

Health and Social Care Committee

Oral evidence: Food and Weight Management, HC 1181

Tuesday 19 May 2026

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Members present: Layla Moran (Chair); Danny Beales; Josh Fenton-Glynn; Andrew George; Alex McIntyre; Gregory Stafford.

Questions 770-847

Witnesses

I: Colette Marshall, Chief Executive, Diabetes UK; and Professor Roy Taylor, Principal Investigator, DiRECT Study.

II: Mr Dimitri Pournaras, Consultant Upper Gastrointestinal and Bariatric Surgeon, North Bristol NHS Trust; and Dr Neil O'Brien, Chief Medical Officer, North East and North Cumbria Integrated Care Board.

Examination of witnesses

Witnesses: Colette Marshall and Professor Roy Taylor.

Q770 Chair: Welcome to the Health and Social Care Select Committee for the seventh session of our food and weight management inquiry. We will be looking particularly at diabetes and at bariatric surgery with panel 2. Without further ado, will our witnesses please introduce themselves and their organisations?

Professor Taylor: I am Roy Taylor. In my consultant physician career, I dealt with acute medicine, as well as diabetes and medicine in pregnancy. All the way through, my main research thrust has been understanding what happens to food inside the body and how it is handled in health, during exercise and, of course, in disease. From my clinical point of view, the main disease was diabetes. That led to suddenly realising that we had the cause of type 2 diabetes at our fingertips. To test that, I needed to develop an effective way of getting people to lose about 15 kg in weight using diet. That has led to a whole series of studies and the remission programme.

Chair: Lovely. Thank you very much for being with us.



Colette Marshall: I am the chief executive of Diabetes UK, a charity for people with diabetes that has been here for 90 years now. We funded the research that Roy Taylor talked about and helped to translate that into practice. I come from a corporate background and have worked in a number of charities. I have also worked for MEND programmes for children and young people who have overweight and obesity. I want to declare that 90% of our income comes from people with diabetes, but we partner with Tesco, with Lilly and with other providers of GLP-1s, and with Slimming World in our work. All that is very welcome, but it does not control any of our policy, nor is it something we are reliant on.

Chair: Much appreciated.

Alex McIntyre: I should say thank you to the panel for the work you have done on this issue. This first session is quite close to my heart, because last year I was diagnosed with type 2 diabetes, and I then went on the path to remission programme. I lost around about 7 stone initially, and put my diabetes into remission.

Chair: Bravo!

Q771 **Alex McIntyre:** Thank you. It is testament to the programme. Professor Taylor, could you briefly describe the path to remission programme and the evidence of its effectiveness?

Professor Taylor: Yes. To start with, on the evidence of effectiveness, this came about in testing the original hypothesis of what was causing the diabetes. We were able to confirm that, and we have devised an effective way of getting 15 kg weight loss in the first week, with plasma glucose normalised, because of a very rapid loss of liver fat. That is the current account of energy—that is where it held, and where it scoots out of when energy is scarce. That understanding led us on to a series of studies, cumulated and direct, which led on to the path to remission.

The path to remission programme offers people under the age of 65 with a body mass index over 27, but with a type 2 diabetes duration of less than six years, the chance of embarking upon this weight loss programme. Before the programme, they are advised that they should discuss it with their spouse and friends—that is a critical part of the whole business of making it successful—and they are invited to think about it very carefully.

They then embark upon 12 weeks of taking packet food only. This has the major advantage of being nutritionally complete, apart from the calories, so there are no problems about protein or iron deficiency. Over that time, we find that people do lose weight. The average weight loss immediately after the course tends to be around 15 kg, but at one year it drops to about 10 kg.

When the path to remission programme was launched, I was slightly concerned because we were not using trained practice nurses who delivered directly, with eight hours of formal training. We were using people who did not have any professional qualifications but were commercially employed to know about it and deliver it. To my surprise and



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pleasure, the average weight loss was 10.3 kg at 12 months, which is remarkable for a population study, and almost half were in remission at that time.

The evidence is very strong and the evidence for persistent effect is also strong. At five years, we know that people are still 6.1 kg below baseline. That is quite different from, for instance, the use of the GLP-1 agents, where there is complete regain in about a year and a half, and it relates to the educational value of the programme—

Chair: We are going to come back to why, so we can hold off on that.

Professor Taylor: That's fine. That outlines the programme and its effectiveness, which I think has now been established beyond doubt in several different countries as well as the UK.

Q772 **Alex McIntyre:** Colette, what are some of the challenges that people with diabetes face when taking part in the programme, and how are they supported through that?

Colette Marshall: The first challenge is access—that primary care is not fully aware—and the second is that, like the rest of the population, there is huge stigma about having overweight and obesity, and therefore about having type 2 diabetes, and healthcare professionals reflect the rest of the population in that way. We know from our research that many of them will not offer it, either because they do not believe it is going to work or because they think that the individual in front of them is a lost cause. So the first challenge is access.

There is not yet data on the full cohort that could be helped. The Wellcome foundation and the AMRC did some work on this and said that if you look at just the inclusion criteria, 613,000 people should be offered remission, whereas at the moment we are reaching about 55,000. They did not apply exclusion criteria to that, but I think it is very clear that there is a big step between what is being offered and the potential. That is the first thing.

The second challenge is actually being able to take up the programme. Our data shows that if people are offered a choice, and the choice is between having it offered digitally or face to face, that makes a massive difference to the number of people who go on to do it. That sense of agency and being given the opportunity to choose how to take part is, of itself, of huge value.

Q773 **Chair:** On that point, is it the fact that they have been offered two things or the fact that they have been offered digital and face to face? Is it one aspect of those, or the fact that they have been offered a choice?

Colette Marshall: I think it is the aspect of being offered a choice. At that point, some people will decide that they are ready in that moment. The reason why they pick digital is either because they do not want the embarrassment or difficulty of dealing with an employer—they do not want to say to somebody, "This this is why I'm off work"—so they choose to go digital, or because access to the location is difficult for them, or because



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digital is more readily available and they say that they know that they are ready now and need to go now and do not want to lose that motivation.

Alex McIntyre: Or in some cases they have just been elected to Parliament and do not know whether they are going to be in Westminster or their constituency.

Colette Marshall: That is so true.

Q774 **Alex McIntyre:** On that point, I was offered the choice between digital and in person, and I chose digital for that reason. How many people is that not being offered to?

Colette Marshall: Let me look at the data. I might have to come back to that. We found that not everybody was being offered the choice.

The other thing that not everybody is being offered is the peer support throughout the programme. Some 84% who have it say it is very helpful, but only 56% are offered it. We found that some people will drop off the programme because they cannot cope with the meal replacement, but, in the main, 84% of people are saying that they like the products, and that they are culturally appropriate and that the coaches provide good cultural support. If the coach is consistent throughout, and the person has a good relationship with the coach, that gives better results. If people struggle with their coach—it is not many of them—that is one of the areas where people find it harder.

Then there is the whole social aspect. It helps if your family and friends are supportive. I think Roy can talk to some stories about this. We know that if the other care giver in the family is not supportive, it is very difficult, because it is very difficult for one person to change how they eat if the rest of the family do not go along with it as well.

Q775 **Alex McIntyre:** I can definitely attest to that. My wife was very supportive, although did not stop buying cakes and biscuits every week, sadly. But I have managed to stay on the course.

To go back to the first point, access came up in our roundtable. People who have experienced the scheme said that there was a lack of knowledge of the programme among GPs in particular. That was the case for me: I had to ask my GP to go on it because my brother-in-law had done a similar programme for people who are pre-diabetic, in Bristol. Why are GPs not offering the programme to everyone who is newly diagnosed? What can we do to improve access to it?

Colette Marshall: The NHS is trying to help on this. They are currently commissioning all these diabetes programmes under a single brand called Healthier You. I think that will help.

There is the issue of the time it takes to embed anything in primary care. One of the key messages I wanted to send today was: when stuff works, please do not change it. There is something here that really works. We are the first country in the world to have a national remission programme. We



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should be really proud of that. The question is, as you say, how do we scale it up? How do we make sure that local areas know about it and call it off? How do we make sure we provide for more so that they are commissioned and paid for? We need to pay for enough places and then call on local systems to be proactive about offering it.

Q776 Alex McIntyre: To be clear, is that being funded centrally, not by ICBs?

Colette Marshall: It is funded centrally and then ICBs call off. That is another reason why this and the national diabetes prevention programme, which is very similar but does not have the total diet replacement element, both work. Over a million people have now started the national diabetes prevention programme, and it has had 2.1 million referrals, so it has achieved scale. You do that over time by making sure that there is central purchasing. The other thing that has worked really well is that they have commissioned a range of providers, so local areas still have choice, but we do not end up with every local area inventing their own prevention programme, as we did maybe 10 years ago.

These programmes are built on a proper evidence base. They collect proper data. The data is analysed to see what is working and what is not, and then it is tweaked. We provide market research. We go out to people with diabetes who have been through the programme and bring back validated responses about what is working and what is not, and that is then fed in. It is done at scale, and you get the economies of scale as well. There is some huge learning here for other forms of weight management programme.

Q777 Alex McIntyre: In terms of scaling it up, one of the biggest challenges with type 2 diabetes is the number of people living in the UK with undiagnosed type 2 diabetes. How could the Government improve the pathway so that we get more people diagnosed, straight on to the programme and working towards remission? What shift would the Government need to make to tackle the very high number of people living with undiagnosed type 2 diabetes?

Colette Marshall: There are 1.3 million people living with undiagnosed type 2 diabetes, which means they are not being treated. When I started at Diabetes UK about 13 years ago, a fair number of those—there are still a number of them—are in their elder years, when it is less medically or clinically risky. The issue we have now is that the biggest increase in the number of people with type 2 diabetes is in the under-40s. They are presenting very fast with very high blood glucose levels, and the complications you get from diabetes are presenting very aggressively. There are big risks for cardiovascular health and a variety of other complications.

At the moment, you have to wait until the age of 40 before you have health checks. We would like to see the populations that are believed to be high risk—black African and Caribbean communities, people from a south Asian background, and particularly women who have had gestational diabetes—being checked. About half of women with gestational diabetes,



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who have a very high risk of having type 2 diabetes, are not getting their post-natal check. I have met someone—who has spoken in this House—who had gestational diabetes, was not checked, had type 2 diabetes, went on to have a second pregnancy and then lost the child. It is about picking up the really high-risk groups, making sure that they are checked for type 2 diabetes and, as you say, offering them the support of the remission programme.

Q778 Alex McIntyre: Thank you. You might not have seen my *New Statesman* article this week on expanding health checks to younger people with other risk factors. I am speaking about that later this evening.

