

Obesity: clinical assessment and management

Quality standard

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This standard is based on CG189.

This standard should be read in conjunction with QS111, QS98, QS94, QS84, QS24, QS6, QS125, QS9 and QS152.

Introduction

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

This quality standard does not cover public health strategies to prevent people becoming overweight or obese, 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 111). 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 reach 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
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<p>1 Preventing people from dying prematurely</p>	<p>Overarching indicators</p> <p>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare</p> <p>i Adults ii Children and young people</p> <p>1b Life expectancy at 75</p> <p>i Males ii Females</p> <p>Improvement areas</p> <p>Reducing premature mortality from the major causes of death</p> <p>1.1 Under 75 mortality rate from cardiovascular disease*</p> <p>1.2 Under 75 mortality rate from respiratory disease*</p> <p>1.3 Under 75 mortality rate from liver disease*</p> <p>1.4 Under 75 mortality rate from cancer*</p> <p>i One- and ii Five-year survival from all cancers</p> <p>Reducing premature mortality in people with mental illness</p> <p>1.5 i Excess under 75 mortality rate in adults with serious mental illness*</p> <p>ii Excess under 75 mortality rate in adults with common mental illness*</p>
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<p>2 Enhancing quality of life for people with long-term conditions</p>	<p>Overarching indicator</p> <p>2 Health-related quality of life for people with long-term conditions**</p> <p>Improvement areas</p> <p>Ensuring people feel supported to manage their condition</p> <p>2.1 Proportion of people feeling supported to manage their condition</p> <p>Improving functional ability in people with long-term conditions</p> <p>2.2 Employment of people with long-term conditions* **</p> <p>Reducing time spent in hospital by people with long-term conditions</p> <p>2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions</p> <p>ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s</p> <p>Enhancing quality of life for people with mental illness</p> <p>2.5 i Employment of people with mental illness**</p> <p>ii <i>Health-related quality of life for people with mental illness**</i></p> <p>Improving quality of life for people with multiple long-term conditions</p> <p>2.7 <i>Health-related quality of life for people with three or more long-term conditions**</i></p>
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<p>3 Helping people to recover from episodes of ill health or following injury</p>	<p>Overarching indicators</p> <p>3a Emergency admissions for acute conditions that should not usually require hospital admission</p> <p>3b Emergency readmissions within 30 days of discharge from hospital*</p> <p>Improvement areas</p> <p>Improving outcomes from planned treatments</p> <p>3.1 Total health gain as assessed by patients for elective procedures</p> <p><i>i Physical health-related procedures</i></p> <p><i>ii Psychological therapies</i></p> <p><i>iii Recovery in quality of life for patients with mental illness</i></p>
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<p>4 Ensuring that people have a positive experience of care</p>	<p>Overarching indicators</p> <p>4a Patient experience of primary care</p> <p>i GP services</p> <p>4b Patient experience of hospital care</p> <p>4c <i>Friends and family test</i></p> <p>4d <i>Patient experience characterised as poor or worse</i></p> <p>i <i>Primary care</i></p> <p>ii <i>Hospital care</i></p> <p>Improvement areas</p> <p>Improving people's experience of outpatient care</p> <p>4.1 Patient experience of outpatient services</p> <p>Improving hospitals' responsiveness to personal needs</p> <p>4.2 Responsiveness to inpatients' personal needs</p> <p>Improving children and young people's experience of healthcare</p> <p>4.8 <i>Children and young people's experience of inpatient services</i></p> <p>Improving people's experience of integrated care</p> <p>4.9 <i>People's experience of integrated care</i>**</p>
<p>Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework</p> <p>* Indicator is shared</p> <p>** Indicator is complementary</p> <p>Indicators in italics in development</p>	

