Obesity: clinical assessment and management

NICE quality standard

Draft for consultation

December 2015

Introduction

This quality standard covers the clinical assessment and management of obesity in adults, young people and children. This includes those with established comorbidities, and those with risk factors for other medical conditions.

This quality standard will not cover public health strategies to prevent overweight and obesity, or the delivery of lifestyle weight management interventions. These are covered by Obesity in children and young people: prevention and lifestyle weight management programmes (NICE quality standard 94) and Obesity in adults: prevention and lifestyle weight management programmes (NICE quality standard; publication expected January 2016). For more information see the Obesity: clinical assessment and management topic overview.

NICE quality standards focus on aspects of health and social care that are commissioned locally. Areas of national policy, such as legislative changes and national programmes, are therefore not covered by this quality standard.

Why this quality standard is needed

The Health Survey for England – 2013 (Health and Social Care Information Centre 2014) reported that approximately a quarter of adults (26% of men and 24% of women) were obese and 41% of men and 33% of women were overweight (but not obese). In addition, 30% of boys and 29% of girls aged 2–15 were either overweight or obese.

Obesity is directly linked to several illnesses including type 2 diabetes, fatty liver disease, hypertension, gallstones, gastro-oesophageal reflux disease and psychological and psychiatric morbidities. For example, Tackling obesity in England

(National Audit Office 2001) estimated that women who are obese are around 13 times more likely to develop type 2 diabetes and 4 times more likely to develop hypertension than women who are not obese.

Healthy lives, healthy people: a call to action on obesity in England (Department of Health 2011) highlighted that the estimated costs to society and the economy of overweight and obesity were almost £16 billion in 2007 (over 1% of GDP) and that this could potentially rise to almost £50 billion by 2050 if obesity rates continue to rise unchecked.

The quality standard is expected to contribute to improvements in the following outcomes:

- change in weight, BMI and waist circumference
- functional status
- long-term mortality
- maintenance of weight loss
- obesity-related comorbidities
- quality of life
- remission in people with type 2 diabetes.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- NHS Outcomes Framework 2015–16
- Public Health Outcomes Framework 2013–16.

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicators*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults ii Children and young people 1b Life expectancy at 75 i Males ii Females ***Improvement areas*** **Reducing premature mortality from the major causes of death** 1.1 Under 75 mortality rate from cardiovascular disease* 1.2 Under 75 mortality rate from respiratory disease* 1.3 Under 75 mortality rate from liver disease* 1.4 Under 75 mortality rate from cancer* i One- and ii Five-year survival from all cancers **Reducing premature mortality in people with mental illness** 1.5 i Excess under 75 mortality rate in adults with serious mental illness* *ii Excess under 75 mortality rate in adults with common mental illness**
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Improving functional ability in people with long-term conditions** 2.2 Employment of people with long-term conditions*, ** **Reducing time spent in hospital by people with long-term conditions** 2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s **Enhancing quality of life for people with mental illness** 2.5 i Employment of people with mental illness** *ii Health-related quality of life for people with mental illness*** **Improving quality of life for people with multiple long-**

	term conditions *2.7 Health-related quality of life for people with three or more long-term conditions***
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** 3a Emergency admissions for acute conditions that should not usually require hospital admission 3b Emergency readmissions within 30 days of discharge from hospital* ***Improvement areas*** **Improving outcomes from planned treatments** 3.1 Total health gain as assessed by patients for elective procedures *i Physical health-related procedures* *ii Psychological therapies* *iii Recovery in quality of life for patients with mental illness*
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care i GP services 4b Patient experience of hospital care 4c *Friends and family test* *4d Patient experience characterised as poor or worse* *i Primary care* *ii Hospital care* ***Improvement areas*** **Improving people's experience of outpatient care** 4.1 Patient experience of outpatient services **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to inpatients' personal needs **Improving children and young people's experience of healthcare** *4.8 Children and young people's experience of inpatient services* **Improving people's experience of integrated care** *4.9 People's experience of integrated care***
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 Public health outcomes framework for England, 2013–16

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities

	Indicators 1.3 Pupil absence 1.9 Sickness absence rate 1.16 Utilisation of outdoor space for exercise/health reasons 1.18 Social isolation*
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.6 Excess weight in 4–5 and 10–11 year olds 2.11 Diet 2.12 Excess weight in adults 2.13 Proportion of physically active and inactive adults 2.17 Recorded diabetes 2.23 Self-reported well-being
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.3 Mortality rate from causes considered preventable** 4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* 4.5 Under 75 mortality rate from cancer* 4.6 Under 75 mortality rate from liver disease* 4.7 Under 75 mortality rate from respiratory diseases* 4.13 Health-related quality of life for older people
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Patient experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to the clinical assessment and management of obesity.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside this quality standard.

