Obesity: Surgical interventions – update

Consultation on draft guideline - Stakeholder comments table
24/02/23 to 24/03/23

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ABL Health	General	General	General	The logic of bariatric surgery makes sense - it likely will reduce the overall spend on overweight and obese patients in the long-run. One criticism though is if a client is in an area where tier 3 is not available and a patient does not want surgery, then what?	Thank you for your comment. The committee are aware of the issues around service provision and that some people may not want surgery. However, the committee noted that regardless of these issues, a comprehensive assessment by a multidisciplinary team within a specialist weight management service was crucial to see whether bariatric surgery is suitable for them. This comprehensive assessment would help identify people for whom bariatric surgery is suitable. Also, patient choice is important, and, in some instances, people may not want surgery. This could mean that alternative treatment options (for example, other locally available specialist weight management services) would need to be discussed using a multidisciplinary approach. The committee did not draft a specific recommendation but highlighted that the principles outlined in the NICE guidance on shared decision making should be followed to ensure patient choice is taken into consideration. The committee discussion section in evidence review A has been amended to highlight this. It should also be noted that the guideline does state that people have the right to be involved in discussion and make informed decision about

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					their care, as described in NICE's information on making decisions about your care. Additionally, the committee were also keen to highlight that the definition of specialist weight management service may encompass tier 3 or tier 4 services but due to variation in commissioning arrangements, it was more important to emphasise the expertise required for this assessment than the setting.
ABL Health	Guideline	005	003	Conditions that can improve weight loss • Add PCOS, back pain that is likely to be contributed by obesity, significant mental health where weight is a central reason for their MH presentation, severe OA requiring surgery. (further down in the explanation at the end, they did say that evidence supporting bariatric surgery for fertility issues and arthritis was not there, but it doesn't mean that bariatric surgery wouldn't help necessarily)	Thank you for your comment. During the development of the review protocol, non-alcoholic fatty liver disease, sleep apnoea, severe asthma, cardiovascular disease, idiopathic intracranial hypertension and depression/anxiety were identified as important comorbidities that could be improved by surgery. Additionally, the protocol included people prevented from receiving treatment because of their obesity e.g., bone marrow and renal transplant, fertility treatment and hip/joint replacements as well as people with impaired physical functionality. PCOS and back pain were not identified as conditions of interest at review protocol stage. Based on the evidence identified, the committee agreed that it was important to include examples of common health conditions that could be

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					improved by surgery to help practitioners decide whether referral was appropriate for those with a BMI below 40 kg/m2. Due to the lack of relevant evidence, the committee were unable to include other conditions in the list, however they agreed that highlighting this list was not exhaustive was important and this has been amended. They also agreed that further research is needed particularly in people who have been refused other treatments because of obesity. Based on this understanding a research recommendation was drafted on the effectiveness and cost effectiveness of bariatric surgery in people needing treatment for other conditions e.g., fertility treatment.
ABL Health	Guideline	005	004	when to offer expedited assessment - please define "expedited" – an assessment at 6 months? (what is the time frame? We currently refer at 6m unless fertility treatment is being sought, cancer, symptomatic previous surgery where we would refer immediately	Thank you for your comment. Recommendations 1.10.3 to 1.10.5 were out of scope for this update. The 2014 guidance did not define 'expedited assessment' but highlighted that the previous guideline committee debated the timing of bariatric surgery, noting that from evidence that having surgery within 3 years of the onset of diabetes could avoid complications but the chances of getting any individual into a bariatric

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					pathway within a 2 year diagnosis of T2DM with current commissioning guidelines would be challenging. The previous guideline committee did agree that surgery within 10 years of diabetes onset could also reduce or delay the need for diabetic medication, however, this reduction may be temporary. Due to these factors, the previous guideline committee did not wish to indicate a specific time frame in their recommendations.
ABL Health	Guideline	006	027	The potential risks and complications – may wish to include stats on impact on mental health and suicide rates (higher)	Thank you for your comment. Recommendation 1.10.8 is out of scope for this update.
ABL Health	Guideline	007	010	Clear information on prescribing post bariatric surgery should be sent to their GP (eg prescribing of vitamins etc and any monitoring instructions) It does mention "shared care" arrangements which may be referring to this.	Thank you for your comment. This is out of scope for the current update which was specifically about referral for bariatric surgery and assessment. However, the committee agreed that further work is required on the shared care models. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. We would also like to draw your attention to NICE Quality Standard 127 on obesity assessment and management which was developed from this guideline; specifically quality statement 7. Under 'definitions of terms used' a description of what is meant by a 'shared care model of management'

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					is provided, along with links to guidelines for the follow-up of patients undergoing bariatric surgery which provides further detail and potential models of shared-care protocols for postoperative management after bariatric surgery.
ABL Health	Guideline	012	000	RE – fertility • We currently expedite a referral if a woman is seeking fertility treatment and meets the local criteria. We do this based on Salford Royals guidance. The aim is to ensure the woman does not miss the age cut off for treatment.	Thank you for your comment. During the development of the review protocol, non-alcoholic fatty liver disease, sleep apnoea, severe asthma, cardiovascular disease, idiopathic intracranial hypertension and depression/anxiety were identified as important comorbidities that could be improved by surgery. Additionally, the protocol included people prevented from receiving treatment because of their obesity e.g., bone marrow and renal transplant, fertility treatment and hip/joint replacements as well as people with impaired physical functionality. Based on the evidence identified, the committee agreed that it was important to include examples of common, significant health conditions that could be improved by surgery to help practitioners decide whether referral was appropriate for those with a BMI below 40 kg/m2. Due to the lack of relevant evidence, the committee were unable to include other conditions in the list, however they agreed that

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					further research is needed particularly in people who have been refused other treatments because of obesity. Based on this understanding a research recommendation was drafted on the effectiveness and cost effectiveness of bariatric surgery in people needing treatment for other conditions e.g., fertility treatment. The committee also agreed that the list should not prohibit people with other conditions being referred for bariatric surgery where appropriate and agreed to highlight in box 1 that this was not an exhaustive list.
Association for the Study of Obesity	Equality impact assessment	General	General	There is recognition of variation in access to services and of deprivation. There is variation in access to receiving the appropriate vitamin and mineral supplements on prescription, with some patients being advised that they must purchase over the counter preparations. The over-the-counter preparations often do not meet the requirements after surgery. Some procedures require different supplements and higher doses. It is essential that we make it easier for people to access and afford the recommended postoperative supplements which will help with adherence.	Thank you for your comment and raising concerns about the variation in receiving supplements on prescription. The remit of this update focused on referring adults for bariatric surgery, therefore further information on vitamin and mineral supplements could not be added. However, NICE have noted that NHS England have already issued guidance for England on when to recommend over-the-counter [OTC] rather than prescribe vitamins and minerals, this has a clear exemption from OTC for those people who have undergone surgery that results in malabsorption (such as bariatric surgery).

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					In addition, the NICE CG189 guideline recommendations set out that people who have undergone bariatric surgery have post-operative monitoring and individualised dietary and nutritional assessment, advice and support (recommendation 1.12.1). Recommendation 1.12.2 also states that people should be offered annual nutritional monitoring and appropriate supplementation following discharge from the initial 2-year bariatric surgery service follow up period.
Association for the Study of Obesity	Evidence review	007	000	We notice that intervention includes Roux-en-Y gastric bypass, Mini gastric bypass / one-anastomosis gastric bypass, Sleeve gastrectomy, Gastric band, Biliopancreatic diversion (with duodenal switch), however, there is no mention of Single Anastomosis Duodenal-Ileal Bypass With Sleeve (SADI-S). Does this mean that the SADI-S is not a NICE approved procedure?	Thank you for your comment. The review question did not focus on the effectiveness of different procedures, rather the question focused what referral criteria is the most effective to achieve weight loss and maintain a healthier weight in adults living with obesity. NICE's guidance on obesity: identification, assessment and management (CG189) does not mention specific procedures. However, NICE's interventional procedures guidance IPG569 recommends that SADI-S should only be used with special arrangements for clinical governance, consent, and audit or research, as evidence on efficacy of SADI-S is limited and there are well-recognised complications.
Association for the Study of Obesity	Evidence review	010	012	Orlistat, liraglutide or semaglutide may be used to maintain or reduce weight before surgery for people	Thank you for your comment. Pharmacological interventions do not feature in the evidence

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				who have been recommended surgery, if the waiting time is excessive. See the recommendations on orlistat in the section on pharmacological interventions and continued prescribing and withdrawal, and NICE's technology appraisal guidance on liraglutide for overweight and obesity, and semaglutide for overweight and obesity.	review as the focus of the review was on the referral criteria for bariatric surgery. However, in response to your comment we have updated an existing recommendation to include orlistat, liraglutide and semaglutide to be in line with the technology appraisals (see recommendation 1.10.12).
Association for the Study of Obesity	Guideline	General	General	There is no reference (e.g. in the pre and post-operative care sections) on providing women of reproductive age with preconception and family planning support. Bariatric surgery can improve fertility rapidly, and there are increased risks for the fetus if pregnancy occurs too quickly or if there are nutritional deficiencies. We need better joined up care between bariatric surgery HCPs and fertility/maternity HCPs.	Thank you for your comment. The remit of the update was on the referral criteria for bariatric surgery, therefore recommendations on pre- and post-operative care were outside the remit of this update. However, the committee agreed that discussing plans for pregnancy is important and have amended recommendation 1.10.8 to include this as part of the discussion. The committee would also like to draw your attention to recommendations in the NICE guideline 'weight management, before during and after pregnancy PH27' which should be followed for this population.
Association for the Study of Obesity	Guideline	004	004	Recommendation 1.10.1 We welcome the rewording which should make it easier for people to access an assessment as to whether bariatric surgery is an appropriate treatment option, and also	Thank you for your comment.

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				have a discussion with specialist weight management health care professionals.	
Association for the Study of Obesity	Guideline	004	012	Rec 1.10.2 For people of South Asian, Chinese, other Asian, Middle Eastern, Black 13 African or African-Caribbean family background consider using a lower BMI threshold for referral (reduced by 2.5 kg/m2 14) than in recommendation 15 1.10.1, if they meet the other criteria. [2023] And 1.10.5 Consider an expedited assessment for bariatric surgery for people of 16 South Asian, Chinese, other Asian, Middle Eastern, Black African or 17 African-Caribbean family background who have recent-onset (diagnosed 18 within the past 10 years) type 2 diabetes at a lower BMI than other populations (reduced by 2.5 kg/m2 19) as long as they are also receiving, or DRAFT FOR CONSULTATION Weight management: NICE guideline DRAFT (February 2023) 6 of 19 1 will receive, assessment in a specialist weight management service. 2 [2014, amended 2023] [CG189 recommendation 1.11.3] We welcome the inclusion of revised BMI criteria for minoritized ethnic groups. However, we question the use of "consider" rather than a clear guideline that these alternative BMI thresholds should be	Thank you for your comment. As highlighted in the NICE manual, if the evidence of efficacy or effectiveness for an intervention is either lacking or too low quality, or too uncertain for firm consultations to be reached, the committee can either make a 'consider' recommendations based on limited evidence, decide not to make a recommendation and make a research recommendation instead, decide not to make a recommendation or a research recommendation, recommend that the intervention is used only in the context of research or make a 'do not offer' recommendation. The rationale and impact section details how no clinical or cost effectiveness evidence was found on the effectiveness of bariatric surgery in adults from minority ethnic family backgrounds. Due to this, stronger recommendations on the use of lower BMI thresholds for assessment for bariatric surgery could not drafted. However, the committee felt it was important to draft recommendation for people of different family backgrounds because their cardiometabolic risk occurs at a lower BMI. A research

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				used due to increased risks at a lower BMI? The use of the term consider is likely to lead to inconsistent interpretation and implementation, and could increase inequalities/postcode lottery relating to access to weight management services for minoritized ethnic groups	recommendation was also drafted to support further research in this field. It should be noted that NICE guidance on obesity identification, assessment and management (CG189) does include firm recommendations (rec 1.2.8) on the general use of lower BMI thresholds as a practical measure of overweight and obesity in people from minority ethnic family backgrounds. This should help address issues in interpretation and implementation of the use of lower BMI thresholds.
Association for the Study of Obesity	Guideline	005	003	Box 1 Examples of common, significant health conditions that could be 3 improved by weight loss We appreciate that the examples of health conditions given are of those where the evidence supports the effectiveness of bariatric surgery. We are concerned that this will be perceived as a definitive list by commissioners, and be a potential barrier to referring people with other conditions for an assessment for bariatric surgery. For example, fertility can be significantly improved with weight loss, and women can't access fertility treatment with a BMI>30 (or >35 depending on local CCG commissioning – another issue of postcode lottery in relation to availability and eligibility for healthcare depending on BMI).	Thank you for your comment. During the development of the review protocol, non-alcoholic fatty liver disease, sleep apnoea, severe asthma, cardiovascular disease, idiopathic intracranial hypertension and depression/anxiety were identified as important comorbidities that could be improved by surgery. Additionally, the protocol included people prevented from receiving treatment because of their obesity e.g., bone marrow and renal transplant, fertility treatment and hip/joint replacements as well as people with impaired physical functionality. Based on the evidence identified, the committee agreed that it was important to include examples of common health conditions that could be improved by surgery to help practitioners decide

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					whether referral was appropriate for those with a BMI below 40 kg/m2. Due to the lack of relevant evidence, the committee were unable to include other conditions in the list, however they agreed that highlighting this list was not exhaustive was important and this has been amended. They also agreed that further research is needed particularly in people who have been refused other treatments because of obesity. Based on this understanding a research recommendation was drafted on the effectiveness and cost effectiveness of bariatric surgery in people needing treatment for other conditions e.g., fertility treatment.
Association for the Study of Obesity	Guideline	006	004	Recommendation 1.10.6 We welcome the emphasis on the multidisciplinary team with the appropriate skills and expertise related to bariatric surgery.	Thank you for your comment.
Association for the Study of Obesity	Guideline	006	008	Recommendation 1.10.7 We welcome the statement to assess "whether any arrangements need to be made, based on the person's needs, ahead of surgery (for example if they need additional dietary or psychological support, or support to manage existing or new comorbidities). It	Thank you for your comment. Recommendation 1.10.17 also states that psychological support tailored to the individual should be offered as part of a follow-up care package.

