

1 **NATIONAL INSTITUTE FOR HEALTH AND CARE**
2 **EXCELLENCE**

3 **Guideline**

4 **Obesity: surgical interventions**

5 **Draft for consultation, February 2023**

This guideline covers bariatric surgery in adults. It does not cover children or women during pregnancy.

The guideline will update and replace the recommendations on bariatric surgery in [NICE's guideline on obesity: identification, assessment and management](#).

Who is it for?

- Healthcare professionals
- Commissioners and providers
- People who work in, and are responsible for providing, services in the wider public, private, voluntary and community sectors
- People using services, their families and carers, and the public

What does it include?

- the draft recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the 2023 recommendations and how they might affect practice and services
- the guideline context.

Information about how the guideline was developed is on the [guideline's web page](#) This includes the evidence reviews, the scope, details of the committee and any declarations of interest.

New and updated recommendations

We have reviewed evidence on bariatric surgery. You are invited to comment on the new and updated recommendations. These are marked **[2023]**.

You are also invited to comment on recommendations that we propose to delete from the previous guidelines.

We have not reviewed the evidence for the recommendations marked **[2014]** or **[2006, amended 2014]** (shaded in grey), and cannot accept comments on them. In some cases, we have made minor wording changes for clarification.

See [update information](#) for a full explanation of what is being updated.

Full details of the evidence and the committee's discussions on the 2023 recommendations are in the [evidence reviews](#). For the evidence on the 2006 and 2014 recommendations see the [supporting evidence for CG189](#).

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1 Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in [NICE's information on making decisions about your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

2 1.10 Bariatric surgery

3 When to refer adults for bariatric surgery

4 1.10.1 Offer adults a referral for a comprehensive assessment by [specialist](#)
5 [weight management services](#) to see whether bariatric surgery is suitable
6 for them if they:

- 7 • have a BMI of 40 kg/m² or more, or between 35 kg/m² and
8 39.9 kg/m² and a significant health condition that could be improved if
9 they lost weight (see box 1 for examples) **and**
- 10 • commit to the necessary long-term follow up after surgery (for example,
11 lifelong annual reviews). **[2023]**

12 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
14 BMI threshold for referral (reduced by 2.5 kg/m²) than in recommendation
15 1.10.1, if they meet the other criteria. **[2023]**

For a short explanation of why the committee made the 2023 recommendations and how they might affect practice, see the [rationale and impact section on when to refer adults for bariatric surgery](#).

Full details of the evidence and the committee's discussion are in [evidence review A: referral for bariatric surgery](#).

1

2 **Box 1 Examples of common, significant health conditions that could be**
3 **improved by weight loss**

Conditions that can improve after weight loss include:

- cardiovascular disease
- hypertension
- idiopathic intracranial hypertension
- non-alcoholic fatty liver disease
- obstructive sleep apnoea
- type 2 diabetes

4 **When to offer expedited assessment**

5 1.10.3 Offer an expedited assessment for bariatric surgery to people with a BMI
6 of 35 kg/m² or more who have recent-onset (diagnosed within the past
7 10 years) type 2 diabetes as long as they are also receiving, or will
8 receive, assessment in a specialist weight management service. **[2014,**
9 **amended 2023] [CG189 recommendation 1.11.1]**

10 1.10.4 Consider an expedited assessment for bariatric surgery for people with a
11 BMI of 30 to 34.9 kg/m² who have recent-onset (diagnosed within the past
12 10 years) type 2 diabetes as long as they are also receiving, or will
13 receive, assessment in a specialist weight management service. **[2014,**
14 **amended 2023] [CG189 recommendation 1.11.2]**

15 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
19 populations **(reduced by 2.5 kg/m²)** as long as they are also receiving, or

1 will receive, assessment in a specialist weight management service.