This specifies that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. It also covers the provision of information to patients. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect patient experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for obesity: clinical assessment and management specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole obesity care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people who are overweight or obese.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality obesity service are listed in related quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating people who are overweight or obese should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source(s) on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting people who are overweight or obese. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1 People who attend their first hospital outpatient appointment after referral have their current BMI or BMI centile calculated.

Statement 2 People identified as being overweight or obese, or at health risk due to their weight, at an outpatient appointment have a discussion during the appointment about their BMI and the likely resulting health problems.

Statement 3 Adults with a BMI of 35 kg/m^2 or more and obesity-related comorbidities, or a BMI of 40 kg/m^2 or more, are offered a referral to tier 3 services if tier 2 interventions have been unsuccessful.

Statement 4 Children and young people with a BMI at or above the 98th centile are assessed for comorbidities.

Statement 5 People 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 assessment in a tier 3 service (or equivalent) for bariatric surgery.

Statement 6 Adults with a BMI above 50 kg/m^2 are offered an assessment for bariatric surgery in a tier 3 service (or equivalent).

Statement 7 People who have had bariatric surgery have a postoperative follow-up care package within the bariatric surgery service for a minimum of 2 years.

Statement 8 People discharged from bariatric surgery service follow-up are offered monitoring of nutritional status at least once a year.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Question 3 Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Question 4 Is there currently variation in the provision or quality of pre-operative psychological assessment carried out before bariatric surgery?

Questions about the individual quality statements

Question 5 For draft statement 1: Is it realistic for BMI or BMI centile to be calculated at all first outpatient appointments after referral? If not, are there priority patient groups, hospital departments or types of outpatient appointment that this statement should focus on?

Question 6 For draft statement 2: Should this discussion about likely resulting health problems take place at the outpatient appointment?

Question 7 For draft statement 2: Is it realistic to have a discussion about BMI and health risks at all outpatient appointments? If not, are there priority patient groups, hospital departments or types of outpatient appointment that this statement should focus on?

Question 8 For draft statement 3: Are there sufficient tier 3 services available nationally to make this statement achievable?

Question 9 For draft statement 4: Where should children and young people with a BMI at or above the 98th centile be referred for assessment of comorbidities?

Question 10 For draft quality statement 8: Are there examples, or details, of shared-care models for nutritional management after discharge from the bariatric service that we could reference in the definitions section of this statement?

Quality statement 1: Measurement of BMI in secondary care

Quality statement

People who attend their first hospital outpatient appointment after referral have their current BMI or BMI centile calculated.

Rationale

The increasing prevalence of overweight and obesity can make it harder for people to recognise that they are (or are at risk of becoming) overweight or obese. It is therefore important to use every possible opportunity to measure BMI, or BMI centile for children and young people, including contacts with secondary care services.

Quality measures

Structure

Evidence of local arrangements and written protocols to ensure that people who attend their first hospital outpatient appointment after referral have their current BMI or BMI centile calculated.

Data source: Local data collection.

Process

Proportion of first outpatient appointments attended after referral at which a person's current BMI or BMI centile is calculated.

Numerator – the number in the denominator at which a person's current BMI or BMI centile is calculated (or at which a person refused to have their BMI measured).

Denominator – the number of first outpatient appointments attended after referral.

Data source: Local data collection. Hospital episode statistics – hospital outpatient activity.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as hospitals) ensure that people attending their first outpatient appointment after referral have their current BMI or BMI centile calculated and recorded whenever possible. This necessitates ensuring that scales and measuring equipment are available. Service providers should also ensure that staff 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.

Healthcare professionals (such as nurses, physiotherapists and healthcare assistants) ensure that they calculate current BMI or BMI centile for people attending their first outpatient appointment after referral. This may be done as part of pre-assessment for an outpatient appointment to ensure that BMI can be discussed during the outpatient appointment.

