Gwyn R. Price:** In level 4, when it comes to surgery, what is the frequency of cancellations in that area?

[140] **Mr Barry:** It is significant; we cannot run away from this. The current state is that we have unprecedented levels of A&E usage; we have ambulances waiting outside A&E in Morriston Hospital. That has a knock-on effect on our elective surgery. Obesity surgery is perceived as a non-malignancy, I refute that. Obesity is a malignant disease, but you have patients who are teed up for their cancer operations or complex vascular surgery and they will take precedence. It is a concern of mine that we have had 11 full operating lists lost in the last financial year.

[141] **Gwyn R. Price:** Yes, one or two of my constituents have said that they have been refused surgery four times.

[142] **Mr Barry:** Sure, that—

[143] **Gwyn R. Price:** That is common, then?

[144] **Mr Barry:** It is absolutely common. It is a cause of concern, but that is not unique to our trust. We are seeing that all across south and north Wales.

[145] **David Rees:** In that sense, you are the only level 4 service within south Wales. Although it is not unique to your trust, is there any consideration by the health board to ensure that you provide the service for south Wales, full stop?

[146] **Mr Barry:** I am sorry, would you repeat the question?

[147] **David Rees:** The cancellations issue clearly has a major impact on your ability to deliver and on patients, but you deliver for south Wales as a whole, do you not?

[148] **Mr Barry:** We deliver for south Wales as a whole, but we take referrals for the entire principality. We serve a population of about 2 million here, but we make decisions on about 1 million patients from north Wales—those patients will actually undergo surgery in England.

[149] **David Rees:** So, you also make the decisions for those.

[150] **Mr Barry:** Absolutely. There is parity across Wales. We try to keep a standardised referral pattern. We implement the DUBASCO and we have fortnightly multidisciplinary team meetings where we assess patients' suitability to go forward for surgery. We are completely blind to that. At the end of the MDT meetings, those patients from north Wales will be referred on to Salford—there are big logistical issues there, for example if somebody who is resident in Bangor has to go to Salford and the family has to travel back and forth. It is a source of great disappointment to me.

[151] **David Rees:** Lindsay is next.

[152] **Lindsay Whittle:** Thank you, Dr Barry—sorry, you are not doctor, are you?

[153] **Mr Barry:** Mister.

[154] **Lindsay Whittle:** Sorry. We have to get the titles right. I will call you Jonathan and you can call me Lindsay. [*Laughter.*]

[155] **Mr Barry:** I am grateful.

[156] **Lindsay Whittle:** You talked about young people—I am chair of governors at a local school and I am sorry to be politically incorrect, but there are young children in that school who are simply fat. By the time many pupils reach their teenage years, body image is important. I think that it is possibly too late by the time these young people are 16, 17 or 18; they are already on that slippery slope to obesity. How do you think we could encourage LHBs to work with local authorities, the education department and the leisure departments? I notice that we have evidence from WeightWatchers here—I have never been, so I do not know whether young children go to WeightWatchers. How do they work together, because in these austere times, leisure centres are among the first to be hit—Plas Madoc in Wrexham announced this week that it was to close. Closing our leisure centres will not help our obesity problem, will it? What can be done with the LHBs?

[157] **Mr Barry:** We have to stop doing things like selling off school playing fields for housing. We have to have a concerted effort to get these children out playing in the streets, taking part in physical activity; we need better education in schools on what constitutes a healthy diet. I have seen this myself—I have a young son who plays rugby in south Wales and in some of the communities that we go to to play, there are children who are exhibiting signs of pre-diabetes with established obesity; these are children of nine and 10. I know what will happen to these children in the next five, 10 or 15 years.

[158] **Dr Datta:** If I may just mention something, I think that there are two factors here, as Jonathan has already said. There is not one intervention within our communities that will make a difference—it is going to be a multiplicity of interventions, some of which we have already mentioned. We have to normalise healthy eating and physical activity, because, certainly in some of the parts of Wales that I visit, the opposite is the norm. Again, as I have mentioned already, an absolutely important part of the problem here is childhood obesity—problems that we already have in terms of health behaviours, or a lack of them. Perhaps we



should also remember that in terms of a lot of the things that Jonathan and I are involved in, it is too late. It is important not to muddle, as we often do, the prevention and the public health aspects of obesity with the medical and surgical aspects. It is the same for so many things in life, for example smoking and lung cancer, alcohol and liver cirrhosis and so on.

10:30

[159] We have to do all of these things. That is why the all-Wales obesity pathway is good. You do not hear any of us indicating that it is not a good thing, because it deals with all of these things. However, if you only deal with one facet, you are destined to fail. So, if we put all of our resources into bariatric surgery, that is not going to be any good for the children you have described. If we put all of our resources into playing fields, and nothing into bariatric surgery, that does nothing for the large number of people who Jonathan and I see, for whom these interventions are too late. We have to look at implementing this from start to finish. That is why we have four tiers and we have to implement all of them. We have made some progress with levels 1 and 2, but very much less so with levels 3 and 4.

[160] **David Rees:** I remind Members that the Children, Young People and Education Committee is looking into childhood obesity and will be producing a report on it.

[161] **Lindsay Whittle:** As a follow-up to that, Chair, I wanted to ask about body image. We all end up in this world with different bodies, and I am not for one minute advocating that we can all be wonderful models and handsome hunks; we are all different, and it is about personality. However, it is about concentrating on the health issues. Is there any work being done on body image?

[162] **Mr Barry:** Pre or post bariatric surgery?

[163] **Lindsay Whittle:** Pre surgery, preferably.

[164] **Mr Barry:** There are certain problems with body image. We see a lot of patients coming to our clinic who have what we call body dysmorphia. They feel socially stigmatised and they stay at home and do not actually leave the house. That is a problem pre-operatively. Post-operatively, you mentioned body contouring surgery, and we know that these patients have had problems with mobility and, once again, body image. However, there was a commissioning process last year—the British Association of Plastic, Reconstructive and Aesthetic Surgeons got together in a consultation process with my society, the British Obesity and Metabolic Surgery Society—that showed that patients who achieve body mass indices of 28 and maintain that for 12 months should be put forward for contouring surgery.

[165] **Kirsty Williams:** Could I go back to the issue of an equitable service across Wales? Again, in all of the papers that we have received, there has been a desire expressed to be able to establish other level 4 services. The Welsh Association of Gastroenterology and Endoscopy paper talks about the ability, potentially, to repatriate patients from north Wales to be able to provide a service at the Wrexham Maelor Hospital. Could you explain to me what would need to happen to establish a north-Wales centre? Is it simply about the resources again?

[166] **Mr Barry:** Yes, it is about resource. I have worked in the Maelor hospital. Two of the surgeons there are trained bariatric surgeons already. I think that the next step—. Hopefully we will increase our numbers sometime soon. I would like to see our unit in south Wales fully saturated and at full capacity, but there is an imperative that we have a north-Wales service. Clearly, the patients are not being disadvantaged from a surgical perspective, because they are undergoing surgery in Salford. However, I think that we are duty-bound—we are working in Wales, and all of these patients should be managed in the principality. So, as I say, it is an imperative to have a second unit in Wrexham before too long.

[167] **Kirsty Williams:** Other papers talk about, potentially, a service in the south east of Wales. Again, are there surgeons available in south-east Wales already trained in these procedures, and it is just a question of commissioning and resources?

[168] **Mr Barry:** I think that we are in a state of flux at the moment. There is certainly reconfiguration of level 3 services. We have seen the centralisation of oesophageal and gastric cancer services in Cardiff, with which I am not altogether in agreement. However, for the time being, I think that we need to reach full capacity in Morriston Hospital. As I say, at the moment, we have two surgeons. I look after 1.5 million and my colleague looks after 1.5 million. However, I think that, in due course, were we to get beyond the 2% with a BMI of 40, we would look at a third surgeon being employed.

[169] **David Rees:** Following on from that, you mentioned that there were two bariatric surgeons in Wrexham—[*Interruption.*]

[170] **Mr Barry:** No; sorry. I will be specific—they have two upper gastrointestinal surgeons in Wrexham, one of whom is bariatric trained and the other who has learnt on—.

[171] **David Rees:** Obviously, one of the issues that people often hear about is that the centralisation of services in specialised centres causes a critical mass issue. So, are the individuals who you are talking about in Wrexham able to get experience in bariatric surgery so that they could actually have the unit there?

[172] **Mr Barry:** They are experienced bariatric surgeons, but they do not provide bariatric surgery on the NHS.

[173] **Elin Jones:** I wanted to take you back, Mr Barry, to something that you said at the start. That was about the need to improve the quality of referrals to tier 4 services and to your unit. I wanted you to explain to me, so that I can understand it a bit better, what the scale of that issue is for you at the moment in terms of the numbers of referrals to your service that are necessary and could have been dealt with in a different way if the services had been there, and how that is affecting your ability to deal with the people that you need to see so that the service be more efficient.

[174] **Mr Barry:** Ideally, the patients who are referred to our service should be, for want of a better phrase, ‘match fit’. They should be ready for surgery. They should have gone through an appropriate level 3 service. We do see patients who are discussed at our multidisciplinary team meeting who would benefit better from a level 3 service. So, those people would not be referred on to us. There are certain things that we would need to do for these patients pre-operatively, such as a psychological assessment. Obviously, there are constraints then on our own bariatric psychologist in Swansea, whereas if Dr Haboubi had his own psychologist in Ebbw Vale, that could be sorted out locally. It would reduce the number of referrals to us and, hopefully, it would reduce the time from referral to surgery.

[175] **Elin Jones:** Does that mean then that you refer people back if you do not believe that they are—

[176] **Mr Barry:** It is not so much that we refer them back, but, for example, if we have a patient referred to us who we feel needs sleep studies because they have a history of potential sleep apnoea, we would not then bring them from Powys to Swansea to do sleep studies when they could be done locally. We see patients in our clinic about whom we say, ‘We need this, but we’re going to send you back to the Royal Gwent Hospital or to Haverfordwest to have these pre-operative investigations performed’, and then they come back to us.

