



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

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

Dydd Mercher, 26 Mawrth 2014
Wednesday, 26 March 2014

Cynnwys **Contents**

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

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

Papurau i'w Nodi
Papers to Note

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi 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

Leighton Andrews	Llafur Labour
Rebecca Evans	Llafur Labour
Janet Finch-Saunders	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
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

Mark Drakeford	Aelod Cynulliad, Llafur (Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour, (Minister for Health and Social Services)
Chris Tudor-Smith	Pennaeth Is-adran Gwella Iechyd, Llywodraeth Cymru Head of Health Improvement Division, Welsh Government
Dr Sarah Watkins	Pennaeth Is-adran Grwpiau Iechyd Meddwl ac Agored i Niwed Llywodraeth Cymru Head of Mental Health and Vulnerable Groups Division, Welsh Government

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 rhan gyhoeddus y cyfarfod am 11:04.
The public part of the meeting began at 11:04.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. I welcome Members to this morning's session of the Health and Social Care Committee. The meeting is to be held bilingually and headphones can be used for simultaneous translation, on channel 1, or for amplification, on channel 0. I

remind Members to turn off their phones or any other electronic equipment that may interfere with the broadcasting equipment. There is no scheduled fire alarm today, so if one does go off, please follow the directions of the ushers. We have not received apologies this morning.

11:05

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

[2] **David Rees:** I thank the Minister for attending this morning. Would you like to introduce your colleagues, Minister?

[3] **The Minister for Health and Social Services (Mark Drakeford):** I am accompanied this morning by Chris Tudor-Smith, who is a senior figure in the public health part of my department, and Dr Sarah Watkins, who leads on mental health and a number of other conditions.

[4] **David Rees:** Before we go into our questioning session, thank you for your written evidence. Would you like to give a statement to start the session?

[5] **Mark Drakeford:** I have just a few opening remarks. History and experience suggest to me that we will spend a great deal of the next 55 minutes looking at some of the areas that need improvement in bariatric services, but I thought that it was important to put on record the way in which the landscape in this area has improved over the last five years and the general context for it over that period. In 2009, we had the first set of access criteria for bariatric surgery developed in Wales. There were no access criteria of any sort on a Welsh basis up until then. In 2010, the all-Wales obesity pathway was agreed and published. In 2011, we moved from all bariatric surgery being commissioned on an individual, patient by patient basis to a national commissioning plan. In 2012, the Welsh Health Specialised Services Committee, which was not in existence in 2009, embarked on a review of access criteria for bariatric surgery. It reported the revised criteria in January of last year and those criteria, over a period of time, bring access criteria in Wales into line with National Institute for Health and Care Excellence guidance. Then, at the start of this year, Public Health Wales began work on a service specification for level 3 services under the pathway. Those specifications have now been published and are being discussed between the LHBs and Public Health Wales, with a view to having an agreed-across-Wales specification within the very near future.

[6] **David Rees:** Thank you, Minister. You have identified the obesity pathway and the different levels, so I ask Gwyn Price to open the questions.

[7] **Gwyn R. Price:** Good morning, everybody. Witnesses have stated that level 1 and 2 prevention services should be separated from level 3 and 4 management. Do you have a view on this, Minister?

[8] **Mark Drakeford:** I do, Gwyn. I do not agree with that proposition. I think that it is more important that we have a pathway that takes people from the very beginning, with preventative services, right through to the level 4 surgery end. I think that it makes sense for those levels to remain integrated. People need to be able to move between them. People need to be able to move down as well as up that hierarchy. While I see that there is a distinction between prevention services at levels 1 and 2 and the more intervening services at levels 3 and 4, I do not think that it makes intellectual or service sense to separate responsibility for them.

[9] **Lynne Neagle:** My initial question is in relation to general practitioners. At the focus

group that I attended in Cwmbran, there was a GP around the table. Quite a lot of concerns were expressed—one about the level of knowledge that GPs have about tackling obesity issues, and also whether they are sufficiently trained to tackle issues like this when people come into their surgeries. We heard that, sometimes, GPs can have a slightly blasé approach to it and not be very bothered about it, or they may be nervous about raising issues that they think are sensitive and personal. I was wondering whether you were thinking of looking at the whole area of GP training and whether there is more that can be done at that early level.

[10] **Mark Drakeford:** Thanks, Lynne, for an interesting question. I should maybe have said at the beginning that I have been following some of the innovative stuff that the committee has been doing around this inquiry in the way that you have gone about focus groups and other things, which, I think, adds a great deal to the information and understanding that we have.