Commissioners (clinical commissioning groups) ensure that they commission outpatient services that calculate the current BMI or BMI centile for people attending their first outpatient appointment after referral.

What the quality statement means for patients and carers

People going to their first hospital appointment have their height and weight measured at the hospital to check if they are overweight or obese.

Source guidance

- Obesity: identification, assessment and management (2014) NICE guideline CG189, recommendation 1.2.1
- Weight assessment and management clinics (tier 3 services) (2014) Royal College of Surgeons

Definitions of terms used in this quality statement

Current BMI or BMI centile

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

BMI measurement in children and young people should be related to the UK 1990 BMI charts to give age- and gender-specific information. BMI centiles can be identified using the Royal College of Paediatrics and Child Health's UK-WHO growth charts.

[Adapted from Obesity: identification, assessment and management (NICE guideline CG189), recommendation 1.2.12]

Question for consultation

Is it realistic for BMI or BMI centile to be calculated at all first outpatient appointments after referral? If not, are there priority patient groups, hospital departments or types of outpatient appointment that this statement should focus on?

Quality statement 2: Discussion of BMI with outpatients in secondary care

Quality statement

People identified as being overweight or obese, or at health risk due to their weight, at an outpatient appointment have a discussion during the appointment about their BMI and the likely resulting health problems.

Rationale

It is important that people understand what their BMI, or BMI centile, score means in terms of their degree of overweight or obesity, and the associated risks to their health. It is important to use every possible opportunity to ensure that people understand the risks to their health associated with their weight, including contacts with secondary care services.

Quality measures

Structure

Evidence of local arrangements to ensure that people who are identified as overweight or obese, or at health risk due to their weight, at an outpatient appointment have a discussion during the appointment about their BMI and the likely resulting health problems.

Data source: Local data collection.

Process

Proportion of people who are identified as overweight or obese, or at health risk due to their weight, at an outpatient appointment who have a discussion during the appointment about their BMI and the likely resulting health problems.

Numerator – the number in the denominator who have a discussion about their BMI and the likely resulting health problems during the appointment.

Denominator – the number of people who are identified as being overweight or obese, or at health risk due to their weight, at an outpatient appointment.

Data source: Local data collection

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (secondary care providers) ensure that healthcare professionals are able to assess the health risks associated with BMI or BMI centile scores, and are able to discuss risks with people (and their families or carers, as appropriate) who have a BMI that shows they are overweight or obese, or at health risk due to their weight. Service providers should also ensure that healthcare professionals are aware that people of black African, African–Caribbean and Asian family origin are at an increased risk of chronic health conditions at a lower BMI.

Healthcare professionals (such as nurses, hospital clinicians and consultants) ensure that they assess the health risks associated with a person's BMI or BMI centile score and discuss the likely resulting health problems, ensuring that there is time in the consultation to answer questions.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission outpatient services in which healthcare professionals 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 due to their weight.

What the quality statement means for patients and carers

People who are identified as being at health risk because of their weight have a discussion with a healthcare professional during their appointment 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 (2014) NICE guideline CG189, recommendation 1.4.8
- Weight assessment and management clinics (tier 3 services) (2014) Royal College of Surgeons

Definitions of terms used in this quality statement

BMI centile

BMI measurement in children and young people should be related to the UK 1990 BMI charts to give age- and gender-specific information. BMI centiles can be identified using the Royal College of Paediatrics and Child Health's UK-WHO growth charts.

[Adapted from Obesity: identification, assessment and management (NICE guideline CG189), recommendation 1.2.12]

Likely resulting health problems

Guidance on defining the degree of overweight or obesity and assessing associated health risks can be found in section 1.2 of the NICE 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.

[Obesity: identification, assessment and management (NICE guideline CG189), recommendation 1.4.8]

People identified as being overweight or obese, or at health risk due to their weight

People are classified as being overweight if their BMI is 25.0–29.9 kg/m^2 and obese if their BMI is 30.0 kg/m^2 or more. BMI should be interpreted with caution in highly muscular adults because it may be a less accurate measure of adiposity in this group. Some other population groups, such as people of Asian family origin and older people, have risk factors that are of concern at different BMIs. Clinical judgement should be used when considering risk factors in these groups, even in people not classified as overweight or obese. BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (NICE guideline

PH46) provides further advice on assessing how body mass index (BMI) in these groups links to the risk of a range of non-communicable diseases.

