ALL-PARTY PARLIAMENTARY GROUP ON OBESITY

The current landscape of obesity services:

a report from the All-Party Parliamentary Group on Obesity

Acknowledgements

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The Group would also like to thank the individuals who gave oral evidence to the inquiry:

- Professor Rachel Batterham, Head of the Centre for Obesity Research, University College London and the UCLH Bariatric Centre for Weight Management and Metabolic Surgery
- Dr James Cavanagh, GP with a specialist interest in Obesity and Bariatric Care
- Maggie Clinton, member of Obesity Empowerment Network
- Dr Hilda Mulrooney, Senior Lecturer in Nutrition, Kingston University; representative of the British Dietetic Association
- Mr Christopher Pring, Specialist Upper GI, Laparoscopic and Bariatric Surgeon
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- Andrew Selous MP - Chair
- Professor the Baroness Finlay of Llandaff – Vice Chair
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Foreword

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The World Health Organisation defines obesity as excessive body fat that presents a risk to health. A crude measure of obesity is the body mass index (BMI) which is a person's weight (in kilograms) divided by the square of his or her height (in metres). A person with a BMI of 30kg/m^2 or more is generally considered as having obesity. Obesity is considered a major risk factor for a number of chronic diseases, including diabetes, cardiovascular diseases and certain types of cancer. The Local Government Association argues that obesity is considered to be one of the most serious public health challenges of the 21st century.[i]

The latest figures from the National Childhood Measurement Programme show that levels of childhood obesity have hit a devastating all-time high. More than one in three children (34.2%) aged 10 to 11 years have a weight status classified as overweight or as being obese, up from 31.6% in 2006/07. The prevalence amongst adults is also concerning, with 58% of women and 68% of men now classed as overweight or having obesity. Obesity prevalence increased from 15% in 1993 to 27% in 2015. According to the UK Foresight Obesity report, by 2050 – if current trends continue – 60% of men and 50% of women could have obesity.

Data from 2005/06, shows that the NHS spends around £5.1 billion on obesity related disease every year. This spend is equivalent to the salary of around 163,000 nurses. The increase in obesity prevalence since 2005/06 would suggest that the NHS is now spending considerably more on obesity related disease. An economic analysis based on 2014 data suggested that health costs associated with being overweight and having obesity costs the UK at least £27 billion every year, and this this is a problem the country cannot afford to defer to the next generation.

This report from the All-Party Parliamentary Group on Obesity is part of an inquiry into the current landscape of obesity services. It is designed to highlight barriers and opportunities for government, commissioners and other stakeholders to improve equitable access to obesity prevention and treatment programmes.

As the Chair of the APPG, I saw the scale of disparity in service provision across the country. With the number of people with obesity projected to rise significantly in the coming years, action must be taken to treat patients with severe and complex obesity now, as well as strengthening prevention programmes and childhood obesity programmes to reverse this escalating trend.

I have been heartened to see the volume and quality of submissions to this inquiry, which demonstrates that there is a clear commitment from a wide range of stakeholders to solve the obesity epidemic. I believe the APPG has a clear role in bringing together cross-party representatives, people with obesity, clinicians and wider stakeholders to find an ultimate and lasting solution.

I would like to thank all those individuals and organisations who submitted evidence to this inquiry and who continue to support the work of the APPG.

“With the number of people with obesity projected to rise significantly in the coming years, action must be taken to treat patients with severe and complex obesity now, as well as strengthening prevention programmes and childhood obesity programmes to reverse this escalating trend.”

Andrew Selous MP
Chair of the All-Party Parliamentary Group on Obesity

Summary of recommendations

- A **national obesity strategy** for both adult and childhood obesity should be developed and implemented by the Government, with input from key stakeholders. This should look to strengthen existing services and replicate best practice across the country.

- **Obesity/weight management training** should be introduced into medical school syllabuses to ensure GPs and other healthcare practitioners feel able and comfortable to raise and discuss a person's weight, without any stigma or discrimination.

- The Government should implement a **9pm watershed** on advertising of food and drinks high in fat, sugar and salt to protect children during family viewing time.

- The Government should lead or support efforts by the clinical community to **investigate whether obesity should be classified as a disease** in the UK, and what this would mean for the NHS and other services.

- The Government should **commission or support the development of a thorough, peer-reviewed cost benefit analysis** of earlier intervention and treatment of patients with obesity.

Key inquiry findings

88%

of people with obesity reported having been stigmatised, criticised or abused as a direct result of their obesity

94%

of all respondents believe that there is not enough understanding about the causes of obesity amongst the public, politicians and other stakeholders

26%

of people with obesity reported being treated with dignity and respect by healthcare professionals when seeking advice or treatment for their obesity

42%

of people with obesity did not feel comfortable talking to their GP about their obesity

> 1/3

of people with obesity who completed the survey stated that they have not accessed any lifestyle or prevention services

39%

of people with obesity who accessed lifestyle and prevention services found it incredibly or moderately difficult to do so

About the APPG's 2018 inquiry

The All-Party Parliamentary Group on Obesity launched its inquiry into the 'Current landscape of obesity services' in February 2018.