On the behavioural support, we talked about the support of family, but what support does the programme offer, particularly in the food-reintroduction phase, to make sure that people stick to it and are able to keep the weight off?

Professor Taylor: That is provided by the individual companies. They are asked to see people frequently—I think it is every two weeks. The support during that phase is crucial, because it is in that phase, as you must be aware, when people learn what they need to maintain their body weight.

Before they start they are, I hope, advised to expect to eat about two thirds of what they would habitually eat, once they have become a smaller person. Smaller people need less food. That is often dressed up in silly scientific terms such as change in metabolic rate; well, of course it has changed, but for a very simple reason. The prior expectation, coupled with the frequency of visits that ought to be provided by the companies providing the care, should put that in place.

I would add that the companies are paid by results, by delivering the various bits of information. I do not know the details of what information is required during the food-reintroduction phase, but I hope that that would be a positive feedback to the company to ensure that reasonable care was given.

Q779 Alex McIntyre: The data shows that about a third of people drop off after the first 12 weeks. They go through the total diet replacement—I think quite a high number pass that—but a third of people who go through it then drop off before the end of the year-long programme. I guess that that aligns with my own experience of the programme, which is that it is quite easy to motivate yourself when, all or nothing, you are going straight into four shakes a day for 12 weeks, but the difficulty of doing it remotely and digitally afterwards is that, without significant behavioural change, it is easy to slip back into old habits. Some of the support, while it is welcome, is on an app, and if you do not look at the app, people are not going to chase you to make sure you do it.

What more could we do? What kind of tools could the Government have to support more people to stick with the programme for longer than just the total diet replacement phase, and to stick with it for the whole year?



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Professor Taylor: The programme is commissioned, as you know, and increasing the number of visits during that critical phase of food reintroduction would be one approach. That would increase the cost of the programme. I would add that all the funded places on the programme are filled, so even though it is only 55,000, that is what has been funded.

The other thing that can be done is to provide more written resource to the companies that are providing the programme. Originally, in the first two waves of commissioning, I spoke to the company representatives who were to pass on the education to their operatives. That could be increased. So yes, this is a process that could and should be improved, but there would be some cost implications.

Colette Marshall: People are offered a rescue package. If they find it difficult and that they are not able to sustain it, they can ask for support in a sort of reboot. If they have spent some time on going back to normal foods, they can ask to go back on the total diet replacement. That really helps people. We also know that peer support helps people, and not everybody gets that offer.

The other thing is recognising that people's lives are complicated and that it might not be the right moment for them, but any weight that they have lost has given them health benefits. They might then come back to it in several years' time. One of the real issues about weight loss is that sense of success or failure being totally binary.

Chair: That is absolutely a theme we have heard over and over again.

Colette Marshall: I won't say any more then.

Q780 **Alex McIntyre:** To come on to the experience, it is great to hear that you have been working directly with people. As I would expect, you do a very good job of it. We have heard evidence that people are much more positive about this programme than, say, GLP-1s or bariatric surgery. Why do you think that is? What lessons could we learn and apply for other methods of weight loss?

Professor Taylor: I think it is the delight of discovering that they have control—they are in the driving seat. They start to feel better—I am sure you did—within a week or two, just getting up out of a chair. The average weight loss in the first weeks is about 4 kg. Over the course of two weeks, that would be lifting at least 6 kg every time you stand up. That makes a huge difference. So it is auto-motivating in a way that they can feel. They are in control. Being in control is what we try to achieve in medicine, but it is so rarely achieved. This is a prime example.

I think those are the reasons why this is generally a well-received programme. I have to point out that it is people who are motivated do this who have joined the programme. That has to be acknowledged. It is not for everybody. Not everybody has the time, the family support and the freedom from other worries of the moment to be able to embark upon it. It is a selected bunch, but I am pleased that they are happy.



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Colette Marshall: I think there is another reason, which is that people can lose medications. They are told, "You're going to go on medication for your type 2 diabetes, but this is a route where you may not have to." You have probably heard a lot about the stigma and shame that comes with having type 2 diabetes and with having overweight. This gives some route to processing some of that.

Professor Taylor: Could I add something? I get a large number of emails from people with diabetes in relation to this. One common recurring theme is a complaint about going to the GP, being diagnosed with diabetes and emerging with a prescription for metformin—no explanation and no mention of this programme. That is so common. That could be tackled. It is a matter of asking the various GP organisations to increase awareness and point out that this is not satisfactory.

The second point is that there is a perverse incentive from NICE. One of the quality standards in diabetes is the number on SGLT-2 inhibitor agents. It is crazy to have a standard for that but not a standard for the provision of weight loss advice. There are some substantial problems around this, but the bottom line is that people do not like taking tablets.

Q781 **Alex McIntyre:** I am sorry to keep coming back to my experience, but given that I am a service user myself, it is helpful context. I found out that I had type 2 diabetes through the NHS app. I saw my results—nobody had contacted me first. Then when I went to my meeting, there was a push to try to get me on the jabs. There was no information about this programme at all, and I got a prescription for metformin. When I got to the end of my prescription—my first 28 days—nobody contacted me again to say whether I needed to continue taking it, whether I could stop taking it or whether I should continue with the programme. There was just no contact at all. In fact, I moved GPs about 18 months after, and I never got a follow-up appointment with my GP throughout the programme.

We are dealing with young people, where there is a stigma attached. I have been very open about my diabetes. I am trying to be helpful with that by using my position here to talk about it as a young person with type 2 diabetes. But when you have that stigma and you are worried about it, it really does have a major impact. What could we do to tackle the stigma and encourage young people? I am not ashamed to admit that it was my wife who booked me a GP appointment. She could tell that I was not very well, and she insisted that I see a GP. Otherwise, I would have kept calm and carried on. How do we stop young men like me trying to just brave it out? How do we get them to go to the GP when they are concerned?

Professor Taylor: Maybe I could comment on that. The recent work that we have been able to do demonstrates that type 2 diabetes has nothing to do with BMI. Obesity and diabetes are completely separate areas. Type 2 diabetes occurs when a person is too heavy for their own constitution. It is genetically determined. We are all polygenic individuals, and we all have our tendencies and susceptibilities. If people with a normal BMI and type 2 diabetes lose weight, we have shown the diabetes goes away. The concept of the personal fat threshold is nothing to do with obesity. Coming down



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from a BMI of 45 to 42 is metabolically healthy—wonderful; that is the diabetes bit sorted.

We can get on top of the stigma to some extent. One reason Diabetes UK was pleased to hear about the truth of the personal fat threshold concept was the business of tackling stigma. We can push more widely that type 2 diabetes is not a disease of obesity. It distresses me to hear that repeated so many times. Only 50% of people at diagnosis have a body mass index above 30. Most of the rest are overweight, but one in six are normal. That is for people of Caucasian ethnicity; it is far, far greater for people of other ethnicities. We need to get across a seminal message, which I am sure could be amplified.

This is relatively new research from the last few years. It takes a long time to break through with new ideas in medicine, but the anti-stigma effect of the personal fat threshold will be potent.

Colette Marshall: From our side, there are so many complex factors that cause obesity and type 2 diabetes. There is a pervasive belief that it is an individual's fault. I have seen some of Our Future Health's data on genetics and they can look between somebody who is at low risk of being overweight and obese and somebody who is high-risk. In order for the high-risk person to reduce their risk, they would have to do an extra 10,000 to 12,000 steps a day. Similarly on calorific intake, somebody who has high risk because of their genetics has to do more. We have to tackle the food environment as well—

Chair: Which was the first half of this inquiry.

Colette Marshall: Just to loop it back, there is something about not internalising it.

Q782 **Andrew George:** We have heard about weight loss. What do we know about weight gain following the completion of the programme and how that compares with other treatments? Alex referred to those who remain in remission after a certain period of time. The trial was from 2018 to 2023; do we know a great deal more now about the weight-gain considerations?

Professor Taylor: We know there is a threshold that people can bounce around where they have diabetes, get rid of diabetes and then have diabetes. But the seminal facts of the remission remain the same. People can be in remission at around 8% to 10% weight loss. If they go below 8%, most will revert to having diabetes.

But I would emphasise that in five years there is still a 6.1 kg average weight loss compared with the baseline. That is a huge effect of the programme, which will have implications for all sorts of aspects of health that we have not touched on: the rates of cancer, ischemic heart disease and stroke will be lower, and sleep apnoea will be much better.

Q783 **Andrew George:** How does that compare with other treatments? Is the weight gain more or less significant following the programme?



Professor Taylor: When it comes to the persistence of weight loss, that's bariatric surgery, and I am sure there will be useful points made in the next session. Second to that perhaps, we have the GLP-1 agents. The headline news about those agents is a little overblown because the first studies are always designed as marketing studies from the companies; they are not designed to inform doctors or patients. In real life tirzepatide will achieve about half of the advertised weight loss unless all the points that are also carefully described in the paper are satisfied.

One aspect is the provision of an intensive lifestyle management along with it. With an intensive lifestyle management and very frequent follow-up, using the drug might get 20% weight loss. If those are not fulfilled, it is about 10%. That aspect is important. But the weight regain is very disappointing because people have not gone through any training about how much they eat. This is not about education or being talked at in a lecture theatre, but training—like learning to use a spade.

The food-reintroduction phase, with careful monitoring of weight, is a real learning point. GLP-1 treatment, by and large, has not had that. Whether it could be built into the end of a programme has not been tested, but the question is clearly important for the future. Without it, according to the best data, weight regain is essentially complete within one and a half years.

Q784 **Andrew George:** You are saying that it is too early to say what the ultimate weight gain scenario is with regard to GLP treatments because so far we do not know enough about the people who have come off them. Is that right?

Colette Marshall: We have the data about—

Professor Taylor: We have very clear data about a very rapid weight regain when people come off them. But by and large that has been without intensive appropriate lifestyle guidance on what to eat to manage the new, lower body weight.

Q785 **Andrew George:** The DiRECT study found that by three years ago only 13% of people remained in remission. Is that a concern? How can we improve on that? What have you learned that might improve the outcome?

Professor Taylor: It is not a matter of concern. Over the period of follow-up, weight loss was just over 2 kg, on average. But the follow-up was not intensive. This was not a study, but real life—people were just in their own practices being seen by the practice nurse at intervals that were not necessarily optimal. Even so, given the training they had had, those people were still lighter. Now, 6 kg is not enough to have a substantial number in remission, so yes, we would have all the other benefits that I have mentioned just now, but no actual freedom from diabetes.

Q786 **Andrew George:** You mentioned earlier that the programme was largely, I think, delivered by non-clinically trained staff.