[Adapted from Obesity: identification, assessment and management (NICE guideline CG189), recommendations 1.2.7 and 1.2.8]

Assessing the BMI of children is more complicated than for adults because it changes as they grow and mature. In addition, growth patterns differ between boys and girls. Thresholds that take into account a child's age and sex are used to assess whether their BMI is too high or too low. These are usually derived from a reference population, known as a child growth reference, with the data presented in BMI centile charts. In a clinical assessment, a child or young person on or above the 98th centile is classified as obese. A child or young person on or above the 91st centile, but below the 98th centile, is classified as overweight.

[Weight management: lifestyle services for overweight or obese children and young people (NICE guideline PH47)]

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.

Questions for consultation

Should this discussion about likely resulting health problems take place at the outpatient appointment?

Is it realistic to have a discussion about BMI and health risks at all outpatient appointments? If not, are there priority patient groups, hospital departments or types of outpatient appointment that this statement should focus on?

Quality statement 3: Referral to tier 3 services for adults

Quality statement

Adults with a BMI of 35 kg/m^2 or more and obesity-related comorbidities, or a BMI of 40 kg/m^2 or more, are offered a referral to tier 3 services if tier 2 interventions have been unsuccessful.

Rationale

Tier 3 services provide specialist multidisciplinary team assessment and interventions for people in whom lower level interventions have not been successful. These can include very-low-calorie diets, pharmacotherapy, specialist psychological support and referral for bariatric surgery.

Quality measures

Structure

Evidence of local arrangements and written protocols to ensure that adults with a BMI of 35 kg/m^2 or more and obesity-related comorbidities, or a BMI of 40 kg/m^2 or more, and for whom tier 2 interventions have been unsuccessful, are offered a referral to tier 3 services.

Data source: Local data collection

Process

a) Proportion of adults with a BMI of 35 kg/m^2 or more and obesity-related comorbidities, and for whom tier 2 interventions have been unsuccessful, who are offered a referral to tier 3 services.

Numerator – the number in the denominator who are offered a referral to tier 3 services.

Denominator – the number of adults with a BMI of 35 kg/m^2 or more and obesity-related comorbidities, and for whom tier 2 interventions have been unsuccessful.

Data source: Local data collection

b) Proportion of adults with a BMI of 40 kg/m^2 or more, and for whom tier 2 interventions have been unsuccessful, who are offered a referral to tier 3 services.

Numerator – the number in the denominator who are offered a referral to tier 3 services.

Denominator – the number of adults with a BMI of 40 kg/m^2 or more, and for whom tier 2 interventions have been unsuccessful.

Data source: Local data collection

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (GP practices and secondary care) ensure that they have agreed pathways for referral to tier 3 services and that healthcare professionals are aware of criteria for referral to these services and how to make a referral.

Healthcare professionals (such as GPs, nurses and diabetologists) ensure that they offer referral to tier 3 services for adults who have a BMI of 35 kg/m^2 or more and obesity-related comorbidities, or a BMI of 40 kg/m^2 or more, if tier 2 interventions have been unsuccessful. Healthcare professionals should ensure that they emphasise to the patient 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 (clinical commissioning groups) ensure that they commission locally available tier 3 services and that there are agreed pathways for referral to these services.

What the quality statement means for patients and carers

Adults whose body mass index (a measure of height and weight, usually shortened to BMI) is 40 or more, or 35 or more and who have conditions such as type 2 diabetes, high blood pressure, high cholesterol or heart disease are referred to a specialist weight loss clinic if they have not been able to lose weight by dieting or participating in weight-loss programmes.

Source guidance

- Obesity: identification, assessment and management (2014) NICE guideline CG189, recommendation 1.3.7
- Weight assessment and management clinics (tier 3) (2014) Royal College of Surgeons

Definitions of terms used in this quality statement

Obesity-related comorbidities

These include type 2 diabetes, metabolic syndrome, hypertension, obstructive sleep apnoea, cardiovascular disease, osteoarthritis, dyslipidaemia, functional disability, infertility and depression if specialist advice is needed for management.

[Adapted from Weight assessment and management clinics (tier 3) (Royal College of Surgeons 2014); expert opinion; and Obesity: identification, assessment and management (NICE guideline CG189), recommendation 1.3.6]

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 Weight management: lifestyle services for overweight or obese adults (NICE guideline PH53)]

Tier 3 services

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 their activities.

