NICE National Institute for Health and Care Excellence

NICE quality standard

Obesity: clinical assessment and management

Quality standard

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This standard is based on CG189 and PH47.

This standard should be read in conjunction with QS111, QS94, QS84, QS24, QS6, QS125, QS9 and QS152.

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Quality statement 1: Informing people of their BMI

Quality statement

People are informed of their body mass index (BMI) when it is calculated and advised about any associated health risks.

Rationale

The increasing prevalence of overweight and obesity can make it harder for people to recognise that they or their children are (or are at risk of becoming) overweight or obese. It is therefore important that people who are identified as being overweight or obese are informed of their BMI and understand what it means, any associated risks to their health and how they can get help. Calculation of BMI is often done as part of registration with a GP, or at hospital or community outpatient appointments for related conditions such as type 2 diabetes, cardiovascular disease or osteoarthritis. BMI measurement can also take place when people are admitted to hospital as inpatients, when they are having preoperative assessments and at booking appointments during pregnancy.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to ensure that people are informed of their BMI when it is calculated.

Data source: Evidence can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service pathways and protocols.

b) Evidence of local arrangements to ensure that people have a discussion with the healthcare professional about the associated health risks related to their BMI measurement.

Data source: Evidence can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service pathways and protocols.

Process

a) Proportion of people who are informed of their BMI when it is calculated.

Numerator – the number in the denominator who are informed of their BMI.

Denominator – the number of people who have had their BMI calculated.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

b) Proportion of people who have a discussion with their healthcare professional about their associated health risks in relation to their BMI.

Numerator – the number in the denominator who had a discussion with their healthcare professional about their associated health risks in relation to their BMI.

Denominator – the number of people informed of their BMI.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

a) Patient awareness of their BMI measurement.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient surveys.

b) Patient understanding of the health risks associated with their weight.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

What the quality statement means for different audiences

Service providers (primary and secondary care providers) ensure that healthcare professionals are able to accurately measure and record height and weight, and are able to determine BMI centile using age- and gender-specific charts for children and young people. Service providers should also ensure that healthcare professionals inform people of their BMI when it is calculated, are able to assess the health risks associated with BMI or BMI centile scores, and are able to discuss health risks with people (and their families or carers, as appropriate) who have a BMI that shows they are overweight or obese, or who have health risks because of their weight.

Healthcare professionals (such as GPs, nurses, hospital clinicians and consultants) ensure that they inform people of their BMI when they calculate it, assess the health risks associated with the person's BMI or BMI centile score, and ensure that there is time during the consultation to answer questions.

Commissioners ensure that they commission services in which healthcare professionals inform people of their BMI when they calculate it, assess the health risks associated with BMI or BMI centile scores, and discuss these risks with people who have a BMI that identifies that they are overweight or obese, or at health risk because of their weight.

People who have their body mass index (a measure of height and weight, often shortened to BMI) measured and who may be at risk of health problems because of their weight are told what their BMI is and have a discussion with a healthcare professional about what this might mean for their health. Their family members or carers can be involved in this discussion.

Source guidance

- Obesity: identification, assessment and management. NICE guideline CG189 (2014, updated 2023), recommendations 1.2.1, 1.2.14 and 1.2.21
- Weight assessment and management clinics (tier 3). Royal College of Surgeons (2014)

Definitions of terms used in this quality statement

BMI or BMI centile

BMI is calculated by dividing weight (in kilograms) by the square of height (in metres).

Royal College of Paediatrics and Child Health UK-World Health Organization (WHO) growth charts and BMI charts should be used to plot and classify BMI centile. The childhood and puberty close monitoring (CPCM) form can also be used for continued BMI monitoring in children aged 2 and over, especially in instances where puberty is either premature or delayed. Refer to special BMI growth charts for children and young people with Down's syndrome, if needed. [Adapted from NICE's guideline on obesity: identification, assessment and management, recommendation 1.2.21]

Associated health risks

Guidance on defining the degree of overweight or obesity and assessing associated health risks can be found in section 1.2 of NICE's guideline on obesity: identification, assessment and management.