2 **[2014, amended 2023] [CG189 recommendation 1.11.3]**

3 **Initial assessment and discussions with the multidisciplinary team**

4 1.10.6 Ensure the weight management multidisciplinary team includes health and
5 social care professionals with expertise in conducting medical, nutritional
6 and psychological assessments, and in assessing the suitability of
7 surgery. **[2023]**

8 1.10.7 Carry out a comprehensive, multidisciplinary assessment for bariatric
9 surgery based on the person's needs. As part of this, assess:

- 10 • the person's medical needs (for example, existing comorbidities)
- 11 • their nutritional needs (for example, dietary intake and eating habits)
- 12 • any psychological factors that may affect whether surgery is suitable or
13 affect their adherence to postoperative care requirements
- 14 • their previous attempts to manage their weight, and any past
15 engagement with weight management services (for example, specialist
16 weight management services)
- 17 • fitness for anaesthesia and surgery
- 18 • whether any arrangements need to be made, based on the person's
19 needs, ahead of surgery (for example if they need additional dietary or
20 psychological support, or support to manage existing or new
21 comorbidities). **[2023]**

22 1.10.8 The hospital specialist or bariatric surgeon should discuss the following
23 with people who are living with severe obesity if they are considering
24 surgery:

- 25 • the potential benefits
- 26 • the longer-term implications **and requirements** of surgery
- 27 • the potential risks and complications
- 28 • perioperative mortality.
- 29

1 Include the person's family **and carers** in the discussion, if appropriate.
2 **[2006, amended 2023] [CG189 recommendation 1.10.2]**

3 1.10.9 Choose the surgical intervention jointly with the person, taking into
4 account:

- 5 • the severity of obesity and any comorbidities
- 6 • the best available evidence on effectiveness and long-term effects
- 7 • the facilities and equipment available
- 8 • the experience of the surgeon who would perform the operation. **[2006]**
9 **[CG189 recommendation 1.10.3]**

10 1.10.10 Give the person information on:

- 11 • the appropriate dietary intake **after** the bariatric procedure
- 12 • monitoring the person's micronutrient status
- 13 • information on patient support groups
- 14 • individualised nutritional supplementation, support and guidance to
15 achieve long-term weight loss and weight maintenance. **[2006,**
16 **amended 2023] [CG189 recommendation 1.10.4]**

For a short explanation of why the committee made the 2023 recommendations and how they might affect practice, see the [rationale and impact section on initial assessment and discussions with multidisciplinary team](#).

Full details of the evidence and the committee's discussion are in [evidence review A: referral for bariatric surgery](#).

17 Preoperative assessment and discussions

18 1.10.11 Carry out a comprehensive preoperative assessment of any psychological
19 or clinical factors that may affect adherence to postoperative care
20 requirements (such as changes to dietary intake, eating habits and taking
21 nutritional supplements) before performing surgery. **[2006, amended**
22 **2014] [CG189 recommendation 1.10.10]**

1 Medicines while waiting for surgery

2 1.10.12 Orlistat, liraglutide or semaglutide may be used to maintain or reduce
3 weight before surgery for people who have been recommended surgery, if
4 the waiting time is excessive. See the [recommendations on orlistat in the](#)
5 [section on pharmacological interventions and continued prescribing and](#)
6 [withdrawal](#), and [NICE's technology appraisal guidance on liraglutide for](#)
7 [overweight and obesity](#) and [semaglutide for overweight and obesity](#).
8 **[2006, amended 2023] [CG189 recommendation 1.10.8]**

9 Qualifications of the weight management multidisciplinary team

10 1.10.13 The surgeon in the multidisciplinary team should have:

- 11
- 12 • had relevant supervised training
 - 13 • specialist experience in bariatric surgery. **[2006, amended 2014]**
[CG189 recommendation 1.10.6]

14 1.10.14 Ensure the multidisciplinary team carrying out bariatric surgery can
15 provide:

- 16
- 17 • preoperative assessment, including a risk-benefit analysis that includes
18 preventing complications of obesity, and specialist assessment for
19 eating disorders (and if appropriate, referral or signposting to specialist
20 eating disorder services)
 - 21 • information on the different procedures, including potential weight loss
22 and potential risks
 - 23 • regular postoperative assessment, including specialist dietetic and
24 surgical follow up (see recommendation 1.10.17)
 - 25 • management of comorbidities
 - 26 • psychological support before and after surgery (for example, a
27 psychological assessment before surgery and, if appropriate, referral to
28 specialist mental health services either before or after surgery)
 - 29 • information on plastic surgery (such as apronectomy) if appropriate.
[2006, amended 2023] [CG189 recommendation 1.10.9]

1 1.10.15 Hospitals undertaking bariatric surgery should ensure there is access to
2 suitable equipment, including scales, blood pressure cuffs, theatre tables,
3 walking frames, commodes, hoists, bed frames, pressure-relieving
4 mattresses and seating suitable for people having bariatric surgery, and
5 staff trained to use them. [2006, amended 2023] [CG189
6 recommendation 1.10.9]

7 1.10.16 Undertake revisional surgery (if the original operation has not been
8 successful) only in specialist centres by surgeons with extensive
9 experience, because of the high rate of complications and increased
10 mortality. [2006] [CG189 recommendation 1.10.11]

11 Postoperative follow-up care

12 1.10.17 Offer people who have had bariatric surgery a follow-up care package for
13 a minimum of 2 years within the bariatric service. Include:

- 14 • monitoring nutritional intake (including protein and vitamins), mineral
15 levels and micronutrient status
- 16 • monitoring for comorbidities
- 17 • medications review
- 18 • individualised dietary and nutritional assessment, advice and support
- 19 • physical activity advice and support
- 20 • psychological support tailored to the individual
- 21 • information about professionally-led or peer-support groups. [2014]
22 [CG189 recommendation 1.10.4 and 1.12.1]

23 1.10.18 After discharge from bariatric surgery service follow up, ensure people are
24 offered at least annual monitoring of nutritional status and appropriate
25 supplementation after bariatric surgery, as part of a shared care model.
26 [2014] [CG189 recommendation 1.12.2]

27 Audit

28 1.10.19 Arrange a prospective audit so that the outcomes and complications of
29 different procedures, the impact on quality of life and nutritional status,
30 and the effect on comorbidities can be monitored in both the short and the

1 long term. (The [National Bariatric Surgery Registry](#) conducts national
2 audits for agreed outcomes.) [2006, amended 2014] [CG189

3 **recommendation 1.10.5]**

4 1.10.20 The surgeon in the multidisciplinary team should submit data for a
5 national clinical audit scheme such as the National Bariatric Surgery
6 Registry. [2006, amended 2014] [CG189 **recommendation 1.10.6]**

7 **Terms used in this guideline**

8 **Specialist weight management service**

9 A specialist primary, community or secondary care-based multidisciplinary team
10 offering surgical or dietary, pharmacological and psychological weight management
11 interventions. These include tier 3 services.

12 **Research recommendations**

13 **1 Surgical referral threshold for people who need treatment for other** 14 **conditions**

15 What is the effectiveness and cost effectiveness of bariatric surgery in achieving
16 weight loss and improving treatment outcomes in people who are unable to receive
17 treatment for other health conditions (such as joint replacement surgery or fertility
18 treatment) because they are living with obesity?

For a short explanation of why the committee made this recommendation for research, see the [rationale and impact section on when to refer adults for bariatric surgery](#).

Full details of the evidence and the committee's discussion are in [evidence review A: referral for bariatric surgery](#).

1 **2 Surgical referral threshold for people from minority ethnic family**
2 **backgrounds**

3 What is the effectiveness and cost effectiveness of bariatric surgery in achieving
4 weight loss and maintaining a healthier weight in adults living with obesity from
5 minority ethnic family backgrounds?

For a short explanation of why the committee made this recommendation for research, see the [rationale and impact section on when to refer adults for bariatric surgery](#).