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 should be used when considering whether to refer to tier 3 services at lower BMI values. People with learning difficulties may have different cognitive and social needs compared with the general population. Tier 3 services should be made accessible to address this need.

Question for consultation

Are there sufficient tier 3 services available nationally to make this statement achievable?

Quality statement 4: Assessment for comorbidities in children and young people

Quality statement

Children and young people with a BMI at or above the 98th centile are assessed for comorbidities.

Rationale

Children who have a BMI at or above the 98th centile are obese and are at high risk of comorbidities. Early identification of comorbidities in obese children and young people will improve quality of life by ensuring that conditions are managed and treated sooner, and will also reduce the risk of premature mortality. The presence of a comorbidity can also influence decisions about the choice of intervention to use for weight management.

Quality measures

Structure

Evidence of local arrangements and written protocols to ensure that children and young people with a BMI at or above the 98th centile are assessed for comorbidities.

Data source: Local data collection

Process

Proportion of children and young people with a BMI at or above the 98th centile who are assessed for comorbidities.

Numerator – the number in the denominator who are assessed for comorbidities.

Denominator – the number of children and young people identified with a BMI at or above the 98th centile.

Data source: Local data collection

Outcome

Number of children and young people with a BMI at or above the 98th centile diagnosed with a comorbidity.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as GP practices and paediatric services) ensure that children and young people with a BMI at or above the 98th centile are assessed for comorbidities.

Healthcare professionals (such as GPs and paediatricians) ensure that children and young people with a BMI at or above the 98th centile are assessed for comorbidities.

Commissioners (clinical commissioning groups) ensure that they commission locally available services for assessing comorbidities in children and young people with a BMI at or above the 98th centile and that services they commission have agreed pathways for referral to these services.

What the quality statement means for patients and carers

Children and young people who are obese have a check-up to find out if they have any other health problems, such as asthma, high blood pressure or type 2 diabetes, that may have been caused by their weight.

Source guidance

- Obesity: identification, assessment and management (2014) NICE guideline CG189, recommendation 1.3.8
- Weight assessment and management clinics (Tier 3) (2014) Royal College of Surgeons

Definitions of terms used in this quality statement

BMI centiles

BMI measurement in children and young people should be related to the UK 1990 BMI charts to give age- and gender-specific information. BMI centiles can be identified using the Royal College of Paediatrics and Child Health's UK-WHO growth charts.

[Adapted from Obesity: identification, assessment and management (NICE guideline CG189), recommendation 1.2.12]

Comorbidities

These include hypertension, hyperinsulinaemia, dyslipidaemia, type 2 diabetes, psychosocial dysfunction and exacerbation of conditions such as asthma.

[Obesity: identification, assessment and management (NICE guideline CG189), recommendation 1.3.9]

Question for consultation

Where should children and young people with a BMI at or above the 98th centile be referred for assessment of comorbidities?

Quality statement 5: Bariatric surgery assessment for people with obesity and recent-onset type 2 diabetes

Quality statement

People 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 assessment in a tier 3 service (or equivalent) for bariatric surgery.

Rationale

Bariatric surgery can improve quality of life and reduce the risk of premature mortality for people with obesity and recent-onset type 2 diabetes by improving glycaemic control and reducing or delaying the need for diabetic medication. Tier 3 services (or equivalent if tier 3 services are not available locally) provide multidisciplinary assessments that will help determine if a person is suitable for, or wants, bariatric surgery or if a different option that the multidisciplinary tier 3 team can offer is more suitable or preferable.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that people 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 assessment for bariatric surgery in a tier 3 service (or equivalent).

Data source: Local data collection.

Process

Proportion of people 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 assessment for bariatric surgery in a tier 3 service (or equivalent).

Numerator – the number in the denominator who have an expedited assessment for bariatric surgery in a tier 3 service (or equivalent).

Denominator – the number of people 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: Local data collection

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (primary care providers, secondary care providers and tier 3 services) ensure that people 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 assessment for bariatric surgery in a tier 3 service (or equivalent).

Healthcare professionals (such as GPs, diabetologists and endocrinologists) ensure that they offer an expedited assessment for bariatric surgery in a tier 3 service (or equivalent) to people with a BMI of 35 kg/m^2 or more who have been diagnosed with type 2 diabetes in the past 10 years. Healthcare professionals should explain the benefits of bariatric surgery, and also the benefits of non-surgical options, when offering referral for assessment.