Local voluntary organisations and support groups can also provide details on the health risks associated with being overweight or obese and help with approaches to weight loss. Discussions about likely resulting health problems can also therefore include providing details of such groups and how to contact them. [NICE's guideline on obesity: identification, assessment and management, recommendation 1.4.8]

Once people are informed of their BMI, they can be made aware of local lifestyle weight management programmes, in line with statement 6 in NICE's quality standard on obesity in adults: prevention and lifestyle weight management programmes and statement 5 in NICE's quality standard on obesity in children and young people: prevention and lifestyle weight management programmes.

Equality and diversity considerations

Some population groups, such as people of Asian family origin and older people, have comorbidity risk factors that are of concern at different BMIs. Clinical judgement should be used when considering risk factors in these groups.

There are circumstances when it may not be appropriate to inform someone of their BMI measurement, such as inpatients approaching the end of life.

Quality statement 2: Discussion on the choice of interventions

Quality statement

Adults with obesity for whom tier 2 interventions have been unsuccessful have a discussion about the choice of alternative interventions for weight management, including tier 3 services.

Rationale

People who have not benefited from tier 2 interventions should have a discussion with their healthcare professional about the options available. This can include tier 3 services, or equivalent, which provide specialist multidisciplinary team assessment and interventions. The choice of intervention should be agreed with the individual.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written protocols to ensure that adults with obesity for whom tier 2 interventions have been unsuccessful have a discussion about the choice of alternative interventions for weight management, including tier 3 services.

Data source: Evidence can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service pathways and protocols.

Process

Proportion of adults with obesity for whom tier 2 interventions have been unsuccessful who have a discussion about the choice of alternative interventions for weight management, including tier 3 services.

Numerator – the number in the denominator who have a discussion about the choice of alternative interventions for weight management, including tier 3 services.

Denominator – the number of adults with obesity for whom tier 2 interventions have been unsuccessful.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Patient satisfaction with knowing the full range of choices on offer.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

What the quality statement means for different audiences

Service providers (primary, community and secondary care) ensure that they have a choice of interventions available for people for whom tier 2 services have been unsuccessful. This includes agreed pathways for referral to tier 3 services, or equivalent, and awareness among healthcare professionals of the criteria for referral to these services and how to make a referral if the person agrees.

Healthcare professionals ensure that they have a discussion with adults with obesity for whom tier 2 interventions have been unsuccessful about their choice of alternative interventions for weight management, including tier 3 services. Healthcare professionals ensure that they emphasise to the person that this should not be seen as a failure on their part, but that it represents another treatment option that may be appropriate for them.

Commissioners ensure that they commission locally available tier 3 services, or equivalent, and that there are agreed pathways for referral to these services.

Adults with obesity have a discussion with their healthcare professional about the choice of other services for weight loss that are available, such as a weight-loss clinic, if they have not been able to lose weight through dieting or weight-loss programmes.

Source guidance

- Obesity: identification, assessment and management. NICE guideline CG189 (2014, updated 2023), recommendations 1.1.2, 1.2.7, 1.2.8 and 1.3.7
- Weight assessment and management clinics (tier 3). Royal College of Surgeons (2014)

Definitions of terms used in this quality statement

Obesity

Obesity is defined according to body mass index (BMI) as outlined below:

- healthy weight: BMI 18.5 kg/m^2 to 24.9 kg/m^2
- overweight: BMI 25 kg/m^2 to 29.9 kg/m^2
- obesity class 1: BMI 30 kg/m^2 to 34.9 kg/m^2
- obesity class 2: BMI 35 kg/m^2 to 39.9 kg/m^2
- obesity class 3: BMI 40 kg/m^2 or more.

Or for people with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background:

- overweight: BMI 23 kg/m^2 to 27.4 kg/m^2
- obesity: BMI 27.5 kg/m^2 or above.

[Adapted from NICE's guideline on obesity: identification, assessment and management, recommendations 1.2.7 and 1.2.8]

Tier 2 services

Although local definitions vary, lifestyle weight management programmes are usually called tier 2 services.

Lifestyle weight management programmes for overweight or obese people are multicomponent programmes that aim to reduce a person's energy intake and help them to be more physically active by changing their behaviour. They may include weight management programmes, courses or clubs that:

- accept people through self-referral or referral from a health or social care practitioner
- are provided by the public, private or voluntary sector
- are based in the community, workplaces, primary care or online.

[Adapted from NICE's guideline on weight management: lifestyle services for overweight or obese adults]

Tier 3 service

NHS England and Public Health England's report Joined up clinical pathways for obesity and the Royal College of Surgeons' report Weight assessment and management clinics (tier 3) provide details on the composition of tier 3 services and activities.