The aim of this inquiry is to gather a body of evidence that highlights the current provision of obesity services, shines a spotlight on barriers to better provision and seeks to establish a consensus around potential solutions.

The inquiry consisted of an online survey which posed questions about their experience to people with obesity as well as healthcare practitioners. The inquiry also invited submissions of email evidence to the group secretariat. The inquiry received around 1,500 submissions in total. This is made up of 48% of submissions from people with obesity, and 52% healthcare professionals and wider stakeholders. An oral evidence session was also held, where a group of experts were invited to Parliament to present formal oral evidence.

Understanding obesity: education, causes and stigma

63%

of adults in England are overweight or have obesity

63% of adults in England are overweight or have obesity.[ii] Yet for a condition that has become the norm for almost two thirds of the adult population, obesity remains largely misunderstood, which is a major factor in the high levels of stigma associated with obesity. The group has sought evidence from healthcare professionals (HCPs) and people with obesity to improve understanding of the stigma associated with obesity, what impact it has on the lives of people with obesity, and how it does little to help people with their obesity. Research evidence demonstrates the widespread nature of weight stigma in the UK,[iii] that weight stigma is experienced in many settings,[iv v] and that people with obesity respond maladaptively to stigma.[vi] Respondents were then asked to offer their views on the level of understanding of obesity, and whether obesity should be classified as a disease.

Stigma associated with obesity

88% of people with obesity who responded to the survey reported having been stigmatised, criticised or abused as a direct result of their obesity. These negative experiences have a detrimental impact on the lives of people with obesity, in many different ways. Respondents reported experiencing stigma ranging in severity from bullying and teasing, missed job opportunities, to being completely excluded by family members and friends.

> **"I have spent my life being judged and ignored or abused because of my weight. Even members of my family don't like or talk to me because of it."**

An oral evidence session undertaken by the APPG highlighted some of the ways in which stigma can have an impact on the lives of people with obesity and why it does little to help reduce obesity. Stigma can reduce a person's motivation by making them feel worthless. Motivation, as was pointed out in the oral evidence session, is one of the main drivers in reducing weight and maintaining weight loss.

> **"I was called names all my life up to having my gastric bypass. I had no confidence at all and felt worthless."**

The APPG was concerned by the number of respondents with obesity reporting their experience of being discriminated against as a direct result of their weight, particularly with regards to job opportunities. This is in line with

research conducted by Flint and Colleagues (2016), which evidenced discrimination in the workplace recruitment process.[vii] Numerous individuals stated that they have missed out on jobs, been overlooked for promotions and even felt that their job was under threat because of their size. This has a direct impact on the career prospects of people with obesity, as well as their self-worth, esteem, earning capacity and even living standards.

"Finding a job is the worst. I have spoken to employers and they exclaim how perfect a fit I am for the position. Once I go in for a face to face it is very different. I have had people look me up and down and actually ask me if their available job will interfere with my dieting. Other instances include people pointing or staring and worst of all, children actually asking their parents, "why is she that big", and the parents say "because she eats too much."

Stigma associated with obesity may negatively affect the mental health of people with obesity and may in fact lead to weight gain. While the causes of obesity are complex, it is widely thought that mental health is one of the main drivers. Having been abused or stigmatised due to their weight, people with obesity may consume unhealthy food, overconsume, or partake in less exercise in a way that would not have been necessary had the abuse not taken place, which may exacerbate the obesity.

"Bullied at school, not thought as highly of by the opposite sex. This damages self-confidence, and what once may have been a physical issue, turns into a psychological one, or was it psychological in the first place?

Stigma within the healthcare setting

Just 26% reported being treated with dignity and respect

Not all stigma associated with obesity comes from the general public. **Just 26% of people with obesity responding to the inquiry survey reported being treated with dignity and respect by healthcare practitioners** when seeking advice or treatment for their obesity. By contrast, **17% said they were not treated with dignity and respect**, and **57% said they were treated better by some healthcare practitioners than others**.

Oral evidence presented to the APPG as part of the inquiry suggests that stigma in healthcare settings can often arise from a lack of education on how to address a person's obesity. The healthcare setting should be a "safe space" for people to talk openly and comfortably about any

healthcare problem. Failure to do so often discourages patients from seeking help and support. If obesity is to be tackled, people with obesity must feel comfortable seeking help or advice, and healthcare professionals should feel able and comfortable to raise and discuss this with individuals. Results from the inquiry survey in this area were mixed, with **58% of people with obesity indicating they felt comfortable talking to their GP** about their obesity, and **42% indicating they did not feel comfortable**.

> **Obesity suffers from significant stigma – and it should also be recognised that for health professionals, obesity is a 'low status' area to work in. In a clinical sense, this also leads to health professionals 'ducking' the issue of obesity when being consulted about children with obesity for other reasons (e.g. asthma). Professionals perceive they lack the skills to have these 'difficult' conversations or perceive that they may cause harm by raising the issue of obesity with CYP and families. This can be particularly challenging where there is intergenerational overweight and obesity.**
>
> **- Royal College of Paediatrics and Child Health**

Medical interventions are rendered useless if the people they are designed for do not feel comfortable engaging with them. Equally, it is important to ensure that healthcare professionals are trained and supported to raise difficult and potentially awkward conversations in a sensitive and constructive manner. **This report recommends that obesity/weight management training be introduced into medical school syllabuses to ensure GPs and other HCPs feel able and comfortable to raise and discuss a person's weight, without any stigma.** This may also involve putting less emphasis on BMI numbers and more emphasis on promoting healthy behaviours.