Commissioners (clinical commissioning groups) ensure that they commission tier 3 services that can provide an expedited assessment for bariatric surgery and that pathways are in place locally to ensure that people 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 assessed by equivalent services until tier 3 services are available.

What the quality statement means for patients and carers

People who were diagnosed with type 2 diabetes within the past 10 years and whose body mass index (a measure of height and weight, usually shortened to BMI) is 35 or over are offered an assessment in a specialist service 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 (2014) NICE guideline CG189, recommendation 1.11.1

Definitions of terms used in this quality statement

Expedited assessment

The criterion that all appropriate non-surgical measures must have been tried before assessment for bariatric surgery can be considered a treatment option does not need to be met before referral for assessment for bariatric surgery in people with type 2 diabetes (and a BMI of 35 kg/m^2 or more).

[Adapted from Obesity: identification, assessment and management (NICE guideline CG189)]

Tier 3 service (or equivalent)

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, in order to facilitate their timely pathway through for bariatric surgery, people should be supported and evaluated in the short term by equivalent services until tier 3 services become available. For example, medical assessment could be done within a tier 4 service if properly configured with a full multidisciplinary team that includes a physician.

[Adapted from Obesity: identification, assessment and management (NICE guideline CG189)]

Equality and diversity considerations

People of Asian family origin have comorbidity risk factors that are of concern at BMI scores different from those of the general population. Clinical judgement should be used when considering risk factors in these groups. Assessment for bariatric surgery for people of Asian family origin who have recent-onset type 2 diabetes should be

considered at a lower BMI than other populations as long as they are also receiving, or will receive, assessment in a tier 3 service (or equivalent).

[Obesity: identification, assessment and management (NICE guideline CG189), recommendation 1.11.3]

In addition, surgical intervention is not generally recommended in children and young people; bariatric surgery may be considered for young people only in exceptional circumstances, and if they have achieved or nearly achieved physiological maturity

[Obesity: identification, assessment and management (NICE guideline CG189), recommendations 1.10.12 and 1.10.13]

Quality statement 6: Assessment for bariatric surgery

Quality statement

Adults with a BMI above 50 kg/m^2 are offered an assessment for bariatric surgery in a tier 3 service (or equivalent).

Rationale

Bariatric surgery can improve quality of life and reduce the risk of premature mortality, and is an important option for adults with a BMI above 50 kg/m^2. 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 postoperative follow-up. Assessing all these criteria will identify people with a BMI above 50 kg/m^2 who could benefit from bariatric surgery.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with a BMI above 50 kg/m^2 are offered assessment for bariatric surgery in a tier 3 service (or equivalent).

Data source: Local data collection

Process

Proportion of adults with a BMI above 50 kg/m^2 who are offered an assessment for bariatric surgery in a tier 3 service (or equivalent).

Numerator – the number in the denominator who are offered an assessment for bariatric surgery in a tier 3 service (or equivalent).

Denominator – the number of adults with a BMI above 50 kg/m^2.

Data source: Local data collection

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (tier 3 services or equivalent) ensure that adults with a BMI above 50 kg/m^2 for whom other interventions have not been effective are offered assessment for bariatric surgery.

Healthcare professionals ensure that adults with a BMI above 50 kg/m^2 for whom other interventions have not been effective are offered assessment for bariatric surgery.

Commissioners (clinical commissioning groups) ensure that services that they commission offer assessment for bariatric surgery to adults with a BMI above 50 kg/m^2 for whom other interventions have not been effective.

What the quality statement means for patients and carers

Adults whose body mass index (a measure of height and weight, usually shortened to BMI) is more than 50 and who have not been able to lose weight are offered an assessment in a specialist service 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 (2014) NICE guideline CG189, recommendation 1.10.7

Definitions of terms used in this quality statement

Assessment for bariatric surgery

Bariatric surgery is a treatment option for people with obesity if all of the following criteria are fulfilled:

- All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss.
- The person has been receiving or will receive intensive management in a tier 3 service.
- The person is generally fit for anaesthesia and surgery.

- The person commits to the need for long-term follow-up.

[Adapted from Obesity: identification, assessment and management (NICE guideline CG189), recommendation 1.10.1]

Quality statement 7: 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

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: Local data collection

Process

Proportion of people who have had bariatric surgery who are offered 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 last 2 years.