[11] GP training is always under huge pressure; it has expanded considerably over the last years. There is always pressure to put more into the curriculum and to find other things that we can teach them about. We are in regular dialogue with the Wales Deanery about the curriculum here in Wales. There are changes that you will have read about in Cardiff, in particular, that will be pursued by undergraduate medical students.

[12] What I hear back from GPs is less that they lack confidence in the clinical side of understanding obesity and what needs to be done, but that they do not always have the confidence to have the conversation with somebody about these issues. In Wales, we have this make-every-contact-count approach, where we try to use the teachable moment, as we say—that point at which someone might be open to hearing information, and turn what they know into what they do. GPs do not always have the confidence to spot that moment or to act on it. Sometimes, using the wider primary care team is important in all of this, but there may be other people who patients come into contact with in primary care who are better placed to have those conversations. The GP may not always be the right person. Part of the reason for saying that is that we also know that, for people at the preventative end of services, one of the things that people do not always like is the medicalisation of their condition. They want to do something about it, but they do not necessarily feel that being treated for it is the right way to do it. There are other ways in which people can receive those preventative services that do not necessarily rely on the medical model of it.

[13] **Lynne Neagle:** One thing that we heard, linked to that, in the focus groups was that there have been some pilot schemes in some places where GPs have been able to refer to places such as Weight Watchers and Slimming World, which are very socially acceptable interventions for people who are overweight. Is that something that you are considering?

[14] **Mark Drakeford:** There are some examples in Wales where people are able to do that. In Cardiff, for example, as part of the optimising outcomes policy, if you are overweight to an extent where you are unlikely to benefit from treatment, what you have to do first is to try to put yourself in a position where that treatment could be successful. They have been considering ways in which they can use a wider range of organisations that already exist in the community that are more acceptable to some people as ways of trying to tackle the issue, and, if necessary, using a bit of the health board's money in order to do that.

[15] **David Rees:** I will take the matter a little further, Minister, because it is not just about the GPs. When we met with the groups, the dieticians, the physiotherapists, the allied professions and the psychologists, indicated that they needed additional specialist training in these areas. Have you had discussions with those groups or colleges or universities to see how they can be developed as well?

[16] **Mark Drakeford:** Dr Watkins, would you like to reply?

[17] **Dr Watkins:** In terms of training modules and availability of training, the deanery website has some e-modules and quite a lot of training resources. That is the place that GPs and any other professional can go to, and we expect professionals to do that. Also, there is a lot of work on motivational interviewing and behaviour-change management, which we are making sure that medical students are taught within their GP training module. That is one of the best rated parts of the training within the medical school. So, there is a real understanding that changing behaviour, whether you are talking about alcohol or whether you are talking about obesity, is something that we need all of our professionals to be able to grasp and improve in terms of how they interact with patients. Telling people does not always work and, actually, will not work, because that is just a paternalistic older model. As the Minister was saying, there is that point when you reflect back and ask, ‘What do you want to do about this?’ and ‘What can we do together?’ and it is about working at that point.

11:15

[18] **Lindsay Whittle:** Minister, as a past Chair of this committee, you would have loved this inquiry. It has been interesting, eye-opening and moving, and it can save us money in the long term as well. We have heard some amazing cases. It really ways quite moving for me, anyway.

[19] **Kirsty Williams:** He only cried once. [*Laughter.*]

[20] **Lindsay Whittle:** Yes, I only cried once.

[21] One of the cases that I heard was that of a young man—I will not say where he lives—who is 15 years of age and whose life could really improve if he was to have this bariatric surgery. What is the Welsh Government doing, please, to assist people at a much younger age? Not only would his life improve, generally, but his emotional life would improve generally as well.

[22] Secondly, we do all of this good work—we have heard a lot of the good work that is being done and more is coming along the way—but we do not complete the job, because some of the patients who we have spoken to have an excess skin problem. When you go from 35 stone down to 12 stone, your confidence is improved, but then it is dented again, because we do not remove the excess skin—and I know that skin is the largest organ in the body. We are not fully completing the job, are we? I think that we should complete it, and then people really would have the confidence to go out there and enjoy life to the full.

[23] **Mark Drakeford:** Thank you, Lindsay, for two very interesting questions. The services that we provide for children in relation to obesity and weight management do not extend to bariatric surgery. I think that there are very good reasons indeed why you would not want to have a routine service available of that sort to people aged under 18. There are clinical exceptions and there are ways in which, if people below that age are very different to what you would normally expect, the Welsh NHS is able to consider those on a case by case basis. However, my approach would not be to say that the answer to childhood obesity is to extend the reach of bariatric surgery routinely to people of that age. It is a last resort, never a first resort. It is a form of intervention that, as your second question suggests, leaves people with a whole range of other things that they have to think about and be aware of. It is not something ever to enter into lightly. If that is true of adults then it is true, even more so, I think, of people who are still in the process of growing up.

