

National Assembly for Wales
Health and Social Care Committee

The availability of bariatric services

May 2014



Cynulliad
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Health and Social Care Committee

The Committee was established on 22 June 2011 with a remit to examine legislation and hold the Welsh Government to account by scrutinising expenditure, administration and policy matters encompassing: the physical, mental and public health of the people of Wales, including the social care system.

Current Committee membership



David Rees (Chair)
Welsh Labour
Aberavon



Leighton Andrews
Welsh Labour
Rhondda



Rebecca Evans
Welsh Labour
Mid and West Wales



Janet Finch-Saunders
Welsh Conservatives
Aberconwy



Elin Jones
Plaid Cymru
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Lynne Neagle
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Torfaen



Gwyn R Price
Welsh Labour
Islwyn



Lindsay Whittle
Plaid Cymru
South Wales East



Kirsty Williams
Welsh Liberal Democrats
Brecon and Radnorshire

William Graham was also a member during the period of the inquiry.



William Graham
Welsh Conservatives
South Wales East

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Chair's foreword

Preventing and managing overweight and obesity are complex problems, with no easy answers. Nevertheless, as a nation, we cannot afford to allow this complexity to prevent us from tackling one of the major public health challenges of our time.

Wales has one of the highest rates of adult obesity in the Western world with a staggering 59 per cent classified as overweight or obese. More worryingly, this doesn't look set to change: our childhood obesity rates are the highest in the UK, with approximately 34 per cent of children under 16 years old being overweight or obese.¹ In a compilation of the childhood obesity rates of 35 countries,² Wales had the fifth highest rate, one that is predicted to continue to rise in forthcoming years.

In 2010 the Welsh Government launched the *All Wales Obesity Pathway*, setting out the approach to the prevention and treatment of obesity in children and adults in Wales. This approach ranges from community-based prevention and early intervention (Levels 1 and 2 of the Pathway), to specialist medical and surgical services (Levels 3 and 4). Although the Pathway has been welcomed as a comprehensive strategic document, its implementation has been reported as patchy, particularly in relation to specialist obesity services. This alleged inconsistency of implementation spurred us to shine a light on bariatric services in Wales.

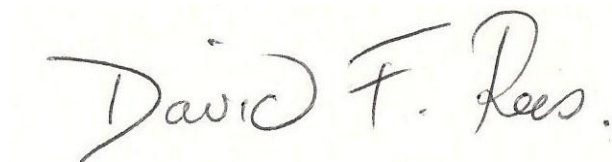
The focus of our inquiry was the availability of specialist Level 3 & 4 services. We found that the delivery of these services varied across Wales with only one out of seven Health Boards providing a comprehensive specialist weight management service (Level 3). Furthermore, we learned that individuals seeking to access surgical provision (Level 4) have been subject to more stringent eligibility criteria than recommended by National Institute for Health and Care Excellence guidelines. Where these services have been provided they have been praised, however the reports of patchy implementation

¹ Welsh Government, [Welsh Health Survey 2012](#), September 2013

² World Health Organisation, [Inequalities in Young People's Health: Health Behaviour in School Aged Children 2005-2006 Survey](#), 2008

proved to be correct with many patients unable to access the specialist services envisaged by the Pathway.

Despite the inconsistent implementation of services across Wales, we have been encouraged by the Welsh Government's commitment, during the course of our inquiry, to improving bariatric service provision. Whilst we hope that our work will drive progress in this specialist area, we also wish to emphasise that bariatric surgery should always remain a last rather than first resort. Bariatric surgery is a potentially complex procedure with far-reaching implications - preventative approaches and sufficiently-resourced weight management services should remain the main tools with which to tackle obesity for our population.

A handwritten signature in black ink on a light yellow background. The signature reads "David F. Rees." in a cursive, slightly slanted script.

David Rees
Chair of the Health and Social Care Committee
May 2014

The Committee's recommendations

The Committee's recommendations to the Welsh Government are listed below. Please refer to the relevant pages of the report to see the supporting evidence:

Recommendation 1. We recommend that the Welsh Government work with Local Health Boards to provide a clear outline of the actions that will be taken to implement the *All Wales Obesity Pathway* fully, and provide details of the associated timescales. These actions and timescales should be informed by the plans being produced by all Local Health Boards in Wales and the service specification for Level 3 services being developed by Public Health Wales. (Page 16)

Recommendation 2. We recommend that the Welsh Government provide assurances that it will require forthcoming Local Health Board plans and the all-Wales Level 3 service specification to include measures to address the lack of multi-disciplinary service provision in Wales within the next 12 months. (Page 30)

Recommendation 3. We recommend that the Welsh Government develop and publish a monitoring and evaluation framework for bariatric services in Wales, which also indicates lines of accountability, to measure the consistency and effectiveness of the referral pathway for overweight and obese patients to move up and down the relevant tiers of support. (Page 30)

Recommendation 4. We recommend that the Welsh Government work with the Wales Deanery and relevant Royal Colleges to consider training for health professionals, across all disciplines, on obesity, its causes, its treatment and the relevant treatment pathway, and its consequences. Training should include motivational interviewing and behaviour-change management. Consideration should also be given to what more can be done to embed the 'make every contact count' methodology. (Page 30)

Recommendation 5. We recommend that the Welsh Government undertake a comprehensive cost-benefits analysis of bariatric surgery procedures, including consideration of societal cost-benefits, to identify the extent to which they provide value for money. The

opportunity provided by invest-to-save bids should be explored, as suggested by the Minister. (Page 44)

Recommendation 6. We recommend that the Welsh Government work with the Welsh Health Specialised Services Committee to consider including a requirement within the eligibility criteria for bariatric surgery – akin to NICE criteria – that a patient commits to long-term follow-up (via the GP or multi-disciplinary team) following surgery. This requirement will need to be accompanied by the necessary expansion of follow-up services across Wales. (Page 45)

Recommendation 7. We recommend that the Welsh Government develop guidance on the processes that should be followed to support a patient deemed ineligible for bariatric surgery. This guidance should pay specific attention to what information is provided to ineligible individuals on the options that remain available. (Page 45)

Recommendation 8. We recommend that the Welsh Government review periodically the need for a local bariatric surgery service in North Wales. (Page 46)

The Committee will request an update on progress against these recommendations before the end of this Assembly.

1. Introduction

The prevalence of obesity in Wales and its impact

1. Overweight and obesity in children and adults represent serious public health problems in Wales. According Welsh Health Survey data for 2012, 59 per cent of adults in Wales were overweight or obese in 2012, with 23 per cent of adults classified obese.³ This is an increase of five per cent since the Survey began collecting data in 2003/4. More worrying, perhaps, is the fact that the trend seems set to continue with Wales having the highest childhood obesity rates in the UK. The 2012 Survey reported that 34 per cent of under-16s were overweight or obese, including 19 per cent of children classified as obese. Given the severity of the situation in relation to childhood obesity in Wales, the Children, Young People and Education Committee has recently undertaken an inquiry into this subject. We welcome its work and note the contents of its report, published in March 2014.

2. Research released by the Welsh Government in 2011 estimated that obesity costs the Welsh NHS £73 million every year, rising to nearly £86 million if overweight people are included.⁴ Obesity is a leading cause of preventable death in Wales. It increases the risk of developing heart disease and can contribute to chronic conditions such as diabetes, some cancers, high blood pressure, sleep apnoea, muscular-skeletal conditions and depression. Obese people are estimated to die around a decade earlier than those with a healthy weight, mirroring the loss of life expectancy suffered by smokers.⁵

Our inquiry

3. The Health and Social Care Committee agreed to undertake an inquiry into the availability of bariatric services in Wales in November 2013. The aim of our inquiry was to review the current provision of all bariatric services in Wales and to identify areas where further action could be effective.

³ Welsh Government, [Welsh Health Survey 2012](#), September 2013

⁴ Welsh Government, [Assessing the costs to the NHS associated with alcohol and obesity in Wales](#), March 2011

⁵ Organisation for Economic Co-operation and Development, [Obesity and the Economics of prevention: Fit Not Fat](#), September 2010

4. Although we recognise the great importance of population level interventions in seeking to prevent obesity, the purpose of this inquiry was to specifically examine the provision of services for those to whom preventative services are no longer applicable. We were particularly keen to explore:

- the effectiveness of specialist services at Level 3 and 4 of the Welsh Government's *All Wales Obesity Pathway* in tackling the rising numbers of overweight and obese people in Wales;
- the availability of specialist weight management services and obesity surgery across Wales and the eligibility criteria associated with accessing these services;
- progress made by Local Health Boards (LHBs) on the recommendations highlighted within the Welsh Health Specialised Services Committee (WHSSC) *Review of Bariatric Surgery Provision and Access Criteria in the Context of the All Wales Obesity Pathway* report.