Full details of the evidence and the committee's discussion are in [evidence review A: referral for bariatric surgery](#).

6 **Rationale and impact**

7 **Bariatric surgery**

8 [Recommendations 1.10.1 to 1.10.2 and 1.10.6 to 1.10.7](#)

9 **Why the committee made the recommendations**

10 **When to refer adults for bariatric surgery**

11 The committee discussed evidence on bariatric surgery for various subgroups of
12 people with and without obesity-related comorbidities. They agreed that it improved
13 several important outcomes, including weight loss, cardiovascular disease and
14 mortality, for people with a BMI of 40 kg/m² or more and for those with a BMI of
15 35 kg/m² or more with obesity-related comorbidities. They also agreed that examples
16 of common, significant health conditions that could be improved by surgery would
17 help practitioners decide whether referral was appropriate for those with a BMI below
18 40 kg/m². They agreed that the economic evidence showed that bariatric surgery
19 was cost effective in these groups.

20 Committee members highlighted that people who met the recommended criteria
21 should be referred to a specialist weight management service where they can
22 receive comprehensive assessment for surgery from a weight management
23 multidisciplinary team.

1 The committee discussed whether non-surgical measures should be tried, including
2 specialist weight management services (referred to as tier 3 services in NICE's 2014
3 guidance) before assessing people for surgery. They agreed that requiring people to
4 try specific measures before referral would create an unjustified barrier to effective
5 treatment, and the evidence did not support using surgery only as a last resort. They
6 also noted that tier 3 services are not available in all parts of the country (in
7 2014/2015 only about 21% of the clinical commissioning groups in England included
8 one), and that information on them was limited. So restricting assessment for surgery
9 to those who have already used a tier 3 service could exacerbate health inequalities.

10 No evidence was found on the effectiveness of bariatric surgery for weight loss in
11 people who had been refused other treatment because of obesity, such as liver or
12 kidney transplant, fertility treatment or joint replacement surgery. Therefore, the
13 committee could not identify a referral criterion for this population. So they
14 [recommended research on the effectiveness and cost effectiveness of bariatric](#)
15 [surgery in people needing treatment for other conditions.](#)

16 Although no evidence was found on the effectiveness of bariatric surgery in different
17 ethnicities, the committee agreed that obesity-related comorbidities affected people
18 from some family backgrounds at lower BMI levels. Offering surgery to people in
19 these groups at a lower threshold could improve outcomes. The committee also
20 agreed that reducing the BMI threshold by 2.5 kg/m² was supported by evidence
21 identified for the recommendations on identifying and assessing overweight, obesity
22 and central adiposity. They noted that this would be in line with guidance developed
23 by other organisations (for example, [British Obesity and Metabolic Surgery Society](#)
24 [guidance on accessing tier 4 services](#) and joint [American Society for Metabolic and](#)
25 [Bariatric Surgery and International Federation for Surgery of Obesity of Metabolic](#)
26 [Disorders guidance](#)). They [recommended research on the effectiveness and cost](#)
27 [effectiveness of bariatric surgery in people from minority ethnic family backgrounds](#)
28 to confirm the appropriate referral criteria.

29 The committee also agreed a similar reduction was needed for people from various
30 family backgrounds who have recent-onset type 2 diabetes.

1 **Initial assessment and discussions with the multidisciplinary team**

2 Committee members highlighted that although bariatric surgery is effective for weight
3 loss, there are risks associated with the procedure, such as nutritional deficiencies
4 and long-term psychological effects, including weight stigma. They noted that
5 another major concern was the lack of service provision and variation in practice,
6 particularly in the initial assessment before surgery.

7 Based on these risks and concerns, the committee agreed it was crucial to stress the
8 importance of an initial comprehensive assessment by a multidisciplinary team to
9 assess the level of risk before surgery. And that to manage the variation in practice it
10 was important to give health and social care professionals and people being referred
11 for assessment information about what to expect during this assessment and about
12 the level of support people need.

13 The committee agreed assessment for bariatric surgery should be carried out by a
14 weight management multidisciplinary team that includes health and social care
15 professionals with expertise in conducting medical, nutritional and psychological
16 assessments - including assessing the person's fitness for anaesthesia and surgery -
17 as appropriate. This team should also assess the person's previous weight
18 management attempts and whether they have already engaged with weight
19 management services (for example, specialist weight management services).
20 Although these points were recommended in NICE's 2014 guideline, the committee
21 agreed they were not yet universal practice so it was important to restate them.

22 Access to expertise in all these areas would allow the team to identify people for
23 whom bariatric surgery is suitable, and discuss other specialist weight management
24 services with people who are not ready or fit for surgery or those who may not wish
25 to have surgery on this occasion. This team would also be able to assess any
26 arrangements needed before surgery based on the findings of the assessment.
27 These arrangements include ways to improve the person's health (for example,
28 managing existing comorbidities or new comorbidities, improving nutrition or
29 providing psychological support).

1 **How the recommendations might affect practice**

2 Offering assessment for bariatric surgery to people even if they have not tried all
3 non-surgical measures or have not already attended a tier 3 service for intensive
4 weight management will reduce variation in practice and will increase uptake in
5 previously overlooked groups. Considering assessment for bariatric surgery at lower
6 BMI thresholds for people from some family backgrounds will reduce inequalities in
7 obesity-related outcomes and improve accessibility of treatment. This is likely to
8 increase the number of referrals and surgeries carried out, and therefore increase
9 costs. But basing the offer of surgery on comorbidities as well as BMI will help those
10 who could benefit most, and the cost will be offset by the long-term reduction in
11 obesity-related complications.

12 **Context**

13 The 2019 Health Survey for England estimated the prevalence of obesity in adults in
14 England to be 28%, with overweight affecting a further 36%. Government estimates
15 indicate that the current costs of obesity in the UK are £6.1 billion to the NHS and
16 £27 billion to wider society.

17 Bariatric surgery is a treatment option and is available on the NHS for people who
18 meet certain criteria. During the scoping phase of this guideline, expert feedback
19 indicated that there may be specific subgroups of people who would benefit from
20 bariatric surgery and highlighted that there is new evidence to support this.

21 This guideline update covers the referral criteria for assessment for bariatric surgery.
22 It updates [NICE's guideline on obesity: identification, assessment and management](#)
23 (CG189).

24 Forthcoming updates will cover preventing and managing overweight and obesity.
25 They will produce a single guideline that will partially replace [NICE's guideline on](#)
26 [weight management before, during and after pregnancy](#) (PH27) (only the
27 recommendations that apply before and after pregnancy) and will fully update and
28 replace this guideline and NICE's guidelines on:

- 29 • [preventing excess weight gain \(NG7\)](#)
- 30 • [weight management: lifestyle services for overweight or obese adults \(PH53\)](#)

- 1 • [weight management: lifestyle services for overweight or obese children and young](#)
- 2 [people \(PH47\)](#)
- 3 • [obesity: working with local communities \(PH42\)](#)
- 4 • [obesity prevention \(CG43\)](#).

5 **Finding more information and committee details**

6 To find NICE guidance on related topics, including guidance in development, see the

7 [NICE topic page on obesity](#).

8 For details of the guideline committee see the [committee member list](#).

9 **Update information**

10 **July 2023**

11 We have reviewed the evidence on bariatric surgery for people with living with

12 overweight and obesity.

13 Recommendations are marked **[2023]** if the evidence has been reviewed.

14 **Recommendations that have been deleted, or changed without an**

15 **evidence review**

16 We propose to delete some recommendations from the 2014 guideline. [Table 1](#) sets

17 out these recommendations and includes details of replacement recommendations.

18 If there is no replacement recommendation, an explanation for the proposed deletion

19 is given.

20 For recommendations shaded in grey and ending **[2014, amended 2023]**, we have

21 made changes that could affect the intent without reviewing the evidence. Yellow

22 shading is used to highlight these changes, and reasons for the changes are given in

23 [table 2](#).

24 For recommendations shaded in grey and ending **[2014]** or **[2006, amended 2014]**,

25 we have not reviewed the evidence. In some cases minor changes have been made

26 – for example, to update links, or bring the language and style up to date – without

27 changing the intent of the recommendation. Minor changes are listed in [table 3](#).

1 See also the [previous NICE guideline and supporting documents](#).

2 **Table 1 Recommendations that have been deleted**

Recommendation in 2014 guideline	Comment
<p>Bariatric surgery is a treatment option for people living with obesity if all of the following criteria are fulfilled:</p> <ul style="list-style-type: none"> • They have a BMI of 40 kg/m² or more, or between 35 kg/m² and 40 kg/m² and other significant disease (for example, type 2 diabetes or high blood pressure) that could be improved if they lost weight. • All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss. • The person has been receiving or will receive intensive management in a tier 3 service (for more information on tier 3 services, see NHS England's report on joined up clinical pathways for obesity). • The person is generally fit for anaesthesia and surgery. • The person commits to the need for long-term follow up. (CG189 recommendation 1.10.1) 	Replaced by new recommendations 1.10.1 and 1.10.7.
<p>Offer an assessment for bariatric surgery to adults with a BMI of more than 50 kg/m² or over. (CG189 recommendation 1.10.7)</p>	This recommendation has been deleted because the group is now covered by recommendation 1.10.1.

3

4 **Table 2 Amended recommendation wording (change to intent) without an**
 5 **evidence review**

Recommendation in 2014 guideline	Recommendation in current guideline	Reason for change
<p>The hospital specialist and/or bariatric surgeon should discuss the following with people living with severe obesity if they are considering surgery to aid weight reduction:</p> <ul style="list-style-type: none"> • the potential benefits • the longer-term implications of surgery • associated risks • complications • perioperative mortality. <p>The discussion should also include the person's family,</p>	<p>The hospital specialist or bariatric surgeon should discuss the following with people who are living with severe obesity if they are considering surgery:</p> <ul style="list-style-type: none"> • the potential benefits • the longer-term implications and requirements of surgery • the potential risks and complications • perioperative mortality. <p>Include the person's family and carers in the discussion, if appropriate. (1.10.8)</p>	<p>Recommendation updated to add discussion of the longer-term follow up associated with surgery, and to highlight that carers should be part of the discussion if appropriate.</p>

Recommendation in 2014 guideline	Recommendation in current guideline	Reason for change
as appropriate. (CG189 recommendation 1.10.2)		
<p>Provide regular, specialist postoperative dietetic monitoring, including:</p> <ul style="list-style-type: none"> information on the appropriate diet for the bariatric procedure monitoring of the person's micronutrient status information on patient support groups individualised nutritional supplementation, support and guidance to achieve long-term weight loss and weight maintenance. (1.10.4) 	<p>Give the person information on:</p> <ul style="list-style-type: none"> the appropriate dietary intake after the bariatric procedure monitoring the person's micronutrient status information on patient support groups individualised nutritional supplementation, support and guidance to achieve long-term weight loss and weight maintenance. (1.10.10) 	<p>Bullet point on diet amended to clarify that the advice refers to diet after the surgery. Information on postoperative care removed because this is covered by recommendation 1.10.17.</p>
<p>Orlistat may be used to maintain or reduce weight before surgery for people who have been recommended surgery as a first-line option, if it is considered that the waiting time for surgery is excessive. (1.10.8)</p>	<p>Orlistat, liraglutide or semaglutide may be used to maintain or reduce weight before surgery for people 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. (1.10.12)</p>	<p>Recommendation expanded to take into account liraglutide and semaglutide, which have become available since the original 2014 recommendation. Recommendation also amended to remove reference to surgery being a first-line option because this statement does not match the clinical pathway.</p>
<p>Surgery for obesity should be undertaken only by a multidisciplinary team that can provide:</p> <ul style="list-style-type: none"> preoperative assessment, including a risk-benefit analysis that includes preventing complications of obesity, and specialist assessment for eating disorders information on the different procedures, 	<p>Ensure the multidisciplinary team carrying out bariatric surgery can provide:</p> <ul style="list-style-type: none"> preoperative assessment, including a risk-benefit analysis that includes preventing complications of obesity, and specialist assessment for eating disorders (and if appropriate, referral or signposting to specialist eating disorder services) information on the different procedures, 	<p>Information about access to apronectomy replaced by information on plastic surgery because the NHS no longer provides apronectomy. Further detail added to explain what referrals may be needed after the preoperative assessment and pre-surgery psychological assessment. The bullet point about access to suitable</p>