[24] In relation to the skin, the thing that you are left with, what we have in Wales is, at least, a national approach. Between 50 and 70 operations in an average year are funded through WHSSC for people where the impact of having bariatric surgery leaves them in a

condition where they are clinically compromised. We do not very often provide surgery for people who simply do not like the way that they look after bariatric surgery. However, where the skin that is left becomes diseased, or has other forms of clinical complexity, it is possible in Wales for people to get additional treatment beyond bariatric surgery to deal with that. It is not generous and it is not easy to get. It is difficult, I think, to see how, in an NHS where there is never enough money to go around to do all of the things that we would like to do, that can take priority over other things that the NHS is trying to do. As I say, the best claim that we can make for our system is that at least we have national criteria; at least it is fair, everywhere. I looked to see in the evidence that you had from the plastic surgery association, which reported the latest evidence in England where there were replies from 60 primary care trusts, and just under half of them have a very definite policy: you cannot get it at all, no matter how ill you are and no matter how clinically compromised you may be. They just do not fund it. In Wales, we do fund it; we fund it at a modest level, and I recognise that the bar is high. However, it is difficult to see how doing more of that can be found when there are so many other calls on the NHS's resources.

[25] **Lindsay Whittle:** On the latter part, the skin removal, I think that we are going to undo all of the good work that we have done because the evidence that we have heard is that people merely put the weight back on. If this is the right phrase, they almost look better without all of this excess skin. I have to disagree with you, although I do not like to disagree with you, but it is not a case of just wanting to look better, with all of this excess skin. We are not asking for double chins to be removed or the bags under my eyes to be removed. This is a really serious issue. I will take up the issue that you mentioned, about under-18s, because that was evidence that I heard from a medical practitioner who wanted to help a 15-year-old. However, I will take that up with him. Thank you.

[26] **Mark Drakeford:** I will just reply on one point. The consequences of bariatric surgery are well known in advance. The real point at which that discussion has to be had with the individual is at the point at which they decide whether or not to go ahead with bariatric surgery. We know that significant numbers of people faced with the effect that that will have in their lives do not always want to go ahead with it. So, there is a job that has to be done in making sure that people embark on that course of treatment at least in full possession of the facts.

[27] **David Rees:** Okay. I will now call on Rebecca, Janet and then Kirsty.

[28] **Rebecca Evans:** Thank you, Chair. I wanted to ask about the criteria that individuals have to meet in order to be eligible for bariatric surgery, particularly with regard to the new criteria being introduced by WHSSC from April of this year. The criteria states that people seeking surgery should have been under a weight management programme multidisciplinary team approach for two years prior to surgery. Are we setting people up to fail in the sense that access to that team of support is so hard to come by?

[29] **Mark Drakeford:** I think that the answer to the question in some ways lies in the experience to date. We know—and you will have heard evidence—that we do not have level 3 services of the sort that we need across Wales. In fact, we have them in only one local health board, where you could say that there is a proper level 3 service, yet people from all over Wales get bariatric surgery. The system already copes with the fact that you cannot ask people to fulfil criteria and then make it impossible for those criteria to be fulfilled. So, where the person is not able to have a level 3 service for two years, as the new criteria suggests, the system is able to respond to that and make decisions that does not advantage the individual because the service is not able to fulfil its part of the bargain.

[30] **Rebecca Evans:** Good. A second element of the criteria is that the individual should have a comorbidity that would be improved through weight loss surgery. Is that a problem in

the sense that we are waiting for or asking people to become so obese that they are developing extra additional health issues, when intervention earlier could have prevented that from happening and could have led to better outcomes in the longer term, perhaps?

[31] **Mark Drakeford:** When we move into the new criteria, by the time we are able to deliver that service, Wales will be fully compliant with the NICE guidance and criteria. Those issues were rehearsed in the work that NICE did in drawing up its criteria, and it concluded that the advantage of the process that it was going to recommend outweighed some of the criticisms that are there to be made. I have read in your evidence claims that are sometimes made on evidence that is hard to pin down, that there are people who eat themselves into a position where they meet the criteria, but I noticed that none of the clinicians that you took evidence from were able to substantiate that in any way. I take the point that Rebecca makes—you do not want to have a set of criteria where people have to make themselves more ill in order to try to get better. However, that whole argument was rehearsed by NICE, and we will now be following its recommendations.