If tier 3 services are not currently commissioned or available, support and assessment can be provided by equivalent services until tier 3 services become available. For example, medical assessment can be done in a tier 4 service if properly configured with a full multidisciplinary team that includes a doctor. [Adapted from NICE's guideline on obesity: identification, assessment and management]

Unsuccessful interventions

Elements of such interventions may include:

- previous attempts to lose weight
- long history of cyclical weight loss and regain
- person not ready to participate in a weight management programme

- interventions that were not appropriate to the person's needs.

[Adapted from Royal College of Surgeons' report Weight assessment and management clinics (tier 3); and expert opinion]

Equality and diversity considerations

Some population groups, such as people of Asian family origin, have comorbidity risk factors that are of concern at different BMIs. Clinical judgement is needed when considering whether to refer to tier 3 services at lower BMI values.

People with learning disabilities may have different cognitive and social needs from the general population. Tier 3 services should be made accessible to address these needs.

Quality statement 3: Referring children and young people for specialist care

Quality statement

Children and young people who are overweight or obese and have significant comorbidities or complex needs are referred to a paediatrician with a special interest in obesity.

Rationale

Children and young people aged under 18 who are overweight or obese are at high risk of significant comorbidities. A paediatrician or GP is likely to identify those comorbidities during an initial assessment and can refer to a paediatrician with a special interest in obesity for investigations and access to tier 3 services.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written protocols to ensure that children and young people who are overweight or obese and have significant comorbidities or complex needs are referred to a paediatrician with a special interest in obesity.

Data source: Evidence can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service pathways and protocols.

Process

a) Proportion of children and young people who are overweight or obese and have significant comorbidities who are referred to a paediatrician with a special interest in obesity.

Numerator – the number in the denominator who are referred to a paediatrician with a special interest in obesity.

Denominator – the number of children and young people who are overweight or obese and have significant comorbidities.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

b) Proportion of children and young people who are overweight or obese and have complex needs who are referred to a paediatrician with a special interest in obesity.

Numerator – the number in the denominator who are referred to a paediatrician with a special interest in obesity.

Denominator – the number of children and young people who are overweight or obese and have complex needs.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

a) Access to tier 3 services for children and young people who are overweight or obese and have significant comorbidities or complex needs.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Weight loss in children and young people who are overweight or obese and have significant comorbidities or complex needs.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

c) Exclusion of underlying medical causes of obesity in children and young people who are overweight or obese.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

d) Treatment of comorbidity in children and young people who are overweight or obese.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

What the quality statement means for different audiences

Service providers (such as primary care, community care and paediatric services) ensure that children and young people who are overweight or obese and have significant comorbidities or complex needs and have been referred to the service have access to a paediatrician with a special interest in obesity.

Healthcare professionals (such as GPs and paediatricians) ensure that they refer children and young people who are overweight or obese and have significant comorbidities or complex needs to a paediatrician with a special interest in obesity.

Commissioners ensure that they commission locally available services that have access to a paediatrician with a special interest in obesity for children and young people who are overweight or obese and have significant comorbidities or complex needs.

Children and young people who are overweight or obese and have another medical condition or a special need such as a learning disability are offered referral to a paediatrician with a special interest in obesity.

Source guidance

- Obesity: identification, assessment and management. NICE guideline CG189 (2014,

updated 2023), recommendation 1.3.10

- Weight assessment and management clinics (tier 3). Royal College of Surgeons (2014)
- Weight management: lifestyle services for overweight or obese children and young people. NICE guideline PH47 (2013), recommendation 8

Definitions of terms used in this quality statement

BMI centile

Royal College of Paediatrics and Child Health UK-World Health Organization (WHO) growth charts and body mass index (BMI) charts should be used to plot and classify BMI centile. The childhood and puberty close monitoring (CPCM) form can also be used for continued BMI monitoring in children aged 2 and over, especially in instances where puberty is either premature or delayed. Refer to special BMI growth charts for children and young people with Down's syndrome, if needed. [Adapted from NICE's guideline on obesity: identification, assessment and management, recommendation 1.2.21]