[177] **Elin Jones:** So, what is the issue that causes the inappropriate referrals to you? Is it just that it is easier for those people working in different health boards to think—

[178] **Mr Barry:** No, these problems would not exist if we had an effective tier 3, but we do see people in clinic, for example, who we get a sense about—it is not a normal clinic environment as it is when you go to see a doctor. We have parts of our MDT present in clinic as well and we discuss each patient on an individual basis. Clearly, if there are problems with binge eating, for example, with these patients, we will say, ‘Hang on a second, we’re not going to proceed with surgery at the moment until we have a proper psychological assessment’.

[179] **Mr Ferguson:** There is a principle that underlies what is currently called the networking of services—I think that we should stop talking about centralising services. What we are talking about is centralising one bit of a service and the rest of the service, in terms of diagnostics and access to out-patient facilities, should be done as locally as possible. That is exactly what we are describing here with level 3 in all localities and the referring in to level 4 for the centralised bit.

[180] **Rebecca Evans:** I wanted to ask about accessing private surgery. First of all, do you work exclusively for the NHS? Do you also know what the scale is of people in Wales accessing surgery privately in Wales?

[181] **Mr Barry:** In answer to your first question, I have a small private practice in south Wales. I cannot give you figures for the number of people who are so desperate that they will seek treatment outside Wales.

[182] **Rebecca Evans:** Or outside the NHS.

[183] **Mr Barry:** I am sorry—

[184] **Rebecca Evans:** What about outside the NHS?

[185] **Mr Barry:** Yes, outside the NHS in the private sector either in England or Wales. However, we see a significant number of problems being referred in from private units outside the principality. Our second most commonly performed type of operation is operating on the complications in patients who have sought private surgery outside the principality. We are admitting a lady today from Belgium who has had a complication. I saw a patient in clinic on Tuesday who had gone to have a bypass in New Delhi. We are frequently seeing patients coming from private providers outside the principality with laparoscopic band related complications. My nurse specialist who is here today frequently gets phone calls from general practitioners in primary care with patients who are desperate because they cannot swallow. These private providers will take the patients’ money, follow them up for three months and then just let them come back to their local communities, and we have to pick up the pieces.

[186] **Dr Datta:** I would echo that. We see a lot of this. In Cardiff and Vale we have just put our head above the parapet in terms of trying to identify folk who have had bariatric surgery outside of the NHS. It is quite frightening. We started looking at this because we had two patients who died at the end of last year following surgery in the distant past, one of which was from a private provider outside Wales. We are aware that, without appropriate follow-up, there are severe potentially life threatening consequences for patients. People access these services all over the world—literally—because it is cheaper in Czechoslovakia, Belgium and India. I have seen patients from all over the world and their follow-up is incomplete and not joined up. What happens is that people are aware that Mr Barry has a service, and they send them all to him. In fact, much of the intervention, although some of it might be surgical, may be nutritional, as Dr Haboubi indicated earlier. The problem is,

because there is no obvious pathway for our primary care colleagues—whether that is a dietician or a GP—to access expert resources, either patients flounder or crash land in accident and emergency two years after their surgery, or worse.

[187] **Mr Ferguson:** It is also worth pointing out that the BOMSS standards that Mr Barry and his colleagues apply, and the level 3 assessments and the psychological assessments, obviously do not apply in the private sector. Patients are very often going without the benefit of that assessment in advance.

[188] **Mr Barry:** For clarification, the private practice we provide has exactly the same MDT structure as we do in the NHS.

[189] **David Rees:** You highlighted, and Rebecca asked a question on this, that you have seen an increasing occurrence of this. Could you provide us with some figures or percentages of how you see that increasing?

[190] **Mr Barry:** I was recently working on a talk for junior doctors on laparoscopic gastric banding. The slides that I made four years ago showed instances of complications with gastric banding between 10% and 15%. I provided a commentary for a paper in the *British Journal of Surgery* in November showing that 58% of these bands are going wrong and need to be removed. We are only seeing an increase in problems with this type of procedure outwith the three months or two years' follow-up from these private sectors elsewhere. I know that we are going to be taking out an awful lot of these bands in the next five, 10 and 15 years. It is not going to slow down.

[191] **David Rees:** I assume that they are seeking that private care outside because there is a long waiting list here in the UK.

[192] **Mr Barry:** They are just not eligible. These patients are desperate. They see, as Dr Datta mentioned, that they can go to some portakabin in Belarus and have a gastric band put in for £4,000 and they go and have it done, and then develop complications and come back to their local hospital.

[193] **David Rees:** You mentioned inertia; looking at eligibility, is that going to have an impact?

[194] **Mr Barry:** Certainly, because you would not have so many. I cannot put a figure on how many people are seeking private surgery elsewhere, but if we were to implement the NICE criteria, which is what we should be doing, we would see a significant reduction in people seeking help elsewhere.

[195] **David Rees:** And, as a consequence, the follow-up work would be undertaken by you.

[196] **Mr Barry:** Absolutely.

[197] **David Rees:** Rebecca, do you want to come back in?

[198] **Rebecca Evans:** On the criteria, I would like to ask your views on the appropriateness of WHSCC criteria for the next commissioning year. They say that there must be morbid or severe obesity present for at least five years and the presence of comorbidities as well. Is that appropriate or, as Kirsty's questions earlier were suggesting, just too late?

[199] **Mr Barry:** It is not too late; by the time patients have gone through level 1, level 2,

level 3 and back, that generally occurs over a period of years anyway. Most of the people we see in our clinic have had morbid obesity for many years, generally since childhood. So, a five-year target is not a problem.

[200] **Rebecca Evans:** What about the presence of comorbidities? Kirsty talked earlier about a constituent who was literally eating to try to get there.

[201] **Mr Barry:** This is something Dr Datta mentioned before. As a surgeon, it is important to get away from the weight loss. It is not the weight loss that we are trying to achieve; it is the metabolic improvement in these patients. You could have a patient who has a body mass index of 45 without diabetes, hypertension, sleep apnoea or the multitude of problems that come with that, but, over time, that patient will develop those complications.

[202] **Mr Ferguson:** It is also worth pointing out that some complications are reversible by bariatric surgery. In the case of diabetes in particular, it is very effective, but in the case of things like arthritis, it may not be. So, there is increasing evidence of that and, in particular, there is some evidence from the United States, where they are talking about operating at a much earlier stage to try to prevent these complications from developing in the first place. Going back to the WHSSC paper, you will see within the enormous gulf that there is between the potential for bariatric surgery to be applicable and what the very modest intention is to commission. There is an enormous difference there that we have to be thinking about.

10:45

[203] **Rebecca Evans:** I have one last question, which I asked Dr Haboubi earlier. It is about interest in your field and whether there is sufficient interest among clinicians to pursue your line of work.

[204] **Mr Barry:** There is interest, but the problem is that if you were to just identify a physician in Wrexham Maelor Hospital and say, 'You're going to look after the obesity service now with a paucity of resource', the answer is going to be 'no'. If you were to set up prospectively allocated dieticians and psychologists, there would be a lot of enthusiasm for this. We know that the physicians generally have a background in diabetes and endocrinology and we have a number of surgical trainees coming through who want to pursue bariatric surgery as a career. However, if you were to just identify a physician in a hospital somewhere and say, 'You're going to sort all this out', you would not get any takers.

[205] **Dr Datta:** Absolutely. It needs to be properly resourced. I do not run a proper obesity service at all, as I mostly see complications. However, if someone said to me, 'You can start a service tomorrow; you can have a room and a clinic clerk', I would not do it because I would not be able to do anything. It is really important to recognise—we are talking about level 3 services here—that it is the multidisciplinary nature of the process and the intervention that is going to be successful. No clinician or physician wants to run a service where they are not going to achieve a good outcome. Certainly, me sitting in a room with an individual patient for half an hour, two or three times a year, is going to achieve very little and would be a poor investment. What would be far more effective would be the implementation of level 3 services. Of course, clinicians and physicians are going to find being involved in high-quality services attractive, because we want to make a difference. Nobody is going to be interested in being involved in something that does not make an important difference to patients. At the moment, without that level of resource and obligation to set up a level 3 service, people are not going to be terribly attracted to this, because there is so much other work to be done. In my diabetes and lipid clinic, I will deal with the blood sugar and the high blood fat and deal with the consequences, rather than the underlying problem, because it is much easier to do. It is very easy to prescribe a tablet; it is very difficult to deal with the underlying problems.

[206] **David Rees:** In the hypothetical situation where all health boards decide to implement level 3 teams, do we have sufficient resources qualified at this point in time, or do we have to put training programmes into place to be able to develop those skills?

[207] **Dr Datta:** From the perspective of level 3 services—perhaps I will ask Jon and Colin to talk about level 4 services—these are physician-led services. Through the Royal College of Physicians, we have already identified a working group of physicians across Wales who are keen to develop services locally. As with so many things in life and in medicine, you do not start something and everybody is already an international expert. However, we have enough qualified clinicians in Wales to establish services that would improve over time. It is, of course, a little bit different for surgical interventions, because you want to have a fully functioning, high-quality surgeon from the outset. So, there is a little bit of a difference. I am pretty confident that we could establish level 3 services with physicians in Wales, if we had resources, fairly shortly. I will ask my colleagues—

[208] **David Rees:** Before you go on, you mentioned physicians, what about the other members of the team?

[209] **Dr Datta:** If we look at the other members of the team—we are talking about dieticians, psychologists and nurses—a lot of the training around this for an MDT is on the basis of the skills set that these individuals already have. Most dieticians will be very familiar with obesity, so gaining that very high level of expertise to function at a level 3 service is not a trip to Mars and back. It is entirely doable. The same goes for most of the other components of a level 3 service. There is the possibility that there are some opportunities to improve training and continuing professional development as part of developing level 3 services, but I do not think that we would have to parachute a large number of expensive, qualified individuals into Wales to service that requirement.