Professor Taylor: Correct.



Andrew George: That is interesting in itself. Although you said that the practice nurse would be reviewing cases, the actual training was undertaken by non-clinically trained staff. Are you content that that is sufficient for the programme going forward?

Professor Taylor: It is more than sufficient. Immediately after the first study—the Counterpoint study, which was published in 2011 and started the whole process—I got huge volumes of emails from the public demanding to know how to do it. We put all the information on the website and a second tsunami of emails arrived. We analysed those and published the results.

People can do this themselves, if provided with the tools. It is a simple concept, although it requires determination and the necessary information. Training non-professionally qualified people to do it is entirely unremarkable. It is not unsafe to lose weight rapidly; it is rather unsafe to sit down to dinner, although I would not advise that if it were me.

Q787 Andrew George: Earlier, in relation to the potential conflation of diabetes with obesity, you mentioned that we are all polygenic individuals. When it comes to the success of this programme—let's call it a success; there is a lot of remission and some good outcomes—can anything be learned in terms of widening it to address wider issues of obesity?

Professor Taylor: Very much so. First of all, to compare this with obesity, this is also a condition of polygenic influences largely on appetite. It is not well recognised that appetite is an unfairly distributed quantity among the population. Some people are blessed with great appetites while others happily skip meals without bothering. That range is really not recognised.

We have to understand that individuals are individuals. As a doctor, I am certainly treating the person in front of me. The polygenic nature that has caused this person to be this weight in this food environment is irrelevant—it has happened. Exactly the same processes can be used, which is why I am so pleased to see the Healthier You suite of programmes arising—because, yes, this can be applied to obesity. It was actually trialled by Professor Susan Jebb in her early DROPLET study, and it produced quite similar results to those of DiRECT. So we know this can work in obesity and that is one of the effective offerings that can be put forward.

On obesity, we have the successful, effective dietary approach. We have GLP-1s that we are still learning how to use, and we have bariatric surgery, which is such a good option for selected people. There are aspects of bariatric surgery that make it out of court for widespread use, but for its best use for individuals who really have problems it is without peer. So we have three big approaches, which can be orchestrated as necessary for the one person in front of us with no stigma.

Colette Marshall: I wonder whether I could add some of the underlying factors that make it work. First, the national diabetes prevention



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programme and the remission programme have been based on high-quality research. So there is an evidence base, globally peer-reviewed. It is not amateurly done somewhere; the data has been pulled together professionally. It has been done at scale with an expert programme of clinicians and commissioners, so they have really thought this through. They have then run pilots, gathered the data and taken the learning from that, and they have then continued doing the learning and gathering data as they have gone through roll-out.

That is why you end up with something that can work at scale, is rigorous and robust and can take the learning and get better—rather than a lot of weight management services that are offered in a very local way, with fairly ad hoc design. The other thing behind these is that they are funded. Some sensible money is being spent on this to achieve results. It is cost-effective and lower cost than doing it in an ad hoc way, but it is being sensibly funded.

Q788 Andrew George: I want to properly understand the interrelationship between obesity and type 2 diabetes. I know there are cases where people are far from obese but have type 2 diabetes. Clearly, the kind of programme you are describing will have less relevance to them. Is that reasonable to say?

Professor Taylor: No, it would have exactly the same relevance. At present, the programme is aimed at people with a BMI of 27 and above. That is because of the evidence base. I had trouble smuggling the first study through the ethics committee. The idea of losing weight makes people nervous—or made people nervous, but it should no longer. That is where the figure of 27 comes from. Because we had already done it once, it stuck with all our studies, including DiRECT. It has now emerged in the national programme, and I can't budge it, despite requests. It has to be said that people with BMI under 27 tend to have less trouble losing weight upon advice. It is very striking that, at one year after the ReTUNE study, which was my study of normal weight people, those people had not put on any weight at all, whereas, in the obese category, with rather greater follow-up, they had put on about 4.5 kg.

Yes, it can be used, but we are talking about cost-effectiveness here. It requires a cost-effective approach to decide whether to move down into these lower ranges, which would be very popular with people in that range. It would certainly advantage ethnic minorities because there is a gross underestimation of the difference in BMI for metabolic disbenefit—it is at least three and probably more. There would be an advantage in moving the limit down, but economic factors and practicalities are to be considered.

Q789 Andrew George: The other side of the coin is: what proportion of people over 40 who are clinically obese are likely to have type 2 diabetes? Or is that simply prejudice?

Professor Taylor: There will certainly be a higher proportion. As I say, overall, 50% of people are obese at the time of diagnosis of diabetes. I do



not know the figure for younger people. It is probably about the same, but with a more rapid time course.

Q790 Andrew George: If you were advising the Government on rolling out the pathway to remission programme further and scaling up, what would your advice be in terms of the design of the programme itself?

Professor Taylor: We would want to make sure that the food-reintroduction phase was adequately resourced; we would want to make sure that the information given at the outset, especially the thinking in advance and the involvement of family and others, was fulfilled; and we would want to fund more places. At the moment, there is no problem in filling the funded places, but it is necessary to somehow get the message out to general practice.

Overall, general practice bodies need to act on this. They have been very silent, and I am afraid there is a feeling that low-carbohydrate diets are the way forward, despite all the evidence. Low-carbohydrate eating is very reasonable, but it just does not cut it. Unfortunately, that has been the drive of various general practice bodies, apart from the Primary Care Diabetes & Obesity Society, who have a specific interest in this and are very positive.

I would add that I have recently devised a toolkit for general practice. All the information, how to do it, and the phrases to use in describing this process are online and available for doctors. That is sponsored by the Primary Care Diabetes & Obesity Society, and it is available online as of about two months ago.

Colette Marshall: Can I add something? People who have been through the remission programme say to us that it would be really helpful to have support beyond that year. Indeed, we are trialling peer support groups in Northern Ireland, who then support people who have been through the programme and form a supportive group afterwards. At the moment, you get to 12 months and then you are left to some extent on your own. That can be quite tough, so coming back and checking in on people would be very useful.

Q791 Andrew George: In terms of the future of the programme itself, do you have a view on how many patients should be reached? Are we talking about the whole population of type 2 diabetics? The evidence suggests that that would produce a saving in excess of £1 billion through the impact it would have.

Colette Marshall: That was the AMRC number, wasn't it? The Wellcome foundation also did a number. They did a number based on the total cohort, without the exclusions to it. That would have been 613,000 people, but we think that is an overestimation. It is a smaller cohort. I do not know if anybody has calculated the cohort who could potentially be getting it. We also know from the research that after six years from diagnosis, you are much less likely to go into remission. That goes back to the earlier question about finding people early, and this is why early diagnosis of type 2 becomes even more urgent. If somebody has been undiagnosed for six



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years, that potentially explains—although it has not been evidenced, I don't think—why they struggle to go into remission, because they have actually had the condition for longer than anybody knows.

Professor Taylor: That is true. It is a matter of some people's insulin-producing cells going downhill, and if they have been exposed too long, they just cannot recover. That takes quite a long time, and it is very varied. Some people can achieve this in a few years. I have had people of 23 years duration going into remission, so it is a very patchy thing. It is individual, but in terms of launching cost-effective global programmes, that has to be factored in very carefully.

Andrew George: And six years is a notional tipping point, in that sense.

Professor Taylor: Six years is very, very rough. That figure was devised from our second big study, the counterbalance study, but it is only a rough estimate. We showed that most people in the first six years would go into remission with sufficient weight loss; it was about 50% by 10 years and much, much less after that. This is entirely open, but in terms of acting on the evidence, that is why we are left with the six-year limit. Even if people do not achieve remission, losing weight with type 2 diabetes will take people off insulin and dramatically change their risk of heart disease.

I can tell you from our counterbalance study, the second study, that the 10-year risk of heart disease was over 22%—nearly 23% at baseline—and went down 15%. It is still raised, but it went down. The group that went into remission—a shorter duration, of course—went from a bit less, because they were a less complicated group. They went from 18 to completely normal—they had normalised their risk. In answer to your question, we now know, because we have hard outcome data on cardiovascular disease, that there are big improvements in health related to the weight loss alone. We can set aside the interesting matter of remission and enjoying the freedom from this condition as separate from the need to go for health, which, of course, is what we are all about.

Q792 **Andrew George:** I would have thought that any Government Minister would be persuaded by the concept of scaling up. But how can that be done? Is there sufficient capacity within the system to be able to scale up to the level that we are talking about having a big impact on the whole population, which could benefit from this? What else would need to be done if the capacity is not there?

Colette Marshall: One of the very clever things about the programme that Roy Taylor devised is that it does not require healthcare professionals. The whole design of it was to make it easy for primary care to be able to use. Healthcare professionals have to refer in. They will then carry on and give check-ups to the individual to make sure that their medications are correct as they go through the remission programme, but the professionals are not actively then involved in the programme itself; that is done by the external provider.

Q793 **Andrew George:** Do you think the Government's proposal for



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neighbourhood health hubs is the right kind of focus on which to build such a programme? Would that aid or disable such a delivery?

Colette Marshall: As long as there is a helpful marriage between doing things centrally and doing things locally. As long as you keep that England-wide commissioning and the data and you do not then decide that every neighbourhood is going to design their own programme. I think at that point you get chaos and you just end up with random quality. As long as you end up with the centralised data, rigour and so on, and the commissioning, and you potentially have obesity leads in each neighbourhood, we would see each neighbourhood hub making sure that primary care is then referring in and there is funding behind it to offer the places for the programme, then that could work very well indeed.

Q794 **Andrew George:** Is there a good network of peer support across the country, as it were, to learn from good practice as well as from where things have not gone so well?

Professor Taylor: Yes. I think it is fair to say that that could easily be done. The hub system could potentially sort and direct properly, and the people leading this full-blown 15 kg weight loss programme could be provided by the commercial companies. I have no doubt that they will grow to take up the space.

Colette Marshall: The providers already do that. There is already research done to look at relative performance across providers in those different locations and to find out what is working and what is not. Again, that is the benefit of that marriage between central and local, and of local choice.

Andrew George: Thank you very much.

Q795 **Chair:** I have a few hopefully quite short, factual questions, and then Alex has some follow-ups. On future commissioning arrangements, are you at all aware of what is going to happen? At the moment, it is commissioned by NHSE, but we are about to have the Second Reading of the Bill that abolishes NHS England. Are you aware of what discussions are being had about exactly what is happening next with the commissioning? Is it going to be ICB commissioning, which will need a clear direction from the top that everyone must do this? What are your thoughts?

Professor Taylor: Commissioning for Healthier You is actually under way, commissioned by NHS England in its present form.