> **I've never been treated with respect or dignity. I've never received help when I've asked for it. I've asked for tests and they've been denied. I've given up - I just accept that I won't ever get rid of my weight and will continue to be judged by society and medical professionals.**

Understanding the causes of obesity

Following the analysis of inquiry survey responses, the Group takes the view that much of the stigma associated with obesity comes from a lack of understanding of what obesity actually is.

94%

believe that there is not enough understanding about the causes of obesity

94% of all respondents to the APPG's survey believe that there is not enough understanding about the causes of obesity amongst the public, politicians and other stakeholders. There is a perception amongst the general public that obesity is simply a result of overeating, laziness, and that it is self-inflicted. This report does not intend to go into a detailed evaluation of the causes of obesity; yet the inquiry received a significant amount of evidence to support the fact that obesity is a complex and multi-faceted condition, with influencers including mental health, genetics and environment.

Despite this, the public, patients, healthcare practitioners and others, are continually informed that obesity is simple and easily manipulated, which contributes to greater perceptions of individual responsibility, when the evidence suggests that many factors outside of a person's control influence obesity. It should be noted that there are many sources within society that contribute to this simplistic view including the media, education, healthcare and workplaces.[viii] The role of the media, in particular, should not be underestimated with regards to the inaccurate

Some of the causes of obesity as highlighted in submissions to the APPG's inquiry include:

and stigmatising perceptions that are evident in UK children and adults. The media can also play an important role in reducing weight stigma and discrimination.

While the cause of obesity is, fundamentally, an imbalance in the uptake and use of calories, there can be many reasons for this divergence. The time old phrase of "eat less and move more" in itself is no silver bullet. The APPG believes that it is important to provide people with obesity with the necessary support – both physical and mental – to enable them to maintain a healthy weight. There is no one-size-fits-all solution, but it is clear that where support is required, it should be easily accessed. The issue of access will be discussed later in this report.

Obesity as a disease

61%

of patients believe obesity to be a disease

Obesity is currently recognised by the World Health Organisation as a disease, as well as in the USA, Canada and Portugal. It is not classified as a disease within the UK. This inquiry gathered the opinions of respondents on whether or not obesity is a disease. **61% of people with obesity who responded to the online survey thought that obesity is a disease** with 26% against, and 14% saying they did not know. Amongst HCPs/commissioners/NHS representatives, **73% responded that they thought obesity is a disease**, with 20% against and just 7% saying they did not know.

Obesity is also a risk factor in other diseases such as Type 2 diabetes, liver and heart disease. For example, a Diabetes UK audit found that 85% of included people with Type 2 diabetes were classed as overweight or with obesity.[ix] It could be argued that the complications associated with obesity and complexity of treatments are congruent with a disease classification and a diagnostic classification may improve access to effective prevention and treatment programmes.

Responses to both the inquiry survey and contributions to the inquiry's oral evidence session suggest that the classification of obesity as a disease could lead to improved outcomes. Firstly, it would remove the blame attached to people with obesity and lead to reduced stigma in both public and healthcare settings. It would also help to prioritise obesity services for commissioning and encourage government and NHS decision makers to establish a national obesity strategy, as recommended by this report.

However, the impact this would have on the NHS must be carefully analysed. An increase in the number of people accessing obesity services and treatments could place strain on NHS resources.

- **This report does not intend to make a decision on whether or not obesity should be classified as a disease, but the APPG recommends that the Government leads or supports efforts by the clinical community to investigate whether obesity should be classified as a disease within the UK, and what this would mean for the NHS and other services.**

Prevention of obesity

A great number of detailed studies have been undertaken to determine the best ways to prevent childhood and adult obesity. Eating habits are established early in life and are significantly influenced by the environments that people experience every day. There needs to be a co-ordinated, whole-system approach to the prevention of obesity at both the local and national level considering the impact of the environments in which people live, including the total household income, as well as the amount and type of food they consume.

This inquiry is not designed to conduct a comprehensive study of this part of the obesity pathway, but to highlight several immediate actions that can be adopted to achieve a short-term impact in the prevention of obesity in children and adults.

The one area in which this report will focus on in terms of causation is the environment in which a person grows up, as this has been demonstrated to have a profound impact on the likelihood of developing obesity. The food that is provided in the home/schools and education centres/ religious centres and more; the examples set by role models, parents, teachers, religious leaders etc.; and opportunities to be physically active in daily life influences weight status.

While in the past children from a lower socioeconomic background might have been more likely to be underweight than children from a more advantaged background, they are now more likely to be overweight or have obesity. There is extensive research which analyses the socioeconomic drivers of obesity, with lower socioeconomic groups associated with higher levels of obesity, in part due to greater availability of food, particularly unhealthy food, that is cheaper and easier than more healthy options.

The findings illustrate a need for new policies to reduce obesity and its socioeconomic inequality in children in the UK, with a focus on societal factors and the food industry, rather than simply individuals or families.