Significant comorbidities

These include benign intracranial hypertension, sleep apnoea, obesity hypoventilation syndrome, hyperinsulinaemia, type 2 diabetes, dyslipidaemia, orthopaedic problems and psychological morbidity. Obesity may result from an underlying condition such as an endocrine disease or condition, or may be associated with various syndromes such as Prader–Willi syndrome. [NICE's guideline on weight management: lifestyle services for overweight or obese children and young people, glossary definition of 'complex obesity'; and expert opinion]

Complex needs

These include learning disabilities, chronic illness, physical disability and other additional needs. [NICE's guideline on obesity: identification, assessment and management, recommendation 1.3.10; and expert opinion]

Quality statement 4: Referring adults with type 2 diabetes for bariatric surgery assessment

Quality statement

Adults with a body mass index (BMI) of 35 kg/m^2 or more who have been diagnosed with type 2 diabetes within the past 10 years are offered an expedited referral for bariatric surgery assessment.

Rationale

Bariatric surgery can improve quality of life and reduce the risk of premature mortality for people with obesity and type 2 diabetes of less than 10 years' duration by improving glycaemic control and reducing or delaying the need for medication to control diabetes. An expedited referral means that people do not need to have tried non-surgical measures before they are referred for bariatric surgery assessment. Expedited referrals can be made by tier 3 services or equivalent if tier 3 services are not available locally.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with a BMI of 35 kg/m^2 or more who have been diagnosed with type 2 diabetes within the past 10 years are offered an expedited referral for bariatric surgery assessment.

Data source: Evidence can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service pathways and

protocols.

Process

Proportion of adults with a BMI of 35 kg/m^2 or more who have been diagnosed with type 2 diabetes within the past 10 years who have an expedited referral for bariatric surgery assessment.

Numerator – the number in the denominator who have an expedited referral for bariatric surgery assessment.

Denominator – the number of adults with a BMI of 35 kg/m^2 or more who have been diagnosed with type 2 diabetes within the past 10 years.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Bariatric surgery assessments for adults with a BMI of 35 kg/m^2 or more diagnosed with type 2 diabetes within the past 10 years.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

What the quality statement means for different audiences

Service providers (primary and secondary care providers) ensure that adults with a BMI of 35 kg/m^2 or more who have been diagnosed with type 2 diabetes in the past 10 years are offered an expedited referral for bariatric surgery assessment.

Healthcare professionals (such as GPs, diabetologists and endocrinologists) ensure that they offer adults with a BMI of 35 kg/m^2 or more who have been diagnosed with type 2 diabetes in the past 10 years an expedited referral for bariatric surgery assessment. Healthcare professionals should discuss the benefits and risks of both bariatric surgery and non-surgical treatment when offering referral for assessment.

Commissioners ensure that they commission services that can provide an expedited referral for bariatric surgery assessment and that pathways are in place locally to ensure that adults with a BMI of 35 kg/m^2 or more who have been diagnosed with type 2 diabetes in the past 10 years are referred to these services. If tier 3 services are not currently commissioned or available, commissioners should ensure that people can be supported and referred by equivalent services until tier 3 services are available.

Adults who were diagnosed with type 2 diabetes within the past 10 years and whose body mass index (a measure of height and weight, often shortened to BMI) is 35 kg/m^{2}or more are offered a referral to find out if they could benefit from an operation to help them lose weight (called bariatric surgery).

Source guidance

Obesity: identification, assessment and management. NICE guideline CG189 (2014, updated 2023), recommendation 1.10.3

Definitions of terms used in this quality statement

Expedited referral

The criterion that all appropriate non-surgical measures must have been tried before referral for bariatric surgery can be considered as a treatment option does not apply. [Adapted from NICE's guideline on obesity: identification, assessment and management]

Equality and diversity considerations

People of South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background who are prone to central adiposity have comorbidity risk factors that are of concern at BMIs different from those of the general population. Clinical judgement is needed when considering risk factors in these groups. Expedited assessment for bariatric surgery for people of these family backgrounds who are prone to central adiposity and who have recent-onset (diagnosed within the past 10 years) type 2 diabetes should be considered at a lower BMI than other populations (reduced by 2.5 kg/m^2) as long as they are also receiving, or will receive, assessment in a specialist weight management service. [NICE's guideline on obesity: identification, assessment and

management, recommendation 1.10.5]

Surgical intervention is not generally recommended for children and young people. Bariatric surgery may be considered for young people only in exceptional circumstances and if they have reached or nearly reached physiological maturity. [NICE's guideline on obesity: identification, assessment and management, recommendations 1.10.21 and 1.10.22]

Quality statement 5: Referring adults for bariatric surgery assessment

Quality statement

Adults with a body mass index (BMI) of 40 kg/m^2 or more, or between 35 kg/m^2 and 39.9 kg/m^2 with a significant health condition that could be improved if they lost weight, are offered a referral for bariatric surgery assessment.

Rationale

Bariatric surgery can improve quality of life and reduce the risk of premature mortality, and is the main option of choice for adults with a BMI of 40 kg/m^2 or more, or between 35 kg/m^2 and 39.9 kg/m^2 with a significant health condition that could be improved if they lost weight. There are additional criteria that need to be met before making a referral for bariatric surgery including, for example, whether a person has received (or will receive) appropriate intensive management and whether there is a commitment to long-term follow-up after surgery. Assessing all these criteria will identify people with a qualifying BMI who could benefit from bariatric surgery.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with a BMI of 40 kg/m^2 or more, or between 35 kg/m^2 and 39.9 kg/m^2 with a significant health condition that could be improved if they lost weight, are offered a referral for bariatric surgery assessment.

Data source: Evidence can be collected from information recorded locally by healthcare

professionals and provider organisations, for example, from service pathways and protocols.

Process

a) Proportion of adults with a BMI of 40 kg/m^2 or more who are referred for bariatric surgery assessment.

Numerator – the number in the denominator who are referred for bariatric surgery assessment.

Denominator – the number of adults with a BMI of 40 kg/m^2 or more.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

b) Proportion of adults with a BMI of between 35 kg/m^2 and 39.9 kg/m^2 with a significant health condition that could be improved if they lost weight who are referred for bariatric surgery assessment.

Numerator – the number in the denominator who are referred for bariatric surgery assessment.

Denominator – the number of adults with a BMI of between 35 kg/m^2 and 39.9 kg/m^2 with a significant health condition that could be improved if they lost weight.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Bariatric surgery assessments for adults with a BMI of 40 kg/m^2 or more, or between 35 kg/m^2 and 39.9 kg/m^2 with a significant health condition that could be improved if they lost weight.

Data source: National Obesity Audit bariatric surgical procedures includes data on the number of NHS funded bariatric surgical procedures delivered in England.

What the quality statement means for different audiences

Service providers (primary, community-based and secondary care tier 3 services or equivalent) ensure that adults with a qualifying BMI are offered a referral for bariatric surgery assessment.

Healthcare professionals ensure that adults with a qualifying BMI are offered a referral for bariatric surgery assessment.

Commissioners ensure that services that they commission offer a referral for bariatric surgery assessment to adults with a qualifying BMI.

Adults whose body mass index (a measure of height and weight, usually shortened to BMI) of 40 kg/m^2 or more, or between 35 kg/m^2 and 39.9 kg/m^2 with a significant health condition that could be improved if they lost weight, are offered a referral to find out if they could benefit from an operation to help them lose weight (called bariatric surgery).

Source guidance

Obesity: identification, assessment and management. NICE guideline CG189 (2014, updated 2023), recommendation 1.10.1

Definitions of terms used in this quality statement

Significant health condition that could improve after bariatric surgery

Conditions that could improve after bariatric surgery include:

- cardiovascular disease
- hypertension
- idiopathic intracranial hypertension
- non-alcoholic fatty liver disease with or without steatohepatitis

- obstructive sleep apnoea
- type 2 diabetes (see statement 4 for adults who have been diagnosed within the past 10 years)

These examples are based on the evidence identified for the NICE guideline on obesity: identification, assessment and management, and the list is not exhaustive. [NICE's guideline on obesity: identification, assessment and management, recommendation 1.10.1 and box 2]

Referral for bariatric surgery assessment

The comprehensive, multidisciplinary assessment aims to establish whether bariatric surgery is suitable for the person. It assesses:

- the person's medical needs (for example, existing comorbidities)
- their nutritional status (for example, dietary intake, and eating habits and behaviours)
- any psychological needs that, if addressed, would help ensure surgery is suitable and support adherence to postoperative care requirements
- their previous attempts to manage their weight, and any past response to a weight management intervention (for example, provided by a specialist weight management service)
- any factors that may impact their response to surgery (for example, language barriers, learning disabilities and neurodevelopmental disabilities, deprivation and other factors of health inequalities)
- whether any arrangements need to be made, based on the person's needs, ahead of surgery (for example, if they need additional dietary or psychological support, or support to manage existing or new comorbidities).
- fitness for anaesthesia and surgery.