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

Domain	Objectives and indicators
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<p>1 Improving the wider determinants of health</p>	<p>Objective</p> <p>Improvements against wider factors that affect health and wellbeing and health inequalities</p> <p>Indicators</p> <p>1.3 Pupil absence</p> <p>1.9 Sickness absence rate</p> <p>1.16 Utilisation of outdoor space for exercise/health reasons</p> <p>1.18 Social isolation*</p>
<p>2 Health improvement</p>	<p>Objective</p> <p>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</p> <p>Indicators</p> <p>2.6 Excess weight in 4–5 and 10–11 year olds</p> <p>2.11 Diet</p> <p>2.12 Excess weight in adults</p> <p>2.13 Proportion of physically active and inactive adults</p> <p>2.17 Recorded diabetes</p> <p>2.23 Self-reported well-being</p>
<p>4 Healthcare public health and preventing premature mortality</p>	<p>Objective</p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities</p> <p>Indicators</p> <p>4.3 Mortality rate from causes considered preventable**</p> <p>4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)*</p> <p>4.5 Under 75 mortality rate from cancer*</p> <p>4.6 Under 75 mortality rate from liver disease*</p> <p>4.7 Under 75 mortality rate from respiratory diseases*</p> <p>4.13 Health-related quality of life for older people</p>

Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework

* Indicator is shared

** Indicator is complementary

Indicators in italics in development

Safety and people's experiences of care

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. They specify 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. They also cover 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 sources 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 are informed of their BMI when it is calculated and advised about any associated health risks.

Statement 2. Adults with a BMI of 30 or more for whom tier 2 interventions have been unsuccessful have a discussion about the choice of alternative interventions for weight management, including tier 3 services.

Statement 3. 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.

Statement 4. Adults with a BMI of 35 or more who have been diagnosed with type 2 diabetes within the past 10 years are offered an expedited referral for bariatric surgery assessment.

Statement 5. Adults with a BMI above 50 are offered a referral for bariatric surgery assessment.

Statement 6. 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 7. 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.

Quality statement 1: Informing people of their BMI

Quality statement

People are informed of their 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

Structure

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

Data source: Local data collection.

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: Local data collection.

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: Local data collection.

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: Local data collection.

Outcome

a) Patient awareness of their BMI measurement.

Data source: Local data collection.

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

Data source: Local data collection.

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

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 (clinical commissioning groups and NHS England) 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.

What the quality statement means for patients and carers

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](#) (2014) NICE guideline CG189, recommendations 1.2.1, 1.2.10 and 1.2.12
- [Weight assessment and management clinics \(tier 3\)](#) (2014) Royal College of Surgeons

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).

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]

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 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]

Once people are informed of their BMI they can be made aware of local lifestyle weight management programmes, in line with statement 6 in [obesity in adults: prevention and lifestyle weight management programmes](#) (NICE quality standard 111) and statement 5 in [obesity in children and young people: prevention and lifestyle weight management programmes](#) (NICE quality standard 94).

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 a BMI of 30 or more 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

Structure

Evidence of local arrangements and written protocols to ensure that adults with a BMI of 30 or more 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: Local data collection.

Process

Proportion of adults with a BMI of 30 or more 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 a BMI of 30 or more for whom tier 2 interventions have been unsuccessful.

Data source: Local data collection.

Outcome

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

Data source: Local data collection.

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

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 who have a BMI of 30 or more 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 (clinical commissioning groups) ensure that they commission locally available tier 3 services, or equivalent, 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, often shortened to BMI) is 30 or more 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 \(2014\) NICE guideline CG189, recommendations 1.1.2, 1.2.7 and 1.3.7](#)
- [Weight assessment and management clinics \(tier 3\) \(2014\) Royal College of Surgeons](#)

Definitions of terms used in this quality statement

BMI

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

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

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

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

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: Local data collection.

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: Local data collection.

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: Local data collection.

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: Local data collection.

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

Data source: Local data collection.

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

Data source: Local data collection.

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

Data source: Local data collection.

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

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 (clinical commissioning groups) 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.

What the quality statement means for patients and carers

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](#) (2014) NICE guideline CG189, recommendation 1.3.10
- [Weight assessment and management clinics \(tier 3\)](#) (2014) Royal College of Surgeons
- [Management of obesity: a national clinical guideline](#) (2010) SIGN, section 19.2.3

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]

Significant comorbidities

These include benign intracranial hypertension, sleep apnoea, obesity hypoventilation syndrome, hyperinsulinaemia, type 2 diabetes, dyslipidaemia, orthopaedic problems and psychological

morbidity.

[[Management of obesity: a national clinical guideline \(SIGN\)](#), section 19.2.3 and expert opinion]

Complex needs

These include learning disabilities, chronic illness, physical disability and other additional needs.

[[Obesity: identification, assessment and management \(2014\) NICE guideline CG189](#), 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 BMI of 35 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

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with a BMI of 35 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: Local data collection.