[210] **Mr Ferguson:** From the point of view of training surgeons, in particular, it is very difficult to attract trainees into a specialty that is currently not established and resourced. The point being that, if there were a clear strategy to develop level 3 and 4 service resourced within Wales, I would have no doubt that we could attract high-quality people to be trained in those specialties.

[211] **Kirsty Williams:** On that resource, I can see lots of figures as to what obesity is costing Wales. I wonder whether it is at all possible to give a ballpark figure on what the Welsh Government needs to spend on these services to get them up to being able to commission them at NICE guideline standards, and to have the level 3 stuff. What is a ballpark figure of the kind of investment that we need, in cash?

[212] **David Rees:** We appreciate that you are not financial experts.

[213] **Mr Barry:** No. That was my opening gambit. I cannot comment on level 3. I know that we would require a sub-£1 million investment in order to become NICE compliant with regard to surgery. With regard to cost-benefit, there is a misperception that this is expensive surgery. These operations pay for themselves in two and a half years' time. We have an 85% remission rate for patients with diabetes. Their hypertension goes away and their sleep apnoea gets better. Women undergoing bariatric surgery halve their risk of developing all types of cancer. Employment rates in the post-bariatric surgery population are the same as in the normal population. The question should not be: can we afford this type of surgery? The question is: can we afford not to fund this surgery?

[214] **Mr Ferguson:** Looking at the NICE criteria, the NICE benchmark is £30,000 for a quality-adjusted life year benefit. It sees that as being cost-effective. Bariatric surgery is about £6,000 per quality-adjusted life year. So, it is enormously effective in terms of the benefit that

you get from it. As Mr Barry said, it pays for itself in terms of the reduced morbidity going forward. So, this is something, in public health terms, irrespective of the individual, we should be investing in big time.

[215] **David Rees:** I will give you the last question, Kirsty.

[216] **Kirsty Williams:** The criteria state that only patients over the age of 18 should have access to this surgery. Is there any evidence that treating people below the age of 18 in this way is effective, or are there ethical issues about carrying out this kind of surgery on people who are under the age of 18? Is that why we do not do it?

[217] **Mr Barry:** The reason we do not do it at the moment is because of funding issues. We cannot sort out the 25-year olds and 30-year-olds. My colleague who is up next has a 15-year-old lad from south Wales who is 32 stone. We cannot help those individuals at the moment. Clearly, there are problems there in that they should not get into that situation. However, no time soon, we will be looking at operating on adolescents in Wales.

[218] **Mr Ferguson:** We have concentrated very much on level 3 and level 4 issues today, but, going back to Mr Price's earlier question about levels 1 and 2 and their effectiveness, clearly, at the moment, they are not being effective. I think that we have to look at the public health side of things as a societal problem, and I think that politicians have a responsibility here too. We have seen a very effective change in smoking as a consequence of the legislative framework being put in by politicians. I think that politicians also have a responsibility in terms of morbid obesity. If we were paying £5 for a Mars bar, perhaps it would not be so.

[219] **David Rees:** Okay. Thank you for that.

[220] **Gwyn R. Price:** Right. Put Mars bars up to £5. Noted. [*Laughter.*]

[221] **Mr Barry:** We have mentioned smoking and alcohol being vices. If your vice is eating, you can completely abstain from drinking alcohol or smoking cigarettes, but we all have to eat. So, comparing it—it is different.

[222] **David Rees:** There is the question of psychological support then.

[223] **Mr Barry:** Sure.

[224] **David Rees:** I am going to call a halt to this session, because we are going to run out of time. I have one question that I want to ask. You mentioned that 11 sessions were lost to cancellations. Would you be able to provide us in writing with the number of sessions that you were doing each year, and, therefore, what proportion that is?

[225] **Mr Barry:** Certainly.

[226] **David Rees:** We can then have clarification about what '11 sessions' actually means, and the number of patients that you would see in those 11 sessions.

[227] **Mr Barry:** It is in the order of—. In fact, it is 41 patients, but those 41 patients are not 41 individual patients, because they sort of bounce back.

[228] **Gwyn R. Price:** Could I just add a quick follow-up? Is there light at the end of the tunnel for my constituents who have been referred four times and are waiting and waiting? The mental strain on these people, again—

[229] **Mr Barry:** I am incredibly sympathetic to that, but we are surgeons here. We like

being in an operating theatre operating. We would rather do that than sit in our offices, so I am sympathetic to the plight of your constituents, but I am no—

[230] **David Rees:** We will ask the question to the health boards.

[231] **Mr Barry:** Sure, okay.

[232] **David Rees:** I have asked this question to others, and I will also give you an opportunity to answer. If you wanted to make one recommendation to us—and I keep it to one recommendation, so focus carefully—what would you say is that one recommendation that we should be focusing upon?

[233] **Mr Barry:** From my point of view, you have to embrace WHSSC's criteria and implement them as soon as possible in order to drive things forward.

[234] **Mr Ferguson:** I would very much agree with that, but recognising that that is a very modest aspiration.

[235] **Dr Datta:** I agree. We have an all-Wales obesity pathway, and I think that it is time to have an integrated way and deliver that. We have the description of what we want. Now is the time to get on and do it.

[236] **David Rees:** Thank you very much for your evidence. You will receive a copy of the transcript for factual corrections. Thank you once again. We will now have a short break before our next session.

*Gohiriwyd y cyfarfod rhwng 10:55 ac 11:06.  
The meeting adjourned between 10:55 and 11:06.*

### **Ymchwiliad i Argaeledd Gwasanaethau Bariatrig: Sesiwn Dystiolaeth 3 Inquiry into the Availability of Bariatric Services: Evidence Session 3**

[237] **David Rees:** Welcome back to the next session of this morning's meeting of the Health and Social Care Committee. We have representatives of the local health boards. Good morning. Before I ask you to introduce yourselves, I thank you for your written evidence in advance of the meeting. We have received papers from various health boards, including those not represented here today. I ask you to introduce yourselves. We will go from my left to the right.

[238] **Dr Layzell:** My name is Dr Jane Layzell. I am a consultant in public health, and I work with the public health team within Aneurin Bevan health board.

[239] **Mr Caplin:** I am Mr Scott Caplin, and I am a consultant surgeon at Morriston in WIMOS, working with Jon Barry. I have been asked to represent the health board, and I have agreed to do that, but I apologise in advance to the committee for where I might not have the perspective that you are actually seeking during this session.

[240] **David Rees:** Thank you for that. Just to let you know, I understand that Mr Roberts, the chief executive, is coming to the session this afternoon, so, if there are any questions that we want to ask, we may be able to ask them then.

[241] **Mr Caplin:** Exactly, yes.

[242] **Ms Smith:** Good morning. I am Jan Smith, director of therapies and health science in



Aneurin Bevan health board and joint executive lead for obesity services with the director of public health.

[243] **Ms Shakeshaft:** Good morning. I am Alison Shakeshaft, the clinical director of therapies in Aneurin Bevan university health board, and also a dietician by background.

[244] **David Rees:** Thank you very much for that. We will go straight into questions, if that is okay, and start with Gwyn Price.

[245] **Gwyn R. Price:** Good morning to you all. This question is to the health board representatives. What is your response to witnesses who have said that the health boards have really made no genuine efforts to combat obesity, especially in relation to levels 3 and 4?

[246] **Ms Smith:** May I make a start on an answer? There are varying levels of activity across all the health boards in Wales. I am not in a position to give you the detail of all of those, but certainly at level 2 you would expect to find a significant amount of activity, and at level 3 there will be elements of the pathway in place, but not comprehensively. I will ask Alison to talk you through what we are doing in Aneurin Bevan, if I may be a bit parochial, in terms of the work that we have started in the last year, and what our health board has agreed to resource to enable us to deliver across the whole pathway. Alison, would you like to take that, please?

[247] **Ms Shakeshaft:** I think it is fair to say that, in the Aneurin Bevan university health board, we are a little bit further forward than perhaps some of the other health boards. As Jan said, all of the health boards have elements of service provision for obesity, but what we have been working on in the last seven months is integrating all of our historical pockets of services, if you like—so, dietetic support to patients, integrating with the traditional one-to-one consultation with patients, the Slim4Life sessions, which is an eight-week nutrition education programme to help support patients with obesity, and also bringing in Dr Haboubi's clinic. We have actually developed a fully integrated adult weight management pathway. The element of the service that we identified to be severely lacking within the health board is clinical psychology. The health board has provided some investment for that. So, we are also about to advertise to implement some clinical psychology support to that pathway. We have rolled out the pathway so far across two of the boroughs served by the health board, and we will have a complete service up and running by April, which will be a single point of access for any patient with a BMI of 30 or above, with other criteria. They will come to an initial consultation clinic and will be signposted to the most appropriate support along that pathway, whether that is clinical psychology input, specialist dietetic input or whether they need to go straight to the level 3 multidisciplinary clinic.

[248] **David Rees:** Thank you for that.

[249] **Gwyn R. Price:** Could I follow up on that?

[250] **David Rees:** I will just ask Mr Caplin to respond first, because, obviously, his is a different health board. Do you have a health board view?

[251] **Mr Caplin:** I know that within Abertawe Bro Morgannwg University Local Health Board there is an integrated obesity taskforce, which has been sitting every three months, I believe, for the past 18 months. It looks at all tiers of the all-Wales obesity pathway. That incorporates members of the local authority in order to look at town planning and other aspects. They are working forward. They have been involved in the national framework, meeting in Cardiff, looking at developing an all-Wales tier 3 framework. So, there are moves forward. The proposals to tier 3 within ABMU are being finalised to place into the three-year intermediate term plan documents that are being produced at the moment.

[252] **David Rees:** Thank you. Gwyn.