Data source: Local data collection

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (bariatric surgery 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 (clinical commissioning groups and NHS England) 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 should 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).

What the quality statement means for patients and carers

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 (2014) NICE guideline CG189, recommendation 1.12.1

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.

[Obesity: identification, assessment and management (NICE guideline CG189), recommendation 1.12.1]

Quality statement 8: 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.

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. To provide this care, monitoring arrangements and responsibilities need to be agreed locally.

Quality measures

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.

Data source: Local data collection.

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

Data source: Local data collection

Process

Proportion of people discharged from bariatric surgery service follow-up who have at least annual monitoring of nutritional status and appropriate supplementation.

Numerator – the number in the denominator who have had their nutritional status monitored within the past year.

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

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (primary care providers and tier 3 services) ensure that they agree care protocols for people who are discharged from bariatric surgery service follow-up.

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 provide appropriate supplementation if needed.

Commissioners (clinical commissioning groups and NHS England) ensure that local shared-care protocols 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.

What the quality statement means for patients and carers

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.

Source guidance

- Obesity: identification, assessment and management (2014) NICE guideline CG189, recommendation 1.12.2

Definitions of terms used in this quality statement

Monitoring of nutritional status

This involves identifying any nutritional deficiencies after bariatric surgery and providing appropriate nutritional supplements.

[Adapted from Obesity: identification, assessment and management (NICE guideline CG189)]

Shared-care management protocol for people who are discharged from bariatric surgery service follow-up

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 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 Obesity: identification, assessment and management (NICE guideline CG189)]

The Clinical Reference Group's 'Guidelines for the follow-up of patients undergoing bariatric surgery' provides further detail and potential models of shared-care protocols for postoperative management of people who have had bariatric surgery. [This document will be referenced once it has published]

Question for consultation

Are there examples, or details, of shared-care models for nutritional management after discharge from the bariatric service that we could reference in the definitions section of this statement?

Status of this quality standard

This is the draft quality standard released for consultation from 14 December 2015 to 14 January 2016. It is not NICE's final quality standard on obesity: clinical assessment and management. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 14 January 2016. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from May 2016.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

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, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

NICE's quality standard service improvement template helps providers to make an initial assessment of their service compared with a selection of quality statements. It includes assessing current practice, recording an action plan and monitoring quality improvement.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in development sources.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

Good communication between health, public health and social care practitioners and people who are overweight or obese is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People who are overweight or obese should have access to an interpreter or advocate if needed.

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.

Development sources

Further explanation of the methodology used can be found in the quality standards process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Obesity: identification, assessment and management (2014) NICE guideline CG189
- Weight assessment and management clinics (tier 3 services) (2014) Royal College of Surgeons

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Health and Social Care Information Centre (2015) Statistics on obesity, physical activity and diet – England, 2015
- National Obesity Forum (2014) State of the nation's waistline 2014 – obesity in the UK: analysis and expectations
- Royal College of Physicians (2015) Action on obesity: comprehensive care for all
- NHS England and Public Health England (2014) Joint report on commissioning obesity services
- National Institute for Health and Care Excellence (2014) Uptake data on obesity: identification, assessment and management of overweight and obesity in children, young people and adults
- Public Health England (2014) Obesity and fitness: the relation between obesity, cardiorespiratory fitness and mortality
- Public Health England (2014) Changes in children's body mass index between 2006/7 and 2012/13
- Public Health England (2014) Adult obesity and type 2 diabetes
- Public Health England (2014) Obesity and disability: children and young people
- Public Health England (2013) Obesity and disability: adults
- Public Health England (2015) Child obesity and excess weight prevalence by Clinical Commissioning Group
- NHS England (2013) Service specification: severe and complex obesity (all ages)

- NHS England (2013) A05/P/a Clinical commissioning policy: complex and specialised obesity surgery
- Academy of Medical Royal Colleges (2013) Measuring up: the medical profession's prescription for the nation's obesity crisis
- National Audit Office (2012) An update on the government's approach to tackling obesity
- National Obesity Observatory (2012) Obesity and alcohol: an overview
- NCEPOD (2012) Bariatric surgery: too lean a service?
- Public Health England (2012) SACN Statement defining child underweight, overweight and obesity
- Royal College of Paediatrics and Child Health (2012) Childhood obesity: position statement
- Department of Health (2011) Healthy lives, healthy people: a call to action on obesity in England
- Department of Health (2011) Strategic high impact changes: childhood obesity
- British Psychological Society (2011) Obesity in the UK: a psychological perspective