[32] **Rebecca Evans:** Okay. I have just one more question, which relates to post-surgery relationships with the clinical team. We heard in our focus groups that people are supposed to stay engaged for two years' follow-up support but that, actually, many people drop out after the surgery. What is your experience of that? Is it a big problem and, if so, how will we deal with it?

[33] **Mark Drakeford:** I might ask my colleagues to comment on the specifics of it. The service we provide in Wales makes available two years' post-operative support to people at Swansea and at Salford. On the extent to which people take advantage of the service, I am not quite so knowledgeable.

[34] **Dr Watkins:** I suppose that there is personal choice. Having met people, I know that some are keen to engage and do that, but other people feel—because weight loss can be quite rapid afterwards—that they are making good progress and choose not to engage. They still have their GP as their primary carer and, hopefully, the practice team would still engage in that discussion with them. However, as you know, they will have improved. I guess our problem is that we cannot make people go, but I suppose you could also say that there should be some outreach, that someone should at least be contacting them to have a discussion.

[35] **Rebecca Evans:** Does it have an impact on outcomes—staying engaged with that team for the two years?

[36] **Dr Watkins:** I know that it definitely improves outcomes to have the option available. I do not think I have even seen any research on that, having done a little bit of background work. It would probably be quite difficult in terms of the numbers across the UK to even get information on who did and who did not and what the factors were that meant that they did well or did not do well, because there will be so many factors that affect that.

[37] **Janet Finch-Saunders:** What baffles me is that, from the medical practitioners in the field and the patients themselves, it is now widely established that a level 3 service is needed, not just in one area but across all the health boards. There are even calls for a level 4 service, just on bariatric surgery. However, if it has been acknowledged that level 3, the multidisciplinary approach, is the way to go—. From the evidence we took, quite often, through motivational change and support, people got to the point where they did not need bariatric surgery because it is not a quick fix; it is not for everybody. However, there were people at the event we were at who thought that it was almost like a magic pill. It is more about motivational change, and bariatric surgery does not come without risk. Why do we not have level 3 multidisciplinary teams across Wales? We even had examples of where people had gone to England and moved in with family members just to have bariatric surgery and

then had come back to Wales. You said that, basically, we have a nationwide consistent approach. I do not think it is consistent. I would urge that we take that level 3 approach. Certainly, for us up in the north, I would like to think that people have the support, the motivational support, so that, at the end of it, they are able to change their life patterns in some way so that they do not have to undergo such invasive surgery. Really, I am asking you whether we can have level 3 support consistently across Wales.

[38] **Mark Drakeford:** Well, I do not disagree with almost anything that Janet said. The biggest gap in the service we have in Wales across the 2010 obesity pathway is the provision of a consistent level 3 service in all parts of Wales. Almost all parts of Wales have some services that are of a level 3 character. In Betsi Cadwaladr LHB area, they have a lifestyle programme alongside their orthopaedic service that nearly 500 people have now used. It has dieticians, physiotherapists and orthopaedic clinicians involved in it, and it is all to do with trying to make sure that people are able to manage their weight in a way that means that they can have some of the orthopaedic interventions they need or even that they do not then need. However, it is confined just to the field of orthopaedics in Betsi Cadwaladr. So, there are elements almost everywhere of a level 3 service, but we do not have a full level 3 service everywhere.

11:30

[39] How are we going to make a difference on that? We are going to do it through Public Health Wales work, in its service specifications. I have seen it, and it is a very substantial document and comprehensive in the things that it says a level 3 service needs to provide. It will need to negotiate with local health boards and now create a climate in which we are encouraging them to try to invest in that service. They will have to do it on the basis that Janet outlined, which is that by investing in level 3 services they might be able to save money in other parts of the system. There is no fresh money around in the Welsh health service that is able to make level 3 services a priority over everything else that we are asked to make a priority, but there was evidence, which you have heard, that if you invest in one part of the system, it releases cash in other parts of the system to pay for it, and that is the sort of discussion that we are going to have with them.

[40] **Kirsty Williams:** Minister, it is almost four years since the all-Wales obesity pathway was published. In your analysis, are you satisfied that that document has been a driver of service change? Could you outline what steps the Welsh Government has taken in the last four years to monitor the implementation of the service specifications set out in the pathway and what priority has the Welsh Government given to the development of the services that are outlined in the pathway?

[41] **Mark Drakeford:** I think that the obesity pathway has been a driver for change in some parts of the pathway. A great deal goes on at level 1, and at level 2, and the pathway has been influential in trying to create that mixed bag of services that you need at that end of the spectrum. Whether they have been as successful as we hoped they would be is a more open question and, actually, the evidence is very difficult to identify, as to what a really successful intervention might be. I think that if you look at what goes on at health board level, and not just at health board level, because, let us remember that the obesity pathway at levels 1 and 2 is very much aimed at other partners in the public sector—it is to do not just with the NHS, but with what local government and others are able to contribute—I think that there has been a drive from the pathway to improve things there. The gap has been at level 3.