[253] **Gwyn R. Price:** Just to follow up on that, do you have meetings with other health authorities and health boards to share your experiences?

[254] **Ms Shakeshaft:** There are individual professional meetings and, obviously, the health boards are involved in the meeting that Mr Caplin just described. Although we have been working on this for several months, we are still in the piloting phase for what we are producing. However, it is absolutely the intention to share that with health boards. In some of the previous elements in previous years we produced something called the joint treatment programme for treating patients with osteoarthritis who were also overweight. There was definitely some sharing of our experience with local health boards—with Cwm Taf Local Health Board and Cardiff and Vale University Local Health Board—around that. So, that is absolutely something that we will be looking to do.

[255] **David Rees:** Kirsty is next.

[256] **Kirsty Williams:** Mr Caplin, you talked about a process that ABMU has set up, and that you have been meeting for 18 months, yet you are still in the process of writing your plan. I appreciate that these things are complex, and that you cannot simply create a service overnight, but what are the barriers to you providing a level 3 service similar to what Aneurin Bevan LHB has been able to do? What barriers do you have to actually stopping meeting and talking about a service and actually delivering a service?

[257] **Mr Caplin:** I think that I need to put my practitioner's hat on a little bit more to answer this. A period of 18 months means six meetings, and committees take results back to committees to present their results and discuss them further.

[258] **Kirsty Williams:** We do love a committee in Wales.

[259] **Mr Caplin:** As such, I can sympathise with the thrust of your question, that it does seem rather tardy. Moving forward everything in ABMU, from my perspective, although I am definitely not an expert on this, has been focused on the three-year planning structure that is coming through. There seems to have been a timescale to slot into that because that is where resource allocation is being made. To me, the planning structure seems to be working in the way that the NHS planning structure works. Perhaps I could put it that way.

[260] **David Rees:** May I ask you, as a practitioner, in that sense, whether it is frustrating that it takes so long because of all of this process?

[261] **Mr Caplin:** I find it extremely frustrating. From personal experience, at times things do not happen that could have happened because the process is so slow. I have personal experience of that in matters unrelated to bariatric surgery in the past. What I personally find especially frustrating in terms of the surgical aspect is, as we heard in the earlier evidence sessions, that you do not need a degree in medicine or a degree from any university to understand the evidence of how beneficial it is. I have actually looked into it but I am not aware of any other single health intervention that has a cost-benefit within the lifetime of a Parliament, and that becomes relevant to the people around this table. You are saving money between elections by investing at the beginning. I sit there as a surgeon and think, 'I do not understand why this is not happening'.

11:15

[262] **David Rees:** Thank you for that.

[263] **Elin Jones:** It was suggested in an earlier evidence session this morning that the fact that, in Wales, there is not a formal commissioning process as part of the development of services is a barrier to a developed service happening at pace and that too much time—your time and other people’s time—is spent in persuading health boards rather than taking a more structured formal commissioning role, whether that is done locally or nationally, even, in Wales. I wonder whether you have any views about the role of formal commissioning rather than this kind of development of services—persuasion, three-year plans and trying to get it into the three-year plans—and that kind of model that we seem to have here in Wales.

[264] **Ms Smith:** I am sure that my colleagues from WHSSC will give a much more eloquent answer to that, but the commissioning of level 4 services is managed through the health boards’ WHSSC process. So, there is a commissioning process in place. That does not apply to the lower tiers, clearly. The lower tiers, tiers 1 to 3, are local health board responsibilities, so we are commissioning our own service, effectively, within the integrated health boards. As I say, WHSSC will give some of the detail about how that is moving and changing, but WHSSC belongs to the health boards and is the agent of the health boards and is the route through which tier 4 surgical services, at least, are commissioned currently. I think that it works reasonably well. The process is slow. However, what I would say in response to Scott’s comment about the time it takes to plan is that, as Alison has alluded to, we have been working locally on this for the last seven months. We have actually been working on it longer than that, and the run-up to the last seven months, which was the beginning of the implementation phase, has taken a significant amount of energy. That energy has gone into researching the evidence, pulling forward different models of care and ensuring that what we are attempting to deliver is fit for purpose across the entire pathway. It is a complex area. You cannot invent that overnight. That is not to say that the evidence to support the level 4 interventions is very clear, but, at levels 1 to 3, it has been quite a complicated journey.

[265] **Elin Jones:** Just to follow that up quickly, is it not the case that even the level 3 services should be commissioned nationally rather than with individual health boards? We have discussed quite a bit this morning the patchiness of level 3 services. There are some health boards that are well developed in that and others that are not.

[266] **Ms Smith:** My personal view—and I think that others may have other views—is that level 3 services should be locally determined services and locally and internally commissioned, but against a national standard, so that the sharing across Wales about how that fits with the pathway is nationally driven. We are, as Alison said, all in different places currently in the delivery and development of services to deliver on the first three tiers. It depends on where you draw the line on what is a specialist service and what is for local determination. My personal view is that this would be for local determination but against a set of national standards.

[267] **David Rees:** Is your question on this, Kirsty?

[268] **Kirsty Williams:** Yes.

[269] **David Rees:** Then I will bring Lindsay in afterwards.

[270] **Kirsty Williams:** Specifically on this, I am just finding it difficult. If it is to be a locally commissioned and determined service—and I have a lot of sympathy with that—but it does not happen or it is taking years to happen, at what stage do we have to hold up our hands and say, ‘We cannot rely on individual local health boards to do this and we are going to have to impose some kind of national programme’? Where do we draw the line in allowing local health boards to take this forward if the evidence is that, after months and months and years

of talking, we do not have services in place? At some point—

[271] **David Rees:** I appreciate that you identified previously that you gave your personal view. So, if you do not want to answer that, do not worry.

[272] **Ms Smith:** Point taken. Where do you draw the answer for that? It could be a Government requirement. It could be a tier 1 target. It could be a number of drivers at national level that bring this particular service to the top of every health board's agenda. It is about getting the balance right, and we are all developing our three-year plans at the moment, and they are vast.

[273] **Kirsty Williams:** The reality is that, unless it is a tier 1 priority, local health boards will continue to busy themselves with the tier 1 stuff, unless we make it a priority for the local health boards. It is very difficult for people working below that senior strategic management level to push it up the agenda.

[274] **David Rees:** I think that it is a bit unfair to ask her to answer that, because she has made it very clear.

[275] **Kirsty Williams:** Sorry.

[276] **Mr Caplin:** May I just chip in with a personal view here? I tend to agree. I agree with Jan that it should be locally commissioned. Part of the reason why I would say that is that we have to recognise that this is everywhere. We could walk from here to the roundabout at the centre of the university and I can guarantee that we would pass people who would need this service. I do not know whether we should be centrally funding that, but I think that it is perfectly reasonable to centrally steer that. I have had reassuring discussions about the commitment—and it is a commitment from the integrated obesity group—at an executive level to this in the future, but I do not know what the process is to make that become a commitment that leads to making a change. I think that that may well be a political drive. However, from my experience with commissioning for the surgical side, I think that central commissioning can add its own delays. If the commitment is there at a local level, which may need a central push, I think that a local level is more appropriate. We are talking about lots of different specialists becoming involved: dieticians, nurse specialists, physiotherapists, psychologists, surgeons, physicians and the council. Getting those people together, as you will know, is not necessarily straightforward. I just think that local provision would be more sensible.

[277] **Lindsay Whittle:** In the written evidence provided by the Aneurin Bevan Local Health Board, it tells us that it recognises

[278] 'the value of the All Wales Obesity Pathway and is taking action to re-align its services to the pathway, including primary care initiatives at level 1 and enhanced adult weight management services at Levels 2 and 3.'

[279] In your oral evidence, you told us that you are guiding 72,000-plus patients who have a BMI of 30-plus into these pathways, but you are still not quite there, I guess. It is good news for me, as a representative of south-east Wales, who represents the Aneurin Bevan Local Health Board area, but as you are attending on behalf of the Welsh NHS Confederation, has it provided you with any evidence to say what is happening? We have to take an all-Wales view of this. Did it provide you with any evidence, please?

[280] **Ms Smith:** You have submissions from some of the other health boards in your papers, and, as I said in my opening comments, all the health boards are in a different position or place in terms of developing the service. However, I do not think that you would find that

any of the health boards would disagree with the merits of the pathway and the different tiers. It is just about getting that priority, getting to an appropriate place and getting that implementation. There is also Public Health Wales work; you are taking evidence from Public Health Wales later. Jane may want to comment on some of the connections that have been made across Wales through the public health networks as well.

[281] **David Rees:** The pass was given to you, Dr Layzell; do you have a comment?

[282] **Dr Layzell:** Yes. There is an all-Wales group looking at what should be the service specification for a level 3 service and I think that, within that group, there is a strong feeling that there probably should be a locally delivered service, because it needs the close links with a number of other areas within the health board and also with the level 2 services that really have to be delivered locally.

[283] **David Rees:** Jan, do you think that Aneurin Bevan is slightly ahead of the game, because it has the level 3 service located in its area?

[284] **Ms Smith:** I think that it has made a difference that we have a physician with a specific interest. There has also been a lot of activity in some of our patches over recent years with the British Heart Foundation, which Jane has been very actively involved in, and the building blocks from a dietetic perspective have been very strong. We have a Slim4Life programme. What we did in Aneurin Bevan when the pathway was published was to map existing services and recognise that we had some gaps. So, we had a reasonable foundation, but we have quite a long way to go. I do not think that it was solely due to the fact that we have Dr Haboubi's clinic; there were many other factors as well.

[285] Chair, I probably should have declared an interest at the beginning of this meeting. You will see that my name is on the pathway. The pathway was initiated from a conversation between the then-Minister, Edwina Hart, some years ago and a group of dieticians at a time when I was working as a professional adviser in Welsh Government. So, my name is on the pathway, but I had left by the time that it was published, so I really should not claim any absolute ownership of it.

[286] **David Rees:** Many people have already highlighted the importance of the pathway and said how good it is, so you should take credit for it.

[287] **Ms Smith:** I did not do the work.

[288] **Lindsay Whittle:** If you were a politician, you would take immediate credit, I promise—[*Laughter.*]

[289] **Ms Smith:** I am a clinician.

[290] **Kirsty Williams:** Take it when you can. [*Laughter.*]

[291] **Ms Smith:** I wonder whether Alison also should make reference to some of the professional networks for dietetics and psychology in Wales.

[292] **Ms Shakeshaft:** All of the professions in Wales have very strong all-Wales managers committees and very strong professional links. I can speak personally from the perspective of the all-Wales dietetic managers; there is also some evidence for today's meeting. I think that the professional view is that the pathway is very well written and covers all of the aspects. As was alluded to earlier in the morning, the key thing is that, although the inquiry is around level 3 and level 4, we must not lose sight of the fact that we need a holistic approach right through from level 1 to level 4. Although level 1 and level 2 are very much community and

prevention elements, to only focus on one aspect of this will not solve the whole problem. However, there are strong professional networks where developments are shared. The professions are very much singing from the same hymn sheet when it comes to where we need to be going with obesity management in Wales.

[293] **David Rees:** You highlighted level 1, level 2, level 3 and level 4, and this morning Dr Haboubi categorically mentioned the separation between 1 and 2, and 3 and 4—between the prevention and the management aspects. Although we are not looking at level 1 and 2, do you believe that levels 1 and 2 have got it right now? Do we have the right process to start slowing down the obesity rates, which we have seen increase over time?

[294] **Ms Shakeshaft:** I do not think that we are quite there yet. I think that there are pockets of very good examples of work that has been happening and is continuing to happen in levels 1 and 2. With the whole pathway, the main issue is that it comes down to resources. It comes down to health boards, local authorities and education working together, but also balancing the limited resources that we have. There is support for taking this work forward. There are very good pockets across all of those elements, but we need to be doing more of it and integrating it together. Although I agree, in some ways, that the prevention aspect—level 1 and level 2—is different to the treatment aspect, it is also a continuum.

[295] **David Rees:** You have said that there are good pockets—I will perhaps come back to Dr Layzell in a minute—but how are those good practices being shared? Is there any programme for that?

[296] **Ms Shakeshaft:** There is national work. One of the examples is the FoodWise programme, which is a programme developed in Wales. It is an eight-week nutrition education programme aimed at the community. That is being developed and rolled out across all areas of Wales. Individually, local areas have developed their own little pockets of work with local education authorities. Up until recently in Torfaen, as Jan alluded to, we had British Heart Foundation funding to help with prevention of obesity in the health board area. It is about sharing that work across Wales, but increasing the resources available to do that.

[297] **David Rees:** So, at this point in time, the sharing is an informal process.

[298] **Dr Layzell:** I think that it is a bit of a mixture. One of the very successful programmes at level 1 is the Welsh network of healthy schools schemes, whereby there is a co-ordinator in each school and an overall co-ordinator in each local authority area. The programme looks at helping schools to provide an ethos of health promotion, which includes healthy eating and physical activity, but includes a number of other things as well. That programme is in virtually all schools in Wales, and it is targeting the whole school population. It works better in some schools than others because different teachers have different degrees of enthusiasm for it. That is one of the examples where the level 1 aspects are working quite well, because there are national and regional meetings for these co-ordinators. They have common training together. There is a common standard and they are working towards common outcomes. So, there are some very successful areas.

[299] **David Rees:** Lindsay wants to come in. We have spoken about levels 3 and 4, and I have opened discussion on levels 1 and 2, so I will let you have a question each.

[300] **Lindsay Whittle:** It is a brief question. Is there any evidence of hard-to-reach communities that we are not getting to?

11:30

[301] **Dr Layzell:** I think that some of the ethnic minority communities and some of the

Traveller/Gypsy communities are hard to reach. Again, that is very variable, I know that there has been a lot of work in Wrexham with some of those communities, but I am not sure how successful that has been in other areas. The Communities First programme is helping with some of these types of things to target some of the most vulnerable areas. There are things like the Families First and Flying Start programmes that are also helping.

[302] **David Rees:** Okay. Kirsty has the next question.

[303] **Kirsty Williams:** You give the example of the healthy schools programme. It exists, but is there any evidence or any evaluation of the effectiveness of that programme? There is a difference, is there not, between level 1 services existing and level 1 services doing any good? The figures on childhood obesity would suggest that the healthy schools programme is not actually having an effect.

[304] **Dr Layzell:** We do not know what the childhood obesity figures would have been if we had not had healthy schools, Appetite for Life and some of the other initiatives. Internationally, there is evidence that children in healthy schools do tend to have better wellbeing and to be slightly fitter. In Wales, we have perhaps been concentrating rather more on some of the process issues until recently. The healthy schools outcome indicators are now being revamped and are being brought in line with the international wellbeing questionnaires that are used in schools—I am frantically trying to remember the name of it—so that we will have a much more outcome focused—

[305] **Kirsty Williams:** Is there an independent evaluation of the programme?

[306] **Dr Layzell:** I would have to check on that, I have to say.

[307] **Kirsty Williams:** Okay. Thank you.

[308] **David Rees:** Right, we are going to bring it back to levels 3 and 4, hopefully. Gwyn has the next questions.

[309] **Gwyn R. Price:** If I may, Chair, I will get back to level 4. With the increase in level 4 cases that will occur in the future, is there a follow-up in LHBs to the post-operative cases? Do you have something in place?

[310] **Ms Smith:** Would it be helpful to start with Scott, who can say how the level 4 centre follows up initially?

[311] **Mr Caplin:** Certainly, as Mr Barry alluded, we follow up for two years through a protocolised follow-up with contact available if people are having any particular problems. At that stage, we have normally discharged back to the community. What I would reiterate is that many of the patients undergoing the surgery that we undertake nowadays do not need tier 3 follow-up. They can be followed up by their GP, especially if we have done well with diabetes resolution. As you heard, roughly two thirds of people will have their diabetes resolved, and roughly two thirds will have their hypertension resolved. There are all sorts of other aspects with subsequent care to do with body confidence, and these were discussed earlier. The need for the follow-up is often very benign. We will contact the GP and describe a simple series of blood tests that will need to be performed on an annual basis. For certain procedures, there will be vitamin supplementation and injections on a regular basis, every three months or so. It is not a complex follow-up regime after a couple of years. I would envisage that, by increasing the surgical workload, we are not increasing enormously the amount of work for the regions that are subsequently taking these patients. That, I would envisage for most patients can be done in primary care.

[312] We are then available to be consulted if there are problems with the follow-up blood tests, or if there are other problems during the follow-up. The goal of the surgery is to allow people to get to a good-quality normal life. It is not that we are trying to commit people to something that requires intensive follow-up and intensive work to keep them on the straight and narrow. We have some patients whom we cannot contact for follow-up—they come and have the surgery and we never see them again. To be fair, depending on the nature of the surgery, with the type of operation that we perform most, they are unlikely to run into trouble. We have not changed things so dramatically that they are going to run into nutritional problems. We do not do the type of surgery that caused patients to come back with severe nutritional deficiencies any more. We do see some patients who, having had the surgery that we do, run into more problems. They would be identified by the follow-up regime that I was talking about. They would probably then be referred back to us for advice, but the majority of patients, in my opinion, can be followed up in primary care.

[313] **David Rees:** Jan, would you like to comment?

[314] **Ms Smith:** I would like to say that I agree with what Scott has said. However, there may need to be a safety net for some patients that may need some local support. I will ask Alison if she would like to comment on that from the perspective of the pathway in Aneurin Bevan health board.

[315] **Ms Shakeshaft:** Yes, certainly at the moment that is not built in to our previous services, but I would envisage that, once we have embedded our integrated pathway, if patients need to be referred back in, whether that is for dietetic follow-up, something quite simple as that, or whether they need some medical management, I think it would provide the opportunity for some patients to be referred back. If we were looking at a different model where all of the patients required follow-up, that could be quite significant for us. However, if there are patients that need something a little bit more than primary care support, I would hope that our pathway would be able to support that.

[316] **Mr Caplin:** One caveat to that, just to emphasise something that Dr Haboubi alluded to, is that obesity is a chronic illness, and we do not cure these patients with surgery. We have enabled treatment of many of their comorbidities and, in conjunction with that, weight loss, but we have not treated the underlying problems that led to people being obese. We will address many of those in the run-up to surgery, but people may well need support to continue with the lifestyle changes that are inherent to getting a good result from surgery.

[317] **Rebecca Evans:** We heard earlier about what seemed to be quite large numbers of people with complications arising from surgery that took place outside the NHS, and sometimes outside the UK. I wonder what your experience is of that and if you are able to make any kind of assessment of the cost of that to the NHS in Wales?

[318] **Ms Smith:** Scott, do you have any comment?

[319] **Mr Caplin:** I can give you my personal experience. A health board perspective is probably more valid because we report back to it. As Mr Barry alluded to, we see a lot of patients. Most clinics now will have patients who are referred with complications that have arisen from surgery done elsewhere, privately. We get an increasing number—a slow but steady increase in the number of patients—who present on our acute intakes with more acute problems related to private sector treatment. I do not mean immediately post-op situations but more acute problems developing from previous surgery performed in the private sector. From chatting with colleagues about this, I think there is an issue in general across the UK. This is not normally related to the procedures that we perform in Morriston. There are certain procedures that we will not perform because of the implications in terms of follow-up and because we are not convinced of their efficacy in the long term. However, it is an issue and it



has cost issues. Certainly, a proportion of the money that, theoretically, we are being funded for in Morriston to perform *de novo* bariatric surgery on the Welsh population who would benefit from it is being diverted, if you like, to provide the service of dealing with complications for people who have had surgery with poor follow-up or poor surgery elsewhere.