In August 2016 the Government published its childhood obesity strategy, 'Childhood obesity: a plan for action'. The top line recommendation in

this was a soft drinks industry levy, which has been implemented and is showing early signs of success. The APPG would like to see the Government go further in taking action to implement this strategy and other methods of preventing childhood obesity. In particular, the **APPG supports a 9pm watershed on advertising of food and drinks high in fat, sugar and salt** to protect children during family viewing time. This recommendation also has support from a wide range of stakeholders; including Jamie Oliver, the Obesity Health Alliance, the Association of Directors of Public Health, the British Medical Association and Diabetes UK.

At the local level, a whole family and whole community approach to tackling obesity is key. The Group therefore encourages a whole system approach where each individual or institution recognises their role in taking steps to understand the environmental causes of obesity, such as portion size and sugar and fat content levels in food, and to help their children make healthier choices. Parents are also encouraged to know their own healthy weight to reduce the risk associated with genetic obesity.

Initiatives are already in place in other areas to support prevention of obesity in children and adults, but these need to go further to achieve the impact needed. As such, the APPG believes that serious steps to improve obesity prevention must factor into a national obesity strategy for both children and adults. This should promote a whole system approach.

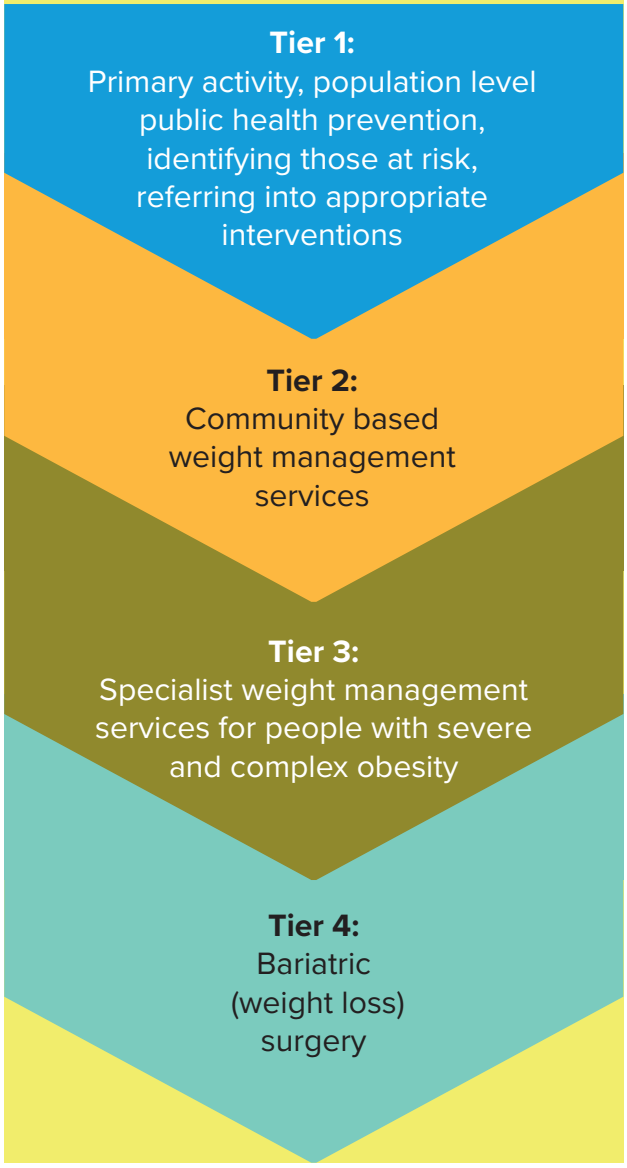
- **The APPG recommends that the Government should implement a 9pm watershed on advertising of food and drinks high in fat, sugar and salt to protect children during family viewing time.**

The current landscape of obesity services

The All-Party Parliamentary Group on Obesity has a focus on the full pathway of obesity services; from prevention through to treatment.

Tiers of obesity services

Obesity services within the United Kingdom are structured into Tiers, with each Tier providing a different intervention:



Commissioning and funding structures

Structure

The current commissioning structure:

- Tier 1 & Tier 2 services are commissioned by Local Authorities (LAs).
- Tier 3 & Tier 4 services are commissioned by Clinical Commissioning Groups (CCGs).

The rationale for reorganising the commissioning structures for obesity services in 2016/17 was to increase consistency in pathway management for obesity across the country, streamlining commissioning in the process.

Funding

According to the Association of Directors of Public Health, public health funding in England will be cut by 9.7% by 2020/21, £331 million in cash terms in addition to the £200 million in-year cut for 2015/16.[x] Reductions in public health funding will inevitably continue to have a negative impact on the levels of funding available for local authority funded obesity services, including weight management services.

There is a clear lack of a financial incentive for GPs to refer patients into obesity services. The current General Medical Services contract does not incentivise referral for adults or children. Furthermore, there is no financial incentive for GPs to assess a child's weight.

CCGs remain stretched; with ever increasing needs of a growing, ageing population living longer with co-morbidities, yet with a finite budget for delivering services. As such, services which are not mandated are often the first to be cut in times of financial constraint.