[Adapted from NICE's guideline on obesity: identification, assessment and management, recommendation 1.10.7]

Equality and diversity considerations

People of South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background who are prone to central adiposity have comorbidity risk factors that are of concern at BMIs different from those of the general population. Clinical judgement is needed when considering risk factors in these groups. Assessment for bariatric surgery for people of these family backgrounds who are prone to central adiposity should be considered at a lower BMI than other populations (reduced by 2.5 kg/m^2). [NICE's guideline on obesity: identification, assessment and management, recommendation 1.10.2]

Surgical intervention is not generally recommended for children and young people. Bariatric surgery may be considered for young people only in exceptional circumstances and if they have reached or nearly reached physiological maturity. [NICE's guideline on obesity: identification, assessment and management, recommendations 1.10.21 and 1.10.22]

Quality statement 6: Follow-up care after bariatric surgery

Quality statement

People who have had bariatric surgery have a postoperative follow-up care package within the bariatric surgery service for a minimum of 2 years.

Rationale

The consequences of poor follow-up care after bariatric surgery can be severe and include weight regain, depression, nutritional deficiencies, osteoporosis, anaemia and death. Psychological screening and support after surgery, dietary advice and support, and specialist physical activity can ensure that the benefits of surgery are maximised.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people who have had bariatric surgery are offered a follow-up care package within the bariatric service for a minimum of 2 years.

Data source: Evidence can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service pathways and protocols.

Process

Proportion of people who have had bariatric surgery who have a follow-up care package within the bariatric service for a minimum of 2 years after bariatric surgery.

Numerator – the number in the denominator who have a postoperative follow-up care package within the bariatric service.

Denominator – the number of people who had bariatric surgery within the past 2 years.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

a) Nutritional status in the first 2 years following bariatric surgery.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

b) Patient satisfaction with bariatric surgery.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

What the quality statement means for different audiences

Service providers (primary, community based, and secondary care tier 3 or tier 4 services) ensure that people who have had bariatric surgery are offered a follow-up care package within the bariatric service for a minimum of 2 years.

Healthcare professionals (bariatric surgery service staff) offer people who have had bariatric surgery follow-up care for at least 2 years after their operation.

Commissioners ensure that bariatric surgery services they commission offer a follow-up care package within the bariatric service for a minimum of 2 years after surgery. In addition, commissioners ensure that there are agreed local arrangements setting out which services will provide aspects of care (for example, a person's GP may be involved in requesting blood tests or review appointments).

People who have had an operation to help them lose weight (called bariatric surgery)

have follow-up care from the bariatric surgery service for at least 2 years after their operation. Follow-up care includes regular health check-ups, tests to make sure they are getting the nutrients they need, support with their diet, help to increase physical activity and psychological support if needed.

Source guidance

Obesity: identification, assessment and management. NICE guideline CG189 (2014, updated 2023), recommendation 1.11.1

Definitions of terms used in this quality statement

Follow-up care package

This should be for a minimum of 2 years and include:

- monitoring nutritional intake (including protein and vitamins) and mineral deficiencies
- monitoring for comorbidities
- medication review
- dietary and nutritional assessment, advice and support
- physical activity advice and support
- psychological support tailored to the individual
- information about professionally led or peer-support groups.

[NICE's guideline on obesity: identification, assessment and management, recommendation 1.11.1]

For the first 2 years after surgery, follow-up appointments are likely to be with a dietitian or a bariatric physician. It is assumed that in the first year, the person has 3 follow-up appointments, with annual follow-up thereafter. After the first 2 years, follow-up appointments are likely to be with either a dietitian or a GP within a locally agreed shared-care protocol. [NICE's full guideline on obesity: identification, assessment and management, section 9.1.3.2]

Quality statement 7: Nutritional monitoring after discharge from the bariatric surgery service

Quality statement

People discharged from bariatric surgery service follow-up are offered monitoring of nutritional status at least once a year as part of a shared-care model of management.