Process

Proportion of adults with a BMI of 35 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 or more who have been diagnosed with type 2 diabetes within the past 10 years.

Data source: Local data collection.

Outcome

Bariatric surgery assessments for adults with a BMI of 35 or more 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 and secondary care providers) ensure that adults with a BMI of 35 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 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 (clinical commissioning groups) 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 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.

What the quality statement means for patients and carers

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 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](#) (2014) NICE guideline CG189, recommendation 1.11.1

Definitions of terms used in this quality statement

BMI

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

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

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 [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 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 Asian family origin diagnosed with type 2 diabetes within the past 10 years should be considered at a lower BMI than other populations.

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

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.

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

Quality statement 5: Referring adults for bariatric surgery assessment

Quality statement

Adults with a BMI above 50 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 above 50. 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 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 are offered a referral for bariatric surgery assessment.

Data source: Local data collection.

Process

Proportion of adults with a BMI above 50 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 above 50.

Data source: Local data collection.

Outcome

Bariatric surgery assessments for adults with a BMI above 50.

Data source: Local data collection.

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

Service providers (primary, community-based and secondary care tier 3 services or equivalent) ensure that adults with a BMI above 50 are offered a referral for bariatric surgery assessment.

Healthcare professionals ensure that adults with a BMI above 50 are offered a referral for bariatric surgery assessment.

Commissioners (NHS England and clinical commissioning groups) ensure that services that they commission offer a referral for bariatric surgery assessment to adults with a BMI above 50.

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 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](#) (2014) NICE guideline CG189, recommendation 1.10.7

Definitions of terms used in this quality statement

BMI

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

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

Referral for bariatric surgery assessment

The assessment aims to establish whether bariatric surgery is suitable for the person. 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 had 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]

Equality and diversity considerations

People of Asian family origin 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 Asian family origin should be considered at a lower BMI than other populations.

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

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.

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

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

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 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: Local data collection.

Outcome

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

Data source:Local data collection.

b) Patient satisfaction with bariatric surgery.

Data source:Local data collection.

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

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 (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 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]

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.

[[Obesity: identification, assessment and management](#) (NICE full guideline CG189), section 8.1.3.2]

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

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: Local data collection.

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: 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 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: Local data collection.

Outcome

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

Data source: Local data collection.

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

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 (clinical commissioning groups and NHS England) 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.

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. 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 \(2014\) 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, 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 [Obesity: identification, assessment and management \(NICE guideline CG189\)](#) 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 [Obesity: identification, assessment and management \(NICE guideline CG189\)](#)]

[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.

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. 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 \(tier 3\) \(2014\) Royal College of Surgeons](#)
- [Management of obesity \(2010\) SIGN guideline 115](#)

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](#)
- Public Health England (2015) [Child obesity and excess weight prevalence by Clinical Commissioning Group](#)
- 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](#)
- National Obesity Forum (2014) [State of the nation's waistline 2014 – obesity in the UK: analysis and expectations](#)
- Public Health England (2014) [Adult obesity and type 2 diabetes](#)
- Public Health England (2014) [Changes in children's body mass index between 2006/7 and 2012/13](#)

- Public Health England (2014) [Obesity and disability: children and young people](#)
- Public Health England (2014) [Obesity and fitness: the relation between obesity, cardiorespiratory fitness and mortality](#)
- Academy of Medical Royal Colleges (2013) [Measuring up: the medical profession's prescription for the nation's obesity crisis](#)
- 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](#)
- Public Health England (2013) [Obesity and disability: adults](#)
- 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](#)
- British Psychological Society (2011) [Obesity in the UK: a psychological perspective](#)
- 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](#)

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](#)
- [Obesity: identification, assessment and management \(2014\) NICE guideline CG189, recommendation 1.2.1](#)

- Royal College of Surgeons (2014) Weight assessment and management clinics (tier 3)

Related NICE quality standards

Published

- [Diabetes in children and young people \(2016\) NICE quality standard 125](#)
- [Obesity in adults: prevention and lifestyle weight management programmes \(2016\) NICE quality standard 111](#)
- [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

- [Early years: promoting health and well-being in the early years, including those in complex families](#). Publication expected August 2016.
- [Diabetes in adults](#). 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:

- 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:

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Lay member

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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](#).

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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
- Royal College of Physicians