Chair: That is the now; my question is about the what next.

Professor Taylor: The simple answer is that we do not know, but it would be disastrous for it go elsewhere.

Colette Marshall: What is exciting about what is happening now is that they are bringing everything under the Healthier You brand, which will make it much easier for people to find the pathway within local levels. They are also bringing in an evidence-based pilot, which Professor Jonathan Valabhji and others have put together—he was also behind the



national diabetes prevention programme. That looks at taking the national diabetes prevention programme and applying it to people who probably have hypertension, as a proper, scaled trial, to see whether that intervention in weight management also leads to better results in blood pressure.

There then ends up being a package, which is going to be the wraparound support for GLP-1s, the remission programme, the diabetes prevention programme and this new pilot. As you say, that has been secured for the moment, but our big concern is whether there will be a diabetes programme or a diabetes clinical lead, for instance, in a year's time. There are big concerns.

Q796 Chair: I have a couple of questions about reach. You already mentioned that black and minority ethnic communities have a different—what was the term? I had never heard it.

Professor Taylor: Personal fat threshold.

Chair: I will go away and look at that; it is really interesting. It is well documented that black and minority ethnic populations are at much greater risk. At the moment, in accessing the programme right now, what proportion of those populations are being reached? My question also includes socioeconomic backgrounds because, as we know, that is one of the causal links to obesity and overweight, so I assume it is the same for diabetes.

Professor Taylor: For the path to remission programme, only 64% were of white European ethnicity, so it was quite well represented for black and Asian minorities. In both DiRECT and the remission programme, they did quite well with the weight loss. Asians tended to lose less weight, but got similar remissions. People of black ethnicity lost considerably less weight and got considerably fewer remissions. There is work to be done on why that is so, but they were well represented. With regard to low socioeconomic class, 26% in DiRECT were in the lowest socioeconomic band.

Q797 Chair: Do you mean the first decile, or the bottom 10%? What do you mean by "low"?

Professor Taylor: Sorry, the lowest quintile—26% were in the lowest quintile. That means that they were well represented, and they actually did surprisingly well with the weight loss. The difficulty was in maintaining the weight, and that is understandable if we just imagine the day-to-day life of living conditions for those people.

Yes, they are included, but we need to work especially on the question of the poor weight loss. Maybe it is health beliefs prevalent in the black ethnic community—that question is open. The Asian community seemed to accept this quite well, and they also seemed to do quite well. They needed to lose less weight to get the same remissions.

Colette Marshall: In practice, the data is a little different. In practice, black African and Caribbean communities and men are more likely to do the programme, but they are still under-represented versus either females or the white population. It is better than other programmes, but not to the representative level they should be in the population.

Chair: Thank you—that is very helpful.

Q798 **Alex McIntyre:** What is the rough cost of a person going through the remission programme?

Professor Taylor: It is about £1,000.

Q799 **Alex McIntyre:** Do we know what a month costs on your GLP-1 inhibitor of choice?

Colette Marshall: It is about twice that. This is about half the cost of GLP-1s, and the national diabetes programme is less than that again.

Q800 **Alex McIntyre:** So it is a very cost-effective way of tackling this.

Professor Taylor: Highly cost-effective, and also for the individuals, because the saving on food is calculated at about £640 per person during the weight loss period and at about £1,000 if alcohol is included as a factor in the 12 months. So, from the individual's point of view, this works well with people from lower socioeconomic classes. They are gaining health and spending less.

However, there is a problem with assessing these figures. The formal economics people tend to be terribly resistant to including things that seem obvious, such as the reduction in cancers that we demonstrated in the five- year follow up of DiRECT.

Q801 **Alex McIntyre:** So I guess that from £1,000 per person investing in their health now, the savings for the NHS in the long term are significantly greater.

Professor Taylor: It was calculated from the five-year DiRECT data—from the economic analysis by the professionals—as being savings of £1,300 per person overall in their lifetime.

Q802 **Alex McIntyre:** We have not touched on exercise yet, but it is obviously part of the behavioural support changes that they try to encourage during the programme. It is quite difficult to take on.

I appreciate that diet and food are the main focus, but in terms of that behavioural support and making those positive changes going forward, what role does exercise play? Is there a role for, say, the social prescription of exercise, to encourage more people to be active, not during the total diet replacement phase—I am conscious that it is advised that you do not exercise heavily during that period—but towards the end of the programme, when you are fully reintroduced to a normal diet?

Professor Taylor: Yes. It is really important to emphasise that exercise is not an option for weight loss in people who are no longer young and have



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put on weight. It does not work. How many friends have said that they have joined a gym, sweated for three months and their weight has gone up?

I came across that in some of our exercise studies. We always have people back for feedback after a study; I learn from them what it was like and tell them the results. However, one lady explained to me, "Well, you shouldn't be surprised there was no drop in weight. When you are coming back from that exercise session, you've only got one thought in your mind—you deserve that pie!" That caused me to go to the literature. This matter of compensatory eating on starting exercise by overweight people is well described, but it is probably the biggest kept secret in the whole of the obesity field.

The reason for asking people not to start a new exercise programme was to achieve the weight loss; we are entirely goal-directed on the weight loss. Once the weight loss is achieved, yes, we encourage the uptake of exercise. Sadly, people who tend to get type 2 diabetes do not like exercise. There may be very good metabolic reasons for that; some of our muscle studies can give a clue about that. However, despite our well-meaning exercise in DiRECT and people reporting that they were doing more exercise, using objective accelerometers it was clear that they did absolutely no more exercise when they were 15 kg lighter than before. There are some issues around this, but it does not hold us back from handing out the advice.

Q803 Alex McIntyre: Is part of the challenge, though, that on the programme they might, for example, refer you to a free resource like Couch to 5k? For anyone who is going through a running programme, they know that people hate it, but actually it helps to get people active; as part of a healthy lifestyle more broadly, being active is important. Is there not a role that we could play as a Government to be more proactive in encouraging people to take up sport, for example, because if people are not interested in running, they might be into tennis, padel or whatever the new thing is nowadays? Is there a role for that as part of the programme?

Professor Taylor: There is a huge role for this in preventing this upswing of gain in weight. Sadly, the biggest decade in which the upswing happens is in the 20s—between 20 and 30.

Alex McIntyre: Tell me about it.

Professor Taylor: Although weight gain between the age of 20 and 50 is about 25 kg, it is disproportionately great from 20 to 30. These people are capable of this. Certainly, exercise plays a huge role in prevention and in keeping weight off once it has been lost, if possible. But it is always the art of the possible. It is specifically recognising that to lose weight, you need to adjust the food. For health in the long term, you need the exercise.

Alex McIntyre: Or a million steps over the summer.

Colette Marshall: Indeed.



Professor Taylor: Yes.

Chair: Thank you. That brings us to the end of panel one. I want to say an enormous thank you to both of you for your time. You are incredibly welcome to stay. We will be discussing bariatric surgeries next.

Examination of witnesses

Witnesses: Mr Dimitri Pournaras and Dr Neil O'Brien.

Q804 **Chair:** Welcome to our second panel. Would you please introduce yourselves and say what you do?

Mr Pournaras: I am Dimitri Pournaras, and I am a full-time NHS consultant surgeon delivering elective upper GI and bariatric surgery care. I also do emergency surgery on call, including major trauma. I work at North Bristol NHS Trust, and I have an honorary position at the University of Bristol. All my research has been on obesity, and particularly on GLP-1 hormones—an obscure molecule 20 years ago when I did my PhD, but not any more. I am also the research lead for the British Obesity and Metabolic Specialist Society, formally the Surgical Society.

Dr O'Brien: I am Dr Neil O'Brien. I am the chief medical officer for the North East and North Cumbria integrated care board, and I am a GP in County Durham.

Q805 **Chair:** Thank you very much. In the previous panel, Alex McIntyre was our expert by experience on diabetes. I am that person for this subject: 20 years ago, I had a sleeve gastrectomy and lost half my body weight. It is the best thing I ever did. I am very interested in access to this surgery, because it worked for me and we know that it is a good thing to do if you can get it, so that is where I will start. Where, in your eyes, does bariatric surgery ideally sit in the suite of things that we can now offer people who are overweight or obese?

Mr Pournaras: I will declare my view. I treat obesity all the way from the primary care referrals that I get with lifestyle interventions, pharmacotherapy, endoscopic treatment and devices, bariatric surgery and even revisional bariatric surgery. I also see obesity outside the obesity clinic in my daily clinical practice as a GI surgeon. First of all, it is really important to destigmatise the condition—thank you for sharing your experience. It is really important to understand that people who live with obesity live with a disease. It is a disease. I know you debated this before. It is absolutely a disease—

Chair: Is it your view that we should say “disease”?

Mr Pournaras: It is absolutely a disease.

Chair: Not a condition.



Mr Pournaras: No. It is absolutely a disease, and we need to treat it as such. Whichever definition of disease you use, you will see that obesity meets it. Historians of the future will look at the way we are treating obesity in 2026 and be appalled, just as we are shocked when we see how diseases were treated 50 or 100 years ago. It is absolutely a disease.

For every disease that we treat—I always use examples of other diseases or conditions, like cancer—we want to do the least amount of treatment and the least invasive treatment, and dare I say the path to remission is inspired by that. My colleagues have spoken about this before—we have a long history. It is amazing for the people that have a successful outcome—it is wonderful to see that—but people who do not respond to that just do not respond to the treatment. If people with hypertension do not respond to a tablet, we do not think that they have done something wrong; we do not tell them to try harder or that they need to be more motivated. We just change the tablet. If we give people chemotherapy that does not work, the first thing we do is stop the chemotherapy. In obesity, we tell people to go back and have exactly the same treatment but try harder. Therefore, escalation of treatment is absolutely essential.

Of course, the escalation stops at the most invasive treatment, which is bariatric surgery. That is where it is at the moment, but the vast majority of people in this country who live with obesity cannot access it. It is important to take a global view. The prevalence of bariatric surgery in this country is the lowest in the G20. It is one of the lowest in high-income—

Q806 **Chair:** There were 117 surgeries per million in the population in England compared with 928 per million in Belgium and 761 in Sweden.

Mr Pournaras: I trust your figures. We do 4,500 operations in the NHS. We have now had national registries for 15 years, so we have amazing data on that. We know that the number of operations performed privately has come down, but it is less than 4,500. We know that a large number of citizens of this country go to access bariatric surgery in another country. I cannot think of another disease that is treated outside the NHS. Aside from cosmetic treatments and dentistry, I do not see anyone going to other countries outside the European Union, for that matter, to access care. It is really problematic and really challenging. We can do better than that.

Q807 **Chair:** Isn't the issue that people consider weight loss cosmetic?