The APPG's inquiry has received evidence that points to the problems of short-term funding cycles for projects. In cases where short-term funding grants have been made to set up a weight management programme, for example, when the funding runs out the service is no longer able to run. This short-term approach to commissioning means that people with obesity are missing out on the consistent care and support required to achieve their personal goals. A more long-term approach to funding of services, with appropriate incentivisation mechanisms, must be taken to achieve real change.

The current landscape of obesity services

A range of NICE guidance exists which makes recommendations to commissioners about the levels of service they should be providing for people with obesity; from obesity prevention, maintaining a healthy weight, and lifestyle weight management services. The APPG, however, has received evidence which highlights the competing priorities of commissioners, which leads to a postcode lottery for individuals with obesity looking to access services.

The APPG is concerned about the patchy access to Tier 1 to Tier 4 services across the country. **Over a third of people with obesity who responded to the APPG's online survey stated that they have not accessed any lifestyle or prevention services.** Of those who reported that they have accessed lifestyle and prevention services, **39% found it incredibly or moderately difficult to do so**.

This anecdotal evidence is supported by a recent Freedom of Information Request - which received responses from 88% of LAs and 91% of CCGs - which found that only 52% of LAs commission Tier 1 services, while 82% commission Tier 2.[xi] It also found that 57% of CCGs commission Tier 3 services and 73% commission Tier 4 services.[xii] This survey also found that ten LAs and seven CCGs do not commission any weight management services at all.[xiii]

>1/3

of respondents with obesity have not accessed any lifestyle or prevention services

According to the Royal College of Paediatrics and Child Health, there is often confusion about whether the Tier system commonly used in adult obesity applies to children and young people. While there are a number of community services (Tier 2/3 services), there are very few specialist services for children and young people with obesity that manage and treat this patient group with extreme or morbid obesity (equivalent to Tier 3/4). Such services have only arisen due to interest and activism by individual professionals, and services exist in a commissioning vacuum – surviving only where individual trusts can 'turn a profit' or individual managers support the service.

The British Medical Association argues that inconsistent provision of specialist multidisciplinary weight management units, which offer tailored weight management programmes

to those with severe and complex obesity to support them to lose weight, risks leaving many vulnerable people without essential support to manage their condition.[xiv] Indeed, the APPG received evidence which demonstrates that in many cases, where both the individual with obesity and the HCP agree that referral to a weight management programme is necessary, there is no service to refer onto. This is unacceptable.

While several respondents to the APPG's online survey acknowledged that although commissioners may wish to run a service, it is not mandated that LAs or CCGs provide obesity services, which makes these services vulnerable to commissioning cuts. LAs have experienced year on year public health budget cuts, which is likely to have had a significant impact on their ability to commission weight management and lifestyle interventions for people with obesity. One recent analysis of obesity services found that 27% of surveyed LAs indicated that they have decommissioned elements of their obesity service in the past five years.[xv]

It should be considered whether mandating a minimum level of obesity service within a particular healthcare economy (such as each Sustainability and Transformation Partnership (STP) footprint or Integrated Care System), would lead to more equitable access to services for people with obesity. In line with this, the APPG supports the development of a nationwide strategy for adult obesity, as well as the adoption of the Childhood Obesity Strategy, which has already been developed.

Access to Tier 3 & 4 services

Bariatric surgery is widely recognised as the most effective treatment for people with morbid obesity to allow substantial, sustained weight loss and to improve or resolve obesity-associated comorbidities such as diabetes, thereby reducing mortality.[xvi] Indeed, a study supported by the National Institute for Health Research found that increasing access to surgery for patients with obesity is likely to save lives, reduce diabetes and be a cost-effective use of NHS resources. Yet fewer than 7,000 patients have weight-loss surgery on the NHS each year, when the number entitled exceeds a million.

> **"Referral from my GP was initially refused. I re-applied with psychiatrist letter which was reviewed by a panel and was accepted."**

The Royal College of Physicians, in its submission to this inquiry, said, "The patchy delivery of [Tier 3] service means that patients in many regions are not only being denied access to this effective service but also there is a blockade in the pathway of care meaning that they are also unable to access bariatric surgery." This is catastrophic for patients who have finally sought help through primary care and find there is nowhere else for them to go, and many will not seek help again.

> **"I had tried before many years ago and was turned down due to lack of funding, which was why it came as quite a surprise to me when the GP suggested it."**

Many people eligible for bariatric surgery may choose not to have it, but there are criteria that must be met by individuals who do wish to have surgery. Currently in the UK NICE recommends that intensive weight management programmes incorporating diet, activity, pharmacotherapy and support for behavioural change are a prerequisite to bariatric surgery.[xvii] Yet in many places across

the country these services are not being commissioned, meaning that eligible patients are denied treatment. Equally, patients who choose not to opt for bariatric surgery can be referred back to Tier 3 services, but this is only possible where these services exist.

> **Took 20 years to get help and changing doctors 5 times. I was told to lose weight and that help would then be provided, so I did and then no help was given. This happened twice.**

A recent Freedom of Information (FOI) request was sent to all registered CCGs in England, of which 198/208 (95.2%) responded. The results found that 135/198 (68.2%) commission a Tier 3 service and a further six (3.0%) were in the process of setting up a service. 39 CCGs (19.7%) reported having no Tier 3 service, while another three (1.5%) had recently decommissioned their service.