5. We would like to thank all those who have taken the time to contribute to this inquiry by giving evidence. A list of those who gave oral evidence is provided in Annex A to this report; a list of all written submissions is provided in Annex B.

6. In addition to gathering formal evidence, the Committee was eager to hear about the experience of patients, healthcare professionals, academic researchers and service commissioners. To this end, we visited Wales' only NHS provider of bariatric surgery at the Welsh Institute of Metabolic and Obesity Surgery (WIMOS), Morriston Hospital, held an informal lunch with academics undertaking relevant research at Swansea University, and hosted a focus group event in Cwmbrân to hear the views of those with direct experience of seeking, receiving or providing bariatric services in Wales. The insight gained from these more informal methods of evidence gathering were invaluable and have helped us frame our conclusions and recommendations with the service user at the forefront of our minds. We would like to note our thanks to all those who participated in this engagement activity, the details of which are provided in Annex C.

2. The All Wales Obesity Pathway

7. The Welsh Government published the *All Wales Obesity Pathway* in 2010.⁶ The Pathway sets out the actions that should be taken by LHBs, working jointly with Local Authorities and other key stakeholders, to help tackle the obesity problem in Wales through local policies, services and activities for both children and adults.

8. The Pathway sets out a four-tier framework for obesity services through primary prevention and early intervention at Level 1, to bariatric surgery at Level 4. Each of the four tiers consists of different types of service for different categories of need:

The All Wales Obesity Pathway: Service levels
<i>Level 1: Community-based prevention and early intervention</i>
<ul style="list-style-type: none"> - Focuses on lifestyle advice and information. - Sits alongside nutrition, physical activity and weight management programmes in community-based settings to which people can self-refer. - Includes opportunities across different settings (education, primary care, local authority services etc.) to develop knowledge about healthy eating and physical activity. - Targeted at all age groups.
<i>Level 2: Community and primary care weight management services</i>
<ul style="list-style-type: none"> - Seeks to identify people who are overweight or obese and have or are developing risk factors. - Primary care weight management services provided and/or community-based weight management programmes to which an individual is referred by primary care. - Available for all ages.
<i>Level 3: Specialist multi-disciplinary team weight management services</i>
<ul style="list-style-type: none"> - Includes specialist weight management services for individuals who have one or more co-morbidities and who have tried several Level 1 and 2 interventions without success. - Delivered by multi-disciplinary weight management clinics in the

⁶ Welsh Government, [All Wales Obesity Pathway](#), August 2010

<p>community or secondary care setting.</p> <ul style="list-style-type: none"> - Includes specialist physical activity, dietetic and behavioural components. - Treatment with medicines considered at level 3. - Available for all ages.
<p><i>Level 4: Specialist medical and surgical services</i></p>
<ul style="list-style-type: none"> - Includes intensive physician-led specialist obesity management by multi-disciplinary team of expert practitioners. - Includes access to specialist assessment and surgery at a bariatric surgery centre offering a choice of surgical interventions. - Provides specialist long-term post-operative follow-up and support. - Surgery not normally available to individuals under the age of 18 and normally only available to those who meet specified eligibility criteria (see chapter 3).

9. The Committee’s focus in undertaking this inquiry was on Levels 3 and 4 of the Pathway.

The Pathway’s implementation

10. There was a general consensus among those who provided evidence to this inquiry that the Pathway outlines an effective and welcome approach to addressing obesity in Wales. Most witnesses expressed concern, however, that many aspects of the Pathway are yet to be fully implemented. Oral evidence from Mr Jonathan Barry, Consultant Laparoscopic Bariatric Surgeon at WIMOS, summarised the view expressed by most witnesses:

“In principle, the Pathway is sound, but we are not making progress quickly enough.”⁷

11. When asked about the piecemeal implementation of the Pathway, LHB representatives noted that no Health Board would disagree with the merits of the Pathway or its respective tiers, but that further

⁷ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 129\]](#), 13 February 2014

prioritisation is needed to deliver it fully.⁸ Written evidence from Hywel Dda University Health Board went further, stating that:

“...within Wales the delivery of the Pathway has received none of the resources required to deliver at the scale required to demonstrate the population health impact required.”⁹

12. Whilst it was noted that pockets of good practice were emerging in relation to Level 1 and Level 2 services,¹⁰ it was generally acknowledged that progress in relation to the Pathway’s implementation remains slow¹¹ and varied¹² across LHBs in Wales.

Level 3 and 4 services

13. Specific disappointment was expressed by witnesses in relation to the lack of implementation of Level 3 and 4 services. We were told that, despite the Pathway’s ambition for each LHB to provide a Level 3 service, only one comprehensive Level 3 service exists in Wales. We were particularly concerned to learn that the waiting time to access this service has now grown to two and a half years.¹³

14. Written evidence received from Cardiff and Vale University Health Board (UHB) – and reflecting the position reported by a number of LHBs – stated:

“In Cardiff and Vale UHB Level 3 Obesity Services are non-existent due to funding constraints. Level 3 services are critical as a gateway into bariatric services [...] Level 3 services are therefore critical to the All Wales Obesity Pathway going forward.”¹⁴

15. Furthermore, whilst a Level 4 service providing bariatric surgery for eligible patients within South Wales is available at Morriston Hospital in Swansea, North Wales patients are required to travel to Salford Royal NHS Trust, Greater Manchester to seek treatment. It was noted that current commissioning intentions for the Level 4 service is

⁸ National Assembly for Wales, Health and Social Care Committee, Ibid, [RoP \[para 280\]](#), 13 February 2014

⁹ Ibid, [Consultation response ABS 19 – Hywel Dda University Health Board](#), para 1.6

¹⁰ Ibid, [RoP \[para 294\]](#), 13 February 2014

¹¹ Ibid, [RoP \[para 264\]](#), 13 February 2014

¹² Ibid, [RoP \[para 246\]](#), 13 February 2014

¹³ Ibid, [RoP \[para 42\]](#), 13 February 2014

¹⁴ Ibid, [Consultation response ABS 2- Cardiff and Vale University Health Board](#), p2

“very modest” in comparison to the potential applicability of bariatric surgery.¹⁵ There was a consensus among those providing evidence to our inquiry that current resource for Level 4 services is insufficient to meet need.

16. The lack of a comprehensive Level 3 service across most LHBs, and the difficulty accessing the Level 4 service, was emphasised repeatedly during the course of our inquiry. It was most clearly illustrated, however, by the experiences of those patients who attended our focus group event in Cwmbrân; a clear consensus emerged across the four focus groups that access to multi-disciplinary teams and weight management clinics is inadequate. Reference was made to the existence of a “post-code lottery” for Welsh patients, with only Aneurin Bevan University Health Board currently providing a Level 3 service.¹⁶

Prevention as distinct from treatment

17. Some witnesses expressed the view that preventative services (Level 1 and Level 2) should be separated from the provision of services to manage and treat obesity (Level 3 and Level 4). Dr Nadim Haboubi, Consultant Physician in Adult Medicine and Gastroenterology and Chair of the National Obesity Forum for Wales, queried the logic of Levels 1 to 4 sitting under the same overarching public health Pathway. He argued that although prevention of obesity is a public health concern, the management of obesity and its associated problems are clinical matters that should be led by physicians and surgeons.¹⁷ This view was echoed by Dr Dev Datta, Consultant in Biochemistry and Metabolic Medicine and representing the Welsh Association of Gastroenterology and Endoscopy, who emphasised that it is:

“...really important [...] 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

¹⁵ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 202\]](#), 13 February 2014

¹⁶ Ibid, [Note of the Committee’s focus group event in Cwmbrân](#), 12 March 2014

¹⁷ Ibid, [RoP \[para 11\]](#), 13 February 2014

to see me tomorrow afternoon with lung cancer. It is a completely different matter.”¹⁸

18. LHB representatives, although acknowledging the differences between prevention and treatment, noted the importance of the Pathway as a continuum from Levels 1 to 4.¹⁹ This message was reiterated by Public Health Wales:

“Dr Suzanne Wood: I think that it is a continuum...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 from the other. You have to be able to shift people up and down the levels as appropriate.”²⁰

The Minister’s evidence

19. Giving evidence to the Committee on 26 March the Minister for Health and Social Services acknowledged that “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”.²¹ The Minister noted that this would be addressed by work being undertaken by Public Health Wales to develop a nationally-agreed common access and service specification for Level 3 services, due for publication at the end of May 2014.²² The Minister warned that no additional funding would be available to make Level 3 services a priority over any other service that LHBs are asked to deliver.²³

20. We were told that the Welsh Government has undertaken “a much more robust assessment” of progress against the Pathway this year than in previous years, adopting a red/amber/green (RAG) approach to monitoring LHB activity.²⁴ It was explained that the decision to apply a more robust monitoring arrangement was attributable to the fact that the LHBs have now been operating under the Pathway for three years. When asked how LHBs judged as ‘red’ in the Welsh Government’s analysis will be encouraged to move to amber or green, the Minister noted that they will be expected to provide plans outlining how they

¹⁸ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 132\]](#), 13 February 2014

¹⁹ Ibid, [RoP \[para 294\]](#), 13 February 2014

²⁰ Ibid, [RoP \[para 362\]](#), 13 February 2014

²¹ Ibid, [RoP \[para 38\]](#), 26 March 2014

²² Ibid, [RoP \[para 39\]](#), 26 March 2014

²³ Ibid, [RoP \[para 39\]](#), 26 March 2014

²⁴ Ibid, [RoP \[paras 42-46\]](#), 13 February 2014

intend to make these changes. The Minister re-iterated that the Welsh Government will not seek to micro-manage LHB activity but that it intends to hold LHBs to account.

21. Whilst acknowledging the differences between public health interventions and the clinical management and treatment of obesity, the Minister rejected the suggestion that Level 1 and 2 services should be separated from Level 3 and 4 services within the Pathway:

“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.”²⁵

Our view

22. Although we welcome the closer, more robust monitoring of LHB activity in relation to weight management and obesity services undertaken by the Welsh Government this year, and the actions reported to map LHBs’ implementation of the Pathway’s different components, we are disappointed at the lack of progress in implementing Level 3 and Level 4 services as specified in the *All Wales Obesity Pathway*.

Recommendation 1: We recommend that the Welsh Government work with Local Health Boards to provide a clear outline of the actions that will be taken to implement the *All Wales Obesity Pathway* fully, and provide details of the associated timescales. These actions and timescales should be informed by the plans being produced by all Local Health Boards in Wales and the service specification for Level 3 services being developed by Public Health Wales.

²⁵ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 8\]](#), 26 March 2014

3. Level 3 and 4 services

23. As noted in the previous chapter, Level 3 and Level 4 services are specific interventions for those with established obesity and co-morbidity. As such, they do not exist to tackle the rising numbers of overweight and obese people in Wales, but to manage and treat those for whom preventative services have not been successful.

24. Level 3 of the *All Wales Obesity Pathway* aims to ensure availability of services for obese people who have:

- one or more co-morbidities and who have tried several interventions without success; and/or
- complex emotional relationships with food.

The service is designed to provide specialist dietary, physical activity and behavioural interventions that can be delivered through primary and secondary care. One of the aims of Level 3 services is to ensure that only those who need hospital-based treatment are referred to hospital for care, ensuring that all others are treated in the community.²⁶ Responsibility for planning and providing Level 3 services sits with each individual LHB.

25. Level 4 services provide specialist medical and surgical interventions – including multi-disciplinary team support and bariatric surgery – to those individuals who have failed to achieve or maintain adequate weight loss through other interventions in the Pathway. Given its specialist nature, responsibility for the planning and delivery of the Level 4 service resides with the Welsh Health Specialised Services Committee (WHSSC) on behalf of LHBs. WHSSC is responsible for deciding how the budget allocated to this service is spent and the criteria to be met if an individual is to qualify for surgery. Bariatric surgery specifically is considered in more detail in the next chapter.

The multi-disciplinary team (MDT)

26. Service requirements within the *All Wales Obesity Pathway* state that specialist interventions at Levels 3 and 4 should be provided by multi-disciplinary teams equipped to provide dietary, physical activity and behavioural support. Multi-disciplinary teams for bariatric services

²⁶ National Assembly for Wales, Health and Social Care Committee, [HSC\(4\)-10-14 Paper 4 – Submission from the Minister for Health and Social Services](#), p3, 26 March 2014

are made up of a variety of health practitioners and specialists, including dieticians, psychologists, clinicians and fitness experts.

27. Participants in the Committee's focus group event noted that access to a multi-disciplinary team is crucial to ensuring sustained weight loss for bariatric patients. The importance of having access to a skilled team with expertise in lifestyle change as well as dietetic and/or clinical interventions was emphasised. Furthermore, participants noted the need for timely access to the support of multi-disciplinary teams – examples of significant waits due to the lack of Level 3 services were cited. Participants highlighted that delays in accessing services often perpetuated already complex and high-risk bariatric cases.²⁷

Availability of MDT services

28. The Royal College of Physicians' written evidence stated that LHBs have been slow to develop Level 3 services and that there appears to be “uncertainty about their underlying structure”.²⁸ The same issue – particularly the lack of access to multi-disciplinary support – was highlighted by almost every participant in our inquiry.

29. In addition to the paucity of Level 3 services, particular concerns were expressed about the lack of clinical psychology capacity to support patients.²⁹ Aneurin Bevan University Health Board representatives noted that they had identified that clinical psychology capacity was “severely lacking” in their service and that investment was being made to address that. The importance of psychological intervention was noted by Cwm Taf University Health Board's written evidence, which also highlighted concerns about a shortage of provision:

“Local experience and the work of specialist clinicians working in this field [...] supports the view that psychological intervention is a fundamental component of any service intervention aimed at supporting people who require bariatric surgery to lose weight. There is currently a significant gap [...]. Identifying trauma underlying a person's over-eating or the presence of Binge Eating Disorder and assessing and treating

²⁷ National Assembly for Wales, Health and Social Care Committee, [Note of the Committee's focus group event in Cwmbrân](#), 12 March 2014

²⁸ Ibid, [Consultation response ABS 5 – Royal College of Physicians](#) para 7

²⁹ Ibid, [RoP \[para 39\]](#), 13 February 2014

post surgical eating disorders such as Post Surgical Eating Avoidance Disorder are examples of how psychological therapy is imperative to providing a good service to this patient group.”³⁰

30. A number of individuals and organisations warned that any intention to increase the capacity and availability of Level 4 multi-disciplinary services and surgery in the absence of adequate Level 3 services would be meaningless.³¹ The Welsh Health Specialised Services Committee noted that, while capacity issues remain at Level 3, demand for Level 4 services would always outstrip supply.³²

Effectiveness of MDT services

31. Dr Nadim Haboubi, the lead physician at Wales’s only fully comprehensive Level 3 service, told us:

“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.”³³

32. He went on to provide details of the outcomes achieved by multi-disciplinary services. As well as weight loss itself, he told us that reductions in the use of medication for patients and improvements in relation to co-morbidities such as arthritis and hypertension are also attributed to such interventions:

³⁰ National Assembly for Wales, Health and Social Care Committee, [Consultation response ABS 16 – Cwm Taf University Health Board](#), para 1.6

³¹ See National Assembly for Wales, Health and Social Care Committee, [Consultation response ABS 5 – Royal College of Physicians](#), para 15; [Consultation response ABS 2 – Cardiff and Vale University Health Board](#), p2; [Consultation response ABS 13 – Welsh Dietetic Leadership Advisory Group and the Welsh Board of the British Dietetic Association](#), para 1.3; and [Consultation response ABS 19 – Hywel Dda University Health Board](#), para 2.4

³² National Assembly for Wales, Health and Social Care Committee, [Consultation response ABS 17 – Welsh Health Specialised Services Committee](#), section 3.1

³³ *Ibid*, [RoP \[para 31\]](#), 13 February 2014

“We are talking not just about the quality of life but the co-morbidity. I am not saying that these conditions, which are linked and associated with obesity, are disappearing but they are certainly diminishing.”³⁴

33. The Welsh Health Specialised Services Committee noted in its written evidence that, as a consequence of the lack of an all-Wales Level 3 service, it is difficult to assess how effective Level 3 and 4 services are in tackling the numbers of overweight and obese people in Wales.³⁵ The Royal College of Physicians’ written evidence cited its own report – [Action on Obesity](#) (published January 2013) – which advocates strongly the use of a multi-disciplinary approach to managing and treating obesity, drawing on evidence of success in relation to cancer care.³⁶

34. It was noted during the course of our inquiry that specialist multi-disciplinary weight management services can – and, in many cases, do – provide sufficient treatment for overweight and obese individuals such that surgery is not a necessary step:

“**Dr Haboubi:** 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.”³⁷

35. Perhaps the most striking evidence of how weight management intervention – or lack thereof – impacts on the lives of patients came from our focus group participants. They told us of the social, physical, economic and psychological impacts of obesity. It was noted that successful weight management interventions can be “life-changing”, not only for patients but for the whole family. We were told that day-to-day tasks such as shopping, socialising, and travelling can all be restricted by obesity; this, in turn, has an impact on an individual’s quality of life and emotional well-being. Furthermore, we were told that many obese people struggle to maintain a working life due to the physical and psychological impact of their weight. The economic

³⁴ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 90\]](#), 13 February 2014

³⁵ Ibid, [Consultation response ABS 17 - Welsh Health Specialised Services Committee](#), section 3.4

³⁶ Ibid, [Consultation response ABS 5 – Royal College of Physicians](#), para 4

³⁷ Ibid, [RoP \[para 69\]](#), 13 February 2014

impact of this – both for the individual and society more widely – was emphasised.³⁸

Commissioning of MDT services

36. Given the variable implementation of Level 3 services across LHBs in Wales, some witnesses to our inquiry suggested that responsibility for commissioning and funding such services should sit with the commissioning of Level 4 services, at a national rather than local level. Dr Nadim Haboubi, speaking on behalf of the National Obesity Forum for Wales, told us:

“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.”³⁹

37. It was suggested that this would assist not only with achieving a higher level of provision of Level 3 services across Wales, but would also allow a more robust clinical service with regular audit and assessment of performance.⁴⁰

38. Responding to this suggestion, Jan Smith of Aneurin Bevan University Health Board noted her personal view 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.”⁴¹

39. The Committee was told that work is currently underway, led by Public Health Wales, to develop and agree an all-Wales service specification for all LHBs. Dr Jane Layzell, Consultant in Public Health at Aneurin Bevan University Health Board, explained:

³⁸ National Assembly for Wales, Health and Social Care Committee, [Note of the Committee's focus group event in Cwmbrân](#), 12 March 2014

³⁹ Ibid, [RoP \[para 17\]](#), 13 February 2014

⁴⁰ Ibid, [Consultation response ABS 5 – Royal College of Physicians](#), para 4

⁴¹ Ibid, [RoP \[para 266\]](#), 13 February 2014

“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 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.”⁴²

Referrals

40. The *All Wales Obesity Pathway* is structured on the premise that an individual can be referred to the next tier of service if they require a different level of support to achieve and maintain a healthy body weight. For those who have been unable to lose or maintain their weight, this may involve moving up to a higher level of specialist intervention; for those who have undergone successful treatment, the referral may be to a lower tier of support.

Referrals between primary care and Level 3 services

41. When asked whether patients are being referred to Wales’ only comprehensive Level 3 service in a timely manner, Dr Nadim Haboubi told us that:

“I think it varies. Some general practitioners are far more engaged with the patient [...] 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.”⁴³

42. Information provided by our focus group participants echoed Dr Haboubi’s evidence. The importance of ensuring “every contact counts”⁴⁴ was highlighted; it was suggested that further work is

⁴² National Assembly for Wales, Health and Social Care Committee, [RoP \[para 282\]](#), 13 February 2014

⁴³ Ibid, [RoP \[para 118\]](#), 13 February 2014

⁴⁴ “Making every contact count” is a National Health Service initiative that encourages conversations between practitioners and patients based on behaviour change methodologies (ranging from brief advice, to more advanced behaviour change

needed to improve primary care's approach to bariatric patients with many participants citing ignorance and prejudice as barriers to accessing specialist services. Examples were given of patients having to request specialist weight management intervention as opposed to being actively offered support of this kind.⁴⁵

43. In cases where general practitioners and primary care workers have a better understanding of the need for specialist bariatric intervention, it was noted that difficulties still remain with referring individuals to multi-disciplinary teams due to the paucity of specialist weight management clinics. It was also noted by some participants that patients often see several general practitioners rather than the same individual and that this can be unhelpful when seeking to establish which services are required.⁴⁶

44. Mr Scott Caplin, Consultant Laparoscopic Bariatric Surgeon at WIMOS, indicated that the use of the Pathway to refer down the tiers to general practice from specialist services should not be forgotten:

“...many of the patients undergoing surgery that we undertake nowadays do not need tier 3 follow-up. They can be followed up by their GP [...] 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 [...] That, I would envisage for most patients, can be done in primary care.”⁴⁷

Referrals between Level 3 and Level 4

45. The important interaction between Level 3 and Level 4 services was a clear theme in our inquiry. Although there was a general consensus among witnesses and focus group participants that, in accordance with the Pathway, referral for Level 4 surgical interventions should arise via a Level 3 service, the problem remains that Level 3

techniques), empowering healthier lifestyle choices and exploring the wider social determinants that influence health.

⁴⁵ National Assembly for Wales, Health and Social Care Committee, [Note of the Committee's focus group event in Cwmbrân](#), 12 March 2014

⁴⁶ Ibid

⁴⁷ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 311\]](#), 13 February 2014

services are not available in the necessary quantity to provide for this. Many witnesses emphasised the importance of Level 3 services as the gateway through which the most appropriate patients should be selected for effective Level 4 surgery.

46. Mr Jonathan Barry, Consultant Laparoscopic Bariatric Surgeon at WIMOS, told us:

“...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 [...] 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.”⁴⁸

He went on to explain:

“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 multi-disciplinary team meeting who would benefit better from a Level 3 service. So, those people would not be referred to us. [...] These problems would not exist if we had an effective tier 3.”⁴⁹

47. Written evidence submitted by the Welsh Health Specialised Services Committee – the body responsible for the planning and delivery of Level 4 surgery – noted that the criteria they have in place to assess eligibility for surgery:

“...will only be effective if Level 3 services are present across all of Wales and that demand can be met by supply [...] An all-Wales Level 3 service will act as a platform for pre-surgical management and post-surgical support. This not only enables patients to attempt lifestyle interventions but also acts as a screening state for assessing suitability for surgery. It will also help ascertain demand for bariatric surgery in the future and

⁴⁸ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 129\]](#), 13 February 2014

⁴⁹ Ibid, [RoP \[para 174 and para 178\]](#), 13 February 2014

quantitatively inform WHSSC commissioning in subsequent years.”⁵⁰

Recruitment, training and skills mix

48. During our inquiry we heard that, although health professionals are encouraged to identify and discuss overweight and obesity issues with patients, these conversations are not always taking place. A number of reasons were cited for this including ignorance, prejudice, lack of training or awareness, and fear of harming the patient/clinician relationship.

49. Participants in our focus group event cited examples of healthcare practitioners displaying ignorance and prejudice towards obese individuals, with many patients being told to simply exercise and improve their diet. The need to train practitioners to improve their understanding of the underlying causes of obesity and raise their awareness of specialist services was emphasised.

50. It was noted that some health professionals lack confidence when raising weight management issues with patients, and that training in this area is required, to reduce frustration for professionals and patients. It was noted that not enough focus is placed on the importance of training for health professionals, and that some GPs in particular may not have sufficient training or time resources to deal with complex weight issues. It was recommended that training about obesity, its causes and its treatment should be mainstreamed across all disciplines.