Mr Pournaras: That is part of the issue. I do not think it is the people; it is that we all do—we are all part of this. Weight loss is considered a cosmetic treatment in the society we live in. We need to challenge that as policy makers, clinicians and commissioners. We know that it is not true. We know that the cosmetic outcomes of bariatric surgery are poor, but the health saving, the health improvement outcomes and the safety outcomes are excellent. I would not consider the cosmetic outcomes the positives of bariatric surgery. More importantly, the reason people go abroad is that they cannot access the care here. It is not just because they see it as cosmetic; it is because they cannot access it in their country.

Q808 Chair: What is different in those countries?

Mr Pournaras: The access to bariatric surgery is a lot better.

Chair: What exactly about it is better in those countries? Is it the thresholds to get it or the knowledge about it?

Mr Pournaras: All of it. It is a whole-system approach. Right now, we know that parts of the country—there is data on it—have no access to bariatric surgery whatsoever. The postcode lottery in bariatric surgery is an embarrassment to the NHS, and I say that as a frontline clinician. On top of that, services are shut. I am sitting next to a GP colleague. Why would you refer someone to a service that is a shut? When you hear that the waiting time is two or two and a half years, why would you refer someone to that service?

We also need to recognise the tiered approach, which is again a UK-unique approach to the obesity gap. I have spent enough time in international conferences to tell you that there is no tiered approach anywhere else. It is a gatekeeping process; it is not working, and it has failed. Not having access to tiered service means that if you do not have tier 2 or tier 3 you cannot get to tier 4. That is again a system approach, not an individual approach of a specific locality or specific service.

Q809 Chair: How do you guys do it? Per head of population, Cumbria well exceeds by more than double anywhere else in the country, so presumably they could do it too. What are you doing differently?

Dr O'Brien: We have a long history of very forward-looking bariatric units across the north-east and north Cumbria. There are five bariatric units. They all work very well together in a networked approach, but they also work with the four specialist weight management clinics that we have. There is a real network and partnership between medical specialists and surgical specialists. They work together to give an individualised approach to the best treatment for the individual with obesity.

That is coupled with a strategic commissioning plan. We commissioned the activity that is being done. We commission 900 bariatric procedures per year, but that is probably still not enough to meet the demand that is out there. We commissioned 4,000 slots for specialist weight management clinics, but again, that is probably not enough, particularly with the advent of new medications. Last year, we chose to invest another £1 million into specialist weight management clinics to improve access for some of the underserved communities. We have a good group of clinicians who work together with commissioners to improve access to this very high-end and specialist end of the obesity pathway.

Q810 Chair: We heard from our last panel something that was also a theme of our lived experience roundtable: that stigma, particularly stigma internalised by GPs and commissioners, is one reason why this disease or condition is harder to deal with than others. Is that something you saw and faced head on in Cumbria? If not, what was different about Cumbria? Does that stigma still exist? Do you recognise that characterisation?



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Dr O'Brien: I recognise the characterisation. There is a lot of stigma around obesity, but remember that we have not provided access to treatment to everybody who could benefit from it. There is still some variation in our patch. The north-east and north Cumbria is quite a large geography, so it has some variation in access. For instance, Sunderland has one of our most active bariatric hubs; that is where the highest number of bariatric surgeries happen in absolute numbers rather than per thousand people. That also happens to be the area with the greatest proportion of morbid obesity. We have tried to work with clinicians across primary and secondary care. Secondary care clinicians reach out to GPs to try to educate them around routes to access to bariatric surgery.

Q811 **Chair:** You said "happens"; was it happenstance that it is in the right place, or was it decided that, "Here is an area of relative deprivation and a large number of health conditions. We're going to put a hub there." Was it happenstance or did it grow over time to serve a population that needs it?

Dr O'Brien: It grew over time to serve a population, but the surgeries that are done in Sunderland are not all for Sunderland residents. For instance, I refer some of my patients in County Durham to Sunderland. They are not all Sunderland residents, but the largest number of bariatric procedures occur in the Sunderland trust because it has developed an area specialty in that over the last 10 years.

Chair: I am trying to get at what people can learn from you.

Mr Pournaras: May I come in on that? First, I may change my train ticket and go to the north-east. I know the history and what is happening there is fantastic. There are existing services there and you capitalise on the fact that there is infrastructure. I have been in this field long enough to tell you that there are very few new centres or new units. The north-east was really good a few years ago; it is amazing now. But there are parts of the country where there is no bariatric surgery, and I can show you maps of that.

Chair: We have a map.

Mr Pournaras: East Anglia is a bariatric surgery desert. Such deserts have not changed; the needle has not moved for the last 15 years. That is the challenge: there were very few new bariatric units established in the last decade. The disease of obesity is changing epidemiologically but we have not responded to that.

Q812 **Chair:** That brings me to my next question. There are calls for us to double the number of people receiving bariatric surgery. What would it take to achieve that?

Mr Pournaras: We can do that tomorrow.

Chair: Oh really?

Mr Pournaras: I can give you the back-of-the-envelope calculation. There are 150 to 160 bariatric surgeons around this country—not all of them are



in the north-east—who contribute to the National Bariatric Surgery Registry. Let's say those surgeons work 40 weeks a year, taking away annual leave, study leave and time to come to Parliament to give evidence. If you ask every one of them to do three operations a day—that is a conservative number; in Bristol we do three by lunch time—that is 20,000 operations with the current infrastructure, and with no new investment, including in training. Of course we need more training and more infrastructure, but if we ask the bariatric surgeons that we currently have in this country to do what we are supposed to do, bariatric surgery, while we may have to deprioritise some other treatments that we provide, such as gallstone surgery or hernia surgery, to prioritise bariatric surgery—I appreciate that is challenging—it is highly doable. If we move to 20,000, that is four times more than what we do now and it is getting closer to where we need to be. About 3.2 million people qualify for bariatric surgery; we do not need 3.2 million operations. We cannot deliver that. We cannot even deliver that in the path to remission programme, but we can do a lot better than 4,500 operations.

Dr O'Brien: Again, I have asked whether we can double our capacity in the north-east and north Cumbria. If we had the right amount of theatre time then, yes, the workforce and the demand are there. The waiting time to access bariatric surgery, even with the amount that we commission, is in excess of a year in the north-east and north Cumbria, so we could do this with the right amount of prioritisation and commissioning of it.

Q813 **Chair:** I am drawing an inference, but tell me if I am wrong. You said that the tiered system is unique to the UK. I had not fully appreciated that it is totally unique. There are calls for a hub model, so you refer in and treat the patient in front of you. Would you advocate for a model like that to counter the fragmentation? Do you have a different view about what needs to happen next with surgeries and treatments for obesity more generally?

Mr Pournaras: The treatment for every complex disease—obesity is complex—is a multi-model treatment with different modalities. Obesity is unique, but if I changed my vocabulary and talked about cancer, we would not be having discussions about whether we should have chemotherapy or radiotherapy first, or whether we should try only immunotherapy but not invest in cancer surgery or robotic surgery. We need everything—not at the same time, of course, but for different individuals at different times. Of course, we will have stepwise approach to any clinical care. We do that for all other treatment that we provide, and obesity is the same.

People don't need to do time. They don't need to do six months of so-called tier 3 service, which is specialist weight management—that has now been removed from the NICE guidance. We just need to see if they respond to that treatment. If people respond to path to remission, that is fantastic news and we just need to continue doing that. For people who do not respond to the path to remission or to GLP-1 receptor agonists, we need to escalate treatment and offer bariatric surgery. This needs to be seamless, and primary care is really well placed to know how to do that.



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We can work together to deliver that model of care, just like we do for every other condition.

Dr O'Brien: I agree. The removal of the barrier, where you had to serve your time in tier 3, has been helpful. We should integrate all the options for treatment for obesity under the specialist weight management clinics. It may be that an individual's access to bariatric surgery should happen sooner than would have happened before. This is becoming a much more technical area for GPs to understand and to know where to refer. That is one of the big benefits of the structured weight management programmes, which have a multi-professional, skilled clinical workforce who can decide which options are the best.

It is about integration and the removal of the tiering. That said, local authorities currently commission tier 2—the behavioural side, and the dietary and exercise advice—and that still needs to be there as a bedrock to improve the success of some of these more technical, high-end treatments.

Mr Pournaras: It is also important to recognise the gap in care. That is demonstrated by the daily news that a lot of people are accessing pharmacotherapy for obesity privately. There is a gap in care there, because they cannot access it via the NHS or primary care to an adequate level. The levels of the disease are reflected by the number of people who access those treatments, not by the levels of commissioning that we do or the care that we provide. We need to recognise the gap in care and do something about it.

Q814 **Chair:** Thank you. I have one more question, and then I will move on. We have heard consistently that some GPs get it and speak about obesity in a way that the patient is grateful for, and others maybe don't know about the services that they can refer into. I was quite shocked by Alex's story about finding out about his diabetes from the app, not from his GP. I thought that was astounding. What more do we need to do to help GPs navigate this complex system in a way that is compassionate to the patient in front of them?

Dr O'Brien: General practice is probably one of the best jobs in the world, but it is becoming one of the most complex jobs in the world. I am fortunate that I am in a practice where I have many partners, and we all have various interests. The variation in experience that people may have had will reflect some of the interests that GPs have. I applaud Healthier You, which has certainly raised my awareness of the diabetes prevention programme.

It is very difficult to keep pace with all the changes happening in this field. The view that obesity is a disease is a relatively new concept for us in medicine to get our heads around. We are not only looking at the individual to manage their cholesterol, their blood pressure and their smoking; we are now looking at treatments for their obesity. That is absolutely the right thing to do, but it will require a lot of education for



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GPs on when and how to refer, and on what they can manage themselves within their practice.

Mr Pournaras: I want to reassure Neil that secondary care is no better. The education gap in secondary and tertiary care where I live is also problematic. Most of us were not educated on obesity.

If there is an epidemic, we know how to respond. Everyone remembers the covid-19 epidemic. We all became experts in virology, micro-engineering and epidemiology very quickly. We learned how to deal with covid-19 in a very short period of time, when we recognised that it was an important disease to treat. Even with elective surgery, a space where I work, we very quickly learned how to do that. There is an element of choice here. If we strategically decide, as a society, and as scientists, clinicians and policymakers, that this is something to invest in, it can happen quickly.

I train medical students at the University of Bristol. I have stopped all my training and I only deliver an obesity lecture, because I think that is the most important bit of the training. That is the part of care that may have an influence on outcomes more than anything else I could spend 45 minutes talking to them about. We can change that.