> **Still awaiting surgery. My only frustration is having to have surgery through a different Trust as my Trust does not perform the surgery themselves.**

The APPG believes that while prevention must be a strong focus of any national obesity strategy, the postcode lottery in access to treatment is unacceptable.

The future of obesity services

The Five Year Forward View made clear that now is the time to get serious about prevention. A common assumption is that, when it comes to obesity, prevention is limited to cutting down on sugary drinks. But prevention also extends to conditions such as diabetes, the causation of which is closely linked to obesity.

The central problem for commissioners and clinicians is that, even if they are able to demonstrate the potential for future savings through preventative care, it is not possible to reflect that on future balance sheets. If preventative care is to be rolled out, the mechanism must be made available for the funding to come from a nationally earmarked budget, or for commissioning bodies to be able to add presumed savings, backed up with evidence, to the balance sheets for future years. Effective prevention for conditions such as diabetes and cardiovascular problems must therefore include the treatment of individuals who currently have obesity. A failure to do this carries its own cost.

> **“...there is a wide body of evidence that shows surgery is an effective treatment option for Type 2 diabetes and can be cost effective for the NHS. However, many people who stand to benefit from this potentially lifesaving treatment are missing out due to needless barriers to obesity surgery services. Even people who meet the criteria for the surgery are being made to wait too long, even though we know that people with Type 2 diabetes benefit most from the surgery if it is carried out closer to the time they were diagnosed.”**
>
> **- Simon O’Neill, Director of Health Intelligence and Professional Liaison at Diabetes UK, May 2016**

Effective prevention for conditions such as diabetes and cardiovascular problems must therefore include the treatment of those who currently have obesity. A failure to do this carries its own cost.

Understanding the cost of obesity

This report has, in very simple terms, attempted to quantify the savings which could be made through the better use of a Tier 4 intervention, such as bariatric surgery.

The 2014 UK National Bariatric Surgery Registry found that out of a sample of 30,933 follow-up entries, over 60% of patients with obesity and Type 2 diabetes returned to a state of **no indication of Type 2 diabetes only one year after primary surgery**.[xviii] In short, they were able to stop their diabetic medications. It is also known that surgery roughly halves the microvascular complications of Type 2 diabetes, such as Peripheral Arterial Disease and neuropathy,[xix] and that surgery reduces long-term mortality by around a third.[xx]

The average cost of treating one of these patients' diabetes is around £3,717 per annum. The cost of performing bariatric surgery is around £6,000. The cost of one year of diabetes treatment and one episode of surgery is £9,717, whereas the cost of three years of diabetes treatment - bearing in mind this would continue for many years - is £11,151. It does not, therefore, take much time before the surgery becomes cost neutral.

In Birmingham, for example, there are 1,852 patients with Type 2 diabetes who would qualify, and we could expect around 1,111 of these patients to show no indication of diabetes one year after surgery. The savings would quickly add up.

This is an example of how the treatment of an existing condition can lead to very large savings further down the line.

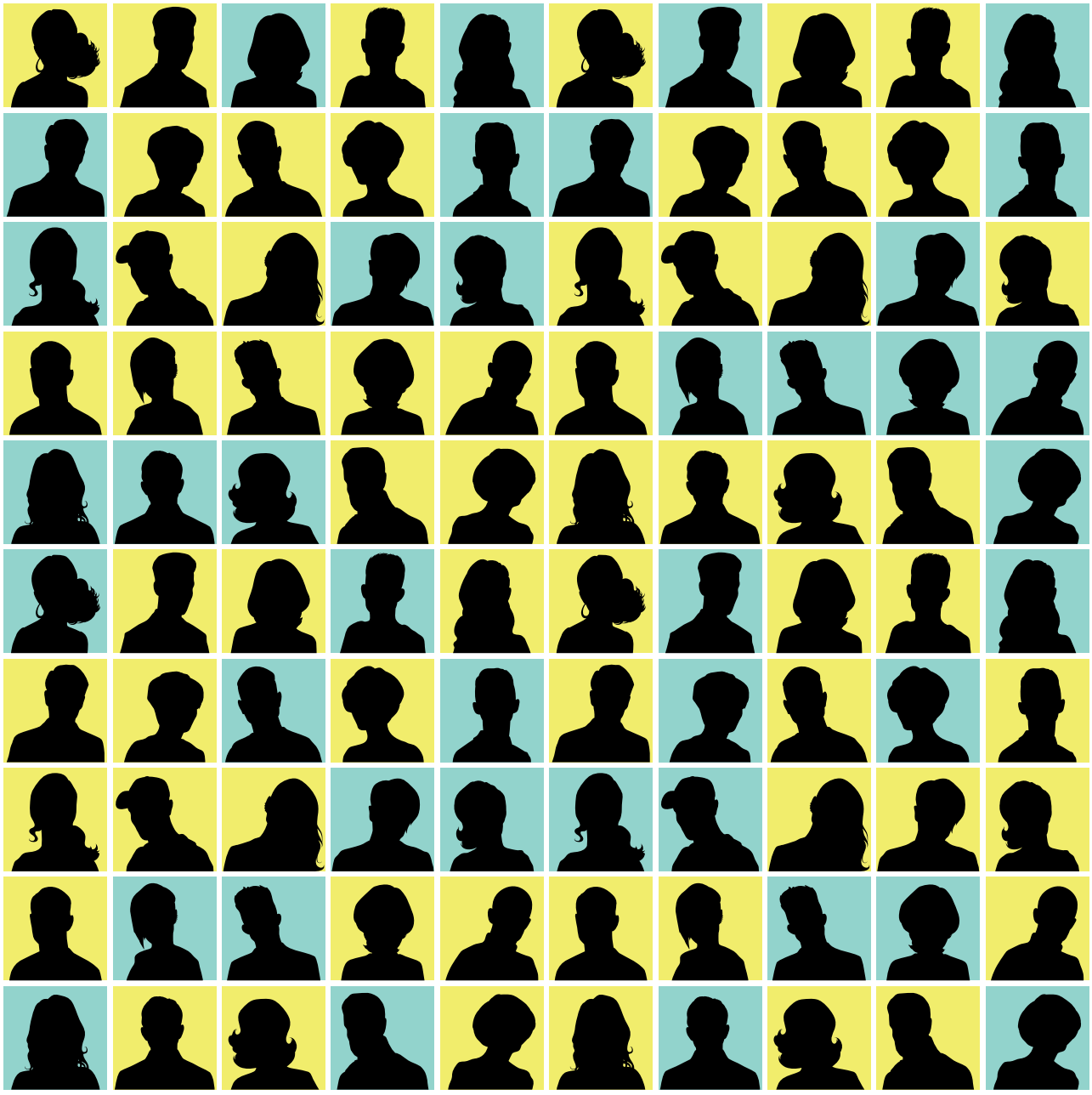
What is the cost of not doing something?