51. The importance of ensuring the correct skills mix among health professionals was also emphasised by participants. The need for specialist training in the field of dietetics, psychology, and lifestyle interventions – including fitness – was noted. This importance of understanding the role that physical activity – even if modest – can play was emphasised during our working lunch with academics researching this field.⁵¹ In this context obesity was likened to mental

⁵⁰ National Assembly for Wales, Health and Social Care Committee, [Consultation response ABS 17 - Welsh Health Specialised Services Committee](#), section 3.2

⁵¹ Ibid, [Note of the Committee's working lunch with Swansea University academics](#), 13 February 2014

health conditions, where longer-term approaches and interventions – rather than diagnoses and one-off treatments – are required.⁵²

52. Both the Royal College of Physicians and the Royal College of Surgeons referred in their written evidence to a “lack of interest” in the problem of obesity from the wider health profession.⁵³ This was echoed by Dr Dev Datta, representing the Welsh Association of Gastroenterology and Endoscopy, who told us:

“No clinician or physician wants to run a clinic where they are not going to achieve a good outcome [...] 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.”⁵⁴

53. Nevertheless, when asked in Committee whether this meant that there would be a shortage of staff if Level 3 and Level 4 services were to expand, there was a consensus among witnesses that, with sufficient commitment to the establishment and resourcing of adequate Level 3 and 4 services, there would not be a problem attracting the correct skills mix. Mr Jonathan Barry, Consultant Laparoscopic Bariatric Surgeon at WIMOS, stated:

“If you were to set up prospectively allocated dieticians and psychologists, there would be a lot of enthusiasm for this. We know that 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.”⁵⁵

⁵² National Assembly for Wales, Health and Social Care Committee, [Note of the Committee’s focus group event in Cwmbrân](#), 12 March 2014

⁵³ See National Assembly for Wales, Health and Social Care Committee, [Consultation response ABS 18 - Royal College of Surgeons and the British Obesity and Metabolic Surgery Society](#), p3 and [Consultation response ABS 5 - Royal College of Physicians](#) para 13

⁵⁴ Ibid, [RoP \[para 205\]](#), 13 February 2014

⁵⁵ Ibid, [RoP \[para 204\]](#), 13 February 2014

Paediatric services

54. The Children, Young People and Education Committee's inquiry on childhood obesity considered paediatric services in detail.⁵⁶ Its report, published in March 2014, includes a number of recommendations of relevance to our inquiry on the availability of bariatric services in Wales.

55. During the course of our inquiry, we were told that no dedicated Level 3 service for children exists in Wales.⁵⁷ Focus group participants emphasised that weight management issues often begin in childhood but that services are more limited for children than adults. The importance of specialist paediatric services being provided to prevent or reduce the escalation of individuals' weight management issues in later life was emphasised.⁵⁸

56. Although nobody argued with the criterion that states under 18 year olds will not normally have access to bariatric surgery, members of WIMOS's multi-disciplinary team did note that, due to the lack of a specialist paediatric Level 3 service, they are often left waiting for young people to "cross the line" to 18 before anything useful can be done to assist them.⁵⁹

The Minister's evidence

57. The Minister told the Committee that the gap which exists at Level 3 of the Pathway would be addressed by Public Health Wales's work to develop an all-Wales, nationally agreed common access and service specification for Level 3 services, due for publication at the end of May 2014.⁶⁰ Furthermore, the Minister noted that LHBs would be expected to provide plans that show how they are going to make improvements in those areas where deficits have been identified.⁶¹ He noted that he would hold all LHBs to account for the delivery of the services against the all-Wales service specification once agreed.⁶²

⁵⁶ National Assembly for Wales, Children, Young People and Education Committee [Inquiry on childhood obesity](#) 2013-14

⁵⁷ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 97\]](#), 26 March 2014

⁵⁸ Ibid, [Note of the Committee's focus group event in Cwmbrân](#), 12 March 2014

⁵⁹ Ibid, [Note of the Committee's visit to WIMOS, Murryston Hospital](#) 13 February 2014

⁶⁰ Ibid, [RoP \[para 39\]](#), 26 March 2014

⁶¹ Ibid, [RoP \[para 42\]](#), 26 March 2014

⁶² Ibid, [RoP \[para 48\]](#), 26 March 2014

58. In relation to the funding of services, the Minister noted that Public Health Wales would, as part of the development of the all-Wales service specification, need to negotiate with LHBs to create a climate in which they are encouraged to invest in the service:

“They will have to do it on the basis 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.”⁶³

59. Responding to the specific concerns raised in relation to the lack of psychological services, the Minister indicated that he may be minded to see a culture of “mutual aid” developing among LHBs, with Level 3 resources being shared across Health Board boundaries:

“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.”⁶⁴

60. On the subject of training, the Minister stated:

“There is always pressure to put more into the curriculum and find other things we can teach them [GPs] about. We are in regular dialogue with the Wales Deanery about the curriculum here in Wales [...] 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. [...] Sometimes, using the wider primary care team is important in all of this, but there may be other people

⁶³ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 48\]](#), 26 March 2014

⁶⁴ *Ibid*, [RoP \[para 72\]](#), 26 March 2014

who patients come into contact with in primary care who are better placed to have those conversations.”⁶⁵

61. In relation to paediatric services, the Minister stated that, although clinical exceptions do exist, bariatric surgery is not – and should not – be routinely available to people aged under 18. He noted:

“It is a form of intervention that [...] leaves people with a whole range of other things that they have to think about and be aware of. It is not something 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.”⁶⁶

62. The Minister went on to say:

“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.”⁶⁷

Our view

63. The importance of having timely access to the support of a multi-disciplinary team for patients for whom preventative services have failed was a clear theme in our inquiry. It is a source of concern and disappointment to us that patients face severe difficulties gaining access to Level 3 services and the support of a multi-disciplinary team. These services, if provided, could lead not only to weight loss but to improvements in relation to other associated conditions and quality of life. They also have an important role to play in identifying which patients would benefit most from bariatric surgery and ensuring that these candidates understand the implications of surgery on their lives.

64. Given the ever rising numbers of overweight and obese people in Wales, it concerns us that the lack of commitment on the part of LHBs

⁶⁵ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 12\]](#), 26 March 2014

⁶⁶ Ibid, [RoP \[para 23\]](#), 26 March 2014

⁶⁷ Ibid, [RoP \[para 58\]](#), 26 March 2014

to establish and resource multi-disciplinary teams is reported to be impacting on health professionals' interest in working in this field.

Recommendation 2: We recommend that the Welsh Government provide assurances that it will require forthcoming Local Health Board plans and the all-Wales Level 3 service specification to include measures to address the lack of multi-disciplinary service provision in Wales within the next 12 months.

65. We welcome the on-going work between Public Health Wales and the Welsh Health Specialised Services Committee to ensure that the referral pathways between Level 3 and Level 4 services are clear and agreed. We believe that this is crucial if we are to ensure that:

- surgery remains the last resort, used only in the minority of cases where lifestyle interventions have been unsuccessful; and
- where surgery is the most effective intervention, the patient receives adequate pre- and post-operative care (this is discussed in more detail in the next chapter).

Recommendation 3: We recommend that the Welsh Government develop and publish a monitoring and evaluation framework for bariatric services in Wales, which also indicates lines of accountability, to measure the consistency and effectiveness of the referral pathway for overweight and obese patients to move up and down the relevant tiers of support.

66. We note that, although health professionals are encouraged to identify and discuss overweight and obesity issues with patients, these conversations are not always taking place.

Recommendation 4: We recommend that the Welsh Government work with the Wales Deanery and relevant Royal Colleges to consider training for health professionals, across all disciplines, on obesity, its causes, its treatment and the relevant treatment pathway, and its consequences. Training should include motivational interviewing and behaviour-change management. Consideration should also be given to what more can be done to embed the 'make every contact count' methodology.

67. We believe that to tackle adult obesity without addressing the growing issue of childhood obesity would be short-sighted. We welcome the detailed work of the Children, Young People and Education Committee on this and have not sought to duplicate its work. Nevertheless, in relation to the specific matter of specialist bariatric services, we welcome the Minister's proposal to consider establishing a service specification for children accessing Level 3 services in Wales and encourage him to develop the service specification. We will be seeking further clarification from the Minister on the timescales within which this service specification will be developed.

4. Bariatric surgery

68. Surgery for the treatment of obesity, also known as bariatric surgery, is a treatment option for people with severe and complex obesity. Surgical procedures for those with obesity aim to reduce weight and maintain any loss through restriction of intake and/or malabsorption of food. In addition to modifying eating habits, patients are encouraged to commit to daily exercise as part of a wider change in lifestyle. A number of weight loss surgery procedures exist, however the principal types are gastric bypass, gastric banding and sleeve gastrectomy.

69. The only NHS provider of bariatric surgery in Wales is the Welsh Institute of Metabolic and Obesity Surgery (WIMOS) at Morriston Hospital, Swansea. Surgery for eligible candidates from North Wales is currently commissioned from Salford Royal NHS Trust, Greater Manchester.