[320] **Rebecca Evans:** Could you describe the impact that that has on your waiting list for NHS patients?

[321] **David Rees:** You do not have to worry about giving us figures.

[322] **Mr Caplin:** No, I am just trying to work it out. I suspect that it has no impact on our waiting lists. The only reason I say that is if you have other aspects of your care that have no real major impact on your waiting lists, then the smaller effect from emergencies is going to have very little effect. If the unit was resourced to run very smoothly, it would definitely have an impact. However, if you have not had a list cancelled but you have admitted someone four days before as an emergency, and the list is cancelled because there are not any beds available because of the backlog of ambulances in A&E, you will have somebody in bed who you admitted four days before as an emergency and you have an empty operating theatre. Even with cancelled operating lists, I spend very little of my time not operating. It is just that I am not operating on the patients that we had planned to operate on. Does that make sense?

[323] **David Rees:** Jan, I know this is slightly different, but do you have any comment on that?

[324] **Ms Smith:** It is a 'no comment' comment, really, because we have no idea what the impact is. I do not think that it would be very easy to measure because we have no knowledge of how many people are going out of area. The health boards will only see those who come back with a problem. We do not know what percentage of people who go out of area for their care into the private sector, whether it is in the UK or beyond, return to the NHS with post-surgical complications.

[325] **David Rees:** Do you have any pathway established for those types of individuals?

[326] **Ms Smith:** Do you mean patients who come back with complications?

[327] **David Rees:** Yes.

[328] **Mr Smith:** They come back, predominantly, as emergency admissions.

[329] **David Rees:** Straight in at level 4.

[330] **Mr Caplin:** If they are admitted to one of the other trusts around the country, then the relevant surgeon or physician will normally contact us. We will discuss it and, if appropriate, arrange a transfer.

[331] **David Rees:** I have one more question before I get to the final point. You mentioned all these pathways you are developing, and we have asked questions beforehand about the resourcing and staffing of teams. Are you confident that the skills and availability of the teams to deliver those pathways are there now, or are we looking to develop programmes to train those individuals?

[332] **Ms Shakeshaft:** I would echo what some of the previous comments have been. I think that we have the skill set out there. Certainly, from a dietetic perspective, obesity management is a bread-and-butter part of dietetic training. You can then develop very

specialist skills to deal with the more complex disorders of obesity. From a dietetic perspective, and similarly from a nursing perspective, I think that those skills are there and can be built upon. The area that we may have more of a challenge with is clinical psychology, because we do not have a huge number of clinical psychologists working in the field of obesity at the moment. However, I know, through detailed conversations that I have been having lately around our pathway, that our clinical psychology leads feel very strongly that the skills that they develop are very transferrable. So, although at the moment they may be dealing with and treating other client groups, their skills are transferrable and could be easily transferrable to obesity. I would not perceive that that would be a major challenge.

[333] **David Rees:** Okay, thank you. I gave the other witnesses an opportunity to give us one recommendation. Three of you represent one board, so I will take one from that board, and perhaps Mr Caplin could give us one of his. When we are tackling issues, if there is going to be one recommendation, which would it be?

[334] **Ms Smith:** I am reasonably confident that other health boards would share this view, which is that obesity needs to be managed across the pathway, across all four tiers, aiming to address the public health needs of patients—or people, rather than patients—in the population and at population level, and for those at the other end of the pathway who need access to surgical interventions, that those surgical interventions are available in a timely fashion. I think that that also reflects some of the comments that came from the surgeons that spoke before us.

[335] **David Rees:** Mr Caplin, you have another chance here.

[336] **Mr Caplin:** Could I ask you to address that question to myself this afternoon, Mr Chairman, when I am not wearing an ABM health board hat? [*Laughter.*]

[337] **David Rees:** Fair enough.

[338] **Mr Caplin:** Thank you.

[339] **David Rees:** Thank you very much for your evidence. You will receive a copy of the transcript to check for factual accuracy. Once again, thank you. We will move on now to the final evidence session this morning.

11:44

#### **Ymchwiliad i Argaeledd Gwasanaethau Bariatrig: Sesiwn Dystiolaeth 4 Inquiry into the Availability of Bariatric Services: Evidence Session 4**

[340] **David Rees:** Good morning. I welcome Dr Khesh Sidhu, deputy medical director and consultant in public health medicine at the Welsh Health Specialised Services Committee. Is that correct?

[341] **Dr Sidhu:** Indeed, yes.

[342] **David Rees:** I also welcome Dr Suzanne Wood, consultant in public health based at Cardiff and Vale health board.

[343] **Dr Wood:** I will be speaking on behalf of Public Health Wales in the context of level 3 services.

[344] **David Rees:** Thank you very much for attending this morning. We have had the written evidence from WHSSC, so thank you for that. We will go straight into questions, if

that is okay, as some of the time has been taken up. Gwyn, do you want to start?

[345] **Gwyn R. Price:** Good morning to you both. Concentrating on level 3, could you give me your response to some witnesses who believe that level 3 services should be funded by WHSSC, as they argue that this would allow a robust clinical service to be established with regular audit and assessment of performances?

11:45

[346] **Dr Wood:** That is a very good comment. There has been a lot of work on the ground on level 3 services across Wales. We had a workshop back in November last year that took an all-Wales approach, including WHSSC, Public Health Wales, LHB clinicians, et cetera, and pulled together a local service specification for each health board. So, it is all-Wales agreed that each health board would adopt it and would be signed up to that process. It is still in draft format at the moment. So, there is agreement on a way forward to agree, like you say, performance and measurements and inclusion and exclusion criteria, to make sure that quality standards are the same across health boards. That is the way forward.

[347] As for resource, however, that probably should be down to local variation and should be determined locally, because the needs are different on each local health board level.

[348] **Gwyn R. Price:** So, you do not have the money.

[349] **Dr Wood:** I am sorry?

[350] **Gwyn R. Price:** You do not have the money. [*Laughter.*] Okay. Thank you, Chair.

[351] **David Rees:** In a sense you are saying that there is agreement as to what should be in place. Is there an agreement that that should be in place in each health board?

[352] **Dr Wood:** There is a lot of commitment to it being in place in each health board and people are signed up to the commitment. That is for sure. Obviously, with each LHB being so different, it is down to local determination in terms of resource and funding for level 3 services.

[353] **Dr Sidhu:** Chair, this question was posed to health boards a while back and the directors of public health expressed a very clear preference to organise this at a local level. If I may suggest, there are some elements of this service, to a certain extent, already present in every health board in different ways. So, it would be difficult to have a joined-up approach that we could suggest at WHSSC level, because we do not really know what is already happening on the ground. Health boards are in a far better position to understand local needs and what, in addition, is required at a local level to provide that service.

[354] **Lindsay Whittle:** There are obvious shortcomings in bariatric services in Wales, as we have heard throughout this inquiry. Who should drive the agenda? Should it be WHSSC, the Welsh Government, local health boards? Who is in charge?

[355] **Dr Sidhu:** Obviously, WHSSC is concerned with commissioning bariatric surgery and members of the committee will be aware that WHSSC is essentially funded by the health boards. Membership of our joint committee is basically all of the chief executives of all the health boards, so there is a very close loop around there in terms of where we get our funding from and where the decision making actually takes place. In terms of the level of funding, that, again, is decided by health boards, because, in essence, they pay WHSSC to commission those services. Therefore, it is a little bit of a circular loop in terms of where the money comes from and who actually decides.

[356] **Lindsay Whittle:** So, there is no supremo in Wales then, I guess, who can drive this forward.

[357] **Kirsty Williams:** Dr Sidhu, some very skilfully answered questions seem to absolve WHSSC of any responsibility in this process. The WHSSC paper, again, seems to try to absolve itself of responsibility; it talks a lot about getting people to walk and cycle more, and how, actually, the most cost-effective way of dealing with these problems is through public health interventions. However, the evidence that we received earlier is that bariatric service is a highly effective intervention. It is cost-effective over a short period of time. Why is it that WHSSC's ambitions for the amount of bariatric service that we provide in Wales does not mirror what NICE says that we should do, and is so modest compared with the need?

[358] **Mr Sidhu:** There were a few questions there. First, I would suggest that we do not absolve ourselves of responsibility. More importantly, we recognise that the original criteria were not in alignment with NICE. Working with local stakeholders, including a lot of clinicians, we have addressed that by changing the thresholds. In terms of actually identifying moneys for funding, WHSSC put that to the chief executives and the joint committee, and particularly the management group, and, again, the case was made and funding was approved to do that. So, we have addressed it to a degree. As has been said on a number of occasions in previous submissions, you need to take a whole-system approach to looking at this particular issue. Of course, we can just look at the top end of the distribution, which is exactly what we are doing now. The committee needs to be mindful of a broader approach that needs to be undertaken.

[359] I will use a corollary, Chair, if that is okay—over the last 20 or 30 years, there has been a 50% reduction in cardiovascular deaths across the UK. Of that 50% reduction only 10% has been due to clinical medicine, and 40% of that has been due to lifestyle. There is a huge opportunity to draw similar sorts of pictures in other areas of medicine and ill health, for example in terms of the obesity pathway, we are just trying to give a broader picture as to what we need to do at a population level to make that change happen.

[360] **David Rees:** You have obviously heard the evidence this morning about levels 1, 2, 3 and 4, and that there is a clear line between levels 2 and 3, effectively, but you have a strong view that there is a consistent theme throughout all of those four levels. Do you agree that we must look at levels 1 and 2 slightly differently to levels 3 and 4?

[361] **Dr Sidhu:** It would be hard for me to comment at a health board level because I am not really engaged with the director of public health sort of remit. I am sure that there is something to be said in that. However, the focus of our work in recent months is to ensure that the integration and the interface between levels 3 and 4 services are such that there are clear pathways and clear referral guidelines between the two. That is where the work undertaken by Public Health Wales and the leadership that it has shown in terms of ensuring that that happens is part of the work that we have been doing.