In a submission to this inquiry, the Obesity Health Alliance (OHA), a coalition of 43 medical colleges, patient groups and charities, noted that "Figures consistently show a widening equality gap with obesity more prevalent in the most deprived children and adults." It is a duty incumbent on government to acknowledge this is a looming social justice issue, and to begin forming a national overarching strategy to tackle the problem.

Alongside the social cost, if prevention and treatment services are not appropriately funded, people with morbid obesity will continue to present a huge ongoing cost to the system for many years to come. Our obesogenic environment "consistently promotes and pushes people towards unhealthy choices", according to the OHA, and while moves to address this challenge are welcome, morbid obesity has many complex causes. Only through providing help and support through services which adequately recognise this complex causation will we be able to bring down the cost to future generations, both in financial and wellbeing terms.

The argument for intervening earlier and supporting the proliferation of Tier 3 services is clear. They are effective in tackling complex cases of obesity, which provides an opportunity to reduce costs in the future before the costly co-morbidities set in.

The Government should commission or support the development of a thorough, peer-reviewed cost benefit analysis of earlier intervention and treatment of patients with obesity. This should include an analysis of the impact on work, earning capacity, mental health and system finances. It should be independent work conducted by a major academic institution to avoid politically charged media coverage.



60% of patients with diabetes who receive bariatric surgery then go into remission

Developing a national obesity strategy

The Royal College of Physicians, in their submission of evidence to the inquiry, noted that the transfer of commissioning responsibility from NHS England to CCGs has led to further inconsistencies and regional variability in delivery of the essential service. CCGs are able to issue their own obesity treatment strategies meaning that access to treatments depend not on the clinical needs of patients but on their geographical location.

An audit by this APPG of the draft plans published by Sustainability and Transformation Partnerships found that around a third of plans did not have any detail on how obesity would be tackled in that footprint.

The APPG believes that the lack of consistent provision across the country - with patches of good practice dotted around the country and not always invested in effectively – must be tackled.

The Government's Childhood Obesity Strategy, which set out a ten-year plan to tackle childhood obesity through encouraging healthier choices and the reformulation of soft drinks, was a welcome intervention into the national debate. The APPG believes that there should be an ambitious national plan for tackling adulthood obesity, and there should be clear achievable asks.

This report has set out that people with obesity are less likely to be in work, often suffer discrimination, and are more likely to suffer from further health problems such as diabetes, some forms of cancer, and cardiovascular disease. Obesity can also have an impact on mental health and wellbeing. All of these conditions have direct and indirect healthcare costs, including social care, and an impact on productivity, wellbeing and the nation's finances.

While it is unrealistic to prevent and treat all adulthood obesity, the financial argument is very much there for a renewed focus on making equitable and appropriate provision across the whole obesity pathway, which a national obesity strategy can set out. The strategy could be co-ordinated by the Cabinet Office and bring in the Department of Health and Social Care (and its executive agencies); Ministry of Housing, Communities and Local Government; Department for Transport; Department for Environment, Food and Rural Affairs; and Department of Digital, Culture, Media and Sport.

This national strategy should set out the minimum level of access to services expected in any locality. It should review services which are deemed "best practice", and look at how these services can be replicated across the country and brought into a best practice pathway for obesity services within the UK.

- **A national obesity strategy for both adult and childhood obesity should be developed and implemented by the Government.**

- **The Government should commission or support the development of a thorough, peer-reviewed cost benefit analysis.**

Case study: Rotherham Institute for Obesity

About the service: The Rotherham Institute for Obesity (RIO) was established by Dr Matt Capehorn, who served as its Clinical Manager. It was established in 2009 as part of the development of the Rotherham Healthy Weight Framework, which was created with £3.5m of funding for a three-year pilot. Referrals came from all GP practices in the Rotherham area.

How it worked: The RIO multidisciplinary team (MDT) was made up of several specialist individuals who have distinct roles, but which work together and have regular consultations with the patient. Each care pathway is different depending on the patient.

Following referral, the patient has a comprehensive consultation, weighing and measuring, and visits the obesity specialist nurse to review the history of their weight problem. Some will be seen by Dr Capehorn, who can assess whether weight loss pharmacotherapy or other treatment is needed. The service has specialist equipment for both adults and children in the on-site gym, which is offered alongside care such as talking therapies.

What was the impact? Throughout 2010 and 2011, 3,325 patients were referred to the service, of which 49% completed the full six-month programme. 1,087 patients met their NHS Rotherham weight loss targets and of these, one in five lost at least 10% of their body weight. The average weight loss was around 5% amongst all completers. Whilst commissioned as an NHS service, the cumulative weight loss due to the Tier 3 service (RIO) alone was 33.7 metric tonnes, demonstrating the impact that can be made at a local population level.

The problem: Following 2014 changes, which handed responsibility for Tier 3 services to CCGs, RIO lost its NHS funding and now operates as a private service. In 2014, Diabetes UK said, 'The success of the Rotherham Health Weight Framework shows that investing in a comprehensive care pathway for obesity, involving community and specialist services, has benefits for patients and can save money in the long term.' That services such as RIO cannot survive as NHS commissioned services in this environment suggests that a national long-term approach is required.

There is now no dedicated weight management service provision for adults.

The total cost of all of the Tiers of interventions, for both children and adults (excluding adult Tier 4, which was initially commissioned via specialist commissioning, and then via NHS England, and more recently after April 2017 by the CCG) was less than £1m. This was to cover a population of approximately 260,000.

If this was scaled up, then an area of approximately one million people could have comprehensive weight management services, like Rotherham did, for less than £4m per year.

If scaled up further, the whole nation could have comprehensive weight management services for less than £240m per year - which is significantly less than the estimated £49.9bn per year that direct and indirect costs of obesity are expected to cost the NHS by as soon as 2050.

Case study: Fakenham Weight Management Service

About the service: Dr Carly Hughes, a General Practitioner in Norfolk specialising in obesity, runs the Fakenham Weight Management Service (FWMS). It was started in 2011 by Dr Hughes, and an endocrinologist and public health consultant.

How it worked: Individuals who present at primary care with a BMI of over 30kg/m2 are initially referred to a Tier 2 service for lifestyle interventions. People with BMI >35 kg/m2 and co-morbidities are then referred to Tier 3 service. Everybody with a BMI of over 50kg/m2 is referred directly to the Tier 3 service. Around 450 patients are referred annually to the service. Tier 3 patients are the most complex, and have often failed to maintain weight loss with Tier 2 services.

The Tier 3 service adheres to NICE CG189, and conducts specialist investigations through a comprehensive team including a bariatric physician, dietician, mental health specialist, physiotherapist, health trainer, and specialist nurse. It may also include a bariatric surgeon if co-located with the surgical unit. The team is able to provide a mixture of individual and group interventions with a high degree of patient participation, incorporating dietary and physical activity advice and pharmacological and psychological interventions. The protocols are shared with the Norfolk & Norwich University Hospital Trust, Luton & Dunstable, and UCLH bariatric surgery units.

What was the impact? In a 2014 study of the programme's results, the mean weight loss was 10.2 kg among the participants who completed the 12-month programme. One quarter of all completers left the programme having lost at least 10% of their initial weight.

Conclusion

This report has demonstrated that the causes of obesity are many and are complex – but that the system set up to prevent obesity from developing in childhood and adulthood, and which is designed to treat obesity amongst those with easily rectified problems and more complex cases, is inadequate.

In childhood, children are exposed to pervasive advertising for deeply unhealthy foods. In adulthood, those with lifelong obesity or excess weight cannot access the multidisciplinary services they need toimprove their health. Even where services are available, access is inconsistent across geographical boundaries. Evidence-based NICE guidance regarding bariatric surgery is also not being implemented. This is deeply counterproductive given the demonstrable savings which can be gained from the application of the right preventative measures and the right treatment at the right time. Allowing problems to escalate helps nobody.

A whole system approach is needed at both the national and local level. Few aspects of government are exempt from needing to pay attention to this looming issue.

We must also acknowledge the voices of those people with obesity who responded to this inquiry. Their stories of being pushed back for treatment, of being rejected for jobs, and of fruitlessly battling to lose weight and save their own health are a lesson to us all that obesity policy must set out what will be done to help those who already live with obesity, as well as those who will develop it in the future.

It is hoped the Government takes note of the recommendations set out in this report. This way, we will be able to take a big step forward in the fight against this destructive condition.

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