Costs and benefits

70. During the course of our inquiry we were told that the National Institute for Health and Care Excellence (NICE) has classified the evidence base for bariatric surgery as level 1. This means that it has the strongest type of evidence base in relation to both its effectiveness.⁶⁸ We were told that, whilst NICE would view £30,000 for a quality-adjusted life year benefit (QALY) as cost-effective, bariatric surgery sits firmly within this boundary at approximately £6,000 per QALY.⁶⁹

71. Mr Jonathan Barry, Consultant Laparoscopic Bariatric Surgeon at WIMOS, told us that:

“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

⁶⁸ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 133\]](#), 13 February 2014

⁶⁹ Ibid, [RoP \[para 214\]](#), 13 February 2014

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?”⁷⁰

72. Clinical and financial evidence in favour of bariatric surgery cited to us included:

- Royal College of Physicians figures illustrating that obesity-related healthcare costs (e.g. joint replacements) are estimated at over £5 billion per year across the UK;
- The National Bariatric Surgery Registry (NBSR) First Registry Report showing around two-thirds of severely obese patients will have three or more associated diseases; a third will have high blood pressure; a quarter will have diabetes; almost three-quarters will have limited function and unable to climb more than 3 flights of stairs without resting – figures show that as well as losing on average 57.8 per cent of excess weight, improvement is recorded in all associated diseases (including an 85.5 per cent reduction in the number of patients with type 2 diabetes).⁷¹

73. When asked about how the cost-benefits of bariatric surgery are monitored in Wales, Dr Kshesh Sidhu, Deputy Director of WHSSC, told us:

“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.”⁷²

74. Written evidence from Hywel Dda University Health Board stated:

⁷⁰ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 213\]](#), 13 February 2014

⁷¹ Ibid, [Consultation response ABS 18 - Royal College of Surgeons and the British Obesity and Metabolic Surgery Society](#), pp 4-5

⁷² Ibid, [RoP \[para 422\]](#), 13 February 2014

“We believe that, in relation to bariatric surgery, it should be common practice for the cost benefits of clients who undergo procedures to be regularly reviewed. Clarity in relation to who is monitoring effectiveness and value for money of services should be considered and may benefit from support at an All-Wales level (alongside Level 3 service evaluation if resources to deliver are made available).”⁷³

Eligibility criteria and commissioning rates

NICE guidance

75. NICE produced guidelines for access to bariatric surgery in December 2006. NICE recommended that bariatric surgery is used as a treatment option for adults with obesity if all the following criteria are fulfilled:

- The individual has a BMI⁷⁴ of 40kg/m² or more, or between 35kg/m² and 40kg/m² and another significant disease (e.g. type 2 diabetes or high blood pressure) that could be improved if they lost weight.
- All appropriate non-surgical measures have been tried but have failed to achieve or maintain adequate, clinically beneficial weight loss for at least six months.
- The individual has been receiving or will receive intensive management in a specialist obesity service.
- The individual is generally fit for anaesthesia and surgery.
- The individual commits to the need for long-term follow-up.⁷⁵

76. NICE does not recommend that surgical intervention be used for children or young people.

77. Bariatric surgery is also recommended by NICE as a first-line option (instead of lifestyle interventions or drug treatment) for adults with a BMI of more than 50kg/m² for whom surgical intervention is deemed appropriate.

⁷³ National Assembly for Wales, Health and Social Care Committee, [Consultation response ABS 19 – Hywel Dda University Health Board](#), para 3.3

⁷⁴ Body Mass Index (BMI) is usually used to calculate if a person is of a health weight. It must be used with caution, however, as a very muscular person’s BMI would not necessarily give an accurate idea of whether they needed to lose weight or not. BMI between 18.5kg/m² and 24.9kg/m² is deemed healthy.

⁷⁵ NICE, [CG43 Obesity – NICE Guidance](#), December 2006

78. NICE commissioning guidance recommends a rate of 10 bariatric procedures per 100,000 head of population per annum.⁷⁶

Review of Welsh bariatric surgery provision and access criteria

79. Since April 2010, the commissioning of bariatric surgery in Wales has been included within the remit of the Welsh Health Specialised Services Committee (WHSSC). Until April 2014, eligibility criteria in Wales were as follows:

- The individual is aged 18 or over.
- The individual has received intensive management in a specialised hospital obesity clinic or a community-based equivalent.
- The referring clinician and patient are in agreement about the referral.
- The individual has a BMI of 50kg/m² or greater in the presence of a serious co-morbidity which may be amenable to treatment if obesity is modified through special obesity services.⁷⁷

80. In 2012, WHSSC undertook a review of bariatric surgery policy to assess the impact on health outcomes and costs to the NHS in Wales of adopting the NICE guidance. The WHSSC review, published in January 2013, recommended reviewing the access criteria and increasing the number of procedures and associated funding as follows:

	2013/14	2014/15	2015/16	2016/17	2017/18
Cases (all Wales)	128	171	214	257	300
Rate (per 100k population)	4.3	5.7	7.1	8.6	10
Spend	£0.96m	£1.29m	£1.61m	£1.93m	£2.21m
South Wales	£0.66m	£0.88m	£1.10m	£1.32m	£1.50m
North Wales	£0.30m	£0.41m	£0.51m	£0.61m	£0.71m

Source: WHSSC, [Review of Bariatric Surgery Provision and Access Criteria in the Context of the All Wales Obesity Pathway](#), p21, January 2013

⁷⁶ NICE, [Bariatric Surgical Service Commissioning Guide](#), May 2010

⁷⁷ WHSSC, [Commissioning Policy on Bariatric Surgery](#), December 2009

Revised Welsh access criteria

81. A clear theme that emerged during our inquiry was the need for Wales to work towards adherence to existing NICE criteria for access to bariatric surgery, as is the case in England. During our focus group event it was stated that, out of 1,000 patients referred to WIMOS, 98 per cent had not been eligible for surgery under Welsh criteria despite meeting the requirements outlined in the NICE guidance.⁷⁸

82. Evidence submitted to our inquiry was summed up by the Royal College of Surgeons and the British Obesity and Metabolic Surgery Society's evidence:

“...the current system in Wales is skewed and results in patients being forced to wait until they develop life-threatening illnesses such as diabetes or stroke before they meet the qualifying criteria for surgery.”⁷⁹

83. Anecdotal evidence was also cited of higher BMI thresholds acting as a perverse incentive for individuals seeking bariatric surgery to put on weight in order to “make the grade”,⁸⁰ however no firm evidence of this was provided.

84. WHSSC's written evidence recognised that the group of patients to whom surgery has historically been available in Wales does not achieve the best outcomes and that “it is important to move the criteria to enable people with lower BMIs to access the service”.⁸¹ We were told that WHSSC would be working towards adopting the following criteria in the 2014/15 commissioning year (April 2014):

⁷⁸ National Assembly for Wales, Health and Social Care Committee, [Note of the Committee's focus group event in Cwmbrân](#), 12 March 2014

⁷⁹ Ibid, [Consultation response ABS 18 - Royal College of Surgeons and the British Obesity and Metabolic Surgery Society](#), p4

⁸⁰ See National Assembly for Wales, Health and Social Care Committee, [Note of the Committee's focus group event in Cwmbrân](#), 12 March 2014; [Consultation response ABS 18 - Royal College of Surgeons and the British Obesity and Metabolic Surgery Society](#), p4; [Consultation response ABS 4 - Royal College of Anaesthetists Advisory Board in Wales](#) p2; and [Consultation response ABS 15 - Aneurin Bevan University Health Board](#), para 4.7

⁸¹ National Assembly for Wales, Health and Social Care Committee, [Consultation response ABS 17 - Welsh Health Specialised Services Committee](#), section 3.2

- The individual is aged 18 years or over.
- The individual has a BMI of 40 or greater, or a BMI of 35 to 40 in the presence of co-morbidity which would be expected to improve if obesity is modified.
- Morbid/severe obesity has been present for at least five years.
- The individual has received, and complied with, an intensive weight management programme at a multi-disciplinary weight management clinic (level 2/3 of the All Wales Obesity Pathway) for at least 24 months duration, but has been unable to achieve and maintain a healthy weigh.
- The individual is assessed using DUBASCO score (an international recognised standard risk assessment method).
- The individual is expected to gain significant benefit from bariatric surgery (assessed by the bariatric multi-disciplinary team at Welsh Institute of Metabolic and Obesity Surgery).⁸²

85. Most witnesses and focus groups participants agreed that the requirement to participate in a Level 2/3 service for two years before being eligible for surgery was sensible in principle, as many people succeed in losing weight without surgical intervention during this period. It was also felt that this process would help ensure that those who are in most need of surgery – and most likely to benefit from it – actually receive it. There was consensus, however, that the criteria to participate for two years in a multi-disciplinary weight management clinic is too high a threshold when such services are not available in the necessary scale in Wales.⁸³

Pre- and post-operative care

86. We heard that patients need to be fully briefed about the consequences of bariatric surgery and its associated risks – and the need for patients to engage fully with a post-operative care regime – before embarking on surgery. Focus group participants warned that a failure to commit to support services following bariatric surgery can have serious physical and psychological consequences.⁸⁴

⁸² National Assembly for Wales, Health and Social Care Committee, [Consultation response ABS 17 - Welsh Health Specialised Services Committee](#), section 3.2

⁸³ Ibid, [Note of the Committee's focus group event in Cwmbrân](#), 12 March 2014

⁸⁴ Ibid

87. The importance of pre- and post-operative care was emphasised by many witnesses; their views were summarised by Mr Scott Caplin, Consultant Laparoscopic Bariatric Surgeon at WIMOS:

“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.”⁸⁵

88. Dr Khesh Sidhu, Deputy Director of WHSSC, told us that:

“...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.”⁸⁶

Corrective procedures

89. Several witnesses referred to those deemed ineligible for surgery in Wales seeking private treatment, often abroad. Examples were given of patients seeking cheaper procedures overseas, returning to Wales and developing complications that require corrective surgery and/or treatment. It was suggested that, for patients who are not eligible for bariatric surgery, an explanation ought to be given as to why they were deemed ineligible and information provided on the options available to them in order to seek to avoid individuals seeking potentially dangerous private treatment in their desperation.⁸⁷

90. WIMOS representatives highlighted the impact on the NHS of correcting sub-standard surgery. According to Mr Jonathan Barry, Consultant Laparoscopic Bariatric Surgeon, WIMOS’s second most commonly performed procedure is operating on the complications in

⁸⁵ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 316\]](#), 13 February 2014

⁸⁶ Ibid, [RoP \[para 408\]](#), 13 February 2014

⁸⁷ Ibid, [Note of the Committee’s focus group event in Cwmbrân](#), 12 March 2014

patients who have sought private surgery outside Wales.⁸⁸ Examples were given ranging from individuals being unable to swallow through to those dying because of post-surgical complications.⁸⁹ Mr Barry warned that restrictions on eligibility for surgery mean that:

“These patients are desperate. They see [...] that they can go to some portakabin in Belarus and have a gastric band put in for £4000 and they go and have it done, and then develop complications and come back to their local hospital.”⁹⁰

91. Mr Scott Caplin, Consultant Laparoscopic Bariatric Surgeon at WIMOS, summarised the impact of poor surgery and poor follow-up care on NHS resources:

“...a proportion of the money that, theoretically, we are being funded for in Morryston 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.”⁹¹

Excess skin

92. The surgical removal of excess skin due to significant weight loss was an issue that arose frequently during the course of our inquiry. For previously obese people to be eligible for excess skin removal following significant weight loss, they must have achieved a stable BMI between 18 and 25kg/m² for at least two years and be suffering from severe functional problems, which include:

- significant problems with activities of daily life (e.g. restrictions on movement); and
- excess skin causing a chronic and persistent skin condition that has proved resistant to medical treatment for at least 6 months.

93. The importance of considering the impact of excess skin following successful bariatric surgery was emphasised by focus group participants. It was noted that, although currently considered a cosmetic procedure unless the specific complications noted above

⁸⁸ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 185\]](#), 13 February 2014

⁸⁹ Ibid, [RoP \[paras 185 - 186\]](#), 13 February 2014

⁹⁰ Ibid, [RoP \[para 192\]](#), 13 February 2014

⁹¹ Ibid, [RoP \[para 319\]](#), 13 February 2014

arise, the psychological impact of excess skin on patients following surgery is significant.⁹²

94. A number of written submissions also emphasised the need to consider the inclusion of excess skin removal as part of the Level 4 bariatric surgery service.⁹³

95. When asked about excess skin removal, WHSSC representatives told us that between 50 and 70 procedures are commissioned each year as part of its post-weight loss surgery policy. Furthermore, we were told that the clinical access criteria have been reviewed in the past and that they will be reviewed periodically in consultation with clinicians.⁹⁴

Surgical capacity: a service for North Wales?

96. As noted in paragraph 80 it has been agreed, through the WHSSC *Review of Welsh bariatric surgery provision and access criteria*, that the population rate of bariatric surgery in Wales will increase from 80 cases to 300 cases over 5 years at a cost of £2.21million. WIMOS will treat 225 cases at a cost of £1.5m and treatment for 75 cases will be commissioned from England at a cost of £0.712 million.

97. During our visit to WIMOS, we were told that with the resource of the two available surgeons being used to full effect, WIMOS could complete 240 operations a year.⁹⁵ Staff explained that the DUBASCO tool is currently used to identify those eligible for surgery in Wales. We were told that this is purely a rationing tool used to satisfy the requirement to operate on the specified number of patients commissioned by WHSSC each year. This figure was 67 (out of a potential caseload approximated at 3,000) in the last year. Furthermore, written evidence submitted jointly by the Royal College of Surgeons and the British Obesity and Metabolic Surgery Society noted that designation as a Centre of Excellence in Metabolic and Bariatric Surgery (COEMBS) – a global patient safety and quality

⁹² National Assembly for Wales, Health and Social Care Committee, [Note of the Committee's focus group event in Cwmbrân](#), 12 March 2014

⁹³ See National Assembly for Wales, Health and Social Care Committee, [Consultation response ABS 13 – Welsh Dietetic Leadership Advisory Group and the Welsh Board of the British Dietetic Association](#), para 4.2; [Consultation response ABS 19 – Hywel Dda University Health Board](#), para 4.2; and [RoP \[para 78\]](#), 13 February 2014

⁹⁴ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 393\]](#), 13 February 2014

⁹⁵ Ibid, [Note of the Committee's visit to WIMOS, Morriston Hospital](#) 13 February 2014

improvement programme – relies on a facility performing 80 qualifying surgery procedures in the preceding 12 months, with each applicant surgeon performing at least 125 qualifying procedures in his or her lifetime, at least 50 of which must have been performed in the preceding 12 months.⁹⁶

98. Some witnesses referred to the need for Level 3 and Level 4 services to serve the North Wales population.⁹⁷ Written evidence from Betsi Cadwaladr University Health Board noted that requests have been made to develop multi-disciplinary team services and surgical provision in North Wales.⁹⁸ Mr Jonathan Barry, Consultant Laparoscopic Bariatric Surgeon at WIMOS, noted:

“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.”⁹⁹

99. WHSSC’s *Review of Welsh bariatric surgery provision and access criteria* noted it has been agreed that until planned volumes of bariatric surgery increase to levels necessary to sustain a local service in line with national quality standards (i.e. increase its current volume of 25 procedures at a cost of £0.235m to approximately 120 procedures at a cost of £0.825m) referrals to bariatric surgery for patients resident in North Wales should continue to be made to England. In oral evidence, WHSSC stated:

“...a critical mass for a centre to be set up in north Wales really depends on a number of variables, including demand, whether

⁹⁶ National Assembly for Wales, Health and Social Care Committee, [Consultation response ABS 18 - Royal College of Surgeons and the British Obesity and Metabolic Surgery Society](#), p4

⁹⁷ See National Assembly for Wales, Health and Social Care Committee, [Consultation response ABS 21 - Chair of the Wales National Obesity Forum](#), para 6; [Consultation response ABS 20 - Betsi Cadwaladr University Health Board](#), para 4.2; [Consultation response ABS 4 - Royal College of Anaesthetists Advisory Board in Wales](#) p2

⁹⁸ National Assembly for Wales, Health and Social Care Committee, [Consultation response ABS 20 - Betsi Cadwaladr University Health Board](#), para 4.2

⁹⁹ *Ibid*, [RoP \[para 393\]](#), 13 February 2014

finances are available and whether clinical expertise is available.”¹⁰⁰

The Minister’s evidence

100. Responding to the evidence received on cost-benefits of bariatric surgery, the Minister told us:

“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 [move] money into things that prevent people from needing the final layer of service.”¹⁰¹

101. In response to a question on the forthcoming eligibility criteria and people being unable to access the requisite Level 3 services for 24 months in advance of being considered for surgery, the Minister stated that the system would be flexible and people would not be disadvantaged if they were unable to access a Level 3 service:

“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 [dis]advantage the individual because the service is not able to fulfil its part of the bargain.”¹⁰²

102. When asked for his response to evidence that the second most commonly performed operation at WIMOS is to correct surgery undertaken privately,¹⁰³ the Minister stated:

¹⁰⁰ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 380\]](#), 13 February 2014

¹⁰¹ Ibid, [RoP \[para 53\]](#), 26 March 2014

¹⁰² Ibid, [RoP \[para 29\]](#), 26 March 2014

¹⁰³ Ibid, [RoP \[para 185\]](#), 13 February 2014

“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.”¹⁰⁴

103. Following the Committee’s session with the Minister, he confirmed in writing that it is not possible to obtain information about the costs to the NHS of operating on complications from private bariatric operations. His letter states:

“Individuals having operations following complications largely have such procedures carried out as a necessity and sometimes as an emergency and regrettably the NHS has no practical and realistic way to enforce recouping costs.”¹⁰⁵

104. On excess skin removal, the Minister was clear: where there is a clinical need for removal, treatment can be sought via the NHS; where the need is cosmetic, excess skin removal cannot be undertaken on the NHS. He referred to the fact that, in England, many trusts do not fund any form of excess skin removal, no matter how clinically compromised an individual may be. He told us:

“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 resource.”¹⁰⁶

105. He went on to say:

“The consequences of bariatric surgery are well known in advance. The real point at which that discussion [about excess skin removal] has to be had with the individual is at the point at which they decide whether or not to go ahead with bariatric surgery [...] there is a job that has to be in making sure that

¹⁰⁴ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 69\]](#), 26 March 2014

¹⁰⁵ Ibid, [Letter from the Minister for Health and Social Services \(ABS – A1 4\)](#), 15 April 2014

¹⁰⁶ Ibid, [RoP \[para 24\]](#), 26 March 2014

people embark of that course of treatment at least in full possession of the facts.”¹⁰⁷

106. With regard to developing a centre for bariatric surgery in North Wales, the Minister noted that although he welcomes services being provided for Welsh residents in North Wales, he would have to be confident that all relevant bariatric services for patients – not only the surgery but the assessments, follow-up etc. – could be delivered in North Wales too:

“We would have to be confident for North Wales patients that we were able to offer them the whole deal, not just 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.”¹⁰⁸

Our view

107. Having a robust understanding of the costs and benefits of bariatric surgery is crucial, in our opinion, to ensuring that access to bariatric services is developed on a sound footing in Wales. In the current economic climate, value for money and effective outcomes must be at the heart of any service development.

Recommendation 5: We recommend that the Welsh Government undertake a comprehensive cost-benefits analysis of bariatric surgery procedures, including consideration of societal cost-benefits, to identify the extent to which they provide value for money. The opportunity provided by invest-to-save bids should be explored, as suggested by the Minister.

108. We welcome the adoption of NICE compliant criteria from April 2014 onwards. We remain concerned that the current lack of Level 3 services could adversely affect the criteria’s implementation, however we believe that delivery of recommendations 1 to 3 of our report will help assist in this context. In the meantime, we welcome the Minister’s assurance that people will not be disadvantaged if they are not able to access appropriate services.

¹⁰⁷ National Assembly for Wales, Health and Social Care Committee, [RoP \[para 26\]](#), 26 March 2014

¹⁰⁸ Ibid, [RoP \[para 56\]](#), 26 March 2014

109. The importance of pre- and post-operative information and care was a clear theme in our inquiry. We believe that further work is needed in this area to ensure that bariatric patients are fully aware of all the implications of surgery, including the possibility of excess skin. Furthermore, the Committee notes the importance of patients taking responsibility for their post-operative care, with adequate support from health professionals, and committing to the follow-up regime necessary to realise the full benefits of surgery.

Recommendation 6: We recommend that the Welsh Government work with the Welsh Health Specialised Services Committee to consider including a requirement within the eligibility criteria for bariatric surgery – akin to NICE criteria – that a patient commits to long-term follow-up (via the GP or multi-disciplinary team) following surgery. This requirement will need to be accompanied by the necessary expansion of follow-up services across Wales.

110. We were surprised to learn about the extent and impact of complications arising from poor surgery undertaken outside the NHS and/or poor follow-up care. It was clear from the evidence that we received that this is in a large part attributable to the desperation felt by individuals deemed ineligible for NHS surgery. We believe that further work needs to be done to quantify this issue and to consider how it could be addressed, but acknowledge that the NHS must provide a comprehensive service to all emergency cases, whatever the circumstances in which they arise.

Recommendation 7: We recommend that the Welsh Government develop guidance on the processes that should be followed to support a patient deemed ineligible for bariatric surgery. This guidance should pay specific attention to what information is provided to ineligible individuals on the options that remain available.

111. In relation to surgical capacity in Wales for Level 4 services, we welcome the proposed increase in activity and investment in bariatric surgery and welcome the opportunity to use the capacity at WIMOS to move closer to NICE-compliant commissioning rates. In relation to providing a service for North-Wales patients within North Wales as opposed to over the border, we agree with the Minister that we must be confident that all services associated with bariatric surgery,

including pre- and post-operative care, are deliverable before repatriating services. We believe that further work should be undertaken to explore this possibility.

Recommendation 8: We recommend that the Welsh Government review periodically the need for a local bariatric surgery service in North Wales.

Annex A – Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. [Transcripts of all oral evidence sessions](#) can be viewed on the Committee’s website.

13 February 2014

Dr Nadim Haboubi	National Obesity Forum for Wales
Dr Dev Datta	Welsh Association of Gastroenterology and Endoscopy
Colin Ferguson	Royal College of Surgeons
Jonathan Barry	British Obesity and Metabolic Surgery Society
Jan Smith	Aneurin Bevan University Health Board
Alison Shakeshaft	Aneurin Bevan University Health Board
Dr Jane Layzell	Aneurin Bevan University Health Board
Scott Caplin	Abertawe Bro Morgannwg University Health Board
Dr Khesh Sidhu	Welsh Health Specialised Services Committee
Dr Suzanne Wood	Public Health Wales

26 March 2014

Mark Drakeford AM	Minister for Health and Social Services
Dr Sarah Watkins	Head of Mental Health and Vulnerable Groups Division, Welsh Government
Chris Tudor-Smith	Head of Health Improvement Division, Welsh Government

Annex B – Written evidence

The following people and organisations provided written evidence to the Committee. All [written evidence](#) can be viewed in full on the Committee’s website.

Organisation	Reference
Royal College of General Practitioners	ABS 1
Cardiff and Vale University Health Board	ABS 2
Welsh Intensive Care Society	ABS 3
Royal College of Anaesthetists Advisory Board in Wales	ABS 4
Royal College of Physicians Wales	ABS 5
Welsh Association for Gastroenterology and Endoscopy	ABS 6
Weight Watchers	ABS 7
Body Contouring after Massive Weight Loss Commissioning Guidance Committee, the British Association of Plastic Surgeons and the Welsh Centre for Burns and Plastic Surgery	ABS 8
ABS 9 was removed at the request of the Royal College of Surgeons and the Academy of Royal Colleges and replaced with ABS 22	ABS 9
Welsh Independent Healthcare Association	ABS 10
College of Occupational Therapists	ABS 11
Velindre NHS Trust	ABS 12
Welsh Dietetic Leadership Advisory Group and Welsh Board of the British Dietetic Association	ABS 13
Royal College of Nursing	ABS 14
Aneurin Bevan University Health Board	ABS 15
Cwm Taf University Health Board	ABS 16
Welsh Health Specialised Services Committee	ABS 17
Royal College of Surgeons and the British Obesity and Metabolic Surgery Society	ABS 18
Hywel Dda University Health Board	ABS 19

Betsi Cadwaladr University Health Board	ABS 20
National Obesity Forum	ABS 21
Academy of Royal Colleges in Wales	ABS 22

[Additional written information](#) was received from the following organisations after the oral evidence sessions on 13 February:

National Obesity Forum	ABS - AI 1
Local Health Boards	ABS - AI 2
Welsh Health Specialised Services Committee	ABS - AI 3
Minister for Health and Social Services	ABS - AI 4

Annex C – Engagement activity

As part of this inquiry, members of the Committee undertook external engagement activity. The purpose of this activity was to enhance Members' understanding of the issues facing those providing and receiving bariatric services in Wales. Notes of the Committee's activity are publicly available – links to these are provided below.

Date	Engagement activity
13 February 2014	<u>Working lunch with Swansea University Academics</u> <u>Visit to the Welsh Institute for Metabolic and Obesity Services (WIMOS), Morriston Hospital, Swansea</u>
12 March 2014	<u>Focus group event with patients and health practitioners</u>