Q815 **Danny Beales:** You have made a compelling case about the untapped potential of bariatric surgery. Given the variation you have spoken about nationally, why do you think local commissioners just do not get it?

Mr Pournaras: It is difficult to say this in front of Neil, who clearly gets it, but the easy answer is stigma, which is dominant not just in society but in every interaction we have. Within my own hospital, in my NHS trust, and among the local policymakers, obesity is not treated as a disease. If obesity was treated as a disease, all the problems would go away.

Q816 **Danny Beales:** That would be the driver. If we treated it as a disease, all these commissioners would suddenly commission more bariatric surgery.

Mr Pournaras: Absolutely. If I only had one button to push, that is the one I would push. We can see that by learning from other diseases. Cancer is a really complex disease to treat. There are waiting times, and I do not envy the health policymakers, and there are difficult discussions about which immunotherapy to use or not, but we deliver that and we deliver that in a timely manner. I do not see thousands of people leaving this country every year to go and get cancer treatment elsewhere.

It is the same thing for benign conditions. I do not see people with hernias, gall bladders and haemorrhoids going elsewhere to access treatment. But they do for obesity, and that tells us everything we need to know.

Q817 **Danny Beales:** Neil, you clearly get it, but do you think there is too much reliance at the moment on personalities, passions and personal beliefs in bariatric surgery and interventions in this space, which drive decisions and lead to variability? Or do you think there are other explanations for why



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lots of areas just do not do what you do?

Dr O'Brien: It is very difficult as a commissioner to try to work out how best to use the finite resource you have. It is the job of every commissioner to understand the health needs of their populations, and certainly in the north-east and north Cumbria we have quite a high prevalence of both obesity and morbid obesity, which has driven commissioning decisions over the years. Coupled with an enthusiastic clinical workforce, some specialists in the area, a desire to develop that and improve the pathway, that has led to the position we are in now. Please do not get me wrong: we have not got this fully sorted and there is much more that we can do. But we are ahead of other areas in respect to the provision of bariatric care.

Mr Pournaras: To add to that, if you look at cost-effectiveness, which usually drives commissioning, bariatric surgery is extremely cost-effective. It is one of the most cost-effective interventions ever assessed by NICE, and it remains dominant. If we start adding societal impact—I will send some of the data—in terms of employment and going back to work, and the cost—

Danny Beales: The case is very strong indeed for bariatric surgery.

Mr Pournaras: It is very strong, but it has not changed the access to care, which demonstrates that something beyond data is lacking. That is why I think stigma is key.

Q818 **Danny Beales:** Neil, you talked about commissioning for local population needs. Is it your view that in the areas that are not commissioning at the moment, their obesity levels are such that it is less of a priority? Would the commissioning of bariatric surgery map to the issues of deprivation, obesity and local need?

Dr O'Brien: If you look at the map, it does not follow that exactly. There are certain areas of the country that have equally as high obesity levels, but that do not have the level of bariatric commissioning that we have.

Q819 **Danny Beales:** Why do you think those commissioners are not commissioning for population need?

Dr O'Brien: I am not quite sure. You would have to ask them. It may be due to historical arrangements, or they have prioritised other areas, or they might be in a different financial position.

Mr Pournaras: I can provide the national picture to answer that question. It is not a coincidence that areas of poor socioeconomic status have limited access to bariatric surgery. Getting bariatric surgery already puts you at a higher socioeconomic level, and that is just in the NHS. You have to have the ability to communicate and get the point across that you want that care. You have to be really articulate and be patient enough to go to enough GP appointments to ask for it in this environment, at a social level—not necessarily in the north-east, but nationally. The reason why people are not getting obesity care in areas with poor socioeconomic status is exactly that. There is also a racial aspect, and there is the



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language barrier on top of that. There are multiple complexities, but it is about the socioeconomic issues that you describe.

Q820 Danny Beales: In 2017, bariatric surgery was devolved by NHS England to local areas—there were known as CCGs at the time, but they are now ICBs—on the basis that they would design effective local pathways, respond to local population need and aim to increase consistency in the pathway of obesity management. It seems that that has not happened, because there are not consistent pathways. It does not seem like bariatric surgery services are commissioned in response to local population need, from the data we are discussing. Do you think there is a case for more nationalised commissioning or clearer national standards?

Dr O'Brien: Having clearer national standards and expectations of commissioners would be helpful. Because it is a whole pathway, national commissioning of the model would require systems working together in the set-up of specialist weight management clinics, and then pathways across primary care through medical specialties, surgical specialties and aftercare. Local commissioners are probably best placed to broker some of that, but some national expectations and commissioning would certainly help.

Q821 Danny Beales: Do you think progress has been made? We have heard about the remission programme and the diabetes prevention programme, which have been committed to nationally and pushed by NHS England, with some degree of local involvement; do you think there is a case for that kind of model for bariatric surgery?

Dr O'Brien: Yes, I think so. Setting some very strong national expectations of what commissioners need to provide for their populations in this aspect of obesity treatment would be helpful, and local commissioners should be held to account for that.

Mr Pournaras: I completely agree with that. National policy is urgently needed, because we have such local variation. I appreciate the local commissioning concerns, but given that we have such a gap in care and wide local variation, national policy is urgently needed to meet that gap.

Q822 Danny Beales: On the NICE standards, some of the data we have seen has suggested that around 31% of ICB areas are not following the NICE criteria in full. There is variation in who can apply for bariatric surgery, which is not compliant with NICE, and some areas have no provision at all. NICE has already produced some kind of clinical standard, but a third of areas are not following it. From an ICB perspective or a provider perspective, what should accountability look like when it comes to standards and expectations, or future standards? Is there enough accountability now, or should there be more accountability?

Dr O'Brien: If you look at compliance with NICE guidance across all disease areas, you will find that, despite best efforts, we cannot deliver that standard of care for everybody in every population.



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We are certainly moving towards a more strategic approach to commissioning this. We could estimate our level of required activity within bariatrics, and we should be commissioning that level of activity. NHS England—or what comes next—could also hold local systems to account to ensure that they are at least commissioning, or on a path towards commissioning, sufficient capacity to make this treatment accessible. The structured weight management clinic approach would allow both access to the new technologies in medication—GLP-1s—and to picking out the people who would benefit from bariatric surgery.

Q823 Danny Beales: What would that accountability look like now? You said that it would be possible for NHS England to achieve that now, or potentially it could be achieved in the future by the Department of Health under the new arrangements, but for the 31% of areas that are now not compliant with NICE criteria around bariatric surgeries, what would accountability look like? What could NHS England do now?

Dr Neil O'Brien: NHS England could put in place some very strict targets around what commissioned capacity they would expect to see in an area, and hold areas to account to deliver that.

Dimitri Pournaras: Thank you for making that really important point. Uniquely to bariatric surgery, NICE guidance is regularly not followed at commissioning level. The first NICE guidance that suggested that bariatric surgery should be considered as first-line treatment for patients with a BMI over 50 was in 2002. I have been seeing patients with a BMI of over 50 coming to my clinic for other conditions, but nobody has ever even told them that they have obesity—that is probably even before the NHS app

The accountability needs to change. Commissioners are not the issue here—it is all of us. Healthcare providers in primary, secondary and tertiary care should be accountable because they have to deliver this. It goes back to the stigma issue that we have. How is it acceptable to have commissioning criteria in parts of the country outside the north-east where the BMI criteria are not meeting the NICE criteria? Imagine doing that for chemotherapy—saying that people who have a particular cancer in a particular area are not going to get treatment under the nationally approved criteria—and there being no implications or consequences. The question of accountability is key and we need to address it urgently.

Q824 Danny Beales: If we moved to a nationally commissioned service, would there be a need to commission a service in every area, or should we be focusing on super-hubs? We have heard some evidence around surgical space, time and facilities being a barrier in certain areas, so should we be commissioning specific national bariatric surgery hubs?

Dimitri Pournaras: Absolutely. I think we should have national coverage, but I do not think that every hospital should deliver bariatric surgery as it is highly specialised. On the safety of bariatric surgery, the 30-day risk of death from bariatric surgery in the UK is now five times lower than the risk of death from a cholecystectomy—a gallbladder removal—which is a routine operation. It is extremely safe because it is performed at high



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frequency and high volume in highly specialised units. We do not need occasional bariatric surgeons or occasional bariatric units.

You can do hub and spoke, and you can centralise, just as we do with cancer. The NHS is amazing at delivering that: cancer care was centralised in this country 20 years ago and we are world-leading; vascular surgery has been centralised; and major trauma care has been centralised and we are now saving lives that we were not saving six or 10 years ago, because everyone gets flown to the same unit. We know how to do that—this is business as usual for the NHS—if there is a will to deliver it. So absolutely, bariatric surgery should at least be centralised, and the model for that can be worked out in detail with the right stakeholders.

Q825 Gregory Stafford: I have questions about tier 3 services. Currently, patients are reviewed in specialist weight services—tier 3 services—for their suitability for surgery. Do you believe that this approach is working? What impact, if any, might it be having on access to bariatric surgery?

Dr Neil O'Brien: The removal of the requirement to do a certain amount of time in a tier 3 service, which is mainly looking at behaviour and education, has been helpful. Specialists in the area would much rather see a referral to a specialist weight management clinic with a multidisciplinary approach to pick out those who may need to be on a more intense behavioural modification programme, those who might benefit from medication or those individuals who should probably be fast-tracked to bariatric surgery. That is a much more helpful way of managing the pathway than mandating tier 3, because even in the north-east and north Cumbria we had pockets where the big waiting time was for tier 3 provision. People were waiting for a very long time to access tier 3, which meant they could not go on to be considered for bariatric surgery. Moving away from tiering and having a more patient pathway approach is probably favoured.

Mr Pournaras: The history is quite important to understand why tier 3 existed in the first place. There was genuine concern among clinicians, commissioners and policymakers that everyone—the whole of the UK with a BMI of more than 30, those 3.2 million people—was going to have bariatric surgery. Tier 3 was seen as a way of gatekeeping and to make sensible decisions. That is not happening any more—it never happened. It delayed care. The access to tier 3 is problematic if you have to do tier 1 or tier 2 but you do not have a local tier 1 or tier 2. You may not have access to tier 3—a lot of tier 3 services in this country are shut to new referrals, so you cannot access them even if they do exist—and then you have to go to tier 4.

Moving it is absolutely important. The focus of a specialist weight management service would be to signpost and improve access to appropriate care. Someone with a BMI of 60 who has already been through the pathway of remission and has not responded needs to go to bariatric surgery sooner rather than later. Someone with a BMI of 34 who got diagnosed with type 2 diabetes last week can maybe try a pathway to remission if their biology, genetic profile and social circumstances allow



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them to have that. That needs to be seamless and rapid so that people can re-enter when treatment does not work, just like we do with oncology. If chemotherapy does not work, we need to be responsive to that as opposed to being rigid and saying, "You need to spend your six months on chemotherapy now."

Q826 Gregory Stafford: Are there any other specific changes that you would make to the pathway to ensure that you get to the position that Dr O'Brien was talking about?

Mr Pournaras: Yes. I would ensure that access to the modalities is, again, really rapid. We need to have a discussion about this. People should be able to access a pathway to remission and intensive lifestyle modifications early, and if they do not meet that, they need to be able to move to pharmacotherapy—GLP-1s, receptor agonist-based treatment. If they do not respond to that or they cannot tolerate it, they need to be offered bariatric surgery. That needs to be responsive in real time, and if people are not able to undergo treatment for obesity right now—it is a chronic disease, it is not an injury but a lifelong condition—then they need to be discharged and then they can re-enter at any point when the conditions are right. That is the change we need to see in the landscape of how we deliver obesity care.

Dr O'Brien: Supplementary to that, GPs are now starting to prescribe GLP-1s to a very limited cohort of patients. It will take time for GPs to become experienced in doing that, so you will start to see in time, when expertise builds, that some of the less technical, if you like, interventions could be done in general practice. Upskilling general practice—the first-line treatment—could start to be done across the country if GPs were resourced to do that, and then people could go on to the specialist weight management clinics. That would be the only other slight adjustment to the pathway.

Q827 Gregory Stafford: In your experience, would GPs welcome doing that if given the resources to be able to do it?

Dr O'Brien: If given the resources to do it, yes, because I see patients every day who I know would benefit from this medication. At the minute, I cannot prescribe it for them, and the wraparound support is not there. But I know that they would benefit from it.

Q828 Gregory Stafford: We have had evidence from the Royal College of Physicians, who raised concerns about surgery being prioritised on a first come, first served-type basis rather than on clinical need. Do you both recognise that characterisation? What could ICBs or, indeed, the Government do to address the problem?

Mr Pournaras: When you have an overloaded system with long waiting lists, those discussions become less important, because if people are waiting for two years to access specialist weight management, does it really matter which is the first operation I do? It is not clinically correct to prioritise on waiting time, because, again, we are not treating obesity as a disease.

Q829 Gregory Stafford: Do you accept the Royal College of Physicians' assessment that that is what is happening?

Mr Pournaras: That is what is happening, but the problem is wider than that. It is the fact that there is a long waiting time. When you have an overwhelmed system, people go by the waiting time. However, we also do operations on people's bowels and colons, and the waiting time for someone who has an inflammatory condition is different from someone who has a polyp that may turn into a cancer and that is different again from someone who has a cancer today. The NHS has very clear targets on those and you will know what they are.

In obesity, we do not have that because we do not treat it as a disease. People's obesities are different. You heard Professor Roy Taylor say earlier that our ability to stage the disease is very poor. We are having debates about the definition and we are even having debates as to whether it is a disease, and we have not moved beyond those. We do not have good data to say who needs an operation first.

I can give you an extreme example: a patient who needs a renal transplant—a kidney transplant—and who must have a lower weight to achieve that will be in a different priority from someone who has a BMI of 50 but is fully functional and has full employment and reduced cardiovascular risk. We do not have great tools to decide that. However, I do not think that is the biggest challenge today: the biggest challenge is the waiting time as opposed to who comes first.

Dr O'Brien: Your point also highlights the inequity of care. Articulate, well-informed individuals will know how to access the system. The systematic identification of individuals who would benefit from treatment also needs to be part of the whole pathway for the treatment of obesity so we can treat people based on need—just as we do screening for other health conditions.

Q830 Gregory Stafford: Who is responsible for doing that? Is it ICBs individually, a national governmental change, or NHS England—or the Department as it will be? Who is responsible for getting it to the state that you are talking about?

Dr O'Brien: As strategic commissioners, we have a responsibility to our population to ensure that we have a pathway of care that allows the people of the north-east and north Cumbria to access all modalities of treatment. We have improvements that we need to make. In some areas we are strong and in others we are not. As I mentioned before, it would be useful if there was a national steer on the expectations around that whole pathway right the way from identification through to what is expected for aftercare.

Mr Pournaras: The quickest way to impact socioeconomic imbalance in this country is to treat obesity, because it is a condition that disproportionately affects BME and poor socioeconomic groups. Access to care in those underserved groups is worse than it is for the rest of the population. By treating obesity, we will improve outcomes and education,



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and there is evidence that in the younger population—adolescents and children—we will improve outcomes and employment. It is really important that we see obesity through this lens and not the other way around.

Gregory Stafford: We could have an interesting debate about causal symptoms, but I will leave it there. Thank you very much.

Q831 Chair: I went to visit one of the CEW clinics in Sheffield and they were making the point that while it is an acute service, it is also preventive in the long term because these are children who are being treated.

I want to talk a bit about aftercare, because you have mentioned it a couple of times and it came up very strongly in our lived experience roundtables. I will use myself as an easy target example. It is not just the case that you have a surgery and then that is it for life.

I have ongoing issues with anaemia—whether B12 or iron. There is the sagging skin, which somewhat offsets the cosmetic benefits that people talk about, and I think that is shared by a lot of people who lose a lot of weight rapidly. I have Barrett's oesophagus, which is one of the outcomes that can happen after the surgery, and which means that you need to watch for cancer down the line. It just feels like it is never ending—and the surgery itself was something that I needed to watch. To add insult to injury, I have now put weight back on and am back on a weight loss programme.

What I found remarkable when I was in that room full of people in our lived experience roundtable is that I suddenly felt like we were all having the same experience in different forms. It was just a matter of what we were experiencing and when that changed. However, the thing that did not change was that all of us, after the intervention, whatever it was, had ongoing issues that needed dealing with at various points over the decades. What was equally uniting was how difficult it was to get any help for them.

I will start with Neil. You mentioned aftercare. What is currently available in your patch, and can you compare that to elsewhere?

Dr O'Brien: We have broken down the aftercare into the immediate two-year period after a bariatric procedure and then care beyond that. We have ensured that all our bariatric units provide the aftercare for that first two-year period, which involves various kinds of nutritional support, blood monitoring and that kind of thing.

We have already mentioned people going abroad. We had a particular problem with people going abroad and then coming back but having no aftercare, and then sometimes ending up in emergency room departments or just pitching up to their GP. That was very difficult. Consequently, we have brokered an agreement with our bariatric units, so that the units will also do the two-year bariatric follow-up for any individual in that situation.

Beyond that, it will be out to general practice and we are currently in the process of developing what is called a local enhanced service, which is an agreement between commissioners and GPs to provide structured



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aftercare for patients following bariatric surgery. That is not yet in place; we are in negotiations about it.

In my practice, we have a register of people. Can I say, hand on heart, that we bring them in every year and do all the things that need to happen with them? Probably not. But that structured annual recall and follow-up, and then the route back into bariatric surgery when people start to develop any kind of complications, are what we need to firm up.

Q832 Chair: Can you be specific? What things? You mentioned blood work and nutritional support; what about psychological support? Is that part of it?

Dr O'Brien: I am not sure whether that is part of the hospital service or not. In general practice, however, it would just be the normal psychological support that we have in mental health services. I do not know if there is anything that anyone wants to add.

Mr Pournaras: I can answer that. It is important to recognise what the purpose of follow-up is. I will just say a bit about the principles here. Obesity is a lifelong condition—I know we treat it like a broken bone, but it is a lifelong condition—and bariatric surgery is surgery that works throughout a lifetime. It does not work on the day of surgery, which is quite unique.

There are two types of follow-up: follow-up for safety and follow-up for enhancing outcomes. Aftercare is there for safety; it is not there for outcomes. I know that this Committee has discussed a lot about wraparound care and medications. Again, that is for safety.

We do research. We know from animal models of bariatric surgery that a bypass still works, just like GLP-1 still works, if you give it to a mouse. But the mouse does not have to live in a society, although it will have weight loss—we will achieve weight loss. What is challenging is to go on through social life and employment, and that is where follow-up is really important. It is not just a nice thing to have.

If the anaemia does not get treated, if the Barrett's oesophagus does not get monitored or if the blood work does not get done, people will get into serious trouble. They will get neuropathies. I have people losing their sight; I have people who are now in a wheelchair. You cannot reverse those things. You can stop their development, but you cannot reverse them. So it is not an elective thing; we need to have that happening.

We do not provide this globally, and it is fair to say that there is constant debate and conflict between commissioners and primary care and secondary care about who should provide it, because it needs to happen. I do not think that it needs to happen in secondary care—it can happen in primary care—but it needs to happen.

Psychology is much more specialised and again it is not well commissioned. Most units—I can definitely say this about my unit—will offer specialised psychology support to people who have complications.



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However, for people who have bariatric surgery privately or out of the country, there is very little support.

Those are the principles, if you like, of having safety first and then enhancing the outcomes. I would argue that psychology support is a safety net, not just a nice thing to have.

Chair: In what way?

Mr Pournaras: Bariatric surgery or acute weight loss—weight loss of 20% to 25%—is a life event.

Chair: Yes.

Mr Pournaras: Therefore, it will have the impact of a life event; people will talk to you differently, people will see you differently and people will react to you differently.

I think that you heard this from Professor Taylor earlier on, but I have to say that food is the only bit that we have control over. I have no control over the questions that you are going to ask me, but I can control what I am having for dinner. If that is taken away from me with bariatric surgery—by rearranging my gut, or with an injection—that could destabilise me.

We also know that people who have had complex obesity very often have a very upsetting sexual abuse history, often as children or young individuals. When we just take away that weight, it can be massively problematic.

I am just using some examples of how we can help people. That is not elective to me; elective perhaps would be to offer some support to everyone who has a weight loss journey. We should be there for everyone who experiences consequences and complications in mental health from obesity care—that is actually across the board. I would argue that on the path to remission programme, some of the people—the super-responders—who will achieve 20% or 50% weight loss will have psychological complications. They will need support beyond what is provided right now.

Q833 Josh Fenton-Glynn: I am going to talk mainly about workforce capacity issues and what we can do. You talked about not having targets for surgical procedures. Do you think we need to get to a point where we do have targets for weight loss surgical procedures?

Mr Pournaras: Absolutely. Waiting lists—and not just waiting lists, but waiting times—should be appropriately managed, and obesity should not be an exception. People who have specific levels of obesity should have access to specialist weight management nationally within a reasonable timeframe, and bariatric surgery, if deemed fit and appropriate, within an appropriate timeframe.