[42] How does the Welsh Government monitor it? It monitors it through a variety of different means. The bariatric services end, which is what the committee's inquiry is about, has been monitored through WHSSC, and the work that WHSSC has done to review access criteria and to negotiate with LHBs on the programme, which you will have been made aware

of, and which, over the next five years, has a steadily rising number of operations to be carried out in Wales with funding set aside against it to show what it would take to do that. At the Welsh Government end, we have taken a more direct approach in the last quarter to the monitoring of this with local health boards. Chris will probably outline it in detail, but we have been in dialogue with them, getting them to account to us for what they have done. We have made an assessment of where we think that places each one of them along the different levels of the obesity pathway. We are in dialogue, again, with them, to see whether they recognise and accept our assessment of their performance, and then we will expect to receive from them plans that show how they are going to make further improvements in those areas where we have identified deficits. However, if you want more detail, then Chris will be able to provide it.

[43] **Kirsty Williams:** I would be interested to know why it is in only the last quarter that the Welsh Government has decided to have this new approach to monitoring implementation when the plan was published almost four years ago. That is a lot of quarters when, perhaps, we were not monitoring it quite as closely as we should have been.

[44] **Mr Tudor-Smith:** Every year, we have done an annual assessment of progress against the obesity pathway. This year, we have done a much more robust assessment, and we are taking reports from the LHBs and rating their performance against each of the minimum criteria for each of the tiers. We have fed that back to the LHBs and asked them for their responses to our assessment by the beginning of April. We have asked them for more details on some of the metrics around the obesity pathway, and we have asked them how they are going to address some of the gaps that have been identified as part of the assessment.

[45] **Kirsty Williams:** This sounds very encouraging—the ‘red/amber/green’ system to assess where people are. May I ask what has prompted this new approach? If it had not been done previously, for the last three and a half years, what changed to make the Government ask for this new approach?

[46] **Mr Tudor-Smith:** In terms of where we are, in 2010 their role was to actually look at the obesity pathway and measure it and come up with a plan against the obesity pathway. Then, in 2011-12, it was really assessing where they were. We felt that, this year, because they had been running the obesity pathway for three years, we should do a more formal assessment. We think it was the right time to do that more detailed approach to see where we are against the obesity pathway.

[47] **Kirsty Williams:** May I ask what will happen to the local health boards that are judged as ‘red’ in your analysis? What steps will you be taking to work with those to move them to an ‘amber’ or ‘green’ situation? If they do not, what are the consequences?

[48] **Mark Drakeford:** It is a matter of working with them once they have identified the picture, and, having agreed identification of the picture, we will expect them to provide us with a plan to move from ‘red’ into ‘amber’ and from ‘amber’ into ‘green’. We have probably rehearsed here before, have we not, the proper relationship between local health boards and the Welsh Government? We cannot micromanage everything that a local health board does. They are designed to have the ability to respond to the needs of their local population, so we have to have some ability for them to explain why they do things the way they do, and to be responsible for them. However, in the sense that we have an all-Wales approach to an obesity pathway, and we have an all-Wales commissioning approach to bariatric services, then the job of Government is to hold LHBs to account for those all-Wales components. That is what we will be doing, and that is what this is part of.

[49] **David Rees:** Thank you, Minister. Darren is next.

[50] **Darren Millar:** I want to explore in a little more detail how the Welsh Government and local health boards are able to assess the potential savings that might be delivered to the NHS as a result of an intervention like bariatric surgery. The committee has received evidence that it is very cost-effective to have a timely bariatric surgery intervention, that it can reduce certain comorbidities such as the incidence of diabetes and sleep apnoea, et cetera. So, what measures has the Welsh Government been able to undertake of the cost implications given that there are significant savings that can arise, as a result, to the public purse?

[51] **Mark Drakeford:** So far, Darren, we have relied on the Office of Health Economics, and its analysis of it. I know that that is what was quoted by a number of witnesses to you in their written and oral evidence as to where they take that evidence. It is quite complicated when you begin to look at it, because they have to try to separate out the savings, if that is what they are, to the health service compared to other savings that they make. So you know that, in some of their analysis, they include as savings the fact that someone who has had bariatric surgery may be able to go back to work, may no longer need to claim unemployment benefit, and may be able to pay taxes. They include that as part of the cost-benefit analysis. That is a perfectly proper thing to count in, but it does not actually pay any money back to the NHS. So, you have to separate out the costs that would be saved in health from the costs that might be saved elsewhere, but they do that and what they show is that it takes a bit longer, then, to pay back the cost to the NHS.

[52] You then have to look at another thing, which is: are the cost savings cash-releasing savings? In my world, this is a very different thing. I sometimes joke that, having done the job for a year, and given the fact that almost every organisation that comes through my door to meet me tells me that they could save money, I am sometimes surprised to find that the health service costs me anything. With the amount of money allegedly saved, it comes as quite a shock to find that any still needs to be found. However, the reason that that does not always stack up is that the savings they claim are not cash-releasing savings. So, people say—and I have heard it said in this evidence, too—that this would mean that people would not need to go to accident and emergency departments, for example. Everybody who goes to A&E costs you and a sum of money is found and so people say, ‘If you don’t go to A&E, it has saved £500’. However, the truth is that A&E department is still there, it is still staffed and it still costs as much as it did before. So, you have to go on to find the savings that genuinely find you cash, and then that cash can be reinvested.

[53] So, that is another layer of complexity, but, having read through the stuff, the Office of Health Economics concludes that, as long as you target your bariatric services at the right sort of patients then there are cash-releasing savings to be made down the line as well. We have had some discussions internally, leading up to today’s committee meeting, about what we might be able to do to encourage some of those people who have come and given that evidence to the committee to develop an invest-to-save bid around this. Invest-to-save, as you will know from other committees, has a fairly firm set of criteria that flushes out whether these are real savings or not. I think that that would be a way of testing some of these claims in the Welsh context. If they do stand up to examination in that way, then it will be a way of helping to do some of the things that Janet was asking about earlier—moving money into things that prevent people from needing the final layer of service.

[54] **Darren Millar:** We know as well, Minister, certainly in the short to medium term, that we are expecting to see an increase in demand for these services. There is obviously limited capacity to be able to deliver services in south Wales and, indeed, over the border in Salford for people from the north. So, what consideration is the Welsh Government giving to being able to invest in the capacity for those people who need a surgical intervention to ensure that our excellence and expertise can be further developed here in Wales and that we can perhaps lead the way on this—why not—in the UK and in a European sense as well?

[55] **Mark Drakeford:** I think that there is a different answer in north and south Wales here, in that the Swansea service is a well-established service. The Welsh Health Specialised Services Committee plan shows, over a five-year period, it moving from under 100 procedures a year to 300 procedures a year. That will bring us into line with the National Institute for Health and Care Excellence's guidelines of 10 procedures for every 100,000 people in the population.

[56] I have read the evidence about north Wales and the possibility that a service could be developed at Wrexham. My starting point is always that, if it is possible to reinvest money in the Welsh NHS in a way that brings services closer to where people live and that service is of comparable quality to the one that they are getting over the border, that would always be a proposition that I would want to look at positively. It is important to recognise that the service that is currently provided at Salford for north Wales patients is not just the surgery part of it. We would have to not just repatriate surgery to Wrexham, if that is what was to be done, but be able to create the whole package that goes with the Salford service. The Salford service offers you all of the stuff that you need in terms of assessment at the front end, it offers the surgery at the middle, and it offers the things that Rebecca was asking about earlier in terms of a two-year follow-up. So, we would have to be confident for north Wales patients that we were able to offer them the whole deal, not just the part of the deal that I think some of the witnesses have concentrated on in their evidence to you. However, if it can be done, then my default position is that I would always rather services be provided as close to where people live as possible.

[57] **Darren Millar:** I have one final question in relation to children and young people under the age of 18, who, obviously, at the moment would not generally be able to access bariatric surgery. Some of the evidence that we have received suggests that there is a need for a specific suite of services for paediatrics in Wales where there is significant obesity. If you are able to intervene at an earlier age, generally people's lifestyles et cetera can be transformed perhaps more easily than trying to teach an older dog new tricks. So, what sort of consideration is the Welsh Government giving to services for younger people in order that we can deal with these problems much earlier on in someone's life, so that the quality of life, et cetera, can be improved literally for a lifetime?

11:45

[58] **Mark Drakeford:** A great deal of consideration has already been given to level 1 and level 2 services. They do not rely on the health service primarily, but on all sorts of other organisations, from the sports council through to local government and others. Having been able over recent weeks to look at the service specification that Public Health Wales is developing for level 3 services for adults, one of my conclusions, having read it all and being impressed by the quality of that piece of work, is to wonder whether I ought to open up a discussion with Public Health Wales about whether we need a level 3 service specification for children in Wales. I will have that conversation with it, certainly. From seeing what it has done so far, I am beginning to think that that will be a useful way to take that next step.

[59] **David Rees:** Kirsty, you had a supplementary on this.

[60] **Kirsty Williams:** You have just mentioned again, Minister, your confidence in the level 1 and level 2 services as being the most robust part of the obesity pathway so far. You said that to me also. However, last year's Welsh health survey said that we had an increase in the level of obesity over the period of that health service. There was no increase in physical activity over the period of that health service, and there was a decline in the consumption of fruit and vegetables during the period of that health service. Given that that is the evidence, can you really be that confident that level 1 and level 2 services, which should be addressing those lifestyle factors, are delivering in the way that you claim that they are?

[61] **Mark Drakeford:** I think that you are in danger of getting the argument the wrong way round, and having a *post hoc ergo propter hoc* sort of analysis here. Obesity levels are rising in the Welsh population, as they are across the western world. They are not rising because of the services that are being provided—

[62] **Kirsty Williams:** The lack of.

[63] **Mark Drakeford:** —or because of the lack of those services either. We have not had a chance this morning to stand back and think of some of those wider questions as to where responsibility for these different developments lies, and how we divide those responsibilities between the lives that people live themselves and the things that Government and services are expected to contribute. The fact that there are rising levels of obesity is not, in my mind, attributable to the services that are provided to combat those things. You might have incredibly effective services, but still struggle to meet an incoming tide of demand that is not caused by the services themselves.

[64] So, I do not want to give the impression, and I do not want what I have said to be slightly misinterpreted as saying, that I think that all of our level 1 and level 2 services are exactly what they need to be, because there is more that we need to do, particularly to understand what services are effective and how effective those services can be. If you look at childhood obesity right across a very large number of countries, and look at the most recent Organisation for Economic Co-operation and Development survey of this, it is able to identify two places where childhood obesity is going down. Its conclusion is that that has nothing to do with services; it is to do with culture. South Korea is one of the two places where childhood obesity is going down. The OECD report says that you could not transpose the way in which that has been achieved in South Korea easily into the context of a European country, because the methods they use and the culture they rely on in order to have made those changes simply will not translate. It is not an easy conclusion, and not one that is not—

[65] **David Rees:** You have highlighted the point and I understand the cultural and societal questions that have been raised about obesity. What we are trying to ensure is that levels 1 and 2 address the cultural and societal positions within Wales as well as possible.

[66] **Mark Drakeford:** Absolutely.

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

[68] **Rebecca Evans:** We have heard examples of people going outside the NHS to receive surgery, not always successfully. Mr Jonathan Barry, a bariatric surgeon, told us that the second most commonly performed operation is operating on complications in patients who have sought private surgery outside the NHS in Wales. Do you have any idea of the cost to us in Wales and is there any way that we could recover some of that money? Does this extend waiting lists for people eligible for surgery in Wales?

[69] **Mark Drakeford:** I am afraid that I do not know the answers to those questions this morning, but we could see whether we could find that information for you. Mr Barry gave a very striking piece of evidence. It illustrates a much wider fact, does it not, that the NHS always has to pick up the pieces for failures elsewhere? Where we can, we pursue those costs. No matter how hard you look at it, you cannot conclude that the NHS ought not to provide a service to people who need it, however that need may have arisen.

[70] **David Rees:** Elin is next.

[71] **Elin Jones:** In all of the evidence that we heard, the relationship between mental

health and obesity was quite striking. Patients as well as clinicians in multidisciplinary teams were keen to point out the really crucial role of psychological support—the support of psychologists. As you develop the service specification for level 3, how confident are you that the local health boards are anywhere near to having the capacity to provide psychological support for level 3 services? The health board in west Wales that I know well enough often struggles to have enough psychological support from people involved in that area. I wonder, as you gauge where local health boards are, whether there is a particular issue around psychological support in level 3 and level 4 services. I was quite struck in the evidence session that that is a crucial area of the support structures.

[72] **Mark Drakeford:** I will ask Dr Watkins to comment on this particular question. I will say to begin with that it is absolutely right, the pressures on psychological services are significant, but they certainly play a very important part in this field. One of the things that I have been thinking about, partly because it was in the written evidence to the committee from the Hywel Dda board, is whether it is the most sensible course of action to expect every health board to have its separate level 3 service, or whether it is one of those areas where we need to think about some lowering of the boundaries between health services, so that where some very scarce resources are concerned, you might be able to borrow some of that capacity from across the border. Hywel Dda makes that point in relation to level 3 services and says that its relationship with ABMU would be very important in that. A number of other health boards make a similar point. When people are hard to find and are being asked to do a number of other things, maybe making sure that we have a culture of mutual aid between health boards in those areas of scarcity would be a way of trying to reinforce those parts of a level 3 service.

[73] **Dr Watkins:** Health psychology is really central to what you would view as a comprehensive tier 3 service. As the LHBs design their services, that is a key component along with dietetics and medical input. That is why we were saying that there are parts of the tier 3 service in every LHB. The question is this: do you have the full multidisciplinary team? For those people who have underlying problems, there are two issues, are there not? One issue is that some of them should be dealt with by health psychology. Secondly, other people may have mental health problems, and perhaps they should anyway, under our measure, be sent on to their own local primary care mental health support services, and, if necessary, on to the community mental health team, because people can become profoundly depressed when they are grossly obese and they are not going out. We have all of that complexity. Can I correct that to ‘morbidly obese’? I should not have—. So, it is a very valid point, but with clinical psychologists, recruiting the specialists, again, can be challenging because, ideally, we would like to see health psychologists in cardiac services and respiratory rehabilitation services, so there is a lot of demand on that time. So, it is about pulling it in and getting that multidisciplinary input.

[74] **David Rees:** Darren is next.

[75] **Darren Millar:** I just wanted to return, Minister, to some of the issues about patient responsibility that you introduced into your response to Elin’s question earlier on, I think. To what extent might the public health (Wales) Bill provide an opportunity to encourage and promote patients to take greater responsibility for their own health, so that the NHS does not have to pick up the tab for, perhaps, their lack of responsibility in terms of the way that they might live their lives in the future?

[76] **Mark Drakeford:** Chair, I think that legislation has two parts to play here. The first part is that Government has a responsibility to create the conditions in which people are able to look after their own health. The public health White Paper, and the Active Travel (Wales) Act 2013 are examples of that—I hope that the first one will be; the second one already is. However, there are other things, too. I write to Jeremy Hunt fairly regularly urging him to

take a more robust attitude towards the food industry, for example, where I think that some mandatory requirements on it, in terms of salt, sugar, fat and the way in which food is promoted, and so on, would be a big help. I also think that it is just as important to say that if you are managing on a very low income, and where that income is constantly being put under pressure, then you are forced into buying food that gives you high calorific impact but is not good for your long-term health.

[77] When Government has established the conditions in which people are able to act responsibly, it is absolutely legitimate that we say to people that they have responsibilities as well, and that if you put yourself in harm's way, and do things that knowingly damage your health, and which could be avoided, then the answer when that harm happens cannot be, 'So, what is the NHS going to do about it?' We are already in the business of trying to redraw that boundary in a practical way—one example you will know from Cardiff, which we mentioned earlier, and another is the Betsi example around orthopaedics. I think that that will be a stronger strand in the NHS in the future.

[78] **David Rees:** Time has caught up with us, Minister, so I thank you for your attendance today and for giving evidence to the committee on this inquiry. You will receive a copy of the transcript to check for any factual inaccuracies. I thank you and your officials for attending.

[79] **Mark Drakeford:** Thank you very much indeed.

[80] **David Rees:** In accordance with Standing Order 17.47, I will now adjourn the meeting.

*Gohiriwyd y cyfarfod rhwng 11:59 a 12:00.
The meeting adjourned between 11.59 and 12.00.*

Papurau i'w Nodi Papers to Note

[81] **David Rees:** You will see the associated papers that are in relation to our inquiry. I refer to papers 5, 6, 7, 8 and 9, and correspondence received in relation to the committee's forward work programme, which is from the Royal College of Nursing Wales, suggesting an inquiry into community nursing and from Crohn's and Colitis UK, suggesting an inquiry into the national guidance on inflammatory bowel diseases. Are Members happy to note those? I see that you are. Thank you very much.

[82] Before closing, I would like to make two points. First, the committee will meet next Thursday, 3 April, to take evidence from the Minister for Health and Social Services on unscheduled care and winter preparedness for 2013-14 during the morning. If you remember, we asked the Minister to come back after our earlier session last term. Also, we will hear from Professor Philip Routledge, chair of the All Wales Medicines Strategy Group, on the inquiry into the access to medical technologies in the afternoon session.

[83] Finally, at the end of last week's meeting, we discussed whether a ministerial statement had been issued that morning, so I would like to take the opportunity to remind Members that, when we raise matters at short notice in future, all reasonable efforts should be made to clarify the issues that are being raised so that we can reflect upon them accurately and fairly for the public record.

[84] I close the meeting.

Daeth y cyfarfod i ben am 12:01.
The meeting ended at 12:01.