Recommendation in 2014 guideline	Recommendation in current guideline	Reason for change
<p>including potential weight loss and associated risks</p> <ul style="list-style-type: none"> • regular postoperative assessment, including specialist dietetic and surgical follow up (see recommendation 1.12.1) • management of comorbidities • psychological support before and after surgery • information on, or access to, plastic surgery (such as apronectomy) when appropriate • access to suitable equipment, including scales, theatre tables, Zimmer frames, commodes, hoists, bed frames, pressure-relieving mattresses and seating suitable for people undergoing bariatric surgery, and staff trained to use them. (CG189 recommendation 1.10.9) 	<p>including potential weight loss and potential risks</p> <ul style="list-style-type: none"> • regular postoperative assessment, including specialist dietetic and surgical follow up (see recommendation 1.10.16) • management of comorbidities • psychological support before and after surgery (for example, a psychological assessment before surgery and, if appropriate, referral to specialist mental health services either before or after surgery) • information on plastic surgery (such as apronectomy) if appropriate. (1.10.14) <p>Hospitals undertaking bariatric surgery should ensure there is access to suitable equipment, including scales, blood pressure cuffs, theatre tables, walking frames, commodes, hoists, bed frames, pressure-relieving mattresses and seating suitable for people having bariatric surgery, and staff trained to use them. (1.10.15)</p>	<p>equipment was made into a separate recommendation because this relates to facilities of the healthcare organisation and not the multidisciplinary team. It was also amended to include access to blood pressure cuffs because this is an important piece of equipment during surgery.</p>
<p>Consider an assessment for bariatric surgery for people of Asian family background who have recent-onset type 2 diabetes at a lower BMI than other populations (see recommendation 1.2.8) as long as they are also receiving or will receive assessment in a tier 3 service (or equivalent). (CG189 recommendation 1.11.3)</p>	<p>Consider an expedited assessment for bariatric surgery for people of South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background who have recent-onset onset (diagnosed within the past 10 years) type 2 diabetes at a lower BMI than other populations (reduced by 2.5 kg/m²) as long as they are also receiving or will receive assessment in a specialist</p>	<p>Groups and thresholds updated in line with the 2022 changes to section 1.2.</p>

Recommendation in 2014 guideline	Recommendation in current guideline	Reason for change
	weight management service. (1.10.5)	

1

2 **Table 3 Minor changes to recommendation wording (no change to intent)**

Recommendation numbers in current guideline	Comment
1.10.3, 1.10.4, 1.10.5	'Tier 3 service (or equivalent)' has been changed to 'specialist weight management service'. Definition of recent onset moved into the recommendations for clarity.
1.10.9	'Degree' changed to 'severity'.
1.10.15	'Zimmer frame' changed to 'walking frames'.
1.10.13 and 1.10.19	CG189 recommendation 1.10.6 has been split into 2 recommendations for clarity: one covering qualifications and one covering audit.
1.10.14	'Units' changed to 'services'.

3

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