Q834 Josh Fenton-Glynn: We have talked about how long people are waiting,



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but we have also talked about moving from fitness to prevention. Obviously, dealing with weight loss prevents further illnesses. Do you think we also need to look at the absolute number, not just how long people are waiting, and perhaps look at increasing that?

Mr Pournaras: At how many we should be doing? Absolutely. I should also tell you something about waiting. Waiting is harmful and we have clinical trials on that. If you take a thousand people who qualify for bariatric surgery and let them wait for a year, eight of them will not be here. That 0.8% mortality is the waiting time price for bariatric surgery—it is not zero; people die.

Q835 **Josh Fenton-Glynn:** So waiting is not a neutral in itself. I am going to move on. In 2021-22, we had 4,400 surgeries, which moved up to 6,900 by 2024-25. As I alluded to just now, that is nowhere near the 28% of adults who are obese. I appreciate that bariatric surgery is not the answer for all those adults, but do you think it is the lack of an experienced workforce that is holding us back from doing that?

Mr Pournaras: If you do not mind, I will make a comment about language. I will say that people are not obese—as has been heard before here—and they are not diabetic. They are not defined by the disease; they just have the disease. Everyone else has used it, including people on this panel. I am just putting that on the record.

As you say, there are millions of people living with obesity. We do not need to treat 28% of them with bariatric surgery. We need to offer care to enough of them across the board. If we do that, we will find that bariatric surgery numbers will go up. We need to recognise that we have a very low figure.

As I said, the first target will be 20,000 and up, and that should happen immediately, because we have the workforce for that. If we need to go beyond that, we need to start building the infrastructure for that. We need to have a target of how much surgery we should be doing.

Q836 **Josh Fenton-Glynn:** You think we have the workforce to deliver 20,000 bariatric surgeries a year, which is three times what we are currently delivering.

Mr Pournaras: Yes. I am going to repeat myself, if that is okay, because you may have missed it; I mentioned that calculation earlier on. Back of the envelope, there are 160 surgeons in this country delivering bariatric surgery every year. If they work 40 weeks, they have annual leave and time to come to parliamentary Committee meetings—I even made the same joke earlier, so you have not missed out. Then if we ask them to do three operations a day, which is highly achievable—I do three by lunch time in Bristol—you are able to deliver 20,000 tomorrow, without any change. You need theatre time, as Neil mentioned earlier, and you need prioritisation of that, but you do not need new people to deliver this immediately.

Q837 **Josh Fenton-Glynn:** That is really useful. Dr O'Brien talked about the



need for more expertise and the need to look at weight loss treatment as a specialty. The Royal College of Physicians believes that it should become a specialty pathway. Is there enough to make weight management its own separate specialty pathway?

Dr O'Brien: The medical management of obesity has been included in the training of sub-specialist endocrinology doctors for some time—since about 2012 or 2015, or something like that. There are calls to make it part of the integrated medical training for all consultant physicians. We also need to upskill the GP workforce to have further knowledge in this area. Should it be a sub-specialty on its own? I think the work is there for it, the demand is there for it and a lot more new treatments are coming along.

Q838 Josh Fenton-Glynn: Why do you not think it should be its own sub-specialty?

Dr O'Brien: Well, it can be. There is not a big problem with that, but currently it is usually diabetic specialist doctors who work into obesity medicine. There is a huge amount of work to be done in the complex management of diabetes as well. We need to be careful not to sub-specialise the profession too far.

Q839 Josh Fenton-Glynn: Quite a lot of the procedures are delivered by SAS and LE doctors; you obviously want to do more to allow those people clearer career paths in weight management.

Mr Pournaras: Another way of seeing that—I can say this as a secondary care doctor—is that obesity is a disease that affects so many people that it cannot be too specialised. How can you be an orthopaedic surgeon fixing people's knees and not know about obesity? How can you be a respiratory physician dealing with people's asthma and sleep apnoea and not know about obesity?

Q840 Josh Fenton-Glynn: I will get into that—that is my next question—but knowing NHS structures as I do, I know that what is specialised is valued in a lot of ways. I wonder whether there is an argument for obesity and weight management credentials, or something like that, now that the GMC is opening up more credentialed pathways. Might that be a way forward to encourage more trusts to have people with those skills?

Mr Pournaras: I would use exactly the same example used earlier about other epidemics. We all became covid-19 specialists for a period of time. Why can we not do that for obesity? It is not a rare disease—we are not in the rare diseases space. If it is affecting 30% of the population, or even more if you are in the north-east, how can we not get credentialed on that? I think that is a really good way forward.

Q841 Josh Fenton-Glynn: It is a comorbidity for so many deaths—I am thinking about the "dying with" element of covid. It is a really apposite point.

What more can we do to make sure that weight management and the different aspects of treatment are incorporated into all medical training so that, as you say, you are more likely to be referred down an effective



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weight management pathway when you deal with your knees or sleep apnoea? How can we improve medical training on that?

Mr Pournaras: First, I tend to use the phrase “obesity care” as opposed to “weight management”, because you can argue that it is much more personalised and humanising. We need to have obesity care everywhere, and I would start with medical school. That is where you have the biggest impact. In my medical school days, I was asked about conditions that I have never seen, but my children will not live as long as my parents because of obesity, and people get one lecture in the whole curriculum. It needs to start in medical school, and there could be a national standard on that.

Q842 Josh Fenton-Glynn: Is it still the case across all medical schools that there is one lecture?

Mr Pournaras: Well, there is very little. I am sure it is the same in the north-east. There is no clear strategy on including obesity as a mainstay of treatment or as a mainstay of education for the doctors of tomorrow. We do not do enough. I have a bit of a global view on that. People are trying to work on it, but we do not do enough.

Neil mentioned it earlier: the evolution of medical education is a slow process. We are still learning things that people studied 200 years ago. It takes a bit of time for something to get into the medical school textbooks, but we don't have time with obesity. I would argue that that needs to happen at medical school. Then there should be credentialing—you can argue that registration is a really good process for that—and then it needs to be included in all the exams. Primary care, the Royal College of Physicians, the Royal College of General Practitioners and the Royal College of Surgeons should all be asking more questions about obesity.

Q843 Josh Fenton-Glynn: Do you think we should expect people to continue to keep abreast of it as part of their ongoing improvement? I am thinking specifically about GLP-1s and things like that; I feel like there are doctors who have trained further back in history and are just not ready to deliver them and the associated care.

Mr Pournaras: You are absolutely right, and again it goes back to the stigma question. You would not accept me delivering cancer care with information that I have from 25 years ago. You would not tolerate me as a cancer specialist if I had not been to a conference for five years and still did what people did in 1993, but in obesity we tend to do that: we still give the same advice that people gave in 1993. That has to change, so absolutely we need to keep asking those questions.

Q844 Josh Fenton-Glynn: Dr O'Brien, you have a slightly broader view because you practise as a GP. When you think about people going into a GP's office, what are their chances of having a GP who has that knowledge of healthcare in this area?

Dr O'Brien: The chances of coming across a GP who has the confidence to adequately advise someone on all the treatment options that are out there



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now for obesity management are pretty slim. There will be some GPs who have an interest and are quite comfortable prescribing in these areas, or who know the criteria for access to bariatric surgery, but it is not universal. We are looking to try to fix the access issue. All patients access these treatments through their GP, so we need a very focused effort and prioritised education for GPs if we want to improve access in the short term.

Q845 Josh Fenton-Glynn: What kind of debate is going on among physicians on this? My knowledge and bitter experience of medical schools is that they don't love politicians telling them how they should design their curriculum. Do you think there is enough debate within the medical community?

Mr Pournaras: Probably not. You make a very strong point, which is that the education piece around obesity is not massive. The issue with obesity is not that people do not know anything about it; it is that people think they know about it and probably have misplaced views on it. I always say that in my next life I will be a cancer specialist. If on my train here I said I was coming to a cancer Committee, nobody would say, "I know about this. You don't need to have a degree in this. I know how to treat cancer." But most people would say, "I know how to treat obesity, because my cousin found this diet on the internet and it worked." That is the aspect of education that we need to look at.

We need to challenge the dogmas, get the actual science there and ask those questions, as opposed to having a very detailed physiology, anatomy and biochemistry lesson. I do not think people need that. I would argue that national policy, maybe with the regulators—the GMC and medical schools are a good place to do this—should treat obesity as a disease. People don't need to have 10 lectures instead of one, because that becomes tokenistic. If you ask me to do something on obesity in my mandatory training, just like I have to have a fire safety lecture, I am likely to tick a few boxes but you are unlikely to change my view on obesity. I think we need to do the opposite: we need to challenge people's views and destigmatise the condition with education.

Q846 Chair: I am sorry, colleagues, but I have one very last question. In the 10-year plan, there is this "moonshot to end the obesity epidemic". It points the way by talking about "new innovative approaches to treating obesity...through our Obesity Pathway Innovation Programme". Out of 10, given that this programme exists, and on our current trajectory, what do you give our chances of ending the obesity epidemic in 10 years' time?

Dr O'Brien: That's very ambitious—

Chair: I asked for a number. Could I have a number out of 10, please?

Dr O'Brien: Within 10 years? I am currently feeling about a three or a four.

Chair: Lovely—three or four. Mr Pournaras?



Mr Pournaras: Zero.

Q847 **Chair:** What would shift the dial upwards if the Government want to do this? They have written it in, and we all know that to get any line into a plan like this takes ambition in and of itself. What would make your three or four a five, or your zero a two?

Dr O'Brien: Viewing obesity as a disease and treating it that way, in a structured way, might give us a chance, while not ignoring all the foundational work that needs to be done around food, exercise and behavioural programmes.

Mr Pournaras: It would be recognising that we need to do prevention, which we are good at and which is much more politically palatable, and we need to do treatment. The reason that will never work is that you cannot end an epidemic in 10 years, but we can start to get better prevention strategies.

Uniquely for obesity, when we talk about treatment the discussion gets derailed to prevention. If I was here talking to you about chemotherapy, nobody would ask me a question about the smoking ban. If I talk about trauma surgery—I do a lot of that—you do not tell me, if I go to schools, to tell people to stop carrying knives. You want me to do the right thing for the patient in front of me and to give people good chemotherapy.

In obesity, we talk about GLP-1s and bariatric surgery, and then someone says, “We need to fix the food environment.” Absolutely we do, but that will only stop the increase of the epidemic in children born today. I am amazed by the smoking ban—it is fantastic that children born today will not get to smoke—but I still see lung cancer every day in my clinical practice, and I have to treat it. Nobody questions whether those patients should get chemotherapy. That is what we need to do for obesity.

Chair: Thank you very much. On that, we end.