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				is important that any findings from the assessment are actioned, as often in clinical practice, especially around psychological support, there is psychological support given in preparing for surgery, but very little access to psychological support after surgery.	
Association for the Study of Obesity	Guideline	006	011	"their nutritional needs (for example, dietary intake and eating habits)" Suggest changing terminology "eating habits" to eating behaviours – habit is a very specific term for regularly repeated behaviour that requires little/no thought, learned rather than innate, and developed through reinforcement and repetition. This doesn't describe the wider influences on an individual's eating behaviours and can be stigmatising language in relation to obesity. This applies throughout where eating habits are referred to.	Thank you for your comment. The committee were divided on the correct terminology (eating habits / behaviours) to be used in this instance and when asked, the committee lay members had no strong feelings in either direction. While the committee felt neither term would be acceptable to everyone, they agreed this should be amended to eating 'habits and behaviours',
Association for the Study of Obesity	Guideline	006	019	Recommendation 1.10.8 "the longer-term implications and requirements of surgery". It is good to see the addition of requirements, in addition to potential risks and complications. This also needs to be discussed by other members of the MDT including the dietitian and psychologist. Unfortunately, sometimes the focus may be on how much weight loss can be achieved by the different procedures, and little account taken of the impact on nutrition. For instance, procedures, such as the duodenal switch, have a higher rate of protein	Thank you for your comment. Recommendation 1.10.8 was out of scope for this update. Recommendations 1.10.7 and 1.10.8 highlight the importance of an MDT approach and how different members of the team can take part in the assessment for bariatric surgery.

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				malnutrition, and fat soluble vitamin and trace mineral deficiencies. People need to be able to adhere to a high protein diet and have access to appropriate vitamins and minerals which are not routinely available. Similarly, the one anastomosis gastric bypass with biliopancreatic limb lengths greater than 150 cm also carries higher risks of protein malnutrition and nutritional deficiencies. It is important that the whole MDT have an active role in determining the most appropriate bariatric surgery procedure and take into account the potential impact on nutrition and psychosocial factors which may affect adherence.	
Association for the Study of Obesity	Guideline	007	010	Recommendation 1.10.10 Following bariatric surgery, people need access to vitamin and mineral supplements. It is important that these are considered to be part of the treatment as some commissioning bodies will not permit appropriate vitamin and mineral supplements to be prescribed. This impacts on adherence. Many over the counter vitamin and mineral supplements do not meet the recommendations of the British Obesity and Metabolic Surgery nutritional guidelines.	Thank you for your comment and raising concerns about the variation in receiving supplements on prescription. The remit of this update focused on referring adults for bariatric surgery, therefore further information on vitamin and mineral supplements could not be added. NICE have noted that NHS England have already issued guidance for England on when to recommend over-the-counter [OTC] rather than prescribe vitamins and minerals, this has a clear exemption from OTC for those people who have undergone surgery that results in malabsorption (such as bariatric surgery).

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					The NICE CG189 guideline recommendations set out that people who have undergone bariatric surgery have post-operative monitoring and individualised dietary and nutritional assessment, advice and support (recommendation 1.12.1). Recommendation 1.12.2 also states that people should be offered annual nutritional monitoring and appropriate supplementation following discharge from the initial 2-year bariatric surgery service follow up period.
Association for the Study of Obesity	Guideline	007	018	Recommendation 1.10.11 It is important that the assessment is discussed by the MDT and appropriate actions are put in place to enable people to move forward for surgery. In addition, if additional postoperative support is needed, it is essential that this is provided. Unfortunately, access to psychological support after surgery is often not available.	Thank you for your comment. As highlighted in 1.10.7, the multidisciplinary team should carry out comprehensive assessment to identify people in whom bariatric surgery is suitable. As part of this assessment, assessment should be made of any arrangements that need to be made, based on the person's needs, ahead of surgery (for example if they need additional dietary or psychological support, or support to manage existing or new comorbidities). Furthermore, postoperative follow-up care was outside the scope of this work, but recommendation 1.10.17 does state that psychological support tailored to the individual should be offered to people who have had bariatric surgery for a minimum of 2 years.

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					Additionally, the committee acknowledged that psychological support may not be directly available in the multidisciplinary team, however, they stressed the importance of services offering specialist psychological support before and after surgery (as highlighted in recommendation 1.10.14).
Association for the Study of Obesity	Guideline	008	014	Recommendation 1.10.14 We welcome the greater emphasis on access to postoperative psychological support as often this is not commissioned.	Thank you for comment.
Association for the Study of Obesity	Guideline	009	023	Recommendation 1.10.18 Despite this being a recommendation in 2014, we are not aware that any shared care services have been commissioned. This leaves both primary care health care professionals and patients vulnerable. The implementation of shared care services and access to annual reviews, including nutritional, would help.	Thank you for your comment. This is out of scope for the current update which was specifically about referral for bariatric surgery and assessment. However, the committee agreed that further work on post operative shared care models is important. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure they are up to date. We would also like to draw your attention to NICE Quality Standard 127 on obesity assessment and management which was developed from this guideline; specifically quality statement 7. Under 'definitions of terms used' a description of what is meant by a 'shared care model of management' is provided, along with links to guidelines for the follow-up of patients undergoing bariatric surgery

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					which provides further detail and potential models of shared-care protocols for postoperative management after bariatric surgery.
Association for the Study of Obesity	Guideline	009	028	Recommendation 1.10.19 We would welcome a prospective audit that also includes nutritional status. A comprehensive dataset of nutritional status is not included in the National Bariatric Surgery Registry. In addition, as many bariatric surgery centres discharge patients back to primary care after two years, longer term data is unlikely to be collected. So primary care should be mandated to submit data beyond two years to NBSR.	Thank you for your comment. Recommendation 1.10.19 is out of scope for the current update which was specifically about referral for bariatric surgery and assessment. The committee considered this issue and agreed that they cannot mandate the measures to be included in a national audit or in data collected by primary care.
Association for the Study of Obesity	Guideline	012	010	Although no evidence was found on the effectiveness of bariatric surgery for weight loss in people who had been refused other treatment because of obesity, such as liver or kidney transplant, fertility treatment or joint replacement surgery, this is likely to cause difficulties in clinical practice, especially as recent IFSO ASMBS guidelines, have been published with different recommendations and different BMI thresholds. Although further research is recommended, it will take years to gather the necessary evidence. Meanwhile, will people who need to lose weight prior to transplants, joint replacements, fertility treatment be denied access to treatment?	Thank you for your comment. During the development of the review protocol, non-alcoholic fatty liver disease, sleep apnoea, severe asthma, cardiovascular disease, idiopathic intracranial hypertension and depression/anxiety were identified as important comorbidities that could be improved by surgery. Additionally, the protocol included people prevented from receiving treatment because of their obesity e.g., bone marrow and renal transplant, fertility treatment and hip/joint replacements as well as people with impaired physical functionality. Based on the evidence identified, the committee agreed that it was important to include examples of common, significant health conditions that could be improved by surgery to help practitioners

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					decide whether referral was appropriate for those with a BMI below 40 kg/m2. Due to the lack of relevant evidence, the committee were unable to include other conditions in the list, however they agreed that further research is needed particularly in people who have been refused other treatments because of obesity. Based on this understanding a research recommendation was drafted on the effectiveness and cost effectiveness of bariatric surgery in people needing treatment for other conditions e.g., fertility treatment. The committee also agreed that the list should not prohibit people with other conditions being referred for bariatric surgery where appropriate and agreed to highlight in box 1 that this was not an exhaustive list. Additionally, the committee were aware of the recent IFSO/ASMBS guidelines, but their decisions were made according to the NICE guideline manual and took into account the evidence relevant to our review question. Although the NICE guidance may differ to the guidance provided by IFSO/ASMBS, the committee were confident that their recommendations reflected the evidence they

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					reviewed and their clinical judgement. It is of particular importance to note that the NICE guideline conducted an extensive systematic review on the clinical and cost effectiveness of bariatric surgery in different populations, while the ADA guidance did not systematically take clinical and cost-effectiveness into account.
Association for the Study of Obesity	Health inequalities briefing	General	General	Deprivation, along with other social factors, will affect ability to afford and adhere to the postoperative diet and supplements, hence these must be considered when determining the most appropriate bariatric surgery procedures. Some procedures require a higher protein intake and additional higher doses of fat-soluble vitamins and trace minerals, which are not routinely available.	Thank you for your comment, which we have incorporated into Section 5.1 of the health inequalities briefing. Deprivation is a key consideration reflected throughout the briefing. In addition, NICE's economic methods allow consideration of out-of-pocket expenses, which poverty is highly relevant to. However, we want to emphasise that post-operative nutrition is outside the scope of the guideline update for bariatric surgery. NICE have noted that NHS England have already issued guidance for England on when to recommend over-the-counter [OTC] rather than prescribe vitamins and minerals, this has a clear exemption from OTC for those people who have undergone surgery that results in malabsorption (such as bariatric surgery). In addition, the NICE CG189 guideline recommendations set out that people who have

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					undergone bariatric surgery have post-operative monitoring and individualised dietary and nutritional assessment, advice and support (recommendation 1.12.1). Recommendation 1.12.2 also states that people should be offered annual nutritional monitoring and appropriate supplementation following discharge from the initial 2-year bariatric surgery service follow up period.
Association of Clinical Psychologists UK	Guideline	General	General	Our bariatric service provides surgery for T3 referrals and also a large number of patients from areas with no T3. We find that patients from T3 are generally more 'ready' for surgery (less chaotic eating behaviours, more weight management control, improved coping and info about surgery) but often have slower access to surgery (T4), however, our other patients tend to require more input at bariatric surgery assessment stage because they are not medically optimised and this causes delays for them on the bariatric pathway and more demand on the bariatric team and hospital services for blood tests etc. We would recommend that patients are medically optimised prior to referral (assessed by obesity specialist physician/ endocrinologist) in order to save time on the bariatric pathway.	Thank you for your comment. The committee discussed whether non-surgical measures should be tried, including specialist weight management services (referred to as tier 3 services in NICE's 2014 guidance) before assessing people for surgery. They agreed that requiring people to try specific measures before referral would create an unjustified barrier to effective treatment, and the evidence did not support using surgery only as a last resort. A briefing for NICE guideline developers and committee members on obesity, weight management and health inequalities also noted that in 204/205 Public Health England (PHE), now Office for Health Improvement and Disparities (OHID) conducted a mapping exercise and found that tier 3 services are not available in all parts of the country (only about 21% of the clinical commissioning groups in England included one),

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					and that information on them was limited. So restricting assessment for surgery to those who have already used a tier 3 service could exacerbate health inequalities. The committee emphasised that assessing and planning for optimisation pre-surgery is important to include as part of the MDT assessment and stated in the final bullet point of recommendation 1.10.7: 'whether any arrangements need to be made, based on the person's needs, ahead of surgery (for example if they need additional dietary or psychological support, or support to manage existing or new comorbidities'
Association of Clinical Psychologists UK	Guideline	006	012	…. And psychological adjustment	Thank you for your comment. Recommendation 1.10.7 does state that any arrangements that need to be made, based on the person's needs, ahead of surgery (including psychological support) should be assessed as part of the assessment.
Association of Clinical Psychologists UK	Guideline	007	000	Give the person information on: Realistic expectations regarding psychological adjustment; Transfer addiction (risk); Need for adaptive coping strategies where food previously addressed emotional needs; How to access psychological support post-op	Thank you for your comment. Recommendation 1.10.8 is out of scope for this update.

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Association of Clinical Psychologists UK	Guideline	008	025	'Specialist' psychological support and assessment before surgery i.e. with expertise to recognise impact of psychological problems on weight management and ability to maintain changes (e.g. experience of trauma such as sexual abuse where weight gain has served as a protective factor against/ prevented further abuse and therefore weight loss might cause considerable anxiety and distress following surgery if not expected or managed appropriately)	Thank you for your comment. While this recommendation is out of scope for the current update which was specifically about referral for bariatric surgery and assessment, the committee agree with your comment and have added the term 'specialist' to psychological support to refresh this. This change has also been made to the rationale and impact section of the guideline and the committee discussion section (1.1.11) in evidence review A.
Association of Clinical Psychologists UK	Guideline	010	008	Specialist weight management service is mentioned frequently but those in primary, secondary and community settings might not have the expertise to assess potential candidates for surgery. Would it be helpful to be clear that SWMSs are for patients who are being considered for surgery? SWMSs would require specialist expertise in conducting comprehensive assessment for surgery and therefore would be different to weight management services that offer lifestyle interventions and not specialist obesity physical/endocrine, dietetic, psychological and surgical assessment.	Thank you for your comment. The committee did acknowledge that due to variation in commissioning of services there may be differences in the structure of the MDT and that this assessment for surgery might lie in tier 3 or tier 4 services. They have highlighted in the rationale that ideally the MDT should include a physician, surgeon or bariatric surgeon (as appropriate), registered dietitian and applied psychologist. We have also updated the recommendation to make it clear that the MDT needs to have – or have access to – medical, nutritional and psychological expertise. The rationale and impact section and the committee discussion section (1.1.11) in evidence review A have been amended to highlight this change.

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Association of Clinical Psychologists UK	Guidance	013	004	Perhaps add 'including weight stigma, adjustment and transfer addictions.	The committee recognised there can be both short and long-term risks of complications with this surgery, including those you have listed and others. Because this is not an exhaustive list, the committee have amended this section of the rationale to group these themes under the broader categories of medical, nutritional, psychological, and surgical. The committee have recommended a comprehensive assessment in recommendation 1.10.7 which will address these complications and risks with the person.
British Dietetic Association	Equality impact assessment	General	General	There is recognition of variation in access to services and of deprivation. There is variation in access to receiving the appropriate vitamin and mineral supplements on prescription, with some patients being advised that they must purchase over the counter preparations. The over-the-counter preparations often do not meet the requirements after surgery. Malabsorptive procedures require different supplements and higher doses. It is essential that we make it easier for people to access and afford the recommended postoperative supplements which will help with adherence. From speaking to patients and patient groups, affordability of supplements and prescriptions is a concern.	Thank you for your comment and raising concerns about the variation in receiving supplements on prescription. The remit of this update focused on referring adults for bariatric surgery, therefore further information on vitamin and mineral supplements could not be added. NICE have noted that NHS England have already issued guidance for England on when to recommend over-the-counter [OTC] rather than prescribe vitamins and minerals, this has a clear exemption from OTC for those people who have undergone surgery that results in malabsorption (such as bariatric surgery). The NICE CG189 guideline recommendations set out that people who have undergone bariatric

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					surgery have post-operative monitoring and individualised dietary and nutritional assessment, advice and support (recommendation 1.12.1). Recommendation 1.12.2 also states that people should be offered annual nutritional monitoring and appropriate supplementation following discharge from the initial 2-year bariatric surgery service follow up period.
British Dietetic Association	Evidence review	007	000	We notice that intervention includes Roux-en-Y gastric bypass, Mini gastric bypass / one-anastomosis gastric bypass, Sleeve gastrectomy, Gastric band, Biliopancreatic diversion (with duodenal switch), however, there is no mention of Single Anastomosis Duodenal-Ileal Bypass With Sleeve (SADI-S). Does this mean that the SADI-S is not a NICE approved procedure?	Thank you for your comment. The review question did not focus on the effectiveness of different procedures, rather the question focused what referral criteria is the most effective to achieve weight loss and maintain a healthier weight in adults living with obesity. NICE's guidance on obesity: identification, assessment and management (CG189) does not mention specific procedures. However, NICE's interventional procedures guidance IPG569 recommends that SADI-S should only be used with special arrangements for clinical governance, consent, and audit or research, as evidence on efficacy of SADI-S is limited and there are well-recognised complications.
British Dietetic Association	Guideline	004	004	Recommendation 1.10.1 We welcome the rewording. This may help to reduce the barriers in referring to specialist weight management and having for an assessment as to whether bariatric surgery is an appropriate treatment option.	Thank you for your comment.

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British Dietetic Association	Guideline	004	012	Recommendation 1.10.2 We welcome the recommendation to use a lower BMI threshold for referral for people of South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background.	Thank you for your comment
British Dietetic Association	Guideline	005	002	Box 1 Although it is helpful to have these examples of common, significant health conditions that could be improved by weight loss, this may prevent people with other conditions being referred for an assessment for bariatric surgery.	Thank you for your comment. During the development of the review protocol, non-alcoholic fatty liver disease, sleep apnoea, severe asthma, cardiovascular disease, idiopathic intracranial hypertension and depression/anxiety were identified as important comorbidities that could be improved by surgery. Additionally, the protocol included people prevented from receiving treatment because of their obesity e.g., bone marrow and renal transplant, fertility treatment and hip/joint replacements as well as people with impaired physical functionality. Based on the evidence identified, the committee agreed that it was important to include examples of common, significant health conditions that could be improved by surgery to help practitioners decide whether referral was appropriate for those with a BMI below 40 kg/m2. Due to the lack of relevant evidence, the committee were unable to include other conditions in the list, however they agreed that further research is needed particularly in people

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					who have been refused other treatments because of obesity. Based on this understanding a research recommendation was drafted on the effectiveness and cost effectiveness of bariatric surgery in people needing treatment for other conditions e.g., fertility treatment. The committee also agreed that the list should not prohibit people with other conditions being referred for bariatric surgery where appropriate and agreed to highlight in box 1 that this was not an exhaustive list.
British Dietetic Association	Guideline	006	004	Recommendation 1.10.6 We welcome the emphasis on the multidisciplinary team with the appropriate skills and expertise related to bariatric surgery.	Thank you for your comment.
British Dietetic Association	Guideline	006	008	Recommendation 1.10.7 This additional statement is welcomed: "whether any arrangements need to be made, based on the person's needs, ahead of surgery (for example if they need additional dietary or psychological support, or support to manage existing or new comorbidities). It is important that findings from the assessment are actioned, and not seen as a barrier. For instance, people with severe mental illnesses may need additional support for preparation for surgery. It is also important to recognise that there may be psychological support	Thank you for your comment. Recommendation 1.10.17 also states that psychological support tailored to the individual should be offered as part of a follow-up care package.

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				given in preparing for surgery, but very little access to psychological support after surgery.	
British Dietetic Association	Guideline	006	019	Recommendation 1.10.8 "the longer-term implications and requirements of surgery". It is good to see the addition of requirements, in addition to potential risks and complications. This also needs to be discussed by other members of the MDT including the dietitian and psychologist. It is important that the whole MDT has an active role in determining the most appropriate bariatric surgery procedure. This includes considering the potential impact on nutrition and psychosocial factors which may affect adherence. Malabsorptive procedures, such as the duodenal switch and the one anastomosis gastric bypass with biliopancreatic limb lengths greater than 150 cm have a higher rate of protein malnutrition, and fat soluble vitamin and trace mineral deficiencies. This requires adherence to a high protein diet and access to appropriate vitamins and minerals, containing high doses of fat soluble vitamins, which are not routinely available. Unfortunately, the focus may be on how much weight loss can be achieved by a procedure, rather than whether the person can afford a high protein diet or whether specific vitamins and minerals are available on prescription.	Thank you for your comment. Recommendation 1.10.8 was out of scope for this update. Recommendations 1.10.7 and 1.10.8 highlight the importance of an MDT approach and how different members of the team can take part in the assessment for bariatric surgery. Additionally, NICE have noted that NHS England have already issued guidance for England on when to recommend over-the-counter [OTC] rather than prescribe vitamins and minerals, this has a clear exemption from OTC for those people who have undergone surgery that results in malabsorption (such as bariatric surgery). In addition, the NICE CG189 guideline recommendations set out that people who have undergone bariatric surgery have post-operative monitoring and individualised dietary and nutritional assessment, advice and support (recommendation 1.12.1). Recommendation 1.12.2 also states that people should be offered annual nutritional monitoring and appropriate supplementation following discharge from the initial 2-year bariatric surgery service follow up period.

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British Dietetic Association	Guideline	007	003	Recommendation 1.10.9 The person's ability to adhere to the postoperative demands is also very important. The MDT collectively play an important role in the decision-making process about the most appropriate procedure. The malabsorptive procedures bring additional challenges as a high protein diet is required and higher doses of fat-soluble vitamins and trace minerals. For instance, for a person with a BMI > 60, following a vegetarian diet, with low income and low protein intake, living in a bedsit, the emphasis may be on a malabsorptive procedure, but this person is not likely to be able to meet the postoperative nutritional requirements. In well-functioning MDTs, the whole team's views in addition to the patients, are considered.	Thank you for your comment. Recommendation 1.10.9 is out of scope for this update. Recommendation 1.10.1 does state that referral for assessment should be offered to adults if they commit to necessary long-term follow up after surgery. Additionally, recommendation 1.10.8 does state that the hospital specialist or bariatric surgeon should discuss the long term implication and requirement of surgery with the person if they are considering surgery.
British Dietetic Association	Guideline	007	010	Recommendation 1.10.10 Access to receiving vitamin and mineral supplements on prescription varies around the country; however, these are an essential part of treatment after bariatric surgery, and help to prevent vitamin and mineral deficiencies. Many over the counter vitamin and mineral supplements do not meet the recommendations of the British Obesity and Metabolic Surgery nutritional guidelines. Nutritional monitoring is very important including fat-soluble vitamins A, E and K following malabsorptive procedures (duodenal switch, one anastomosis	Thank you for your comment and raising concerns about the variation in receiving supplements on prescription. The remit of this update focused on referring adults for bariatric surgery, therefore further information on vitamin and mineral supplements could not be added. NICE have noted that NHS England have already issued guidance for England on when to recommend over-the-counter [OTC] rather than prescribe vitamins and minerals, this has a clear exemption from OTC for those people who have

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				gastric bypass with biliopancreatic limb greater than 150 cm.	undergone surgery that results in malabsorption (such as bariatric surgery). The NICE CG189 guideline recommendations set out that people who have undergone bariatric surgery have post-operative monitoring and individualised dietary and nutritional assessment, advice and support (recommendation 1.12.1). Recommendation 1.12.2 also states that people should be offered annual nutritional monitoring and appropriate supplementation following discharge from the initial 2-year bariatric surgery service follow up period.
British Dietetic Association	Guideline	007	018	Recommendation 1.10.11 Appropriate actions, arising from MDT discussion, should be put in place to enable people to move forward for surgery. In addition, if additional postoperative support is identified, it is essential that this is provided, including psychological support after surgery.	Thank you for your comment. As highlighted in 1.10.7, the multidisciplinary team should carry out comprehensive assessment to identify people in whom bariatric surgery is suitable. As part of this assessment, assessment should be made of any arrangements that need to be made, based on the person's needs, ahead of surgery (for example if they need additional dietary or psychological support, or support to manage existing or new comorbidities). Furthermore, postoperative follow-up care was outside the scope of this work, but recommendation 1.10.17 does state that psychological support tailored to the individual

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					should be offered to people who have had bariatric surgery for a minimum of 2 years.
British Dietetic Association	Guideline	008	014	Recommendation 1.10.14 We welcome the greater emphasis on access to postoperative psychological support as often this is not commissioned.	Thank you for comment.
British Dietetic Association	Guideline	009	023	Recommendation 1.10.18 Despite this being a recommendation in 2014, we are not aware that any shared care services have been commissioned. This leaves both primary care health care professionals and patients vulnerable. The implementation of shared care services and access to annual reviews, including nutritional, is essential.	Thank you for your comment. This is out of scope for the current update which was specifically about referral for bariatric surgery and assessment. However, the committee agreed that further work on post operative shared care models is important. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure they are up to date. We would also like to draw your attention to NICE Quality Standard 127 on obesity assessment and management which was developed from this guideline; specifically quality statement 7. Under 'definitions of terms used' a description of what is meant by a 'shared care model of management' is provided, along with links to guidelines for the follow-up of patients undergoing bariatric surgery which provides further detail and potential models of shared-care protocols for postoperative management after bariatric surgery.
British Dietetic Association	Guideline	009	028	Recommendation 1.10.19 We would welcome a prospective audit that also includes nutritional	Thank you for your comment. Recommendation 1.10.19 is out of scope for the current update

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				status. The National Bariatric Surgery Register does not include a comprehensive audit of nutritional status. In addition, as many bariatric surgery centres discharge back to primary care after two years, longer term data is unlikely to be collected.	which was specifically about referral for bariatric surgery and assessment. The committee considered this issue and agreed that they cannot mandate the measures to be included in a national audit or in data collected by primary care.
British Dietetic Association	Guideline	012	010	Although no evidence was found on the effectiveness of bariatric surgery for weight loss in people who had been refused other treatment because of obesity, such as liver or kidney transplant, fertility treatment or joint replacement surgery, this is likely to cause difficulties in clinical practice, especially as recent IFSO ASMBS guidelines, have been published with different recommendations. Although further research is recommended, it will take years to gather the necessary evidence. Meanwhile, will people who need to lose weight prior to transplants, joint replacements, fertility treatment be denied access to treatment?	Thank you for your comment. the committee were aware of the recent IFSO/ASMBS guidelines, but their decisions were made according to the NICE guideline manual and took into account the evidence relevant to our review question. Although the NICE guidance may differ to the guidance provided by IFSO/ASMBS, the committee were confident that their recommendations reflected the evidence they reviewed and their clinical judgement. It is of particular importance to note that the NICE guideline conducted an extensive systematic review on the clinical and cost effectiveness of bariatric surgery in different populations, while the ADA guidance did not systematically take clinical and cost-effectiveness into account. It should also be noted that, during the development of the review protocol, non-alcoholic fatty liver disease, sleep apnoea, severe asthma, cardiovascular disease, idiopathic intracranial hypertension and depression/anxiety were identified as important comorbidities that could be

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					improved by surgery. Additionally, the protocol included people prevented from receiving treatment because of their obesity e.g., bone marrow and renal transplant, fertility treatment and hip/joint replacements as well as people with impaired physical functionality. Based on the evidence identified, the committee agreed that it was important to include examples of common, significant health conditions that could be improved by surgery to help practitioners decide whether referral was appropriate for those with a BMI below 40 kg/m2. Due to the lack of relevant evidence, the committee were unable to include other conditions in the list, however they agreed that further research is needed particularly in people who have been refused other treatments because of obesity. Based on this understanding a research recommendation was drafted on the effectiveness and cost effectiveness of bariatric surgery in people who are unable to receive treatment for other conditions (such as joint replacement surgery or fertility treatment) because they are living with obesity. The committee also agreed that the list should not prohibit people with other conditions being referred for bariatric surgery where appropriate and agreed to highlight in box 1 that this was not

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					an exhaustive list because there is potential for evidence to be identified in the future.
British Dietetic Association	Health inequalities briefing	General	General	Deprivation, along with other social factors, will affect ability to afford and adhere to the postoperative diet and supplements, hence these must be considered when determining the most appropriate bariatric surgery procedures. Malabsorptive procedures require a higher protein intake and additional higher doses of fat-soluble vitamins and trace minerals, which are not routinely available.	Thank you for your comment, which we have incorporated into Section 5.1 of the health inequalities briefing. Deprivation is a key consideration reflected throughout the briefing. In addition, NICE's economic methods allow consideration of out-of-pocket expenses, which poverty is highly relevant to. However, we want to emphasise that post-operative nutrition is outside the scope of the guideline update for bariatric surgery. NICE have noted that NHS England have already issued guidance for England on when to recommend over-the-counter [OTC] rather than prescribe vitamins and minerals, this has a clear exemption from OTC for those people who have undergone surgery that results in malabsorption (such as bariatric surgery). In addition, the NICE CG189 guideline recommendations set out that people who have undergone bariatric surgery have post-operative monitoring and individualised dietary and nutritional assessment, advice and support (recommendation 1.12.1). Recommendation 1.12.2 also states that people should be offered annual nutritional monitoring and appropriate

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					supplementation following discharge from the initial 2-year bariatric surgery service follow up period
British Obesity and Metabolic Surgery Society	Guideline	004	003	This should read when to refer adults for **ASSESSMENT** or **CONSIDERATION** for bariatric surgery	Thank you for your comment. This change has been made.
British Obesity and Metabolic Surgery Society	Guideline	004	004	We welcome the term specialist weight management services. These services appear to be highly heterogeneous and the way these services interact as clinical networks with each other and specialist surgical centres will need to be clearly defined, to ensure equity of access to consideration of surgery regardless of which type of service people initially encounter.	Thank you for your comment. The committee agree that there is a lot of variation in how these services are set up across the country but have provided the following definition in the guideline: 'A specialist primary, community or secondary care-based multidisciplinary team offering a combination of surgical dietetic, pharmacological and psychological weight management interventions, including but not limited to tier 3 and tier 4 services'
British Obesity and Metabolic Surgery Society	Guideline	004	010	We welcome acknowledgement of need for long term follow up following surgery. We note that there is a lack of clarity and joined up services for people who have had surgery both during the initial 2 years post procedure and subsequent to this when people are generally referred back into primary care. This applies to all people who have had surgery- NHS funded bariatric surgery in the UK, as self funding patients in the UK and also medical tourists having surgery abroad.	Thank you for your comment. This is out of scope for the current update which was specifically about referral for bariatric surgery and assessment. However, the committee agreed that further work is required on shared care models. We have passed your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. We would also like to draw your attention to NICE Quality Standard 127 on obesity assessment and management which was developed from this

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					guideline; specifically quality statement 7. Under 'definitions of terms used' a description of what is meant by a 'shared care model of management' is provided, guidelines for the follow-up of patients undergoing bariatric surgery which provides further detail and potential models of shared-care protocols for postoperative management after bariatric surgery.
British Obesity and Metabolic Surgery Society	Guideline	005	004	We welcome expedite assessment for recent onset diabetes. We would welcome expedited assessment also includes conditions where progressive deterioration or loss of function may be expected without prompt and urgent weight loss intervention: e.g. people with severe idiopathic intracranial hypertension with progressive neurological symptoms or where surgical intervention will be required to prevent	Thank you for your comment. Recommendation 1.10.3 to 1.10.5 were out of scope for this update.
British Obesity and Metabolic Surgery Society	Guideline	006	003	Multidisciplinary team – does this refer to bariatric surgery MDT or specialist weight management service? It is not clear where surgical assessment for suitability etc takes place and by whom. It may that this does not matter as long as the team leading this process has the appropriate knowledge and skills.	Thank you for your comment. We have amended recommendation 1.10.7 to state that the recommendations refer to the MDT found within a specialist weight management service. Furthermore, the committee wanted to emphasise the importance of the multidisciplinary assessment in the recommendation but did acknowledge that due to variation in commissioning of services there may be

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					differences in the structure of the MDT and that this assessment for surgery might lie in tier 3 or tier 4 services. They have highlighted in the rationale that ideally the MDT should include a physician, surgeon, or bariatric surgeon (as appropriate), registered dietitian and applied psychologist.
British Obesity and Metabolic Surgery Society	Guideline	006	025	We suggest: 1. Shared decision-making principles are applied when surgery is discussed 2. Discussion about risks and complications relate to: i. Immediate per-operative phase ii. Medium and longer term It may be appropriate to use a term such as side effects rather than risks and complications when considering medium and longer term risk(s) and again this discussion should follow shared decision making principles.	Thank you for your comment. Recommendation 1.10.9 does highlight the importance of choosing the surgical intervention jointly with the person. This recommendation also highlights that factor such as the best available evidence on effectiveness and long-term effects should be taken into account when choosing the surgical intervention. It should also be noted that the guideline does state that people have the right to be involved in discussion and make informed decision about their care, as described in NICE's information on making decisions about your care.
British Obesity and Metabolic Surgery Society	Guideline	008	001	We welcome use of effective drugs prior to surgery to maintain or deliver further weight loss prior to surgery. We suggest omission of 'if the waiting time is excessive' as this is not clearly defined or amending this to '…. For example if the waiting time is excessive'	Thank you for your comment. This change has been made.

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British Obesity and Metabolic Surgery Society	Guideline	009	023	Following discharge from bariatric surgery service at 2 years post operatively primary care should be able to refer directly back into specialised weight management services or the bariatric surgery service in event of serious side effects or complications relating to surgery	Thank you for your comment. This is out of scope for the current update which was specifically about referral for bariatric surgery and assessment. However, the committee agreed that further work on post operative shared care models is important. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure they are up to date. We would also like to draw your attention to NICE Quality Standard 127 on obesity assessment and management which was developed from this guideline; specifically quality statement 7. Under 'definitions of terms used' a description of what is meant by a 'shared care model of management' is provided, along with links to guidelines for the follow-up of patients undergoing bariatric surgery which provides further detail and potential models of shared-care protocols for postoperative management after bariatric surgery.
British Obesity and Metabolic Surgery Society	Guideline	012	General	Research Recommendations. We welcome acknowledgement of uncertainty for people needing surgery as a bridge to treatment of other conditions(page 12), and note that the national bariatric surgery registry has capability to deliver clinical data regarding key outcomes for these groups of people	Thank you for your comment.

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Diabetes UK	General	General	General	We are concerned that there is no acknowledgement of the potential for bariatric surgery to enable people with type 2 diabetes to achieve remission, in particular those with recent onset type 2 diabetes. There is not only proven clinical effectiveness of bariatric surgery resulting in remission of type 2 diabetes (Schauer et al., 2021) but putting this condition into remission using this intervention will be more cost effective due to a reduction in the medication, blood glucose management technology and healthcare professional resource that are required to manage this condition. It is important this is highlighted to encourage and support healthcare professionals to make the decision to refer individuals for this intervention where appropriate. Reference: Clinical Outcomes of Metabolic Surgery: Efficacy of Glycemic Control, Weight Loss, and Remission of Diabetes | Diabetes Care | American Diabetes Association (diabetesjournals.org)	Thank you for your comment. As highlighted the effectiveness of bariatric surgery for people with recent-onset type 2 diabetes was not within the scope of this current update. As a result, the current review question did not specifically focus on people with type 2 diabetes, although improvement in obesity related comorbidities (including type 2 diabetes) was listed as a critical outcome. However, the new recommendations do highlight type 2 diabetes as a condition that can be improved after weight loss (see Box 1 in the bariatric surgery section of the guideline), which should help encourage and support healthcare professionals to make the decision to refer people to bariatric surgery. Additionally, the reference provided was reviewed and was deemed outside the remit of this current update.
Diabetes UK	General	General	General	One of the major barriers to healthcare professionals referring more people for bariatric surgery is stigma. Diabetes UK's own qualitative research has found that there are deeply ingrained negative views towards surgery amongst GPs (particularly older GPs) who consider their patients seeing this surgery as a quick fix and assume they are unwilling or unable to make necessary lifestyle	Thank you for your comment. The committee agree that stigma from healthcare professionals is a significant issue but this is outside the remit of this review on referral criteria for bariatric surgery. As highlighted in the scope**,** the update of this guideline involves the amalgamation of 8 different weight management guidelines. We anticipate

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				changes. Our research also found that GPs are unlikely to offer surgery to anyone with a BMI below 40. As a result, despite the committee keeping the recommendation to offer expedited assessment for those with a BMI of 35kg/m2 with recent onset type 2 diabetes, this is not happening in practice. It would be beneficial for the guideline update to address healthcare professional attitudes and the role they play.	that this work will help to address the wider issues, such as stigma.
Diabetes UK	Guideline	005	000	As referenced previously, it is important that type 2 diabetes is added as one of the conditions that can improve after weight loss; there is not only good evidence that surgery does improve type 2 diabetes management, but also that surgery also leads to remission of the condition. Therefore, this should be added so the wording for the bullet point on type 2 diabetes reads: *type 2 diabetes with the possibility of remission*	Thank you for your comment. As highlighted in the scope, bariatric surgery for people with recent-onset type 2 diabetes was out of scope. Current review question did not specifically focus on people with type 2 diabetes, however improvement in obesity related comorbidities (including type 2 diabetes) was listed as a critical outcome. The new recommendations do highlight type 2 diabetes as a condition that could be improved after weight loss.
Diabetes UK	Guideline	005	010	We welcome in the inclusion of and explanation 'recent onset' as 10 years since diagnosis.	Thank you for your comment.
Diabetes UK	Guideline	006	004	Whilst we agree with the rewording from tier 3 to 'specialist weight management service', there is a lack of explanation on what qualifies as one and how to access them. Since the positive appraisal of	Thank you for your comment. The committee did acknowledge that due to variation in commissioning of services there may be differences in the structure of the MDT and that

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				semaglutide (which can only be accessed via a 'specialist weight management service') we have heard from a number of Integrated Care Boards that are struggling to make sense of how to deliver multi-disciplinary care under stretched budgets. It would, therefore, be beneficial to provide further guidance on the minimum requirements to qualify as a specialist weight management service, how they can be established and where they can be accessed. Additionally, it would be of benefit to be explicit about the minimum composition of this team i.e., a prescriber, such as a diabetes specialist nurse, and a dietitian, and formal integrated specialist psychological support. Given that long term and multimorbid care is being increasingly delivered in a primary care setting, outlining these requirements will ensure a minimum standard of care across ICSs and that multidisciplinary teams have sufficient experience conducting assessments for surgery.	this assessment for surgery might lie in tier 3 or tier 4 services, therefore it was difficult to be prescriptive about every member. We have added in the rationale and impact section that ideally the MDT should include a physician, surgeon, or bariatric surgeon (as appropriate), registered dietitian and specialist psychologist. We have also updated the recommendation to make it clear that the MDT needs to have – or have access to – medical, nutritional, surgical and psychological expertise. The rationale and impact section of the guideline and committee discussion section (1.1.11) of evidence review A have also been amended.
Diabetes UK	Guideline	009	011	It would be beneficial for the update to include more specific follow up care guidance and/or signpost to clinical resources that are available from the British Obesity and Metabolic Surgery Society Clinical Resources (bomss.org).	Thank you for your comment. This is out of scope for the current update which was specifically about referral for bariatric surgery and assessment. However, the committee agreed that further work on post operative shared care models is important. We will pass your comment to the

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					NICE surveillance team which monitors guidelines to ensure they are up to date. We would also like to draw your attention to NICE Quality Standard 127 on obesity assessment and management which was developed from this guideline; specifically quality statement 7. Under 'definitions of terms used' a description of what is meant by a 'shared care model of management' is provided, along with links to guidelines for the follow-up of patients undergoing bariatric surgery which provides further detail and potential models of shared-care protocols for postoperative management after bariatric surgery.
Diabetes UK	Guideline	011	005	We welcome the committee's conclusion that restricting surgery to people who have been assessed in tier 3 services risks exacerbating health inequalities however, this guideline update does nothing to change the need for an individual to be assessed within a tier 3 service. The committee also acknowledge that the evidence doesn't support surgery as a last resort, but it is also unclear how this update will change this approach.	Thank you for your comment. The remit of this update was on referral for bariatric surgery. Therefore, a full review of the clinical pathway for weight management in adults was not reviewed. The key issue identified with the 2014 recommendations was the expectation that people needed to have been receiving or plan on receiving intensive management in a tier 3 service. This was seen as a barrier due to lack of tier 3 services, However, the committee agreed in the value of initial assessment for bariatric surgery taking place in a specialist weight management service due to the expertise available at these services.

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					The committee did acknowledge that due to variation in commissioning of services there may be differences in the structure of the MDT and that this assessment for surgery might lie in tier 3 or tier 4 services. Therefore, the focus of the recommendations was not on tier 3 services but specialist weight management services, as locally available. Based on stakeholder feedback, recommendation 1.10.6 has also been updated to highlight that specialist weight management services should have access to or include health and social care professionals with expertise in conducting medical, nutritional and psychological assessments. This change was made to accommodate to the fact that these services may be set up differently across the country. The rationale and impact section and the committee discussion section (1.1.11) in evidence review A have been amended to highlight this change.
Johnson and Johnson Med Tech UK and Ireland	Guideline	004	010	We agree with the need for lifelong follow up as obesity is a chronic condition. We also recognise the impact of such long term follow up on use of resources. We suggest to consider a recommendation of a minimum follow up of 3 years	Thank you for your comment. This is out of scope for the current update which was specifically about referral for bariatric surgery and assessment. However, the committee agree that future updates will need to address postoperative

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				with the multidisciplinary team in the surgical centre and lifelong follow up in primary care and possibility of re-referral in case of weight gain or long-term complications.	follow up care including the effectiveness of specialist and non-specialist follow up and the recommended length of follow up. We have passed your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Johnson and Johnson Med Tech UK and Ireland	Guideline	005	003	It is important to clarify if the list included in the box has to be considered exhaustive or if it just include some examples. Other conditions can improve after bariatric surgery like hyperlipidaemia (possibly included in the cardiovascular disease bullet point), obesity hypoventilation syndrome, Pickwickian syndrome, non-alcoholic fatty liver disease, non-alcoholic steatohepatitis, GERD, debilitating arthritis, Polycystic Ovarian Syndrom, infertility. The adjective "significant" used in the title does not have a clear definition and should be clarified "significant for whom?". As an example two additional conditions that are extremely significant for people living with obesity like mental health and quality of life are not included in the box.	Thank you for your comment. During the development of the review protocol, non-alcoholic fatty liver disease, sleep apnoea, severe asthma, cardiovascular disease, idiopathic intracranial hypertension and depression/anxiety were identified as important comorbidities that could be improved by surgery. Additionally, the protocol included people prevented from receiving treatment because of their obesity e.g., bone marrow and renal transplant, fertility treatment and hip/joint replacements as well as people with impaired physical functionality. Other conditions such as GERD or polycystic ovarian syndrome were not identified as conditions of interest during the development of the protocol. Based on the evidence identified, the committee agreed that it was important to include examples of common health conditions that could be improved by surgery to help practitioners decide whether referral was appropriate for those with a BMI below 40 kg/m2.

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					Due to the lack of relevant evidence, the committee were unable to include other conditions in the list, however they agreed that highlighting this list was not exhaustive was important and this has been amended. They also agreed that further research is needed particularly in people who have been refused other treatments because of obesity. Based on this understanding a research recommendation was drafted on the effectiveness and cost effectiveness of bariatric surgery in people needing treatment for other conditions e.g., fertility treatment. The committee agreed that 'significant' did not have a clear definition and this has been removed.
Johnson and Johnson Med Tech UK and Ireland	Guideline	005	004	We agree with the concept of "expedite assessment". We are concerned that without a clear definition of what expedite means, "expedite assessment" could be interpreted differently in the country and contribute to drive inequity of access to care.	Thank you for your comment. Recommendations 1.10.3 to 1.10.5 were out of scope for this update. The 2014 guidance highlighted that the previous guideline committee debated the timing of bariatric surgery, noting that from evidence that having surgery within 3 years of the onset of diabetes could avoid complications but the chances of getting any individual into a bariatric pathway within a 2 year diagnosis of T2DM with

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					current commissioning guidelines would be challenging. The previous guideline committee did agree that surgery within 10 years of diabetes onset could also reduce or delay the need for diabetic medication, however, this reduction may be temporary. Due to these factors, the previous guideline committee did not wish to indicate a specific time frame in their recommendations.
Johnson and Johnson Med Tech UK and Ireland	Guideline	005	004	We agree with the points 1.10.3, 1.10.4, 1.10.5. There is a group of people living with obesity with BMI >50 who can benefit from an "expedite assessment". We suggest including this group as an additional point (1.10.x)	Thank you for your comment. Recommendations 1.10.3 to 1.10.5 were out of scope for this update. People living with obesity with BMI >50 are covered in recommendation 1.10.1.
Johnson and Johnson Med Tech UK and Ireland	Guideline	006	004	We agree with the essential members of the MDT. To ensure equity of access and minimise geographical disparity it is worth considering the change of the wording to bariatric surgeon, dietician, psychologist. We realise the potential implication in term of workforce, and we suggest that if this was the reason for a "more general" wording of the expertise needed in the multidisciplinary team a clear recommendation on the need for expansion of the workforce could be included.	Thank you for your comment. The committee did acknowledge that due to variation in commissioning of services there may be differences in the structure of the MDT and that this assessment for surgery might lie in tier 3 or tier 4 services, therefore it was difficult to be prescriptive about every member. We have added in the rationale and impact section that ideally the MDT should include a physician, surgeon, or bariatric surgeon (as appropriate), registered dietitian and specialist psychologist. We have also updated the recommendation to make it clear that the MDT needs to have – or have access to – medical, nutritional, surgical and psychological expertise. The rationale and impact section of the guideline and committee discussion

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					section (1.1.11) of evidence review A have also been amended.
Johnson and Johnson Med Tech UK and Ireland	Guideline	006	012	We agree on the need for psychological assessment, and we suggest that a psychological assessment is also needed to rule out any existing severe eating disorders.	Thank for your comment. Recommendation 1.10.7 does state that a person's nutritional needs, including eating habits and any psychological factors need to be assessed as part of the assessment.
Johnson and Johnson Med Tech UK and Ireland	Guideline	007	003	We agree with point 1.10.9 and with the choice of surgical intervention made "…jointly with the person…". There is an opportunity to modify the wording and ensure that the person is an "appropriately informed person"	Thank you for your comment. Recommendation 1.10.8 details how people would be appropriately informed, as it states that the hospital specialist or bariatric surgeon should discuss aspects such as potential benefits, longer-term implications and requirements of surgery, the potential risks, including perioperative mortality, and complications, with people who are living with severe obesity if they are considering surgery. Based on stakeholder feedback, the recommendation was also amended to include discussions on plans for conception and pregnancy (if someone is of childbearing age).
Johnson and Johnson Med Tech UK and Ireland	Guideline	007	012	Obesity is a chronic condition and need long term follow up. There is an opportunity here to specify for how long it is sensible that the MDT is responsible to monitor micronutrient status and to state how the handover between the specialised centre and GP should happen.	Thank you for your comment. This is out of scope for the current update which was specifically about referral for bariatric surgery and assessment. However, the committee agreed that further work is required on the shared care models and post-

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					operative care. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. We would also like to draw your attention to NICE Quality Standard 127 on obesity assessment and management which was developed from this guideline; specifically quality statement 7. Under 'definitions of terms used' a description of what is meant by a 'shared care model of management' is provided, along with links to guidelines for the follow-up of patients undergoing bariatric surgery which provides further detail and potential models of shared-care protocols for postoperative management after bariatric surgery.
Johnson and Johnson Med Tech UK and Ireland	Guideline	007	017	We agree with the content of point 1.10.11. We suggest to add that endocrine causes for obesity should be ruled out during the preoperative assessment.	Thank you for your comment. Recommendation 1.10.11 was out of scope for this update. Recommendation 1.10.7 does state that as part of the comprehensive, multidisciplinary assessment, the person's medical needs, for example existing comorbidities should be assessed.
Johnson and Johnson Med Tech UK and Ireland	Guideline	009	005	In addition to the equipment mentioned the presence of suitable CT scans should be included to ensure a prompt diagnosis of postsurgical complications.	Thank you for your comment. While this recommendation is out of scope for the current update which was specifically about referral for bariatric surgery and assessment, the committee discussed this and agreed that while suitable CT scans should be included, the list provided in the wording was not supposed to be exhaustive.

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					They agreed that the wording should be refreshed to say 'suitable equipment, including but not limited to' to highlight that the list was not exhaustive.
Johnson and Johnson Med Tech UK and Ireland	Guideline	009	008	The concepts of" specialist centres" and "extensive experience" are not well defined. An initial definition could be based on international standards matched with the data included into the National Bariatric Surgery Registry.	Thank you for your comment. While this recommendation is out of scope for the current update which was specifically about referral for bariatric surgery and assessment, the committee discussed this and agreed that 'extensive experience' should be retained as this term is widely understood. The concern with removing the term 'specialist centres' was that even if a surgeon is experienced, there is a need for supporting infrastructure. They did amend 'specialist centres' to the term 'appropriate high-volume centre', which is also a widely understood term.
Johnson and Johnson Med Tech UK and Ireland	Guideline	009	009	We suggest changing the wording to "increased rate of complications and mortality". The word "high" in the context of the guideline might stop GP referring people living with obesity or the same persons not accepting a referral because of the word "high". While the risk and benefit of revision surgery should be discussed by MDT members with the person in consideration.	Thank you for your comment. While this recommendation is out of scope for the current update which was specifically about referral for bariatric surgery and assessment, the committee discussed this and decided the recommendation could be refreshed to clarify that this is about a 'higher' rate of complications associated with

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					revisional surgery when compared to primary surgery.
Johnson and Johnson Med Tech UK and Ireland	Guideline	009	025	Additional clarity would be beneficial regarding the "shared care" concept. It is implied that the person is discharged to GP after a minimum of two years (if this is the case it would be beneficial to add "GP"). Similar clarity on who is responsible for the annual check after two years would be beneficial. The risk is that people after discharge would find them discharged from the specialist service but not taken over by GP care with both entity assuming the other is doing the annual assessment.	Thank you for your comment. This is out of scope for the current update which was specifically about referral for bariatric surgery and assessment. However, the committee agreed that further work on post operative shared care models is important. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure they are up to date. We would also like to draw your attention to NICE Quality Standard 127 on obesity assessment and management which was developed from this guideline; specifically quality statement 7. Under 'definitions of terms used' a description of what is meant by a 'shared care model of management' is provided, along with links to guidelines for the follow-up of patients undergoing bariatric surgery which provides further detail and potential models of shared-care protocols for postoperative management after bariatric surgery.

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Johnson and Johnson Med Tech UK and Ireland	Guideline	009	027	We agree with the need for audit. To ensure equity of access and minimise disparity in quality of care the participation in national audit should be considered part of the standard to be recognised as a specialised service for treatment of obesity.	Thank you for your comment.
Johnson and Johnson Med Tech UK and Ireland	Guideline	010	012	We agree with the current research recommendations. Obesity is a chronic condition and surgery induces lifelong changes. There is therefore on one side to have a lifelong follow up, on the other side there is a pragmatic approach where persons are followed up for 2-3 years. The question of "how long is the optimal follow up in specialist centres" could be added to the current research recommendations.	Thank you for your comment. Follow up after bariatric surgery was outside the remit of this update, therefore further research recommendations on post-bariatric follow up cannot be added.
Johnson and Johnson Med Tech UK and Ireland	Guideline	013	002	In the first sentence it is only mentioned that bariatric surgery is effective for weight loss. Bariatric surgery is also important for resolution/improvement of other comorbidities like diabetes. Mentioning only "weight loss" might involuntarily convey the message "bariatric surgery is cosmetic surgery" and therefore perpetuate the stigma of obesity. We suggest adding diabetes and other comorbidities. Weight loss can be considered a surrogate parameter for effectiveness while the improvement and or resolution of other comorbidities are the real important effects for patients.	Thank you for your comment. This section of the document relates to the rationale for recommending a multidisciplinary assessment within a specialist weight management service and reflects the committee's discussion of this. The recommendations do highlight other conditions which can be improved by bariatric surgery, specifically in box 1. During the development of the review protocol, non-alcoholic fatty liver disease, sleep apnoea, severe asthma, cardiovascular disease, idiopathic intracranial hypertension and depression/anxiety were identified as important comorbidities that could be improved by surgery. Additionally, the protocol included people prevented from receiving

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					treatment because of their obesity e.g., bone marrow and renal transplant, fertility treatment and hip/joint replacements as well as people with impaired physical functionality. Based on the evidence identified, the committee agreed that it was important to include examples of common health conditions that could be improved by surgery to help practitioners decide whether referral was appropriate for those with a BMI below 40 kg/m2. Due to the lack of relevant evidence, the committee were unable to include other conditions in the list, however they agreed that highlighting this list was not exhaustive was important and this has been amended. They also agreed that further research is needed particularly in people who have been refused other treatments because of obesity. Based on this understanding a research recommendation was drafted on the effectiveness and cost effectiveness of bariatric surgery in people needing treatment for other conditions e.g., fertility treatment.
Johnson and Johnson Med Tech UK and Ireland	Guideline	013	017	We agree with the need to assess previous weight management attempts, but it is not clear how this information will be used. As stated in the paragraph	Thank you for your comment. We have amended the wording of this as the committee wanted to emphasise that this is about taking someone's

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				the message might be misinterpreted and the "engagement or not" could be seen as a factor precluding a person to join a waiting list for surgery.	weight management history and assessing their response to treatment. It should not be seen as something that precludes them from surgery but rather to help aid their conversation of the different treatment options available in order to come to a shared decision with the person.
Medtronic Ltd	Guideline	General	General	Medtronic would like to thank NICE for the opportunity to contribute to this important consultation. Given the complexity and the size of the current clinical guideline *"CG189 Obesity: identification, assess and management"*, we welcome the attention that is being given to the individual section *"Surgical interventions"* for the treatment of obesity. Medtronic welcomes the findings and acknowledges the breadth of supporting evidence reviewed to ascertain bariatric surgery as a cost-effective intervention, for individuals with obesity and associated comorbidities, as part of the clinical pathway to tackle the developing national obesity crisis. While Medtronic largely support the general patient pathway for surgical interventions, we feel that the recommendations are open to interpretation which	Thank you for your comment. We will respond to each of your points below.

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				will lead to a variation in treatment, expertise and will continue to be a barrier for patient access to bariatric surgery. The concerns of Medtronic are detailed below in specific comments, and we politely request that NICE take into consideration all our comments before finalising these guidelines.	
Medtronic Ltd	Guideline	004	003	In *"Section 1.10 Bariatric surgery",* the subheading ***'When to refer adults for bariatric surgery'*** is misleading. Recommendation 1.10.1 and 1.10.2 are the referral criteria for individuals to access a comprehensive assessment completed by the specialist weight management service and are not the criteria used to offer bariatric surgery. Medtronic recommend changing the subheading to ***''when to refer adults for assessment by a specialist weight management service'***	Thank you for your comment. Changes have been made to the section heading based on stakeholder feedback.
Medtronic Ltd	Guideline	004	004	Medtronic are concerned that no detailed criteria has been provided for when to offer patients bariatric surgery.	Thank you for your comment. The committee highlighted that the first steps to offering bariatric surgery is to refer people for a comprehensive assessment by a specialist weight management

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				Recommendation 1.10.1 advises a comprehensive assessment for bariatric surgery for patients with a "*BMI of 40 kg/m^2 or more, or between 35 kg/m^2 and 39.9 kg/m^2 and a significant health condition that could be improved if they lost weight*". In 2018 the morbidly obese (BMI >40kg/m^2) population within England, was in excess of 1.4million (PHE 2020), this figure does not include those patients with a BMI>35kg/m^2 and a significant health condition, and in 2019/20 only 6,740 bariatric surgery procedures were performed in England. This equates to treating less than 0.5% of the population eligible for surgical intervention (NHS Digital 2021). The health inequalities briefing states that, *"NICE guidance can help by encouraging those delivering services to use local expertise within systems to identify populations of greatest burden, and design services with these target populations so interventions are undertaken in a way that is most likely to help people meet recommendations and complete programmes"* (page 37, NICE 2023). Service providers require guidelines tailored to help treat individuals who would most benefit from bariatric surgery. Medtronic are concerned that with an imprecise referral criterion for bariatric surgery	service, which is covered in recommendation 1.10.1. The referral for assessment contains precise BMI and comorbidity criteria. This recommendation is then followed on with recommendation 1.10.7 which highlights the key parts to the assessment. As highlighted in the rationale and impact section, this assessment should allow the identification of people for whom bariatric surgery is suitable. Additionally, each person being assessed for bariatric surgery will have individual and different needs, and therefore any discussion with them and decision to provide surgery needs to be done on this tailored basis. We are therefore unable to provide precise criteria for providing surgery as it will be different for each patient. Instead, the committee have specified precisely the criteria that need to be considered for the assessment, i.e., medical, nutritional, psychological needs etc, and upon which a clinical judgement can then be made. Additionally, the references provided in your comment were reviewed. The briefing report (reference 3) has been referenced in the committee discussion section (1.1.11) of evidence review A. Other references included were deemed as not applicable for inclusion focus of

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				will lead to an inconsistency of referral for surgical treatment across the country. Medtronic respectfully ask that clear specific criteria is provided for patients accessing bariatric surgery to ensure that payers can plan for and provide sufficient budgets to commission surgery. References: 1. Public Health England (2020). *Estimated number of adults who are morbidly obese in England.* PHE. Available at: https://www.gov.uk/government/publications/estimated-number-of-adults-who-are-morbidly-obese-in-england (Accessed: 23 March 2023) 2. NHS Digital (2021) *Statistics on Obesity, Physical Activity and Diet, England 2021, Part 1: Obesity-related hospital admissions*. NHS Digital. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-obesity-physical-activity-and-diet/england-2021/part-1-obesity-related-hospital-admissions (Accessed: 20 March 2023) 3. National Institute for Health and Care and Excellence (2023). *Health inequalities briefing, Obesity and weight management:*	review was on published randomised controlled trials (RCTs) and systematic reviews of comparative observational studies or non-randomised controlled studies. For further information on the inclusion criteria for this review, please see Appendix A in evidence review A.

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				a briefing for NICE guideline developers and committee members. NICE. Available at: https://www.nice.org.uk/guidance/gid-ng10373/documents/health-inequalities-briefing-2 (Accessed: 20 March 2023)	
Medtronic Ltd	Guideline	004	010	Recommendation 1.10.1 states that adults referred for a comprehensive assessment must be able to *"commit to the necessary long-term follow up after surgery (for example, lifelong annual reviews)"* Medtronic support patients requiring long-term follow up post bariatric surgery. However, there is lack of evidence to suggest that life-long follow-up is effective. BOMSS (2023) only recommend life-long follow-up care for patients diagnosed with type 2 diabetes prior to bariatric surgery, even if their diabetes has gone into remission. Biron et al, (2018) and Carbajo et al (2017) concluded that post operative management for a minimum of 2 years (effective maximum of 8 years) post-surgery is most important time-period to monitor nutrition and BMI reduction. Further, annual follow-ups, post discharge from the bariatric weight management service is usually completed within primary care (BOMSS, 2023),	Thank you for your comment. This is out of scope for the current update which was specifically about referral for bariatric surgery and assessment. However, the committee agree that future updates will need to address postoperative follow up care including the effectiveness of specialist and non-specialist follow up and the recommended length of follow up. This has been flagged with our surveillance team who will take this into consideration when reviewing evidence for future updates. Additionally, the references provided in your comment were reviewed and were deemed as not applicable for inclusion as these did not meet the objectives of this review.

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				adding further pressure to an already stretched healthcare system. Medtronic believe that the length of follow-up post-surgery should reflect an achievable time-period. We suggest the life-long follow up be made explicitly for patients with type 2 diabetes and that the statement is changed to read, *"Commit to the necessary long-term follow up after surgery (for example annual reviews and life-long reviews for patients with type 2 diabetes)".* References 1. Biron, S. et al. (2018) *Long-term follow-up of disease-specific quality of life after bariatric surgery,* Surgery for obesity and related diseases: official journal of the American Society for Bariatric Surgery, 14(5), pp. 658–664. 2. Carbajo, M.A. et al. (2017). *Laparoscopic One-Anastomosis Gastric Bypass: Technique, Results, and Long-Term Follow-Up in 1200 Patients*, Obesity surgery, 27(5), pp. 1153–1167. 3. British Obesity and Metabolic Surgery Society (2023). *BOMSS GP consultation guide for post-bariatric surgery annual reviews*. Available at: https://bomss.org/wp-content/uploads/2023/03/BOMSS-GP-	

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				consultation-guide-for-post-bariatric-surgery-annual-reviews-final-draft-6.1.23.pdf (Accessed: 22 March 2023)	
Medtronic Ltd	Guideline	006	004	Medtronic strongly recommend that a bariatric surgeon should be included within the Multidisciplinary team (MDT). The ASMBS (2022) and Durrer et al (2019) highlighted the importance of including an expert dietician and psychologist within the MDT, however they emphasised that the identification of patient readiness and those that would most benefit from bariatric surgery would ultimately be determined by a surgeon or medical physician specialising in obesity/weight management. Medtronic kindly ask that the wording in section 1.10.6 is changed to read "Ensure the weight management multidisciplinary team includes health and social care professionals with expertise in conducting medical, nutritional and psychological assessments, and include ***a physician or surgeon specialising in bariatric surgery."*** References: 1. Eisenberg D, Shikora SA, Aarts E, et al. 2022 American Society of Metabolic and	Thank you for your comment. The committee did acknowledge that due to variation in commissioning of services there may be differences in the structure of the MDT and that this assessment for surgery might lie in tier 3 or tier 4 services, therefore it was difficult to be prescriptive about every member. We have added in the rationale and impact section that ideally the MDT should include a physician, surgeon, or bariatric surgeon (as appropriate), registered dietitian and specialist psychologist. We have also updated the recommendation to make it clear that the MDT needs to have – or have access to – medical, nutritional, surgical and psychological expertise. The rationale and impact section of the guideline and committee discussion section (1.1.11) of evidence review A have also been amended. Additionally, the references included in the comment were reviewed: 1. ASMBS/ IFSO 2022 guidance: This was not used as a source or evidence but has been referenced in the rationale and impact section of the guideline and in the

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				Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) Indications for Metabolic and Bariatric Surgery. Obesity Surgery: The Journal of Metabolic Surgery and Allied Care. November 2022:1-12 2. Durrer Schutz, D., Busetto, L., Dicker, D., Farpour-Lambert, N., Pryke, R., Toplak, H., Widmer, D., Yumuk, V., & Schutz, Y. (2019). European Practical and Patient-Centred Guidelines for Adult Obesity Management in Primary Care. Obesity Facts, 12(1), 40–66	committee discussion section (1.1.11) of evidence review A. 2. Durrer 2019: Not a study design applicable for this review (see appendix A in evidence review A for information on inclusion criteria). Reference to guideline not included as this did not specifically focus on bariatric surgery.
Medtronic Ltd	Health Inequalities Briefing	006	023	Medtronic recommends using data from the recently published NHS Health Survey for England, 2021 (NHS Digital, 2022). The recent 2021 NHS Health Survey for England has now been published and the percentage of men and women living with obesity or overweight has been updated. Medtronic would like to kindly suggest the following statement, *"The 2019 NHS Health Survey for England shows that most adults in England, 68% of men and 60% of women, are living with overweight or obesity."* is updated to now read:	Thank you for your comment; we have updated the figures in Section 2 of the briefing to reflect those from the 2021 NHS Health Survey for England.

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				*"The 2021 NHS Health Survey for England shows that most adults in England, **69%** of men and **59%** of women, are living with overweight or obesity."* References: 1. NHS Digital (2022) *Health Survey for England, 2021 part 1, Overweight and obesity in adults Summary*. NHS Digital. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2021/part-2-overweight-and-obesity (Accessed: March 14 2023).	
Medtronic Ltd	Health Inequalities Briefing	007	007	Medtronic recommends using data from the recently published NHS Health Survey for England, 2021, (NHS Digital, 2022). The recent 2021 NHS Health Survey for England has now been published and the percentage of men and women living with obesity or overweight in accordance with the deprivation category has been updated. Medtronic would like to kindly suggest the following statement, *"The 2019 NHS Health Survey for England shows this difference is particularly pronounced for women, with 39% of women in the most deprived areas are obese, compared with 22% in the least deprived areas. In 2019 the obesity gap between the most and least deprived areas stood at 8% for men and 17% for women."*	Thank you for your comment; we have updated the figures in Section 2.1 of the briefing to reflect those from the 2021 NHS Health Survey for England.

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				be updated to now read: *"The 2021 NHS Health Survey for England shows this difference is particularly pronounced for women, with **40%** of women in the most deprived areas are obese, compared with **19%** in the least deprived areas. In 2019 the obesity gap between the most and least deprived areas stood at **9%** for men and **21%** for women."* References: 1. NHS Digital (2022) *Health Survey for England, 2021 part 1, Overweight and obesity in adults Summary.* NHS Digital. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2021/part-2-overweight-and-obesity#overweight-and-obesity-by-area-deprivation-and-sex (Accessed: March 14 2023).	
NHS England	Guideline	General	General	We welcome the outlined changes to referrals for bariatric surgery for people with obesity as these have the potential to open up services to a wider cohort and to reduce inequalities for autistic people and people with a learning disability.	Thank you for your comment.

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NHS England	Guideline	General	General	We strongly suggest making reference to reasonable adjustments throughout the guideline: This is a legal requirement as stated in the Equality Act 2010 and is important to help you make the right diagnostic and treatment decisions for an individual. You can ask the person and their carer or family member what reasonable adjustments should be made. Adjustments aim to remove barriers, do things in a different way, or to provide something additional to enable a person to receive the assessment and treatment they need.	Thank you for your comment. The committee did consider reasonable adjustments required and identified existing NICE guidelines that could help health and care professionals plan the care for people with learning disabilities and neurodevelopment disabilities. These include guidance on learning disabilities and behaviour that challenges: service design and delivery (NG93), care and support for people growing older with learning disabilities (NG96), autism spectrum disorder in adults: diagnosis and management (CG142) which can help healthcare professionals. This is covered section 1.1.11 evidence review A. Additionally, based on stakeholder feedback, the rationale and impact section and committee discussion of evidence review A was amended to state that input from a learning disability team or liaison nurse may be needed during the assessment. Furthermore, as highlighted in the scope, the aim of this work is to bring together the different guidelines on weight management. As part of this work, we will also include cross-referrals to NICE guidelines, including adjustments required in care.

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NHS England	Guideline	General	General	It would be helpful to take this opportunity to review shared care arrangements for postoperative follow-up care as increased provision of procedures may have an impact on primary care services and their workload.	Thank you for your comment. This is out of scope for the current update which was specifically about referral for bariatric surgery and assessment. However, the committee agreed that further work is required on the shared care models. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. We would also like to draw your attention to NICE Quality Standard 127 on obesity assessment and management which was developed from this guideline; specifically quality statement 7. Under 'definitions of terms used' a description of what is meant by a 'shared care model of management' is provided, along with links to guidelines for the follow-up of patients undergoing bariatric surgery which provides further detail and potential models of shared-care protocols for postoperative management after bariatric surgery.
NHS England	Guideline	004	000	We suggest inclusion of reminding professionals of the principles of the Mental Capacity Act: People with a learning disability and autistic people do not automatically lack capacity. Assess capacity in line with the person's communication abilities and needs, and remember the principle of the Mental Capacity Act in making appropriate efforts and	Thank you for your comment. The committee did consider reasonable adjustments required and identified existing NICE guidelines that could help health and care professionals plan the care for people with learning disabilities and neurodevelopment disabilities. These include guidance on learning disabilities and behaviour

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				adjustment to enable decision making wherever possible. We strongly suggest these recommendations are expanded to reference the importance of communication. Staff should communicate with and try to understand the person they are caring for. Check with the person themselves, their family member or carer or their hospital or communication passport for the best way to achieve this and involve families and carers in conversations regarding their care where requested or stated as a preference. Use simple, clear language, avoiding medical terms and 'jargon' wherever possible. Some people may be non-verbal and unable to tell you how they feel. Pictures may be a useful way of communicating with some people, but not all. Staff should also be aware of and pay attention to healthcare passports: Some people with a learning disability and some autistic people may have a healthcare passport giving information about the person and their health needs, preferred method of communication and other preferences. Ask the person or their accompanying carer if they have one of these.	that challenges: service design and delivery (NG93), care and support for people growing older with learning disabilities (NG96), autism spectrum disorder in adults: diagnosis and management (CG142) which can help healthcare professionals. This is covered section 1.1.11 of evidence review A. It should also be noted that the guideline does state that people have the right to be involved in discussion and make informed decision about their care, as described in NICE's information on making decisions about your care. Additionally, based on stakeholder feedback, the rationale and impact section and section 1.1.11 in evidence review A was amended to state that input from a learning disability team or liaison nurse may be needed during the assessment. Furthermore, as highlighted in the scope, the aim of this work is to bring together the different guidelines on weight management. As part of this work, we will also include cross-referrals to NICE guidelines, including adjustments required in care.

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NHS England	Guideline	006	004	We strongly suggest this section is expanded to include consideration for existing multidisciplinary input into the care of the person. This may include but is not limited to epilepsy, cardiology, syndrome specific specialists. Consideration should also be given to the role of an organisation's learning disability team or liaison nurse on issues of communication, reasonable adjustments, pain assessment etc.	Thank you for your comment. The committee agree that due to comorbidities, specialist input from other MDTs already involved in someone's care may be required, or if they have learning difficulties, input from a learning disability team or liaison nurse. This has been added to our explanation of the recommendation in the rationale section and the committee discussion section (1.1.11) in evidence review A. It was not possible to add every potential specialist that may already be involved in someone's care into the recommendation, but the committee feel the final bullet point of the assessment recommendation 1.10.7 covers this adequately: 'whether any arrangements need to be made, based on the person's needs, ahead of surgery (for example if they need additional dietary or psychological support, or support to manage existing or new comorbidities).' We have also added the following to this recommendation as part of the assessment: 'Any factors that may impact their attempts to manage their weight (for example learning disabilities and neurodevelopmental disabilities, deprivation or language barriers)'
NHS England	Guideline	006	007	We strongly suggest this section is expanded to include a direct reference to reasonable adjustments (see comment #2) and consideration	Thank you for your comment. The committee did consider reasonable adjustments required and identified existing NICE guidelines that could help

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				given to people's communication needs and preferences. We strongly suggest this section includes reference to the consideration for existing pathways to support people with a learning disability and autistic people for example, desensitisation programmes to support successful intervention.	health and care professionals plan the care for people with learning disabilities and neurodevelopment disabilities. These include guidance on learning disabilities and behaviour that challenges: service design and delivery (NG93), care and support for people growing older with learning disabilities (NG96), autism spectrum disorder in adults: diagnosis and management (CG142) which can help healthcare professionals. This is covered section 1.1.11 of the evidence review. They also agreed that a input from a learning disability team or liaison nurse may be required. This has been added to the rationale and impact section of the guideline. Furthermore, as highlighted in the scope, the aim of this work is to bring together the different guidelines on weight management. As part of this work, we will also include cross-referrals to NICE guidelines, including adjustments required in care.
NHS England	Guideline	006	014	There is concern that previously attempts to manage their weight may not be documented and difficult to evidence.	Thank you for your comment. The committee agree that previous attempts to manage their weight may not be documented and that these methods may be informal and self-reported. The wording has been amended to reflect this and the committee wanted to emphasise that this is about taking someone's weight management history and their response to treatment, and it should not

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					be seen as something that precludes them from surgery but rather to help aid their conversation of the different treatment options available in order to come to a shared decision with the person.
NHS England Healthcare Inequalities Improvement Team	Guideline	General	General	Include in multidisciplinary assessment the importance of considering patient factors that may lead to inequalities in access and outcomes. Eg. "Be aware of the impact of health inequalities (eg. Learning disability, deprivation, language-barriers) on access to and outcomes from care and aim to mitigate against these" Could include same text as NICE Metastatic Spinal Cord Compression guidance: Page 7, line 15 1.1.13 Be aware of the impact of health inequalities (for example, deprivation) on outcomes for people with spinal metastases or MSCC. Ensure that: • information is collected and analysed by local services to identify any health inequalities • education is provided within services on reducing local health inequalities • reasonable adjustments are made by local services to address any health inequalities.	Thank you for your comment. Following discussion with the committee we have amended recommendation 1.10.7 to include the assessment of other factors that may affect someone's response after surgery. Examples outlined in the recommendation include language barriers, deprivation and other factors related to health inequalities.
NHS England Healthcare Inequalities Improvement Team	Guideline	General	General	Excellent health inequalities briefing, suggest making reference to this content in the NICE guideline itself to highlight the impact of health inequalities on obesity, on access to and	Thank you for your comment. The briefing played a big part in committee discussion and has been referenced in section 1.1.11 of the evidence review.

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				completion of.weight management programmes and on benefit from services.	
Perspectum	Guideline	General	General	Expedited assessment for bariatric surgery should be offered to people with a BMI of 35 kg/m2 or more who have recent-onset (diagnosed within the past 10 years) nonalcoholic fatty liver disease / nonalcoholic steatohepatitis (NAFLD/NASH) as long as they are also receiving, or will receive, assessment in a specialist weight management service. Expedited assessment for bariatric surgery should be considered in people with a BMI of 30-24.9 kg/m^2 or more who have recent-onset (diagnosed within the past 10 years) nonalcoholic fatty liver disease / nonalcoholic steatohepatitis (NAFLD/NASH) as long as they are also receiving, or will receive, assessment in a specialist weight management service. Expedited assessment for bariatric surgery should be considered for people of South-Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background at a lower BMI than other populations (reduced by 2.5 kg/m2) who have recent-onset (diagnosed within the past 10 years) nonalcoholic fatty liver disease / nonalcoholic steatohepatitis (NAFLD/NASH) as long as they are also receiving, or will receive,	Thank you for your comment. One study (Aminian 2021) was included in our review, which is also listed in the reference list provided in your comment. Based on this evidence, the committee agreed that NAFLD (with or without steatohepatitis) could be improved by weight loss. Recommendation 1.10.1 does state that people with a BMI between 35 kg/m2 and 39.9 kg/m2 and a significant health condition, which can include non-alcoholic fatty liver disease (NAFLD) with or without steatohepatitis, can be offered a referral for a comprehensive assessment by specialist weight management services to see whether bariatric surgery is suitable for them. As highlighted in the scope, recommendations on expedited bariatric surgery for people with recent-onset type 2 diabetes was out of scope for this review. Therefore, these recommendations on expedited assessment could not be updated to include NAFLD. Lastly, studies included in your reference list were reviewed and reasons for exclusion are provided below:

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				assessment in a specialist weight management service. The committee has recommended that patients with a diagnosis of recent-onset type 2 diabetes (T2D) should receive expedited assessment for bariatric surgery. Whilst it is encouraging that the committee realises the benefits of early intervention and weight loss in T2D, the same logic should be extended to those with NAFLD/NASH, where the same principle holds true. Weight loss and reduction of steatohepatitis are the most important endpoints in the management of patients with NAFLD/NASH and multiple studies have shown that weight loss triggered by bariatric surgery not only reduces liver fat but can also resolve steatohepatitis (1,2). It is no longer sufficient to wait until patients develop fibrosis or cirrhosis before an intervention is deemed necessary. Evidence shows that patients with isolated steatosis (NAFLD), steatohepatitis (NASH), NASH with fibrosis, and cirrhosis ALL have an increased likelihood of adverse clinical outcomes (3). Indeed, bariatric surgery has been shown to improve long term liver- and cardiovascular-related outcomes (4).	- Lassailly 2020 – Study was identified at title and abstract stage but was not a comparative observational study. - Fakhry (2019)- Not a systematic review of comparative observational studies. - Simon (2020)- Not identified in our search but due to the fact the study does not reflect our research question. - Udelsman (2019)- Identified in our search and excluded at title and abstract stage as study focuses on prevalence data.

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				Furthermore, NASH is highly prevalent in patients undergoing bariatric surgery, with some estimates suggesting up to 30% of patients undergoing bariatric surgery had NASH on routine liver biopsy (5). NASH is becoming a leading cause for liver transplantation (LT), and in patients who experience progression of NASH over time, lower body mass index makes the LT operation safer and less complicated. Offering expedited access to patients with NAFLD/NASH is therefore highly likely to benefit those patients in the short term whose liver health improves, but also those whose disease progresses regardless of the weight loss induced by bariatric surgery. <u>References</u> 1. Lassailly G, Caiazzo R, Ntandja-Wandji LC, Gnemmi V, Baud G, et al. Bariatric surgery provides long-term resolution of nonalcoholic steatohepatitis and regression of fibrosis. *Gastroenterology*. 2020;159:1290–1301.e5. 2. Fakhry TK, Mhaskar R, Schwitalla T, Muradova E, Gonzalvo JP, Murr MM. Bariatric surgery improves nonalcoholic fatty liver disease: a contemporary systematic review and meta-analysis. *Surg Obes Relat Dis*. 2019;15:502–11	

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				3. Simon TG, Roelstraete B, Khalili H, et al. Mortality in biopsy-confirmed nonalcoholic fatty liver disease: results from a nationwide cohort. *Gut* 2021;70:1375-1382 4. Aminian A, Al-Kurd A, Wilson R, et al. Association of Bariatric Surgery With Major Adverse Liver and Cardiovascular Outcomes in Patients With Biopsy-Proven Nonalcoholic Steatohepatitis. *JAMA*. 2021;326(20):2031–2042. doi:10.1001/jama.2021.19569 Udelsman BV et al. Risk factors and prevalence of liver disease in review of 2557 routine liver biopsies performed during bariatric surgery. Surg Obes Rel Dis. 2019;15(6):843-849.	
Perspectum	Guideline	General	General	Preoperative assessment should include a comprehensive non-invasive liver assessment with multiparametric magnetic resonance imaging biomarkers (LiverMultiScan) to risk-stratify patients at greatest need and to exclude inappropriate candidates. Liver volumetry should also be assessed at the same time. Patients living with obesity and steatohepatitis with/without fibrosis are candidates at high need of bariatric surgery and for whom it can be an effective treatment for both their weight and liver health (1,2). However, in patients with advanced fibrosis, cirrhosis, and portal hypertension, bariatric surgery	Thank you for your comment. Specific diagnostic tests to assess liver function were outside the remit for this update. However, recommendation 1.10.7 states that a comprehensive assessment for bariatric surgery must be carried out, including assessment of the person's medical needs. The type of bariatric surgery that is performed was also outside the remit for this update, however, recommendation 1.10.9 includes that the surgical intervention should be decided based on any comorbidities.

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				may have adverse consequences and has traditionally been a contraindication. More recent evidence suggests that those with well compensated cirrhosis are suitable candidates, but risk assessment is still an essential part of candidate selection. Additionally, the health of the liver may inform what type of bariatric surgery the patients should undergo. The presence of liver disease activity may encourage a less invasive method of surgery such as LAGB or sleeve gastrectomy instead of more expansive surgery. This personalises the approach to patients and ensures the best possible surgical plan. With the scale of bariatric surgery likely to increase, it is unfeasible to perform pre-operative liver biopsies on everyone, therefore non-invasive assessment is necessary to inform planning. Liver cT1 can provide a panoramic view of the whole liver's disease activity, equivalent to a "virtual biopsy" (3), correlates with histological measures on biopsy (4,5), predicts clinical outcomes (6) and has been shown to provide invaluable information pre-operatively to improve surgical outcomes in patients undergoing liver surgery (7). As bariatric surgery becomes more accessible to a wider pool of patients, a uniform, standardised, comprehensive	Lastly, studies included in your reference list were reviewed and reasons for exclusion are provided below: - Lassailly 2020 – Study was identified at title and abstract stage but was not a comparative observational study. - Fakhry (2019)- Not a systematic review of comparative observational studies. - Muratori (2023)- Not identified in our search due to search limits. Also focus of review on autoimmune hepatitis which was not a condition of interest for this review. - Banerjee (2014)- Not identified in our search. Also, focus of study is on diagnosis of liver disease. - Andersson (2022)- Not identified in our search. Also, study focused on the clinical utility of magnetic resonance imaging. - Jayaswal (2020)- Not identified in our search. Also, study focused on the prognostic value of multiparametric magnetic resonance imaging. - Sundaravadanan 2023 AHBPA (abstract)- we do not include abstracts in our reviews. - Mojtahed (2022)- Not identified in our search. Also, study focuses on

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				liver assessment is necessary to generate the best possible outcomes for patients and the NHS. Quantifying liver volume prior to surgery is an important assessment to make, as ideally a patient will have undergone a Very Low Calorie (VLC) diet that aims to shrink the liver to allow the surgeon adequate access and visibility during the procedure. If the liver has not reached the required volume, it may be optimal to lengthen the duration of the VLC diet and postpone surgery, or to take a decision not to operate. Currently, either objective, qualitative assessments are made on the size of the liver on imaging, or a laborious, time-consuming approach of manually contouring is performed by radiologists. Perspectum's AI-based liver volume and segmentation calculation is the only technique that has reported on its repeatability & reproducibility with excellent results (8), it saves radiologists significant time and is pending UKCA marking – in the future, this technique should be incorporated into pre-operative assessment. For these reasons, a comprehensive assessment of liver health using multiparametric MRI and liver volumetry as part of pre-operative workup should be carried out to ensure that the right patients are	repeatability and reproducibility of non-invasive imaging techniques. - Udelsman (2019)- Identified in our search and excluded at title and abstract stage as study focuses on prevalence data.

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				referred for bariatric surgery and the most appropriate bariatric procedures offered (9). <u>References</u> 1. Lassailly G, Caiazzo R, Ntandja-Wandji LC, Gnemmi V, Baud G, et al. Bariatric surgery provides long-term resolution of nonalcoholic steatohepatitis and regression of fibrosis. *Gastroenterology*. 2020;159:1290–1301.e5. 2. Fakhry TK, Mhaskar R, Schwitalla T, Muradova E, Gonzalvo JP, Murr MM. Bariatric surgery improves nonalcoholic fatty liver disease: a contemporary systematic review and meta-analysis. *Surg Obes Relat Dis*. 2019;15:502–11 3. Muratori et al. (2023) Diagnosis and management of autoimmune hepatitis. BMJ, 380, e070201 4. Banerjee, R., et al. (2014). Multiparametric magnetic resonance for the non-invasive diagnosis of liver disease. Journal of Hepatology, 60(1), 69–77 5. Andersson, A., et al. (2021). Clinical utility of MRI biomarkers for identifying NASH patients at high risk of progression: A multi-center pooled data and meta-analysis. Clinical Gastroenterology and Hepatology, 20(11), 2451–2461	

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				6. Jayaswal et al. (2020) Prognostic value of multiparametric magnetic resonance imaging, transient elastography and blood-based fibrosis markers in patients with chronic liver disease. Liver International, 40(12), 3071-3082 7. Sundaravadanan 2023 AHBPA (abstract) 8. Mojtahed, A., et al. (2021). Repeatability and reproducibility of deep-learning-based liver volume and Couinaud segment volume measurement tool. Abdominal Radiology, 47(1), 143–151. Udelsman BV et al. Risk factors and prevalence of liver disease in review of 2557 routine liver biopsies performed during bariatric surgery. Surg Obes Rel Dis. 2019;15(6):843-849.	
Perspectum	Guideline	004	010	**Follow up of patients should include a comprehensive, non-invasive liver assessment.** Although bariatric surgery can elicit improvement in the liver health (reduction in fat, fibrosis and inflammation) of patients, these benefits are not seen in all patients. Patients who, despite losing body fat, do not resolve their underlying liver condition must continue to be monitored by a hepatologist as part of their clinical care. It is impractical and unethical to identify these patients using a liver biopsy, and other non-invasive tests often only show signs of disease change at a late	Thank you for your comment. Specific follow-up tests are outside the remit for this update. However, details of post-operative follow-up care are provided in recommendations 1.10.17 and 1.10.18, including monitoring for comorbidities. Additionally, the references included in the comment were reviewed and were identified as being not applicable to the current review. The reasons for this are provided below: 1. Harrison 2020: Paper did not focus on effectiveness of bariatric surgery in different populations.

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				stage. Liver cT1 (an MRI-based biomarker) can accurately assess change in liver disease activity and liver fat over a short timeframe (1) and predicts clinical outcomes in chronic liver disease (2), so is ideal to identify those patients who are still at risk of liver-related outcomes, despite surgery. There is also evidence that higher risk patients (i.e. those with pre-operative cirrhosis) have a higher incidence of immediate post-operative complications, including acute hepatitis (3). Often, in these cases, despite these complications, in follow up, liver biochemistry and liver function tests are normal. The MRI-based biomarker liver cT1 (iron corrected T1) can show the presence of underlying disease activity when liver biochemistry is still normal (4), and therefore is an essential follow-up assessment to ascertain whether a patient is likely to require an involved management strategy, such as total parenteral nutrition (TPN). Liver cT1's high reproducibility and repeatability make it an appropriate biomarker to quantify change over a short or long time scales (5,6). Liver cT1 can therefore identify those patients whose liver health has not improved as a result of surgery and need to be seen by hepatology specialists and may also provide useful information	2. Jayaswal 2020: Paper did not focus on effectiveness of bariatric surgery in different populations. 3. Van Golen 2022: Incorrect study design (case series) 4. Arndtz 2021: Paper did not focus on effectiveness of bariatric surgery in different populations. 5. Bachtiar 2019: Paper did not focus on effectiveness of bariatric surgery in different populations. 6. Harrison 2018: Paper did not focus on effectiveness of bariatric surgery in different populations.

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				on those likely to develop acute hepatitis post-operatively. **References** 1. Harrison et al. (2020) NGM282 improves liver fibrosis and histology in 12 weeks in patients with nonalcolohic steatohepatitis. *J Hep;* 71(4), 1198-1212 2. Jayaswal et al. (2020) Prognostic value of multiparametric magnetic resonance imaging, transient elastography and blood-based fibrosis markers in patients with chronic liver disease. Liver International, 40(12), 3071-3082 3. Van Golen et al. (2022) Acute liver injury and acute liver failure following bariatric surgery. Case Reports in Gastroenterology; 16(1), 240-246 4. Arndtz et al. (2021) Multiparametric MRI imaging, autoimmune hepatitis, and prediction of disease activity. Hepatology Communications, 5(6), 1009-1020 5. Bachtiar et al. (2019) Repeatability and reproducibility of multiparametric magnetic resonance imaging of the liver. PLoS One, 14(4), e0214921 Harrison et al. (2018) Utility and variability of three non-invasive liver fibrosis imaging modalities to evaluate efficacy of GR-MD-02 in subjects with	

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				NASH and bridging fibrosis during a phase-2 controlled study. PloS One, 13(9), e0203054	
Rhythm Pharmaceuticals	Guideline	006	010	In the list of things that need to be assessed, we suggest adding two things: 1 – The presence of hyperphagia 2 – The presence of monogenic or syndromic obesity There is now strong evidence that bariatric surgery is contraindicated in patients with severe hyperphagia that is a hallmark of monogenic or syndromic obesity. It can even lead to severe adverse events. Please see Poitou et al for reference https://pubmed.ncbi.nlm.nih.gov/34083135/	Thank you for your comment. Recommendation 1.10.7 does state that the person's medical needs should be assessed.
Rhythm Pharmaceuticals	Guideline	006	027	We recommend to add: especially in patients with severe hyperphagia	Thank you for your comment. Recommendation 1.10.8 is out of scope for this update.
Royal College of Nursing	General	General	General	we received no member comments this time	Thank you for your comment.
Royal College of Paediatrics and Child Health	General	General	General	I have read the draft guidelines. They are VERY well written so bravo! I am commenting as a young people and children's expert. My one observation that you may wish to consider changing or moving emphasis is regarding diet in children. There is an inadequate emphasis on the parent/carer (and implicitly budget holder) Children	Thank you for your comment. The review question for this update focused on adults living with obesity. Therefore, the recommendations on bariatric surgery for children and young people were not updated. Further updates have been planned for the weight management guideline which include review questions on weight management programmes and healthy living programmes in

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				are dependent on their parents for what they eat, except during school meals. That does not come out of the guidelines and needs to be emphasised as without their buy in (no pun intended) , the whole process can fail	children and young people. For further information, please see the scope.
Select Research Ltd	Guideline	005	006	The use of the Body Mass Index (BMI) singularly as a differentiator for health risk has severe limitations as highlighted in this heavily cited paper on 250,000 patients from Mayo Clinic:- https://pubmed.ncbi.nlm.nih.gov/16920472/ . The use of waist-to-height ratio, measured manually or digitally, short term is advised as a differentiator in the lower BMI thresholds, with implementation and use of the Body Volume Index (BVI), focussing on abdominal body volume, better long-term. BVI is currently under separate NICE review at this time, but BMI alone has severe limitations as a differentiator for risk and appropriateness for surgical intervention. Therefore, additional valid measures centred on waist circumference or proportional abdominal volume will be required in time to allow for better patient selection for surgical eligibility.	Thank you for your comment. Appropriate anthropometric measures are outside the remit of this update.
Select Research Ltd	Guideline	008	002	This recommendation is cost prohibitive as it recommends pharmaceutical intervention pre-surgery with a wider cohort given that BMI thresholds for surgical eligibility are being reduced. Any pharmaceutical interventions should perhaps be limited to those with a BMI of over 40, with	Thank you for your comment. Recommendations on medicines while waiting for surgery were out of scope, however these were refreshed in line with the technology appraisals on liraglutide and semaglutide, Furthermore, these recommendations are for people waiting for

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				optional prescription to those below a BMI of 40. This could be reviewed for those in the lower BMI thresholds subject to waist and/or abdominal volume proportional measures having been assessed and measured prior to selection for bariatric surgery. The volume of the abdomen has a direct association with abdominal surgery needs.	surgery, and not for general use of pharmaceutical interventions. Recommendations on pharmacological interventions are covered in section 1.8 of CG189. Adults who have a BMI of 40 kg/m^2 or more, or between 35 kg/m^2 and 39.9 kg/m^2 and a significant health condition can be offered referral for a comprehensive assessment
Society for Endocrinology	General	000	000	**Equality impact assessment** Box 1 in the guideline leaves out some obesity complications relevant to women's health such as infertility secondary to obesity, polycystic ovarian syndrome which are associated with obesity and which improve after treatment of obesity.	Thank you for your comment. During the development of the review protocol, people prevented from receiving treatment, such as fertility treatment, were listed as subgroup of interest. Additionally, changes in fertility was identified as a critical outcome. Polycystic ovarian syndrome was not identified as a condition of interest during the development of the review protocol. No evidence was identified in people prevented from receiving treatment such as fertility treatment. Additionally, no evidence was identified for changes in fertility. It should be noted that Box 1 is not an exhaustive list of conditions but rather examples of common, significant health conditions that could be improved by weight loss. However, due to the lack of relevant evidence, the committee were unable to draft specific recommendations related

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					to fertility. Box 1 and the rationale and impact section has been amended to reflect this. To facilitate further research, the committee did draft a research recommendation to further explore the effectiveness of bariatric surgery in people who are unable to receive treatment for other health conditions, such as fertility treatment, because they are living with obesity.
Society for Endocrinology	Guideline	004	004	1.10.1 - is the implication that all bariatric patients require lifelong annual review? If so, it needs to be clear who is doing this as SWMS have no capacity.	Thank you for your comment. This is out of scope for the current update which was specifically about referral for bariatric surgery and assessment. However, the committee agree that future updates will need to address postoperative follow up care including the effectiveness of specialist and non-specialist follow up and the recommended length of follow up. We have passed your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
Society for Endocrinology	Guideline	005	002	Box 1 should include other conditions such as infertility secondary to obesity, polycystic ovarian syndrome. Possibly discriminatory to leave out such conditions that mostly pertain to women's health.	Thank you for your comment. During the development of the review protocol, people prevented from receiving treatment because of their obesity e.g., fertility treatment were included as an important population group. Polycystic ovarian syndrome was not identified as a condition of interest at review protocol stage.

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					As evidence was not identified in this population group, the committee were unable to draft specific recommendations for this population group. However, they did note the importance of further research in this group. Based on this discussion, the committee recommended further research on the effectiveness and cost-effectiveness of bariatric surgery in people needing treatment for other conditions., such as fertility treatment.
Society for Endocrinology	Guideline	005	005	1.10.3, 1.10.4, 1.10-5 – these recommendations seem to imply that there is a route to bariatric surgery which does not necessarily involve an SWMS. We believe that bariatric surgery should be considered in a multidisciplinary setting via an SWMS. If the intention was to allow for a direct route to surgery without a futile trial of Tier 3 intervention, this should be made clearer.	Thank you for your comment. Recommendations 1.10.3 to 1.10.5 specifically state that expedited assessment for bariatric surgery should be offered or considered in people who have recent-onset type 2 diabetes as long as they are also receiving, or will receive, assessment in a specialist weight management service.
Society for Endocrinology	Guideline	008	002	1.10.12 – this recommendation should also include semaglutide treatment and a reference to NICE ID3850 when this is finalised.	This has been added.
Society for Endocrinology	Guideline	010	012	Research recommendations: it is somewhat disappointing that the approach taken relies on BMI cut-offs which do not take into account different body compositions, nor the differences in health outcome in obesity which are not necessarily captured by BMI. We believe that the committee should recommend research on the long-term effects of bariatric surgery in people with lower BMIs where obesity co-morbidities are identified	Thank you for your comment. As highlighted in appendix L of the evidence review, important outcomes for research recommendation 1 included long-term effects of bariatric surgery such as improvement in condition, adverse events and revision rates. Furthermore, research recommendation 2 specifically focuses on the use of lower BMI thresholds in adults from minority ethnic family backgrounds.

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Society for Endocrinology	Guideline	013	003	p.13, l.3 – the committee should also recognise other long-term significant complications such as post-bariatric hypoglycaemia and adverse effects on pregnancies after bariatric surgery.	Thank you for your comment. The committee recognised there can be both short and long-term risks of complications with this surgery, including those you have listed and others. Because this is not an exhaustive list, the committee have amended this section of the rationale to group these themes under the broader categories of medical, nutritional, psychological, and surgical. The committee have recommended a comprehensive assessment in recommendation 1.10.7 which will address these complications and risks with the person.
University of Wolverhampton	Guideline	004	000	1.10.1 - regarding the following statement 'commit to the necessary long-term follow up after surgery' - is it possible to hyperlink to a resource noting what the necessary long-term follow up includes.	Thank you for your comment. Recommendation 1.10.1 does state that long-term follow up after surgery includes the possibility of lifelong annual reviews. This is discussed in greater depth in the committee discussion section of evidence review A. Additionally, what should be included in follow up care is detailed in recommendations 1.10.17 – 18. Furthermore, the committee agree that future updates will need to address postoperative follow up care including the effectiveness of specialist and non-specialist follow up and the recommended length of follow up. We have passed your comment to the NICE surveillance

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					team which monitors guidelines to ensure that they are up to date.
University of Wolverhampton	Guideline	004	001	As this document is intended for people using services, their families and carers and the public, it is important that information presented is understandable among the lay population. As such can off-label use be defined or re-phrased in the following 'and has information about prescribing medicines (including off-label use),'	Thank you for your comment. The text in the introduction box is standard text used in all guidelines and therefore cannot be modified.
University of Wolverhampton	Guideline	004	007	Couldn't see here. But before some countries had their own policies to accept patients with BMI over 40 or less, which seemed unfair for equal treatment of patients. Is this still applied in the UK for different counties?	Thank you for your comment. The recommendations state that people who have a BMI of 40 kg/m^2 or more, or between 35 kg/m^2 and a significant health condition that could be improved if they lost weight. Recommendation 1.10.2 also includes a BMI threshold for people of South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background. Additionally, this guidance applies to England and Wales and aims to reduce variation in practice.
University of Wolverhampton	Guideline	004	012	Can the reason of the reduction be explained, is it because of the height or ethnicity as a confounder?	Thank you for your comment. As part of a previous update of CG189, it was identified that people with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family backgrounds are prone to central adiposity and their cardiometabolic risk occurs at a lower BMI. Based on this finding, the

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					committee drafted recommendations for the use of lower BMI thresholds in this population. As part of this update, no evidence was found on the effectiveness of bariatric surgery in different ethnicities. However, the committee felt it was important to draft recommendation for people of different family backgrounds because their cardiometabolic risk occurs at a lower BMI. A research recommendation was also drafted to support further research in this field. The committee discussion has been captured in the rationale and impact section of the guideline and in section 1.1.11 of evidence review A.
University of Wolverhampton	Guideline	006	005	Consider a more precise requirement for the personnel conducting assessments. I would recommend 'qualified' or accredited to conduct the assessment, not merely 'experienced'. There are protected titles to describe the personnel required e.g. Clinical, Counselling, or Health Psychologist, Dietitian.	Thank you for your comment. The committee acknowledged that due to variation in commissioning of services there may be differences in the structure of the MDT and that this assessment for surgery might lie in tier 3 or tier 4 services, therefore it was difficult to be prescriptive about every member. The committee also discussed that there aren't many specialty qualifications available in obesity for the different professional groups That they could specify. We have added in the rationale and impact section of the guideline and in the committee discussion section (1.1.11) in evidence review A that ideally the MDT should include a physician, surgeon or bariatric surgeon (as appropriate), registered

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					dietitian and specialist psychologist. We have also updated the recommendation to make it clear that the MDT needs to have – or have access to – medical, nutritional, surgical and psychological expertise (and not just experience).
University of Wolverhampton	Guideline	006	012	It would be good to get a unified and consistent evidence-based approach to this assessment i.e. The qualifications of the person undertaking it, specific assessment tools, benchmarks/cut off scores to consider; 'any psychological factors' is too vague. Again, the person making this assessment should be qualified to do so.	Thank you for your comment. The committee were unable to add specific details on the qualifications of the person undertaking the assessment but agreed that multidisciplinary team within a specialist weight management service should have access to or include a specialist psychologist. The rationale and impact section of the guideline and the committee discussion section (1.1.11) in evidence review A have been amended to reflect this discussion. Furthermore, the committee agreed that 'factors' was too vague, and this has been amended to psychological needs instead. The emphasis of the recommendation has also been changed to ensure the psychological assessment should be done to support their suitability for surgery.
University of Wolverhampton	Guideline	006	014	The following which is presented as part of a multidisciplinary assessment for bariatric surgery	Thank you for your comment. The committee agree with this and wanted to emphasise that this is about taking someone's weight management

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				'their previous attempts to manage their weight, and any past engagement with weight management services (for example, specialist weight management services)' ...needs better contextualising for the intended audience against a later statement on page 12 line 1-9 – an extract from this being as follows 'They agreed that requiring people to try specific measures before referral would create an unjustified barrier to effective treatment, and the evidence did not support using surgery only as a last resort.' The first extract suggests this is a requirement, which is then noted not to be the case on the grounds of exacerbating health inequalities. The explanation of this decision in the equality impact assessment was useful here and could be used to rephrase recommendations fort this assessment as follows: it is important to assess a person's previous attempts to manage their weight, including any past engagement with weight management services at point of assessment. This can allow people who may not have been able to engage with weight management services due to the lack of services in their area to still be assessed for surgery	history and understanding their response to treatment, and it should not be seen as something that precludes them from surgery but rather to help aid their conversation of the different treatment options available in order to come to a shared decision with the person. The recommendation has been changed to focus on this response to treatment rather than about prior engagement with services. The rationale has also been updated to reflect this.

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University of Wolverhampton	Guideline	006	018	The standard offer of care should be to provide support that is described, it should not be reserved for extreme cases. This should be the default. Surgery is life-changing. It should be assumed that some support around coping, diet, and co-morbidities would be provided.	Thank you for your comment. The assessment listed as part of recommendation 1.10.7 should be offered to everyone selected for comprehensive assessment for bariatric surgery, but this assessment should be based on the person's needs. This recommendation is not reserved for extreme cases.
University of Wolverhampton	Guideline	006	025	Also to be discussed: Whether food has been used historically for the purpose of coping and/or emotional regulation, and how the patient can work on different ways of coping moving forward. How they will cope with day to day activities around eating.	Thank you for your comment. Recommendation 1.10.7 does highlight that as part of the assessment, the person nutritional needs, for example their eating habits, should be assessed.
University of Wolverhampton	Guideline	007	011	Information should also be provided on psychological support, and the psychology of long term weight-loss e.g. emotional eating, coping, motivation, perception of hunger and fullness.	Thank you for your comment. Recommendation 1.10.10 is out of scope for this update. The recommendation does state that information on patient support groups and individualised support and guidance to achieve long-term weight loss and weight maintenance should be given.
University of Wolverhampton	Guideline	008	002	Need to draw attention that both medications must be stopped at least one day before the surgery.	Thank you for your comment. Recommendations on medicines while waiting for surgery were out of scope for this update. These recommendations were refreshed to make reference to the new technology appraisals on semaglutide and liraglutide. Additionally, we will pass your comment to the NICE surveillance team which

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					monitors guidelines to ensure that they are up to date.
University of Wolverhampton	Guideline	008	014	In annual follow up, extra skin due to weight loss, management need to be considered or indicated as an element of the follow up in the same manner psychological and mental health are checked.	Thank you for your comment. Recommendation 1.10.14 does state that the multidisciplinary team carrying out bariatric surgery can provide information on plastic surgery (such as apronectomy), if appropriate.
University of Wolverhampton	Guideline	009	013	With these points, a large number of patients regain weight after bariatric surgery, especially after 2-3 years. It seems that the minimum follow-up should be more than this.	Thank you for your comment. This is out of scope for the current update which was specifically about referral for bariatric surgery and assessment. However, the committee agree that future updates will need to address postoperative follow up care including the effectiveness of specialist and non-specialist follow up and the recommended length of follow up. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure they are up to date.
University of Wolverhampton	Guideline	009	023	Annual monitoring should also include factors such as quality of life, eating behaviour, (e.g. grazing is common substitute behaviour for binge eating and can incrementally increase such that weight gain occurs), and psychosocial outcomes.	Thank you for your comment. Recommendation 1.10.18 is out of scope for this current update, therefore further changes to the recommendation cannot be made. Additionally, the committee agree that future updates will need to address postoperative follow up care including the effectiveness of specialist

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					and non-specialist follow up and the recommended length of follow up. We have passed your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date.
University of Wolverhampton	Guideline	010	007	Maybe we need to add this point to the guidelines as well. Patients who were UK (NHS) patients but had surgery overseas (due to long waiting times, access to family for aftercare, fees, etc.) should consider how they can follow up their treatment after returning to the UK. Although it seems the NHS may not accept them, this point is still worth including them in care; if they regain weight or have any weight-related problems, they need to be treated by the NHS.	Thank you for your comment. This is outside the remit of this update.
University of Wolverhampton	Guideline	010	011	For the lay audience would it be worth noting what tier 3 services are at this point, as this description does not come until page 12 line 2-3? Indeed, as the following change has been made to guidelines 1.10.3, 1.10.4 and 1.10.5 ''Tier 3 service (or equivalent)' has been changed to 'specialist weight management service', is the use of the term tier 3 necessary and to be consistent can specialist weight management service be used throughout?	Thank you for your comment. Recommendation 1.10.1 includes a hyperlink to our definition of specialist weight management services. The terms specialist weight management service is also used throughout the recommendations.

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