[362] **Dr Wood:** I think that it is a continuum, basically, going from level 1 through to level 4. I do not think that you should be able to disaggregate them as easily. I think that one flows to the other. You have to be able to shift people up and down the levels as appropriate. So, I think that it is a continuum, basically, and they should not be disaggregated in such a fashion.

[363] **Dr Sidhu:** Perhaps I could give you an example. There are some clusters of individuals who live in a household where there might be someone who is grossly obese and others who are not so. However, the levels of intervention for that particular household, such as family-based interventions, might be something specifically at level 3 or possibly level 4 for the grossly obese person, but there will be an opportunity to look at lifestyle interventions

for the whole family as well. It is not an either/or situation; there is a bit of greyness in between.

[364] **Elin Jones:** We heard evidence this morning that something that clearly needed to be improved for level 4 services was the quality of referrals into level 4 from level 3, which is something that really should interest the national commissioning process, so that you make level 4 more efficient by ensuring that you have a quality level 3 service throughout all health boards. So, I am interested in this area of where the responsibility lies for ensuring that the level 3 services, at some point in the near future, become quality services and services that make the right referrals into level 4, and for those same services to be offered in Hywel Dda Local Health Board as in Aneurin Bevan Local Health Board. How far away are we from that?

[365] I want to understand this a bit better, Dr Wood. You said that level 3 should be determined locally because of local need, but I am not sure whether the need is what is actually locally determined, but rather what is there already in terms of the supply side of the clinicians and the various people employed by the health board. I am keen to understand where the responsibility lies, or should lie, to make sure that these level 3 services are working effectively and as uniformly as possible throughout Wales to allow level 4 to be as effective as possible.

[366] **Dr Wood:** I do believe that an effective level 3 service should be locally determined; that is at local health board level. So, once they are signed up to the agreement that is now being created, there will be a genuinely common standard across each LHB. So, that is where the responsibility lies in terms of delivering the service and ensuring quality standards and good-quality referrals going into level 4 et cetera.

[367] **Elin Jones:** So, who monitors that quality standard? Is it Public Health Wales?

[368] **Dr Wood:** They would have to monitor it themselves.

[369] **Elin Jones:** The health boards.

[370] **Dr Wood:** Yes, the health boards.

[371] **Elin Jones:** Who monitors the health boards? It is then a Welsh Government responsibility, is it not?

[372] **Dr Wood:** That is a very good question.

[373] **Elin Jones:** I will use it as a rhetorical question. It is there in a number of services, I think.

[374] **David Rees:** Kirst is next.

[375] **Kirsty Williams:** As you said, there is a continuum across the service, but I am just wondering whether you, as public health specialists, think that the way in which we evaluate our public health services in tier 1 and tier 2 are adequately evaluated and evidence-based. I am also wondering about the capacity for public health specialists. Are there enough of you to be able to adequately plan and implement those services?

[376] **Dr Sidhu:** Again, there are very good questions here. Members of the committee need to be aware that trying to monitor outcomes at tier 1 and tier 2 is very different and, perhaps, currently very difficult compared with monitoring outcomes for tiers 3 and 4. The reason is that you are looking at outcomes at a population level, which take longer to observe;

it takes longer to see change happening. When you are looking at commissioning an individual patient-specific service, however, it is very clear because the patient walks through the door and you can see the difference. So, the measures for monitoring may be process measures in terms of the numbers of people seen or how many interventions were done, whereas, when it comes to an individual patient, you might need to look at changes in body mass index, diabetes status et cetera. If I could just reflect on what is happening in England, there appears to be a change in the rise in the levels of childhood obesity, and one can only assume that is as a result of a much broader approach to improving lifestyles for children. Hopefully, as time goes by, we may see that in Wales. However, I am not really close to that area of work, so I would not want to presuppose anything.

[377] **Dr Wood:** I agree with what Dr Sidhu said, certainly in terms of level 1 services. They are very difficult to evaluate. However, there is evidence, for example, that healthy urban planning works, as does making sure that there are not junk food shops near schools and stuff like that. That is evidence-based through studies in England. So, there are elements that are evidence-based and that work on the ground at level 1, for example. At level 2, you are probably aware that there is a national exercise referral scheme that is robustly monitored and evaluated regularly. The same is the case with dietetic interventions at level 2 at each LHB level. There is robust monitoring and evaluation at certain points within that 1 to 4 pyramid, if you like.

[378] **Dr Sidhu:** Very briefly, there are examples from other areas of public health interventions, such as around tobacco and alcohol, which show that community-based interventions do make a difference in terms of those particular lifestyles. Therefore, certainly from a public health point of view, we can draw some degree of comfort that we know that these things work. It is just a different context that we are trying to apply them in. It will take time for that evidence to show itself.

[379] **David Rees:** Dr Sidhu, this morning, we heard evidence about the hopeful development of level 4 services in north Wales. WHSSC did not recommend increasing the activity levels in north Wales. Do we have an indication of the view that WHSSC took to make that decision?

[380] **Dr Sidhu:** I would like to respond to that, if I may. Subsequent to my submitting the response from WHSSC, I was able to obtain our trajectories for commissioning over the next few years and I have the values here. In terms of trajectories from 2013-14 to 2017-18, the total number of cases that we would like to commission, and which has been agreed in principle, rises from 128 procedures to 300. A proportion of those will be from north Wales. The greater proportion will be from south Wales, so there will be a rise. Whether that results in a critical mass for a centre to be set up in north Wales really depends on a number of variables, including demand, whether finances are available and whether clinical expertise is available. That is a broader discussion that needs to be taken further down the line.

[381] **David Rees:** Will that rise in demand have an impact if we are commissioning in Salford for the moment? There are pressures on Salford as well. Have you taken those into consideration?

[382] **Dr Sidhu:** Yes. The work in Salford is useful in terms of quantifying the amount of money that is being spent there. It adds further weight to the case for providing services in north Wales, subject to the total quantum of activity or workload that is being done in Salford being sufficient to fund a service in north Wales.

[383] **David Rees:** Rebecca is next.

[384] **Rebecca Evans:** I would like to ask you about the criteria for bariatric surgery. The

current criteria do not meet the NICE guidelines, so I am wondering what clinical evidence you have to support the current criteria, in the absence of following the NICE guidelines, I suppose.

[385] **Dr Sidhu:** In all honesty, I was not employed in WHSSC when the original policy was set, but during my time in WHSSC it has certainly been recognised that the criteria do not meet the NICE guidelines, and working with clinicians as well as other public health colleagues, we have moved to change those criteria.

12:00

[386] You will see in my submission that they are consistent with NICE guidelines in terms of the threshold being a BMI of 40 and slightly lower BMI levels for those with comorbidities. The only thing that is different is the use of the DUBASCO tool, and that was something that was suggested by the clinicians. So, it is not as if these things were done in isolation; it was the result of working with clinicians in terms of the use of that tool.

[387] **David Rees:** May I ask something for clarification before Kirsty comes in? Your paper says that you are 'currently working' to adopt these criteria. Are those criteria now adopted or are you still working towards that?

[388] **Dr Sidhu:** My understanding is that, as of the new commissioning year, which starts in April, that is what we will be working to, but, obviously, we need to work closely with the clinicians, and they will apply the DUBASCO score as they see fit on an individual patient basis, and that is where we have to leave it up to the clinicians to use.

[389] **David Rees:** Rebecca, do you want to come back in?

[390] **Rebecca Evans:** Yes, it took four or five years of working to guidelines that did not meet the NICE standards. I am wondering why it took that long to conduct an evaluation to develop the new guidelines. Is it because the workload of WHSSC is just too big?

[391] **Dr Sidhu:** Again, because I have only recently joined WHSSC, I cannot say what happened prior to my starting, but what I am aware of is that, over the period of time that I have been in WHSSC, and it is not just due to me, but, obviously, a team effort, we have had the bariatric surgery review and we have also been looking at the evidence around bariatric surgery and using that as part of our scrutiny of evidence-based commissioning, which we have been undertaking within our directorates. So, there have been other streams of work that have helped to inform that shift in position.

[392] **Rebecca Evans:** Right. We heard earlier about the impact that excess skin can have on people who have undergone surgery. Do you intend to develop some new guidelines as to how people can access surgery to deal with that?

[393] **Dr Sidhu:** WHSSC already has a policy on surgery post weight loss and, every year, we commission between 50 and 70 procedures. It changes on a year-to-year basis. The clinical access criteria have been looked at in the past, and that is where some of the thresholds for treatment have been introduced, but my understanding is that we are looking to review these periodically over time and we will be consulting with clinicians in terms of whether those criteria are reasonable and whether they need to be changed.

[394] **Rebecca Evans:** Just as an observation, the criteria seem to be quite strict in terms of having ambulatory problems as a result of excess skin and so on. They do not really tend to take into account the psychological impact that it might have. So, will you be including that in the future scope perhaps?

[395] **Dr Sidhu:** I am sure that the clinicians will raise that, and, certainly, we would be happy to look at that, because that is, essentially, how a lot of clinical access policies are defined: we look at the evidence, speak to clinicians and look at other criteria to see whether we can apply them. Some things are easy to measure, and other things are not. So, it needs to be something that is relatively precise, that can be defined and that enables us to write a clinical access policy. Sometimes, if it is not so clear, it makes it very hard to interpret and, therefore, it is not applied consistently.

[396] **David Rees:** Kirsty, do you want to come in?

[397] **Kirsty Williams:** Yes. Could I go back to the DUBASCO—I keep wanting to call it ‘Tabasco’ rather than DUBASCO—score? The evidence that we had this morning was that the DUBASCO score was nothing more than a rationing tool and that there is nothing clinically based in it; it is purely a way of rationing the service. Yet, you have just said that it was at the clinicians’ suggestion that DUBASCO was included. Am I right?