Rationale

After bariatric surgery, unidentified nutritional deficiencies can occur and cause long-term harm (such as Wernicke's encephalopathy, peripheral neuropathy, anaemia, osteoporosis or night blindness) or death. It is therefore important for people who have had bariatric surgery to have lifelong nutritional monitoring and appropriate nutritional supplementation, as part of a shared-care model of management. The management plan should involve collaboration between named tier 3 specialists and primary care as well as locally agreed monitoring arrangements and responsibilities.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements and written clinical protocols to ensure that people are offered at least annual monitoring of nutritional status and appropriate supplementation after discharge from bariatric surgery service follow-up as part of a shared-care model of management.

Data source: Evidence can be collected from information recorded locally by healthcare

professionals and provider organisations, for example, from service pathways and protocols.

b) Evidence of a locally agreed shared-care model of management for people who are discharged from bariatric surgery service follow-up, developed by tier 3 specialists and primary care.

Data source: Evidence can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service pathways and protocols.

Process

Proportion of people discharged from bariatric surgery service follow-up who have at least annual monitoring of nutritional status and appropriate supplementation as part of a shared-care model of management.

Numerator – the number in the denominator who have had their nutritional status monitored within the past year as part of a shared-care model of management.

Denominator – the number of people discharged from bariatric surgery service follow-up more than 1 year ago.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Nutritional status after discharge from bariatric surgery service follow-up.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

What the quality statement means for different audiences

Service providers (primary, community-based, and secondary care services) ensure that

people who are discharged from bariatric surgery service follow-up are offered monitoring of nutritional status at least once a year as part of a shared-care model of management.

Healthcare professionals (primary care and tier 3 service staff) ensure that they monitor the nutritional status of people discharged from bariatric surgery service follow-up at least once a year and prescribe appropriate supplementation if needed, as part of a shared-care model of management.

Commissioners ensure that local shared-care models of disease management are agreed between primary care and tier 3 services for people who are discharged from bariatric surgery service follow-up, and that a named person or unit responsible for recalling people and performing ongoing checks is clearly specified. This is part of a shared-care model of management.

People who had an operation to help them lose weight (called bariatric surgery) and have finished their follow-up care are offered a check-up at least once a year to make sure they are getting the nutrients they need. The check-up is part of a care plan that has been agreed between the person, their GP and other healthcare professionals involved in their care.

Source guidance

Obesity: identification, assessment and management. NICE guideline CG189 (2014, updated 2023), recommendation 1.11.2

Definitions of terms used in this quality statement

Monitoring of nutritional status

This involves identifying any nutritional deficiencies, including vitamins, minerals and trace elements, after bariatric surgery and providing appropriate nutritional supplements. Clinicians should liaise with the local bariatric unit about patient-specific nutritional deficiencies and necessary treatment. [Adapted from NICE's guideline on obesity: identification, assessment and management; and expert opinion]

Shared-care model of management

A clear plan that outlines how a shared-care model of chronic disease management for lifelong annual follow-up after discharge from the bariatric surgery service will be implemented, including monitoring arrangements, common nutritional responsibilities and their treatment and responsibilities of the tier 3 specialist, the GP and the patient. The plan should involve collaboration between named tier 3 specialists and primary care. [Adapted from NICE's guideline on obesity: identification, assessment and management]

Guidelines for the follow-up of patients undergoing bariatric surgery (O'Kane et al. 2016) provides further detail and potential models of shared-care protocols for postoperative management after bariatric surgery.

Update information

Minor changes since publication

July 2023: Changes have been made to align this quality standard with the updated NICE guideline on obesity: identification, assessment and management. Statement 5 has been reworded to better reflect the source recommendations. Definitions and source guidance references have been updated throughout.

September 2022: Changes have been made to align this quality standard with the NICE guideline on obesity: identification, assessment and management. Links, definitions and source guidance references have been updated throughout.

October 2020: The evidence base for statement 3 has been updated because the SIGN guideline on obesity management has been withdrawn.

May 2020: Links to the Royal College of Surgeons guidance have been updated.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource

impact work for the source guidance. Organisations are encouraged to use the resource impact products for NICE's guideline on obesity: identification, assessment and management to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Chartered Society of Physiotherapy
- Royal College of General Practitioners (RCGP)
- Royal College of Physicians (RCP)