NICE National Institute for Health and Care Excellence

NICE quality standard

# Overweight and obesity management

Quality standard

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This standard replaces QS94, QS111 and QS127.

This standard is based on NG246 and PH49.

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In 2025 this quality standard was updated and statements prioritised previously were updated (2016, updated 2025) or replaced (new 2025). For more information, see update information.

The previous versions of the quality standards for obesity are available as pdf files:

- obesity: clinical assessment and management
- obesity in adults: prevention and lifestyle weight management programmes
- obesity in children and young people: prevention and lifestyle weight management programmes.

# Quality statement 1: Recording BMI and waist-to-height ratio in adults

## Quality statement

Adults with a long-term condition have at least annual recording of their BMI and, if they have a BMI lower than 35 kg/m$^2$, recording of waist-to-height ratio. **[new 2025]**

## Rationale

Regular measurement and recording of BMI, or BMI and waist-to-height ratio if somebody has a BMI lower than 35 kg/m$^2$ (taking into account increased risks based on ethnic background), during a consultation for a long-term condition allows all of the following:

- definition of overweight, obesity and central adiposity
- prediction or identification of weight-related conditions
- identification of changes in weight and central adiposity.

It can also help in assessment and management of a long-term condition. Healthcare professionals should seek permission in a sensitive, non-judgmental way before discussing and measuring weight, because people may then be more receptive to offers of support that could have a positive impact on their health. Healthcare professionals should avoid attributing all symptoms to weight (diagnostic overshadowing) and the purpose of the appointment should always be prioritised.

## Quality measures

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

## Process

a) Proportion of adults with a long-term condition who have a recorded BMI in the last 12 months.

Numerator – the number in the denominator who have a recorded BMI in the last 12 months.

Denominator – the number of adults with a long-term condition.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from the electronic medical record. For some long-term conditions, national data collection and reporting are already in place:

- Quality and Outcomes Framework indicator MH006 reports the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months.
- The National Diabetes Audit reports the percentage of people with type 1 and type 2 diabetes who have a record of BMI in the preceding 12 months.
- CVDPREVENT indicator CVDP001BMI reports the percentage of patients aged 18 and over, with GP recorded coronary heart disease, stroke or transient ischaemic attack, peripheral arterial disease, heart failure, diabetes mellitus, non-diabetic hyperglycaemia, familial hypercholesterolaemia, chronic kidney disease, hypertension or atrial fibrillation whose notes record BMI status in the preceding 12 months.
- NHS Digital Health and Care of People with Learning Disabilities includes data on the percentage of registered patients on the learning disability register who have had a health check annually.

b) Proportion of adults with a long-term condition whose most recent BMI was lower than 35 kg/$m^2$ who have a recorded waist-to-height ratio in the last 12 months.

Numerator – the number in the denominator with a recorded waist-to-height ratio in the last 12 months.

Denominator – the number of adults with a long-term condition whose most recent BMI was lower than 35 kg/$m^2$.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from the electronic medical record.

# What the quality statement means for different audiences

**Service providers** (such as primary care services and secondary care services) ensure that adults with a long-term condition can have their BMI and, if needed, waist-to-height ratio recorded at least annually. They ensure that healthcare professionals have appropriate equipment to measure height, weight and waist circumference and systems to record BMI and waist-to-height ratio.

**Healthcare professionals** (such as doctors, nurses and allied health professionals) accurately measure and record height and weight of adults with a long-term condition at least annually, and if they have a BMI of under 35 kg/$m^2$ also record waist circumference. They are able to identify when it is appropriate to take measurements and ask for permission before discussing weight. They approach conversations in a sensitive, non-judgemental way and respect the person's choice (and that of their family or carer, if relevant) if they do not wish to discuss their weight.

**Commissioners** ensure that they commission services in which adults with a long-term condition can have their BMI and, if needed, waist-to-height ratio recorded at least annually.

**Adults with a long-term condition** have their BMI (weight and height), and their waist-to-height ratio (waist measurement and height) if they have a BMI lower than 35 kg/$m^2$, recorded at least annually by healthcare professionals if they consent to this.

# Source guidance

Overweight and obesity management. NICE guideline NG246 (2025), recommendations 1.9.2, 1.9.3, 1.9.7 and 1.9.8

The 12-month timeframe in the quality statement is based on advice from the NICE quality standards advisory committee. The timeframe is not derived from the NICE guideline on overweight and obesity management. It is considered a practical timeframe to enable stakeholders to measure performance.

# Definitions of terms used in this quality statement

## Long-term condition

There is no definitive list of long-term conditions. For quality improvement purposes, services could focus on conditions such as:

- chronic obstructive pulmonary disease
- coronary heart disease
- hypertension
- diabetes: type 1 or type 2 diabetes or at high risk of developing type 2 diabetes (a high-risk score and a fasting plasma glucose of 5.5 to 6.9 mmol/litre, or HbA1c of 42 to 47 mmol/mol)
- dyslipidaemia
- heart failure
- learning disability
- obstructive sleep apnoea
- peripheral arterial disease
- polycystic ovary syndrome
- rheumatoid arthritis
- schizophrenia, bipolar disorder or other psychoses
- stroke or transient ischemic attack.

[NICE's guideline on chronic obstructive pulmonary disease in over 16s, recommendation 1.2.103; NICE's guideline on psychosis and schizophrenia in adults, recommendation 1.1.2.5; NICE's guideline on bipolar disorder, recommendation 1.2.12; NICE's guideline on type 2 diabetes: prevention in people at high risk, recommendation 1.6.5; NICE's CKS on polycystic ovarian syndrome, NICE's indicator on learning disabilities, NICE's technology appraisal guidance on tirzepatide for managing overweight and obesity and expert opinion]

# Equality and diversity considerations

Reasonable adjustments should be considered when measuring height and weight in adults with a learning or physical disability. This may include use of seated or hoisted scales, or scales that will accept a wheelchair, measuring height with a tape measure, rollameter, or with the person lying down. Measurements may need to be modified for example using sitting height or demi-span (the distance between the mid-point of the sternal notch and the finger roots with the arms outstretched laterally) instead of overall height, meaning specialist assessment may be needed. [NICE's guideline on overweight and obesity, rationale and impact section for classifying overweight, obesity and central adiposity in adults and Public Health England's guidance on obesity and weight measurement for people with learning disabilities].

People with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean background are prone to central adiposity and so are at an increased risk of chronic weight-related conditions at a lower BMI. For people in these groups, obesity class 3 (BMI 35 kg/$m^2$ to 39.9 kg/$m^2$) is usually identified by reducing the threshold by 2.5 kg/$m^2$.

BMI should be interpreted with caution in people aged 65 and over, taking into account comorbidities, conditions that may affect functional capacity and the possible protective effect of having a slightly higher BMI when older.

# Quality statement 2: Recording BMI in children and young people aged over 2 years

## Quality statement

Children and young people aged over 2 years have opportunistic recording of their BMI at key points of contact with a healthcare professional. **[new 2025]**

## Rationale

Measurement and recording of BMI during key points of contact allows all of the following:

- definition of overweight and obesity
- prediction or identification of weight-related conditions
- identification of changes in weight.

Healthcare professionals should seek permission from the family or carer and the child or young person in a sensitive, non-judgmental way before discussing and measuring weight, because they may then be more receptive to offers of support that could have a positive impact on their health. Healthcare professionals should avoid attributing all symptoms to weight (diagnostic overshadowing) and the purpose of the appointment should always be prioritised.

## Quality measures

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

### Process

Proportion of children and young people aged over 2 years that have had an appointment with a healthcare professional in the last 12 months, who have a recorded BMI in the last 12 months.

Numerator – the number in the denominator who have a recorded BMI in the last 12 months.

Denominator – the number of children and young people aged over 2 years that have had an appointment with a healthcare professional in the last 12 months.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from the electronic medical record.

## What the quality statement means for different audiences

**Service providers** (such as primary care services and secondary care services) ensure that children and young people can have their BMI recorded opportunistically. They ensure that healthcare professionals have appropriate equipment to measure height and weight, and systems to record BMI.

**Healthcare professionals** (such as doctors, nurses and allied health professionals) accurately measure and record height and weight of children and young people opportunistically. They are able to identify when it is appropriate to take measurements and ask for permission before discussing weight. They approach conversations in a sensitive, non-judgemental way and respect the person's choice (and that of their family or carer, if relevant) if they do not wish to discuss their weight.

**Commissioners** ensure that they commission services in which children and young people can have their BMI recorded.

**Children and young people aged over 2 years** have their BMI (weight and height) taken and recorded by healthcare professionals when there is an appropriate opportunity at routine health checks and non-urgent appointments, if they consent to this.

# Source guidance

Overweight and obesity management. NICE guideline NG246 (2025), recommendations 1.10.1 to 1.10.4, and 1.10.7

The 12-month timeframe in the process measure is based on advice from the NICE quality standards advisory committee. The timeframe is not derived from the NICE guideline on overweight and obesity management. It is considered a practical timeframe to enable stakeholders to measure performance.

# Definitions of terms used in this quality statement

## Key points of contact

Recording of BMI can take place based on practitioner judgement and with permission at potentially suitable opportunities such as routine health checks and non-urgent appointments (such as immunisation appointments). [Adapted from NICE's guideline on overweight and obesity management, recommendations 1.10.3 and1.10.4]

# Equality and diversity considerations

Reasonable adjustments should be considered when measuring height and weight in children and young people with a learning or physical disability. This may include special growth charts, use of seated or hoisted scales, or scales that will accept a wheelchair, measuring height with a tape measure, rollameter, or with the person lying down. Measurements may need to be modified for example using sitting height or demi-span (the distance between the mid-point of the sternal notch and the finger roots with the arms outstretched laterally) instead of overall height, meaning specialist assessment may be needed. [NICE's guideline on overweight and obesity, rationale and impact section for measures of overweight, obesity and central adiposity in children and young people and Public Health England's guidance on obesity and weight measurement for people with learning disabilities].

# Quality statement 3: Access to services for people with a learning disability

## Quality statement

People with a learning disability are supported to access overweight and obesity management services. **[new 2025]**

## Rationale

People with a learning disability are at greater risk of obesity than the general population and may need tailored support to access services that can help them achieve or maintain a healthy lifestyle and manage their weight. They may benefit from tailored messaging, targeted follow up after intervention, changes to local service and commissioning approaches, and services accessible for people with different complexity of needs.

## Quality measures

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

### Structure

Evidence of action plans that identify strategies and measures for people with a learning disability to access overweight and obesity management services.

**Data source:** Evidence can be collected from information recorded locally by healthcare professionals and provider organisations, for example local health equity audits.

### Outcome

a) Rates of access to overweight and obesity management services, by the population with a learning disability and the population without a learning disability.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from the electronic medical record.

b) Prevalence of overweight in people with a learning disability.

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

c) Prevalence of obesity in people with a learning disability.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from the electronic medical record.

# What the quality statement means for different audiences

**Service providers** (including residential and supported living services, primary care, weight management services and specialist weight management services) ensure that they provide information and services that are accessible to people with a learning disability, and that their staff are trained to consider the individual needs of people accessing the service.

**Health and social care practitioners** (including residential and supported living care staff, GPs, nurses, dietitians) consider the needs of people with a learning disability when delivering information and services on weight management.

**Commissioners** ensure that the local approach to delivering weight management services engages with and is coproduced by people with a learning disability and their carers, and that services consider their needs (including when providing information) to reduce health inequalities experienced by people with a learning disability. They undertake an equality assessment of the diverse needs of their population, specifically people with a learning disability, and conduct local health equity audits of their services to identify areas where access and services are not equitable.

**People with a learning disability** are supported and have their needs recognised when receiving information or accessing weight management services, including annual health checks and when taking part in care plans. Their family and carers are involved if

appropriate.

# Source guidance

Overweight and obesity management. NICE guideline NG246 (2025), recommendation 1.19.2

# Equality and diversity considerations

Some people with a learning disability, such as those who may lack capacity or those experiencing homelessness, may benefit from the involvement of an advocate when discussing available local interventions and national programmes (see NICE's guideline on advocacy services for adults with health and social care needs).

# Quality statement 4: Maintaining details of local and national overweight and obesity management interventions and services

## Quality statement

Local authorities and healthcare commissioning organisations maintain and give access to an up-to-date list of local and national overweight and obesity management interventions and services. **[new 2025]**

## Rationale

Overweight and obesity management interventions and services can be delivered by a range of organisations and in different locations, both locally and nationally. Local authorities and healthcare commissioning organisations should maintain an up-to-date list of services and make it available to the public and health and social care organisations and practitioners. Maintaining a list of available services is important to ensure that the public know about the services in their area and how to enrol in them. It is essential that any information is up to date to avoid people disengaging after trying to access unavailable services.

## Quality measures

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

**Structure**

a) Evidence of local arrangements to ensure that lists of local and national overweight and obesity management interventions and services are kept up to date.

**Data source:** Data can be collected from information recorded locally by provider organisations, for example from service level agreements, audits, and key performance indicators.

b) Evidence of local arrangements to ensure that organisations in the public, community and voluntary sectors are given access to lists of local and national overweight and obesity management interventions and services.

**Data source:** Data can be collected from information recorded locally by provider organisations, for example from service level agreements, audits, and key performance indicators.

# What the quality statement means for different audiences

**Service providers** (including health promotion services, primary care, behavioural overweight and obesity management services) ensure that they provide details of their service to relevant local authorities and health commissioning organisations. They make them aware when these details are updated or are no longer relevant.

**Health and social care practitioners** (including GPs, nurses, health promoters, dietitians) have access to up-to-date information on available local interventions and national programmes.

**Commissioners** ensure that they coordinate, maintain and make accessible up-to-date information on available local and national interventions and services that are accessible within the areas they commission.

**People interested in treatment for overweight, obesity or central adiposity** have access to up-to-date information on services that may help them manage their weight.

# Source guidance

Overweight and obesity management. NICE guideline NG246 (2025), recommendations 1.11.5, 1.19.20, 1.19.21, 1.19.24 and 1.19.25

# Quality statement 5: Providing information about local and national weight management interventions and services

## Quality statement

People identified as living with overweight, obesity or central adiposity are given sources of information and details of local and national interventions and services. **[new 2025]**

## Rationale

Understanding what interventions and services are available and what they involve will help to ensure that people identified as living with overweight, obesity or central adiposity can engage with the most appropriate interventions and services that meet their needs and preferences.

## Quality measures

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

### Process

Proportion of people identified as living with overweight, obesity or central adiposity in the last 12 months who receive information on local and national interventions and services in the last 12 months.

Numerator – the number in the denominator who receive information on local and national interventions and services in the last 12 months.

Denominator – the number of people identified as living with overweight, obesity or central

adiposity in the last 12 months.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from the electronic medical record.

### Outcome

Rates of access to local and national interventions and services by people living with overweight, obesity or central adiposity.

**Data source:**The National Obesity Audit includes the number of weight management service referrals by provider.

## What the quality statement means for different audiences

**Service providers** (including health promotion services, primary care, behavioural overweight and obesity management services) ensure that their staff have access to information on local and national interventions and services and give this to people identified as living with overweight, obesity or central adiposity.

**Health and social care practitioners** (including GPs, nurses, health promoters, dietitians) ensure that they know what local and national interventions and services are available and that they are aware of the details of what each involves, and give this to people identified as living with overweight, obesity or central adiposity when appropriate.

**Commissioners** ensure that they maintain lists of up-to-date information on available local and national interventions and services that are accessible within the areas they commission, and make it available to the public and health and social care organisations and practitioners.

**People interested in treatment for overweight, obesity or central adiposity** are given information on services that may help them manage their weight.

## Source guidance

Overweight and obesity management. NICE guideline NG246 (2025), recommendations

1.3.4, 1.11.5, 1.11.11 and 1.12.6

The 12-month timeframe in the process measure is based on advice from the NICE quality standards advisory committee. The timeframe is not derived from the NICE guideline on overweight and obesity management. It is considered a practical timeframe to enable stakeholders to measure performance.

# Definitions of terms used in this quality statement

## Overweight, obesity and central adiposity

Overweight and obesity are chronic, relapsing and progressive conditions characterised by excess body fat, that can lead to significant health and social difficulties associated with an increased risk of morbidity and mortality.

In adults they are usually defined by body mass index measurements:

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

Clinical judgement should be used when interpreting the healthy weight category because a person in this category may nevertheless have central adiposity (the accumulation of excess fat in the abdominal area). People with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African–Caribbean background are prone to central adiposity and their cardiometabolic risk occurs at lower BMI, so lower BMI thresholds should be used as a practical measure of overweight and obesity:

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

BMI should be interpreted with caution in adults with high muscle mass because it may be a less accurate measure of central adiposity in this group.

BMI should be interpreted with caution in people aged 65 and over, taking into account comorbidities, conditions that may affect functional capacity and the possible protective effect of having a slightly higher BMI when older.

BMI can be used as a practical estimate of overweight and obesity in children and young people if charts used are appropriate for children and young people and adjusted for age and sex:

- overweight: BMI 91st centile + 1.34 standard deviations (SDs)
- clinical obesity: BMI 98th centile + 2.05 SDs
- severe obesity: BMI 99.6th centile + 2.68 SDs.

Central adiposity in adults with a BMI under 35 $kg/m^2$ of both sexes and all ethnicities, including adults with high muscle mass, can be classified based on waist-to-height ratio:

- healthy central adiposity: waist-to-height ratio 0.4 to 0.49, indicating no increased health risks
- increased central adiposity: waist-to-height ratio 0.5 to 0.59, indicating increased health risks
- high central adiposity: waist-to-height ratio 0.6 or more, indicating further increased health risks.

Central adiposity in children and young people of both sexes and all ethnicities can be based on waist-to-height ratio as follows:

- healthy central adiposity: waist-to-height ratio 0.4 to 0.49, indicating no increased health risk
- increased central adiposity: waist-to-height ratio 0.5 to 0.59, indicating increased health risk
- high central adiposity: waist-to-height ratio 0.6 or more, indicating further increased health risk.

[Adapted from NICE's guideline on overweight and obesity management, recommendations 1.9.10, 1.9.11, 1.9.14, 1.10.7, 1.10.9, 1.10.10, 1.19.12 and 1.19.13]

# Equality and diversity considerations

Some people living with overweight, obesity or central adiposity, such as those who may lack capacity, those with a learning disability or those experiencing homelessness may benefit from the involvement of an advocate when discussing available local interventions and national programmes (see NICE's guidelines on advocacy services for adults with health and social care needs and integrated health and social care for people experiencing homelessness).

# Quality statement 6: Wraparound care alongside medicines for weight management

## Quality statement

People living with overweight or obesity who are prescribed medicines for weight management receive wraparound care focusing on diet, nutrition and increasing physical activity. **[new 2025]**

## Rationale

Medicines for weight management are recommended as options for people with relevant clinical criteria (specific to the medicine). The decision to start medicines should be made after discussion, and providing information, support and counselling on additional dietary, physical activity and behavioural strategies.

## Quality measures

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

### Process

Proportion of people living with overweight or obesity who are prescribed medicines for weight management who receive wraparound care.

Numerator – the number in the denominator receiving wraparound care.

Denominator – the number of people living with overweight or obesity who are prescribed medicines for weight management.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from the electronic medical record.

### Outcome

Rates of overweight and obesity in people aged 16 and over.

**Data source:**Health Survey for England.

## What the quality statement means for different audiences

**Service providers** (specialist overweight and obesity management services, primary care) ensure that protocols are in place for providing information, support and counselling on additional dietary, physical activity and behavioural strategies alongside prescription of medicines for weight management.

**Health and social care practitioners** (GPs, overweight and obesity management service staff) ensure that they provide and record any outcomes of information, support and counselling on additional dietary, physical activity and behavioural strategies alongside prescription of medicines for weight management.

**Commissioners** ensure that any services able to prescribe medicines for weight management have protocols in place to ensure that information, support and counselling on additional dietary, physical activity and behavioural strategies are provided alongside them.

**People living with overweight and obesity** receive support with making changes to what they eat and how active they are when they are given medicines to manage their weight.

## Source guidance

Overweight and obesity management. NICE guideline NG246 (2025), recommendations 1.17.1 to 1.17.3 and 1.17.8 to 1.17.11

# Definitions of terms used in this quality statement

## Medicines for weight management

Medicines for managing a person's weight that are prescribed after dietary, exercise and behavioural approaches have been started and evaluated, and after discussion and agreement by adults living with overweight or obesity.

Medicines options for weight management in adults:

- tirzepatide
- semaglutide
- liraglutide
- orlistat.

Weight management medicines are not generally recommended for children under 12 years. In children under 12, medicines may be used only in exceptional circumstances, if severe comorbidities are present. Prescribing should be started and monitored only in specialist paediatric settings.

In children aged 12 years and over, treatment with orlistat is recommended only if physical comorbidities (such as orthopaedic problems or sleep apnoea) or severe psychological comorbidities are present, and if started in a specialist paediatric setting by a multidisciplinary team.

Medicines for children and young people may be continued in primary care, for example with a shared-care protocol, if local circumstances or licensing allow. [Adapted from NICE's guideline on overweight and obesity management, recommendations 1.17.1, 1.17.3 and 1.17.8 to 1.17.11. NICE's technology appraisal guidance on tirzepatide for managing overweight and obesity, NICE's technology appraisal guidance on semaglutide for managing overweight and obesity, and NICE's technology appraisal guidance on liraglutide for managing overweight and obesity]

## Wraparound care

Information and support focusing on diet, nutrition and increasing physical activity. It is

available through specialist weight management services or at the point of prescribing in primary care through the NHS England national programme and locally commissioned services. [Adapted from NICE's guideline on overweight and obesity management, recommendations 1.17.2 and 1.17.10]

# Quality statement 7: Advice and support after stopping medicines for weight management or completing behavioural interventions

## Quality statement

People who are stopping medicines for weight management or have completed a behavioural overweight and obesity management intervention are given advice for maintaining changes and support for improving their health and wellbeing. **[new 2025]**

## Rationale

Advice and support for maintaining weight after stopping medicines for weight management or completing a behaviour change intervention can help to prevent weight regain and weight cycling. It can also help people to maintain changes and enable them to experience long-term benefits.

## Quality measures

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

### Process

a) Proportion of people who have stopped taking medicines for weight management and been given advice for maintaining changes and support for improving their health and wellbeing.

Numerator – the number in the denominator given advice for maintaining changes and support for improving their health and wellbeing.

Denominator – the number of people who have stopped taking medicines for weight management.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from behavioural overweight and obesity management service records.

b) Proportion of people who have completed a behavioural overweight and obesity management intervention and been given advice for maintaining changes and support for improving their health and wellbeing.

Numerator – the number in the denominator given advice for maintaining changes and support for improving their health and wellbeing.

Denominator – the number of people who have completed a behavioural overweight and obesity management intervention.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from behavioural overweight and obesity management service records.

# What the quality statement means for different audiences

**Service providers** (specialist overweight and obesity management services, primary care) ensure that they have protocols in place for providing advice for maintaining changes and support for improving health and wellbeing at the end of prescribing or as part of discharge from the service. They should be embedded in care planning protocols, training and templates.

**Healthcare professionals** (dietitians, nutritionists, behavioural overweight and obesity management specialists, GPs) ensure that they deliver advice for maintaining changes and support for improving health and wellbeing at the end of prescribing or as part of discharge from the service and care planning.

**Commissioners** ensure that they commission services that provide advice for maintaining changes and support for improving health and wellbeing, and that there are established

pathways into ongoing support for people stopping medicines for weight management or completing behavioural change interventions.

**People living with overweight, obesity or central adiposity** stop taking weight management medication or leave weight management services with advice about how they can maintain their weight and know where to find support.

# Source guidance

- Behaviour change: individual approaches. NICE guideline PH49 (2014), recommendation 10
- Overweight and obesity management. NICE guideline NG246 (2025), recommendations 1.12.10, 1.14.32, 1.17.5 and 1.19.6

# Definitions of terms used in this quality statement

## Advice for maintaining changes and support for improving their health and wellbeing

Ensuring that people stopping medicines for weight management or leaving behavioural weight management services after completing a behavioural overweight and obesity management intervention:

- receive feedback and monitoring at regular intervals for a minimum of 1 year so they can get help if they are not maintaining changes
- have well-rehearsed action plans (such as 'if–then' plans) that they can easily put into practice if they are not maintaining changes
- have thought about how they can make changes to their own immediate physical environment to prevent weight regain
- have the social support they need to maintain changes
- are helped to develop routines that support the new behaviour (note that small, manageable changes to daily routine are most likely to be maintained)
- are offered a range of options for follow-up sessions after an intervention active phase

has been completed, including at different times and in easily accessible and suitable venues.

And ensuring that weight management interventions encourage people to make lifelong behavioural changes and prevent future weight gain, by:

- fostering independence and self-management (including self-monitoring)
- encouraging dietary behaviours that support weight maintenance and can be sustained in the long term (for example, emphasise that national programmes promoting healthy eating like NHS Better Health can support overweight and obesity management)
- emphasising the wider benefits of keeping up levels of physical activity over the long term
- discussing strategies to overcome any difficulties in maintaining behavioural changes
- encouraging family-based changes
- discussing sources of ongoing support once the intervention or referral period has ended (opportunities could include the programme itself, online resources or support groups, other local services or activities, and help from family or friends).

[Adapted from NICE's guideline on behaviour change: individual approaches, recommendation 10 and NICE's guideline on overweight and obesity management, recommendations 1.14.32 and 1.19.6]

# Quality statement 8: Monitoring after discharge from the bariatric surgery service

## Quality statement

Adults discharged from the bariatric surgery service have follow up at least annually, as part of a shared-care model between specialist weight management services and primary care. **[2016, updated 2025]**

## Rationale

Lifelong nutritional monitoring and supplementation is important after bariatric surgery to avoid nutritional deficiencies that can cause long-term harm. After discharge from the bariatric surgery service an agreed shared-care model of management should be in place with collaboration between specialist weight management services and primary care as well as locally agreed monitoring arrangements and responsibilities. This will enable follow up care, at least annually, to ensure the benefits from bariatric surgery are maximised and prevent harm.

## Quality measures

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

### Process

Proportion of adults discharged from the bariatric surgery service more than 12 months ago with a record of follow up by a primary care or specialist weight management service in the preceding 12 months.

Numerator – the number in the denominator who have a record of follow up by a primary

care or specialist weight management service in the preceding 12 months.

Denominator – the number of adults discharged from the bariatric surgery service more than 12 months ago.

**Data source:** Data can be collected from information recorded locally by healthcare professionals, for example from the electronic medical record.

### Outcome

Proportion of adults who had bariatric surgery who developed a micronutrient deficiency.

Numerator – the number in the denominator who developed a micronutrient deficiency.

Denominator – the number of adults who had bariatric surgery.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from the electronic medical record.

## What the quality statement means for different audiences

**Service providers** (such as secondary care services, specialist weight management services and primary care services) ensure that adults who have had bariatric surgery have lifelong annual follow up as part of an agreed shared-care model of management between specialist weight management services and primary care.

**Healthcare professionals** (such as GPs, nurses and dietitians) offer lifelong annual follow-up care as part of an agreed share-care model between specialist weight management services and primary care.

**Commissioners** ensure that they commission services that provide lifelong follow-up care for adults who have had bariatric surgery. They ensure commissioning of shared-care models of management between specialist weight management services and primary care.

**Adults who have had an operation to help them to lose weight (called bariatric surgery) and have been discharged from the bariatric surgery service** have a check-up at least

once a year for the rest of their life to make sure they are getting the support they need.

# Source guidance

Overweight and obesity management. NICE guideline NG246 (2025), recommendation 1.18.18

# Definitions of terms used in this quality statement

## Follow up

Follow up after discharge from a bariatric service involves identifying any nutritional deficiencies, including vitamins, minerals and trace elements, after bariatric surgery and providing appropriate nutritional supplements. Other elements of follow up could include weight check, assessment of comorbidities such as hypertension, sleep apnoea, atherosclerosis disease and metabolic dysfunction-associated steatotic liver disease, investigation of abnormal test results and appropriate treatment and review of potential concerning symptoms such as vomiting and heartburn. There should be a process in place to allow primary care clinicians to liaise with the local bariatric unit or specialist weight management services about patient-specific nutritional deficiencies and necessary treatment (shared-care model of management). [Adapted from NICE's guideline on overweight and obesity management, recommendations 1.18.17 and 1.18.18, Guidelines for the follow-up of patients undergoing bariatric surgery (O'Kane et al. 2016) 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, involving collaboration between named weight management specialists and primary care. The plan should include monitoring arrangements and responsibilities of the specialist weight management service, the GP and the patient. [Adapted from NICE's guideline on overweight and obesity management]

# Update information

**August 2025:** This quality standard was updated and statements prioritised previously were replaced. The topic was identified for update following a review of quality standards. The review identified:

- changes in the priority areas for improvement
- updated guidance on overweight and obesity management
- that the quality standards on overweight and obesity management should be combined.

Statements are marked as:

- **[new 2025]** if the statement covers a new area for quality improvement
- **[2016, updated 2025]** if the statement covers an area for quality improvement included in the 2016 quality standard and has been updated.

The previous versions of the quality standards for obesity are available as pdf files:

- obesity: clinical assessment and management
- obesity in adults: prevention and lifestyle weight management programmes
- obesity in children and young people: prevention and lifestyle weight management programmes.

# 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 high-quality external guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

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

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

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

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

## Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact template and summary report for the NICE guideline on overweight and obesity management to help estimate local costs.

## Diversity, equality and language

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

For all quality statements where information is given, it is important that people are provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with health and social care services. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter if needed. People should also have access to an advocate, if needed, as set out in NICE's guideline on advocacy services for adults with health and social care needs.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

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

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# Endorsing organisation

This quality standard has been endorsed by Department of Health and Social Care, 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.

- Association for the Study of Obesity
- British and Irish Hypertension Society
- Society for Endocrinology
- Primary Care Diabetes and Obesity Society
- Chartered Society of Physiotherapy
- British Obesity and Metabolic Surgery Society (BOMSS)
- Obesity UK
- British Dietetic Association – Obesity Specialist Group