[398] **Dr Sidhu:** Yes. I have to concur that the clinicians use those phrases in terms of it being a rationing tool. A lot of the criteria used in DUBASCO—I am not an expert in this area, so please forgive me—are clinical—

[399] **Kirsty Williams:** You know more than I do, so you are okay.

[400] **Dr Sidhu:** They are clinical criteria. It then informs a broader discussion in terms of whether surgery is suitable for that individual. It might be better to ask the clinicians about how it is actually implemented, but when multidisciplinary teams work, they look at a variety of parameters or factors around a particular patient and then a joint decision is made. This, from my understanding, is one of the things that are considered, but, again, I would be happy to defer to the clinicians to confirm how it is used.

[401] **Kirsty Williams:** Given the appearance of the contradictory nature of the evidence, I am wondering whether there is any kind of—

[402] **Dr Sidhu:** With respect, how is it contradictory?

[403] **Kirsty Williams:** It seemed to me, but we can follow it up with the surgeons, that it was being imposed upon them, rather than being something that they had actively sought.

[404] **Dr Sidhu:** Again, I can only speak in terms of the meetings that I was at.

[405] **David Rees:** I think that we will have to ask the surgeons. We have an opportunity to do that.

[406] **Kirsty Williams:** Okay. Thank you.

[407] **David Rees:** I have a question, as other Members are quiet. Level 4 aftercare has been highlighted as an issue. Are you looking at the level 4 aftercare? Is it part of your commissioning process as to what that aftercare is?

[408] **Dr Sidhu:** Absolutely. This is a very important part of this, because as the clinicians and others have said, if lifestyle changes do not continue after this surgery, then, in some respects, the actual benefits of the surgery will not be as great. I am aware of patients who sort of work their diet post surgery, and there is no net benefit. So, that additional support for lifestyle changes post surgery is actually very important. It is certainly something that, again, through the service specification being developed by Public Health Wales, we are keen to



ensure that there is a joined-up approach to pre-surgical management and post-surgical management, so that there is a balanced approach to how patients are managed, and they do not fall off a cliff edge and then get sent home.

[409] **David Rees:** Is it therefore a concern of WHSSC that there are low numbers of psychologists in this area at this point in time?

[410] **Dr Sidhu:** I could not possibly comment on level 3, because it is an area that I am not familiar with. However, I think it is absolutely correct that there are certain specialties where there is a greater critical mass of individuals with interest in this area. We would be keen to ensure that, through our service specifications, particular groups of skills and staff are represented, including clinical psychology. So, we need to be sure that there is a balanced team around that, rather than just in one given area.

[411] **David Rees:** We have also had questions on the primary care aspects. What is WHSSC's view on the primary care aspect?

[412] **Dr Sidhu:** Private care?

[413] **David Rees:** Primary care.

[414] **Dr Sidhu:** Again, this is bordering on local health board territory, and I would be very—

[415] **David Rees:** You are being careful.

[416] **Dr Sidhu:** Yes, indeed. The committee will be aware that, as there is a variation in terms of the way in which health boards approach this particular topic, clinicians also have variations in the way that they understand and respond to clinical conditions. You will find that the same thing applies to primary care. One of the things that I would guess local health boards would want to look at is the interface between primary care services in tier 2 and how they then integrate and fit in with tier 3. But that really is not my bag, and it would be for colleagues in local health boards to decide how that works in their local areas.

[417] **Rebecca Evans:** The new commissioning guidelines state that a patient should have received and complied with an intensive weight management programme at a multidisciplinary weight management clinic for at least 24 months before accessing level 4 surgery. However, given the paucity of level 3 services, is that a fair thing to ask?

[418] **Dr Sidhu:** That is a very good question. It is a difficult one, because as you have quite rightly identified, there is a step change that needs to happen in terms of the provision of level 3 services before somebody can have a 24-month period in that particular period of time. I cannot honestly say whether it is fair or not, because 'fair' is a subjective thing, but what I would suggest this always has to go back to is that it is down to the individual clinician who is seeing that patient at that time to make a decision as to how they ought to manage that patient, based on that individual patient's needs. You will have heard from Dr Haboubi that he has his urgents and his not-so-urgents, and clinicians not infrequently equally prioritise their case mix and their patient mix depending on the patients they are presented with. The same thing applies to health boards in terms of how they fund services, and equally to hospitals, in terms of whether or not they prioritise emergency procedures as opposed to elective procedures, and therefore the activity levels you would expect for things like bariatric surgery actually drop.

[419] **Rebecca Evans:** Are you suggesting there is an element of flexibility within that requirement at the moment, depending on the clinician?

[420] **Dr Sidhu:** Clinicians are famous for wanting their clinical freedoms, and as a doctor I would agree with that, but they obviously need to see things as they are individually for that patient, and work around that accordingly.

[421] **Rebecca Evans:** How do you monitor the cost-benefit of bariatric surgery?

[422] **Dr Sidhu:** That is a very good question. Committee members will be familiar with the NICE and other evidence around quality-of-life years and the benefits that accrue to that. There are many ways of trying to measure quality and cost-benefit around services. In a real world you would want to see that, having undertaken this procedure, you had a quantum of money of which you could pull out the saving and say, 'Here's the money we've saved'. Unfortunately, life is not like that in the health service and it tends to get merged with all the rest of everything else that goes on. Therefore, we are assured from looking at the evidence that there is a cost-benefit to these procedures, but making it real is a different ball game altogether.

[423] There is a further dimension to this, in that even if you know that it is a cost-beneficial service and you paid for x number of procedures—as we have done, for example, in Morriston in a given year—yet only a proportion of those were done, that changes the cost-benefit comparison. If you are saying, 'Having funded 100 procedures, you're only getting 40 or 50 procedures', that automatically affects your understanding of the cost-benefits. So, there is not an easy answer to this particular question.

[424] The way that we can do this—I would suggest this from a public health point of view—is to epidemiologically track these patients over time to look at, for example, how many admissions that they have had over time, how many drugs they had been prescribed and carefully calculate the cost-benefit. However, at a system level, it is a very hard thing to quantify and say, 'This is the amount of money we've saved by implementing this service'.

[425] **Rebecca Evans:** Are you aware of any work that has been done like that in terms of tracking patients over time, or is it something that would need to be newly developed?

[426] **Dr Sidhu:** There are systems of doing this. The technical term for this is something called 'record linkage'. I have done something like this elsewhere, and within Public Health Wales we have an opportunity within the secure anonymised information linkage database to look at this. There are some technical issues around the SAIL database, including the coverage of SAIL, but I will not bore you with that. However, there are ways of doing this. It would be something on which I would again defer to public health colleagues in the observatory to monitor and to see whether it made a difference.

[427] **David Rees:** Do Members have any other questions? You are going to be let off lightly. I have given others an opportunity to give a recommendation, if they would like to do so.

[428] **Dr Wood:** What I would like to see for obesity in Wales is a concerted effort by individuals, communities, the industry and local and national government to reduce obesity.

[429] **David Rees:** That is quite broad.

[430] **Dr Wood:** It is very broad. [*Laughter.*]

[431] **Dr Sidhu:** Within that, there has been huge interest and focus on tier 3, and that is quite rightly a major area of focus. However, to concur with my colleague, it is with the broader approach that we can get bigger bangs for our bucks. Simple interventions at a

community and societal level have a much greater impact on levels of obesity over time. That is the thing that I would like to reflect on and draw back to your attention.

[432] **David Rees:** I am going to ask one final question to be cheeky. You mentioned in answer to a previous question that, when referring back to your projected figures for individuals, you will see the number of people who are in need of procedures.

[433] **Dr Sidhu:** Yes.

[434] **David Rees:** Is that based upon a model to be able to come up with those figures? We heard from Dr Haboubi this morning who indicated that only a small percentage of patients referred actually received treatment. Is that based on a model, and what type of percentage is expected?

[435] **Dr Sidhu:** I am working on figures that I have culled from a report that I have here. I cannot remember the name of the report; it takes the figures from NICE. What the epidemiologists have done is to extrapolate the NICE figures on to the population of Wales. I am telling you this from having read it, so I cannot speak with any authority apart from responding to this. Using the paper as a point of reference, it might be estimated that the population of individuals in Wales who may be eligible for being referred to this service is in the order of 64,000. However, of those, only a proportion will be eligible for surgery. According to this paper, that is in the order of 38,000. However, those who accept surgery will be a subset of that. According to this paper, it is something in the order of 15,000. I cannot tell you about the veracity of this and how it is worked out; I am just relaying that to you. However, if it gives you a sense of the ballpark figures, it gives you a feel for where it is coming from.

[436] **David Rees:** That is very helpful. As you were saying, it is important to understand where those figures come from.

[437] **Dr Sidhu:** I can maybe check this paper and get back to you.

[438] **David Rees:** That would be very helpful. Thank you very much. Thank you for your evidence this morning. You will receive a copy of the transcript for factual corrections.

12:15

### **Papurau i'w Nodi Papers to Note**

[439] **David Rees:** We have the minutes of the committee's meeting on 30 January. Is everyone happy to note those? Thank you.

[440] Before I close the meeting, may I draw everyone's attention to the following points? I thank all Members and witnesses for their presence today. You have clearly had to travel and the fact that you have made the effort is very much appreciated, particularly given the bad conditions in certain areas. I know that some people have driven long distances, so thank you very much.

[441] I thank Swansea University and its staff for their welcome and assistance with this morning's meeting. I also thank Members for their contributions and their attendance today, because, again, travel conditions have been difficult for many Members.

[442] We will now have a working lunch with academics from the university who undertake research in this field. We will follow that up with a meeting with the Welsh

Institute of Metabolic and Obesity Surgery at Morriston Hospital after lunch.

[443] I close the meeting.

*Daeth y cyfarfod i ben am 12:16.*  
*The meeting ended at 12:16.*