Definitions and data sources for the quality measures

- Health and Social Care Information Centre (2015) Hospital episode statistics – hospital outpatient activity
- The National Bariatric Surgery Register (2014) The 2014 national bariatric surgery register report
- National Institute for Health and Care Excellence (2014) Obesity: identification, assessment and management NICE guideline CG189, recommendation 1.2.1
- Royal College of Surgeons (2014) Weight assessment and management clinics (Tier 3 services)

Related NICE quality standards

Published

- Maternal and child nutrition (2015) NICE quality standard 98

- Obesity in children and young people: prevention and lifestyle weight management programmes (2015) NICE quality standard 94
- Physical activity: for NHS staff, patients and carers (2015) NICE quality standard 84
- Nutrition support in adults (2012) NICE quality standard 24
- Diabetes in adults (2011) NICE quality standard 6

In development

- Obesity in adults: prevention and lifestyle weight management programmes. Publication expected January 2016.
- Diabetes in children and young people. Publication expected June 2016.
- Diabetes in adults (update). Publication expected August 2016.

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Early years: promoting health and well-being in the early years, including those in complex families.
- Physical activity: encouraging activity within the general population.

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 2. Membership of this committee is as follows:

Mr Ben Anderson
Consultant in Public Health, Public Health England

Mr Barry Attwood

Lay member

Professor Gillian Baird

Consultant Developmental Paediatrician, Guy's and St Thomas' NHS Foundation Trust, London

Dr Ashok Bohra

Consultant Surgeon, Royal Derby Hospital

Dr Guy Bradley-Smith

Freelance GP and Clinical Commissioning Lead for Learning Disability, North, East and West (NEW) Devon Clinical Commissioning Group

Mrs Julie Clatworthy

Governing Body Nurse, Gloucester Clinical Commissioning Group

Mr Michael Fairbairn

Quality Manager, NHS Trust Development Authority

Mr Derek Cruickshank

Consultant Gynaecological Oncologist/Chief of Service, South Tees NHS Foundation Trust

Mrs Jean Gaffin

Lay member

Dr Anjan Ghosh

Consultant in Public Health, Public Health Merton, London

Mr Jim Greer

Principal Lecturer, Teesside University

Mr Malcolm Griffiths

Consultant Obstetrician and Gynaecologist, Luton and Dunstable University Hospital NHS Foundation Trust

Dr Ulrike Harrower
Consultant in Public Health Medicine, Public Health England

Mr Gavin Lavery
Clinical Director, Public Health Agency

Dr Tessa Lewis
GP and Medical Adviser in Therapeutics, Aneurin Bevan University Health Board

Ms Robyn Noonan
Area Service Manager Learning Disability, Oxfordshire County Council

Dr Michael Rudolf (Chair)
Hon. Consultant Physician, London North West Healthcare NHS Trust

Dr Anita Sharma
GP and Clinical Director of Vascular and Medicine Optimisation, Oldham Clinical Commissioning Group

Dr Amanda Smith
Director of Therapies, Health Service and Governance, Powys Teaching Health Board

Ms Ruth Studley
Director of Strategy and Development, Healthcare Inspectorate Wales

The following specialist members joined the committee to develop this quality standard:

Professor Rachel Batterham
Head of Obesity Services, University College London/University College London Hospitals

Mr Ken Clare
Lay member

Dr Rachel Holt

Consultant Clinical Psychologist/Clinical Lead, Derbyshire Community Health Services Foundation Trust

Dr Carly Hughes

Clinical Lead, Fakenham Weight Management Service, Fakenham medical practice

Dr Mars Skae

Consultant in Paediatric Endocrinology, Royal Manchester Children's Hospital

Miss Lucy Turnbull

Clinical Lead Dietitian, Central London Community NHS Trust

Mr Richard Welbourn

Consultant Surgeon, Musgrove Park Hospital, Taunton, Somerset

NICE project team

Associate Director

Nick Baillie

Consultant Clinical Adviser

Karen Slade

Programme Manager

Esther Clifford

Project Manager

Jenny Mills

Senior Technical Analyst

Alison Tariq

Technical Analyst

Thomas Walker

Coordinator

Nicola Cunliffe

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.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

ISBN: