NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Obesity: clinical assessment and management

Output: Prioritised quality improvement areas for development.

Date of Quality Standards Advisory Committee meeting: 9 October 2015

Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for obesity: clinical assessment and management. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development sources referenced in this briefing paper are:

- Obesity: identification, assessment and management of overweight and obesity in children, young people and adults. NICE clinical guideline 189 (2014)
- Commissioning guide: Weight assessment and management clinics (tier 3). Royal College of Surgeons and British Obesity & Metabolic Surgery Society (2014)

2 Overview

2.1 Focus of quality standard

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

This quality standard will not cover public health strategies to prevent overweight and obesity or the delivery of lifestyle weight management interventions. These are covered by 2 other quality standards.

2.2 Definition

People are defined as being in different weight classes based on their body mass index (BMI) as follows:

- healthy weight: 18.5–24.9 kg/m^2
- overweight: 25–29.9 kg/m^2
- obesity I: 30–34.9 kg/m^2
- obesity II: 35–39.9 kg/m^2
- obesity III: 40 kg/m^2 or more.

The use of lower BMI thresholds (23 kg/m^2 to indicate increased risk and 27.5 kg/m^2 to indicate high risk) to trigger action to reduce the risk of conditions such as type 2 diabetes, has been recommended for black African, African-Caribbean and Asian (South Asian and Chinese) groups. BMI should be interpreted with caution in highly muscular adults as it may be a less accurate measure of adiposity in this group.

2.3 Incidence and prevalence

Obesity is directly linked to a number of different illnesses including type 2 diabetes, fatty liver disease, hypertension, gallstones and gastro-oesophageal reflux disease, as well as psychological and psychiatric morbidities.

The Health and Social Care Information Centre reported that in 2013/14 there were 9,325 hospital admissions in England with a primary diagnosis of obesity (Statistics on obesity, physical activity and diet - England, 2015). This is 15% less admissions than in 2012/13[1] but over five times the number that occurred 10 years ago. In every year between 2003/04 and 2013/14 more than twice as many females were admitted to hospital with a primary diagnosis of obesity than males.

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

Ethnic differences exist in the prevalence of obesity and the related risk of ill health. For example, compared with the general population, the prevalence of obesity is lower in men of Bangladeshi and Chinese family origin, whereas it is higher for women of African, Caribbean and Pakistani family origin (as reported in 'Bariatric surgery for obesity' by the former National Obesity Observatory, now Public Health England's obesity knowledge and intelligence team, in 2011).

[1] This data refers to inpatients only. A decrease in recorded inpatient admissions from one provider (Derby Hospitals NHS Foundation Trust; 183 inpatient admissions in 2013/14 with a primary diagnosis of obesity compared to 920 inpatient admissions in 2012/13) accounted for a large part of the decrease seen in national figures (which decreased by 1,632, or 15%).

The cost of being overweight and obese to society and the economy was estimated to be almost £16 billion in 2007 (over 1% of gross domestic product). The cost could increase to just under £50 billion in 2050 if obesity rates continue to rise, according to projections from the Department of Health. A simulated model reported in the Lancet predicted that there would be 11 million more obese adults in the UK by 2030, with combined medical costs for treatment of associated diseases estimated to increase by up to £2 billion per year.

2.4 Management

There are a variety of different management strategies for people who are overweight or obese. These include lifestyle, behavioural, dietary, pharmacological and surgical interventions.

Initial approaches should generally focus on eating a healthy, reduced-calorie diet and regular exercise. This can involve, as examples, eating a balanced, calorie-controlled diet as recommended by a GP or a weight loss management health professional (such as a dietitian) and taking up activities such as fast walking, jogging, swimming or tennis. If lifestyle changes alone don't help to lose weight, pharmacological and surgical interventions may be options[2].

See the NICE Obesity overview pathway for associated care pathways and algorithms.

2.5 National Outcome Frameworks

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

[2] NHS Choices Obesity

Table 1 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicators*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults ii Children and young people 1b Life expectancy at 75 i Males ii Females ***Improvement areas*** **Reducing premature mortality from the major causes of death** 1.1 Under 75 mortality rate from cardiovascular disease* (PHOF 4.4) 1.2 Under 75 mortality rate from respiratory disease* (PHOF 4.7) 1.3 Under 75 mortality rate from liver disease* (PHOF 4.6) 1.4 Under 75 mortality rate from cancer* (PHOF 4.5) **Reducing premature mortality in people with mental illness** 1.5 i Excess under 75 mortality rate in adults with serious mental illness* *ii Excess under 75 mortality rate in adults with common mental illness*
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Improving functional ability in people with long-term conditions** 2.2 Employment of people with long-term conditions*, ** **Reducing time spent in hospital by people with long-term conditions** 2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions **Enhancing quality of life for people with mental illness** 2.5 i Employment of people with mental illness** *ii Health-related quality of life for people with mental illness*** **Improving quality of life for people with multiple long-term conditions** *2.7 Health-related quality of life for people with three or more long-term conditions***
3 Helping people to recover from episodes of ill health or	***Overarching indicators*** 3a Emergency admissions for acute conditions that should

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

Table 2 Public health outcomes framework for England, 2013–2016

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

3 Summary of suggestions

3.1 Responses

In total 17 stakeholders responded to the 2-week engagement exercise [14/08/15 – 28/08/15].

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 3 for further consideration by the Committee.

Full details of all the suggestions provided are given in appendix 3 for information.

Table 3 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Identification • Measuring height and weight • Providing information	OGBDA, RCPCH, SCM1, SCM2, SCM7, WLS, WW
Assessment • Clinical and psychological assessment • Follow-up to assessment	ADMP, SCM3, SCM5, WW
Tier 3 services	JJ, OGBDA, RCP, RCPCH, SCM1, SCM3, SCM4, SCM6, SCM7, WW
Surgical interventions • Reconstructive surgery • Psychological assessment • Outcome auditing • Assessment for bariatric surgery	JJ, OGBDA, RCP, SCM1, SCM3, SCM4, SCM7, WLS
Follow-up care after bariatric surgery • Follow-up care within the bariatric service • Follow-up care after discharge from bariatric surgery service follow-up • Antenatal care following bariatric surgery	JJ, OGBDA, RCP, SCM1, SCM3, SCM4, SCM7,WLS
Additional areas • Issues of engagement, inequalities and family involvement • Provision of training • Lifestyle weight management programmes • Suggestions for commissioning arrangements • Further interventions • Developing a patient support network and other resources	ADMP, CWP, LL, RCPCH, SCM2, SCM3, SCM4, SCM6 SCM7, SW, WW

ADMP, Association for Dance Movement Psychotherapy UK
CWP, Cambridge Weight Plan
JJ, Johnson & Johnson Medical Limited
LL, LighterLife
OGBDA, Obesity Group of the British Dietetic Association
RCP, The Royal College of Pathologists
RCPCH, Royal College of Paediatrics and Child Health
SCM, Specialist Committee Member
SW, Slimming World
WW, Weight Watchers UK
WLS, WLSinfo

3.3 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings, 2,494 studies were identified for this topic. In addition current practice examples were suggested by stakeholders at topic engagement (13 documents) and internally at project scoping.

Of these studies 12 were assessed as having potential relevance to this topic and the suggested areas for quality improvement identified by stakeholders (see appendix 3). A summary of relevant studies is included in the current practice sections for each suggested area of improvement.

4 Suggested improvement areas

4.1 Identification

4.1.1 Summary of suggestions

Measuring height and weight

Stakeholders suggested that regular, opportunistic weighing of people would aid earlier identification of people who are, or at risk of becoming, overweight or obese. In particular, stakeholders highlighted that BMI could be measured for outpatients on arrival or for all people engaging with primary or secondary health care services.

Stakeholders highlighted that as the number of people who are overweight or obese increases in the population, people often do not realise that they are overweight or obese. In addition, it also becomes more difficult for healthcare professionals to use their personal judgement to decide if weight status needs to be assessed.

A stakeholder highlighted that children with neurodevelopmental disorders are a particularly vulnerable group at increased risk of the consequences of obesity and that they are often excluded from weight monitoring.

A stakeholder also suggested regular measurement of waist circumference as an area for improvement.

Stakeholders also noted that different threshold BMI values should be used for different ethnic groups.

Providing information

A stakeholder highlighted the importance of providing information about treatment options to people who have been identified as being overweight or obese (and their families and carers).

A stakeholder also commented that improving access to support groups would help to produce sustainable outcome and lead to greater quality of life.

4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 4 to help inform the Committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Measuring height and weight	**Identification and classification of overweight and obesity** NICE CG189 Recommendation 1.2.1 NICE CG189 Recommendation 1.2.5 NICE PH46 Recommendation 3 Commissioning guide: Weight assessment and management clinics (tier 3). British Obesity & metabolic Surgery Society and Royal College of Surgeons
Providing information	**Lifestyle interventions** NICE CG189 Recommendation 1.4.8

Measuring height and weight

NICE CG189 Recommendation 1.2.1

1.2.1 Use clinical judgement to decide when to measure a person's height and weight. Opportunities include registration with a general practice, consultation for related conditions (such as type 2 diabetes and cardiovascular disease) and other routine health checks.

NICE CG189 Recommendation 1.2.5

1.2.5 Waist circumference is not recommended as a routine measure. Use it to give additional information on the risk of developing other long-term health problems.

NICE PH46 Recommendation 3 General awareness raising

Ensure practitioners are aware that members of black, Asian and other minority ethnic groups are at an increased risk of chronic health conditions at a lower BMI than the white population (below BMI 25 kg/m2).

Commissioning guide: Weight assessment and management clinics (tier 3). British Obesity & metabolic Surgery Society and Royal College of Surgeons

Guidance for General Practitioners:

- Use every opportunity to identify overweight and obese patients including opportunistic case finding and routine health checks
- Record the patient’s current weight and height to calculate body mass index (BMI) and measure waist circumference if BMI < 35 kg/m2

Providing information

NICE CG189 Recommendation 1.4.8

1.4.8 Give people who are overweight or obese, and their families and/or carers, relevant information on:

- being overweight and obesity in general, including related health risks
- realistic targets for weight loss; for adults, please see NICE's guideline on managing overweight and obesity in adults
- the distinction between losing weight and maintaining weight loss, and the importance of developing skills for both; advise them that the change from losing weight to maintenance typically happens after 6–9 months of treatment
- realistic targets for outcomes other than weight loss, such as increased physical activity and healthier eating
- diagnosis and treatment options
- healthy eating in general
- medication and side effects
- surgical treatments
- self-care
- voluntary organisations and support groups and how to contact them.

Ensure there is adequate time in the consultation to provide information and answer questions.

4.1.3 Current UK practice

Measuring height and weight

A study using a random sample of one million records (of individuals aged 16 years or older) from the Clinical Practice Research Database (CPRD; a database of computerised medical records from GPs in the UK) assessed the prevalence of BMI recording in primary care[3]. The proportion of individuals sampled with at least one previously recorded BMI was 77% in the period 2005-2011. The proportion of people with BMI recorded within the previous 3 years was 51% in 2005-2011. Data was also

[3] Bhaskaran K, et al. (2013) Representativeness and optimal use of body mass index (BMI) in the UK Clinical Practice Research Datalink (CPRD) BMJ Open 2013;3:e003389

reported for recent (within 3 years) BMI measurement in particular patient sub-groups: 97% patients with a record of type II diabetes, 78% patients with a diagnosis of schizophrenia/psychoses and 82% for current stain users. The study authors concluded that most recent BMIs are unlikely to reflect current BMI for a large proportion of patients (based on a comparison of these data with Health Survey for England [HSE] data from a corresponding time period).

An audit published in 2015 measured the assessment and management of obesity by occupational health (OH) service staff in an acute NHS hospital in Northwest England[4]. The audit reported that 53% of staff attending a medical examination had their weight recorded.

A retrospective audit of the records of 75 patients attending for HIV-related care reported that 81% had their BMI recorded in the last year of attendance[5].

An audit of medical notes from 77 children with autism spectrum disorder (ASD) reported that BMI was measured in just 5% of cases[6].

Quality and Outcomes Framework (QOF) results from 2013/14 reported an average achievement in England of 99.9% for an indicator concerned with establishing and maintaining a register of patients aged 16 or over who have a recorded body mass index (BMI) of 30 or higher[7]. 24 Area Teams scored the maximum of 100 per cent.

Stakeholders identified a number of studies highlighting the prevalence of weight misperception. This included a cross sectional study conducted in 2012 in Great Britain that identified that 11% women and 7% men who had a BMI ≥30 selected the term 'obese' to describe their body size[8]. In addition, 34% of women and 23% men selected either 'obese' or 'very overweight'. The authors of this study therefore concluded that the majority of the obese population of the Great Britain do not identify themselves as either being obese or very overweigh.

Providing information

No published studies on current practice data were identified for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

[4] Implementing NICE obesity guidance for staff: an NHS trust audit (2015) Occup. Med. 65, p75-85
[5] Howe BH & E (2015) Obesity in HIV audit and pathway development: Are we addressing an expanding problem? HIV Medicine, Conference (var.pagings): April.
[6] Grylls, EK et al. (2013) G109 Obesity in Children with Autism Spectrum Disorder Audit. Arch Dis Child 2013;98:A52
[7] Quality and Outcomes Framework (QOF) - 2013-14 (2014) HSCIC
[8] Johnson F, et al. (2014) Do weight perceptions among obese adults in Great Britain match clinical definitions? Analysis of cross-sectional surveys from 2007 and 2012. BMJ Open 2014 Vol. 4 Issue 11

4.2 Assessment

4.2.1 Summary of suggestions

Clinical and psychological assessment

Stakeholders highlighted the importance of psychological assessment (including psychosocial distress, psychological problems, disordered eating and underlying causes of obesity), commenting that people with severe and complex obesity have a high incidence of psychological morbidity.

A stakeholder also highlighted the importance of proactively identifying comorbidities in children identified as being obese, because early identification will lead to more effective treatment.

A stakeholder also commented that it is important to assess an individual's readiness and confidence to make lifestyle changes to ensure patient engagement and motivation to make such changes.

Follow-up to assessment

Stakeholders commented on the importance of offering people repeat consultations and support for those identified as being overweight or obese who are not at that time ready for change, as attitudes and beliefs about weight can change over time

4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Clinical and psychological assessment	**Assessment** NICE CG189 Recommendation 1.3.4 NICE CG189 Recommendation 1.3.6 NICE CG189 Recommendation 1.3.9
Follow-up to assessment	**Assessment** NICE CG189 Recommendation 1.3.3

Clinical and psychological assessment

NICE CG189 Recommendation 1.3.4

1.3.4 Recognise that surprise, anger, denial or disbelief about their health situation may diminish people's ability or willingness to change. Stress that obesity is a clinical term with specific health implications, rather than a question of how people look; this may reduce any negative feelings.

During the consultation:

- Assess the person's view of their weight and the diagnosis, and possible reasons for weight gain.
- Explore eating patterns and physical activity levels.
- Explore any beliefs about eating, physical activity and weight gain that are unhelpful if the person wants to lose weight.
- Be aware that people from certain ethnic and socioeconomic backgrounds may be at greater risk of obesity, and may have different beliefs about what is a healthy weight and different attitudes towards weight management.
- Find out what the person has already tried and how successful this has been, and what they learned from the experience.
- Assess the person's readiness to adopt changes.
- Assess the person's confidence in making changes.

NICE CG189 Recommendation 1.3.6

Adults

1.3.6 Take measurements (see recommendations in section 1.2) to determine degree of overweight or obesity and discuss the implications of the person's weight. Then, assess:

- any presenting symptoms
- any underlying causes of being overweight or obese
- eating behaviours
- any comorbidities (for example type 2 diabetes, hypertension, cardiovascular disease, osteoarthritis, dyslipidaemia and sleep apnoea)
- any risk factors assessed using lipid profile (preferably done when fasting), blood pressure measurement and HbA1c measurement
- the person's lifestyle (diet and physical activity)

- any psychosocial distress
- any environmental, social and family factors, including family history of overweight and obesity and comorbidities
- the person's willingness and motivation to change lifestyle
- the potential of weight loss to improve health
- any psychological problems
- any medical problems and medication
- the role of family and care workers in supporting individuals with learning disabilities to make lifestyle changes.

NICE CG189 Recommendation 1.3.9

Children

1.3.9 Take measurements to determine degree of overweight or obesity and raise the issue of weight with the child and family, then assess:

- presenting symptoms and underlying causes of being overweight or obese
- willingness and motivation to change
- comorbidities (such as hypertension, hyperinsulinaemia, dyslipidaemia, type 2 diabetes, psychosocial dysfunction and exacerbation of conditions such as asthma)
- any risk factors assessed using lipid profile (preferably done when fasting) blood pressure measurement and HbA1c measurement
- psychosocial distress, such as low self-esteem, teasing and bullying
- family history of being overweight or obese and comorbidities
- the child and family's willingness and motivation to change lifestyle
- lifestyle (diet and physical activity)
- environmental, social and family factors that may contribute to being overweight or obese, and the success of treatment
- growth and pubertal status
- any medical problems and medication

- the role of family and care workers in supporting individuals with learning disabilities to make lifestyle changes.

Follow-up to assessment

NICE CG189 Recommendation 1.3.3

1.3.3 Offer people who are not yet ready to change the chance to return for further consultations when they are ready to discuss their weight again and willing or able to make lifestyle changes. Give them information on the benefits of losing weight, healthy eating and increased physical activity.

4.2.3 Current UK practice

Clinical and psychological assessment

The National Confidential Enquiry into Patient Outcome and Death's (NCEPOD's) 'Bariatric Surgery: Too Lean a Service?' report[9] identified a need for greater emphasis on psychological assessment and support at an earlier stage in the obesity care pathway (i.e. prior to referral for consideration of surgical intervention). This was identified as a principal recommendation of the report.

Less than 30% of the patients in this study (sampled from adult patients >16 years old who underwent bariatric surgery between 1st June 2010 to 31st August 2010) had any documented evidence of having received psychological support. Of these patients, 23% received psychological assessment prior to referral for surgery.

No published studies of current practice data relating to the prevalence of assessment for comorbidities were identified.

Follow-up to assessment

No published studies on current practice data were identified for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

[9] Bariatric Surgery: Too Lean a Service? (2012) NCEPOD

4.3 Tier 3 services

4.3.1 Summary of suggestions

Referral to tier 3 services

Several stakeholders highlighted a lack of access to tier 3 services, commenting that the availability of these services varies nationally. Tier 3 services are important to provide access to alternative interventions (if interventions at lower tiers haven't been effective). They are also a requirement for access to tier 4 services for bariatric surgery. Stakeholders highlighted that a lack of access to tier 3 services is a major barrier to access to bariatric surgery, especially for BME groups.

Stakeholders commented that not all CCGs commission tier 3 services and there is a need for pathways to be developed to inform referral to these services. A stakeholder also highlighted a lack of obesity management services for children with learning disabilities.

Stakeholders also highlighted several characteristics for groups with severe and complex obesity that should lead to referral to a tier 3 service.

A stakeholder noted that referrals should be considered at lower BMI or waist circumference thresholds in Asian populations (as these populations are at increased risk of ill-health at lower levels of body fat).

A stakeholder highlighted the need for outcome measures of tier 3 services, noting that at present there is no set of agreed measures. A further stakeholder cautioned that services shouldn't just be commissioned based on weight or BMI change, highlighting that increases in physical activity or functional ability, or dietary improvements are also desirable outcomes.

4.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Referral to Tier 3 services	**Assessment** NICE CG189 Recommendation 1.3.7 NICE CG189 Recommendation 1.3.10 Commissioning guide: Weight assessment

	and management clinics (tier 3). British Obesity & Metabolic Surgery Society and Royal College of Surgeons

Referral to Tier 3 services

NICE CG189 Recommendation 1.3.7

Adults

1.3.7 Consider referral to tier 3 services if:

- the underlying causes of being overweight or obese need to be assessed
- the person has complex disease states or needs that cannot be managed adequately in tier 2 (for example, the additional support needs of people with learning disabilities)
- conventional treatment has been unsuccessful
- drug treatment is being considered for a person with a BMI of more than 50 kg/m2
- specialist interventions (such as a very-low-calorie diet) may be needed
- surgery is being considered.

NICE CG189 Recommendation 1.3.10

Children

1.3.10 Consider referral to an appropriate specialist for children who are overweight or obese and have significant comorbidities or complex needs (for example, learning disabilities or other additional support needs).

Commissioning guide: Weight assessment and management clinics (tier 3). British Obesity & metabolic Surgery Society and Royal College of Surgeons

In discussing with a patient whether to refer him/her to the Weight Assessment and Management Clinic GPs should:

- Consider that it is an accepted option to refer a patient with BMI of ≥ 35 kg/m2 and type 2 diabetes
    - This recommendation may be reduced by 2.5 kg/m2 of BMI in Asians,

    - in exceptional circumstances a patient with BMI < 35 kg/m2 may be referred to the Tier 3 clinic

- Consider referring adults with a BMI of 40 or ≥ 35 kg/m2 + obesity-related comorbidity e.g. metabolic syndrome, hypertension, obstructive sleep apnoea (OSA), functional disability, infertility and depression if specialist advice is needed regarding overall patient management

    - Occasionally a patient may be referred whose BMI is below these thresholds, if he/she has exceeded the thresholds in the past; this may include a patient who has already had bariatric surgery presenting with a problem such as weight regain or nutritional deficiency or where revisional surgery might be considered

- Consider referring children and adolescents with obesity to age-appropriate specialist services especially if their weight interferes with secondary school education

4.3.3 Current UK practice

A report from an NHS England and Public Health England convened working group looking into the commissioning of obesity services reported that in some areas of England no organisations were commissioning tier 3 services[10].

The NICE costing analysis for clinical guideline 189 reported that tier 3 services were not comprehensively available across the country[11].

No data on the proportion of people meeting criteria for referral to tier 3 services who were offered a referral were identified.

[10] Report of the working group into: Joined up clinical pathways for obesity (2014) NHS England and Public Health England
[11] CG189 Obesity (update): costing report. NICE

4.4 Surgical interventions

4.4.1 Summary of suggestions

Assessment for bariatric surgery

Stakeholders highlighted the importance of access to specialist obesity surgical centres, identifying several criteria that should lead to an offer of assessment for bariatric surgery.

Stakeholders also commented that is important to offer an expedited referral for people with BMI ≥35 and type 2 diabetes.

A stakeholder commented that the provision levels of bariatric surgery falls significantly below the level needed to offer surgery to all willing patients.

A stakeholder commented that the majority of people with type 2 diabetes and BMI of 35 or over are not aware of the health benefits of surgery and that diabetes care providers should give verbal and written advice about the benefits of bariatric surgery.

Psychological assessment

A stakeholder raised the importance of pre-operative psychological assessment for people being considered for bariatric surgery, highlighting that this can identify issues that can affect compliance with post-operative diet modification and that there is currently significant variation in the provision of psychological support.

Outcome auditing

A stakeholder commented that it is important to collate and share outcome data from weight management interventions to identify optimum strategies. A further stakeholder also commented that it is important to audit short and long term outcomes from different bariatric surgical procedures to help evaluate the impact of the service.

Reconstructive surgery

A stakeholder commented that it is important to improve access to reconstructive surgery following bariatric surgery, commenting that loose skin following surgery can be physically and psychologically debilitating and that this procedure is variably available.

4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Assessment for bariatric surgery	**Surgical interventions** NICE CG189 Recommendation 1.10.1 NICE CG189 Recommendation 1.10.7 **Bariatric surgery for people with recent-onset type 2 diabetes** NICE CG189 Recommendation 1.11.1 NICE CG189 Recommendation 1.11.2 NICE CG189 Recommendation 1.11.3 Commissioning guide: Weight assessment and management clinics (tier 3). British Obesity & metabolic Surgery Society and Royal College of Surgeons
Psychological assessment	**Surgical interventions** NICE CG189 Recommendation 1.10.10 NICE CG189 Recommendation 1.10.16 Commissioning guide: Weight assessment and management clinics (tier 3). British Obesity & metabolic Surgery Society and Royal College of Surgeons
Outcome auditing	**Surgical interventions** NICE CG189 Recommendation 1.10.5
Reconstructive surgery	**Surgical interventions** NICE CG189 Recommendation 1.10.9 NICE CG189 Recommendation 1.10.14

Assessment for bariatric surgery

NICE CG189 Recommendation 1.10.1

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

- 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.
- The person is generally fit for anaesthesia and surgery.
- The person commits to the need for long-term follow-up.

See recommendations 1.10.12 and 1.10.13 for additional criteria to use when assessing children, and recommendation 1.10.7 for additional criteria for adults. See also recommendations 1.11.1–1.11.3 for additional criteria for people with type 2 diabetes.

NICE CG189 Recommendation 1.10.7

Adults

1.10.7 In addition to the criteria listed in 1.10.1, bariatric surgery is the option of choice (instead of lifestyle interventions or drug treatment) for adults with a BMI of more than 50 kg/m2 when other interventions have not been effective.

NICE CG189 Recommendation 1.11.1

1.11.1 Offer an expedited assessment for bariatric surgery to people with a BMI of 35 or over who have recent-onset type 2 diabetes as long as they are also receiving or will receive assessment in a tier 3 service (or equivalent).

NICE CG189 Recommendation 1.11.2

1.11.2 Consider an assessment for bariatric surgery for people with a BMI of 30–34.9 who have recent-onset type 2 diabetes as long as they are also receiving or will receive assessment in a tier 3 service (or equivalent).

NICE CG189 Recommendation 1.11.3

1.11.3 Consider an assessment for bariatric surgery for people of Asian family origin 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).

Commissioning guide: Weight assessment and management clinics (tier 3). British Obesity & metabolic Surgery Society and Royal College of Surgeons

The patient should be referred for bariatric surgery if the Weight Assessment and Management Clinic is satisfied that:

- The patient is adequately engaged with the team, fully understands the surgery, is well-informed and motivated to have surgery and has realistic expectations

- All management options have been put to the patient including the characteristics of the various surgical procedures available and the risks and side effects

- He/she is medically optimised

- There is no medical, surgical, nutritional, psychological, psychiatric or social contraindication

- He/she understands the importance of complying with nutritional requirements before and after surgery and recognises the need for life-long follow up

Psychological assessment

NICE CG189 Recommendation 1.10.10

Adults

1.10.10 Carry out a comprehensive preoperative assessment of any psychological or clinical factors that may affect adherence to postoperative care requirements (such as changes to diet) before performing surgery.

NICE CG189 Recommendation 1.10.16

Children

1.10.16 Ensure all young people have had a comprehensive psychological, educational, family and social assessment before undergoing bariatric surgery.

Commissioning guide: Weight assessment and management clinics (tier 3). British Obesity & metabolic Surgery Society and Royal College of Surgeons

In the Weight Assessment and Management Clinic:

- Given the high prevalence of psychiatric comorbidity the patient should be screened for psychological and lifestyle issues which may interfere with engagement, including anxiety and depression, self-harm and suicidal behaviours, eating disorders such as binge eating and bulimia nervosa, borderline personality disorders, alcohol / substance misuse, childhood adversity and blocks for voluntary weight which are not clearly understood, so as to identify the patient who may need additional long term support or who

may be at risk of self-harm after surgery; examples of screening tools are the IWQOL-Lite, SF-12 V2, EQ5D, GIQLI, HADS, EDE-Q and EHQ

- When screening for bariatric surgery the clinical psychologist and liaison psychiatry professional should
    - Identify the patient for whom surgery may be inappropriate (severe learning disability, active uncontrolled psychosis, severe personality disorder)
    - Identify individuals not presently suitable for surgery (e.g. untreated or unstable mental health presentation, active alcohol or substance misuse, active eating disorder, self-harm in past 12 months, dementia, current non-adherence to treatment and recent significant life event e.g. bereavement or relationship breakdown) and provide an intervention or access to treatment before reassessing for surgery
    - Identify and manage weight gain associated with psychotropic medications
    - Identify the patient who may need specific attention and support following surgery
- After a mental health assessment a traffic light system may be useful to identify a patient who is not currently suitable for surgery or who may be suitable although deemed at higher risk and requires psychological treatment before being considered for surgery

Outcome auditing

NICE CG189 Recommendation 1.10.5

1.10.5 Arrange prospective audit so that the outcomes and complications of different procedures, the impact on quality of life and nutritional status, and the effect on comorbidities can be monitored in both the short and the long term

Reconstructive surgery

Adults

NICE CG189 Recommendation 1.10.9

1.10.9 Surgery for obesity should be undertaken only by a multidisciplinary team that can provide:

- preoperative assessment, including a risk-benefit analysis that includes preventing complications of obesity, and specialist assessment for eating disorder(s)

- information on the different procedures, including potential weight loss and associated risks

- regular postoperative assessment, including specialist dietetic and surgical follow up (see 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.

NICE CG189 Recommendation 1.10.14

Children

1.10.14 Surgery for obesity should be undertaken only by a multidisciplinary team that can provide paediatric expertise in:

- preoperative assessment, including a risk-benefit analysis that includes preventing complications of obesity, and specialist assessment for eating disorder(s)

- information on the different procedures, including potential weight loss and associated risks

- regular postoperative assessment, including specialist dietetic and surgical follow up

- 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 children and young people undergoing bariatric surgery, and staff trained to use them.

4.4.3 Current UK practice

Assessment for bariatric surgery

The Health & Social Care Information Centres' (HSCIC's) 2015 report Statistics on Obesity, Physical Activity and Diet identified a 20% decrease in the number of inpatient bariatric surgery procedures in 2013-14, as compared to 2012-13 (a decrease from 8,020 to 6,380 procedures). However over half this decrease was attributed to a hospital trust now recording bariatric maintenance procedures in an outpatient rather than inpatient setting. The number of bariatric surgeries per 100,00 of the population varied across commissioning regions, from 19 in London to 7 in Midlands and East of England.

The 2014 National Bariatric Surgery Register report provides details on bariatric surgery carried out between 2011 and 2013, including the fact that at the time of primary surgery:

- The average BMI was 48.8 kg/m^2, which means that patients were almost twice their ideal weight.
- 53.9% of men and 41.4% of women had a high level of co-existing disease (4 or more obesity related diseases).
- 44.6% of men and 25.9% of women had type 2 diabetes.

The report also identified that, when comparing data from financial years 2009-2010 and 2011-2013, that the average BMI at the time of surgery had increased from 48.5 kg/m^2 to 48.8 kg/m^2. In addition, the average number of co-morbidities has also increased from 3.2 to 3.4.

The study also identified 62 patients aged 18 years or less who had bariatric surgery between 2011 and 2013.

The NCEPOD's 'Bariatric Surgery: Too Lean a Service?' reported that the main sources of referral for bariatric surgery are GP (60%; 236/340), self-referral (26%; 1919/390) and referral by secondary care clinic, such as diabetes and obesity clinics (14%; 53/390).

The study also reported that 13/96 (14%) hospitals that undertook weight loss surgery included in this study reported that they operate on patients who did not

meet NICE criteria. 10 of these were private hospitals and the remaining 3 were NHS hospitals.

The study also reported that 86% of included cases were assessed as meeting NICE criteria (according to CG43) for bariatric surgery (295/345; in 36 further cases it wasn't possible to assess based on available records). Of the cases that did not meet NICE criteria, 42 were privately funded and 8 were NHS patients. Furthermore, in the opinion of the study authors, 19% patients assessed had a less than adequate standard of pre-assessment for surgery. Only 32% patients had documented evidence that they were seen by an anaesthetist prior to admission to surgery and the predicted difficulty of intubation was not recorded in 32% of patients.

No data on the proportion of patients meeting NICE criteria who were not assessed for bariatric surgery were identified.

Psychological assessment

The NCEPOD's 'Bariatric Surgery: Too Lean a Service?' reported that less than a third of patients included in this study (91/309) had any documented evidence of having received any psychological input in their care. In terms of timing when his support was received, in most cases this was post-referral for surgery (69%) rather than pre-referral (23%). In approximately 8% cases support was received both pre- and post-referral. Of the cases where the study authors were able to make an assessment, it was their opinion that 33% patients (54/162) did not receive adequate psychological support.

Outcome auditing

The NCEPOD's 'Bariatric Surgery: Too Lean a Service?' reported that 57% of the study population (sampled from adult patients >16 years old who underwent bariatric surgery between 1st June 2010 to 31st August 2010; sample was limited to 3 patients per surgeon per hospital) had their data entered into the National Bariatric Surgery Registry (NBSR). When data is split by type of funding, this corresponds to 70% NHS funded patients and 40% privately funded patients.

Of the population whose data was entered into the NBSR at the time of surgery, 30% did not have any follow-up data entered into this registry.

Reconstructive surgery

No published studies on current practice data were identified for this suggested area for quality improvement; this area is based on a stakeholder's knowledge and experience.

4.5 Follow-up care after bariatric surgery

4.5.1 Summary of suggestions

Follow-up care within the bariatric service

Several stakeholders commented that people who have had bariatric surgery should have follow-up care for 2 years after their operation. Stakeholders commented that inadequate follow-up can lead to malnutrition and delayed recognition of surgical complications. A stakeholder commented that bariatric surgery units can often be geographically distant from patient's homes leading to a tendency for people to drop out of follow-up care early. A further stakeholder commented that duration of follow-up by surgical provider centres is variable and people are often discharged back to their GP without adequate follow-up. Stakeholders also commented on the importance of psychological support following bariatric surgery.

A further stakeholder commented that serious problems can arise in years 3-5 after surgery and that the practice of discharge from specialist service after 2 years is inappropriate.

Follow-up care after discharge from bariatric surgery service follow-up

Stakeholders also commented that people who are discharged from a surgical centre after their 2 year follow-up period should have an annual review every year. This should be based on a protocol shared between their GP and the specialist bariatric unit; however; a stakeholder commented that there is a little evidence that such shared care protocols have been established or agreed. A stakeholder also highlighted concerns raised by GPs about the expertise, facilities and resources to conduct these reviews.

Antenatal care following bariatric surgery

A stakeholder noted that women who have undergone bariatric surgery should have access to specialist antenatal care with appropriate expertise regarding bariatric surgery. This is because complications resulting from bariatric surgery can occur during pregnancy (such as band slipping and internal hernias) and variations to normal practice may be required for women who have previously had this surgery.

4.5.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Follow-up care within the bariatric service	NICE CG189 Recommendation 1.12.1
Follow-up care after discharge from bariatric surgery service follow-up	NICE CG189 Recommendation 1.12.2
Antenatal care following bariatric surgery	No recommendations identified.

Follow-up care within the bariatric service

NICE CG189 Recommendation 1.12.1

1.12.1 Offer people who have had bariatric surgery a follow-up care package for a minimum of 2 years within the bariatric service. This should include:

- monitoring nutritional intake (including protein and vitamins) and mineral deficiencies
- monitoring for comorbidities
- medication review
- dietary and nutritional assessment, advice and support
- physical activity advice and support
- psychological support tailored to the individual
- information about professionally-led or peer-support groups.

Follow-up care after discharge from bariatric surgery service follow-up

NICE CG189 Recommendation 1.12.2

1.12.2 After discharge from bariatric surgery service follow-up, ensure that all people are offered at least annual monitoring of nutritional status and appropriate supplementation according to need following bariatric surgery, as part of a shared care model of chronic disease management.

Antenatal care following bariatric surgery

No recommendations identified.

4.5.3 Current UK practice

Follow-up care within the bariatric service

The NCEPOD's 'Bariatric Surgery: Too Lean a Service?' study reported that 63% of NHS funded patients were seen by the operating surgeons within 6 months of surgery. The majority of patients who weren't seen by the operating surgeon were seen by an alternative consultant bariatric/upper GI surgeons within this time frame. The study also reported that 72/102 hospitals sampled used early telephone follow-up prior to scheduled outpatient appointments (this includes a mix of NHS and private hospitals).

In the opinion of the study's authors, (based on a review of outpatient notes and follow-up/clinic letters and completed questionnaires), almost a third of patients didn't receive an adequate follow-up. When considering cases where there was documented evidence of follow-up, in the opinion of the study authors 32% of NHS funded patients were judged to have had inadequate follow-up in their first 6 months after surgery.

In addition, 95/105 hospitals who provided completed questionnaires ran follow-up clinics on-site (surgeon and dietitian led clinics being the most common). Of the 10 clinics that did not run follow-up clinics, 4 were part of a larger group of hospitals that shared follow-up responsibilities.

Follow-up care after discharge from bariatric surgery service follow-up

Of the 103 hospitals providing data to the NCEPOD's 'Bariatric Surgery: Too Lean a Service?' study, 96 routinely contact people's GPs when they had undergone bariatric surgery.

No published studies on current practice data were identified for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Antenatal care following bariatric surgery

No published studies on current practice data were identified for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.6 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the Committee to establish potential for statement development.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 9 October 2015.

Issues of engagement, inequalities and family involvement

A stakeholder highlighted the issues of equality of access to services and also ensuring engagement with populations that are at high risk of obesity and who may be 'hard to reach' (for example, people from areas of high social deprivation, individuals with enduring mental health conditions or a learning disability). A stakeholder also highlighted inequality in access to sport/physical activity for children with a neurodisabilty as an area for improvement.

A stakeholder commented that patient engagement is an area for quality improvement, highlighting that options for treatment should be discussed with patients. A further stakeholder also commented that services should encourage a family approach in the successful management of obesity. A stakeholder also cautioned that while personal preference should be taken into account, interventions should also be chosen based on evidence of effectiveness.

All of these issues will be considered while developing all quality statements.

Provision of training

Stakeholders commented that training is needed for health professionals to ensure that they are able to sensitively raise the issue of weight with patients. Quality statements on staff training and competency are not usually included in quality standards, unless recommendations exist in development source(s) on specific types of training for the topic that exceed standard professional training are considered during quality statement development. No such recommendations have been identified for this area.

Lifestyle weight management programmes

Several stakeholders raised issues concerning lifestyle weight management programmes (including referral to these services and the management of these programmes). However this topics area is already covered in published or in

development Quality Standards (QS94 Obesity: prevention and lifestyle weight management in children and young people and Obesity in Adults - prevention and lifestyle weight management programmes [publication expected in January 2016]).

Suggestions for commissioning arrangements

Several stakeholders suggested amendments to arrangement of commissioning services. These included pooling budgets for Tier 3 and 4 services, the commissioning of longer term services and encouraging the use of private providers of weight management services. These topics areas fall outside the scope of Quality Standards.

Developing a patient support network and other resources

A stakeholder suggested the need to develop a good quality national patient-led support network. A stakeholder also highlighted the need to develop standalone packages of information for bariatric patients 3-5 years after surgery. However, the development of such resources is beyond the scope of a Quality Standard.

Further interventions

A stakeholder suggested that Dance Music therapy should be included as a suggested intervention for people who engage in emotional eating. However, we have no source recommendations to base such a statement on.

A stakeholder also commented that there is a need to develop effective strategies to prevent and manage excess weight in disabled children and young people. However, developing new guidelines is beyond the scope of a Quality Standard.

Appendix 1: Obesity: prevention and lifestyle weight management in children and young people [QS94] - Statements

Published date: July 2015

Statement 1. Children and young people, and their parents or carers, using vending machines in local authority and NHS venues can buy healthy food and drink options.

Statement 2. Children and young people, and their parents or carers, see details of nutritional information on menus at local authority and NHS venues.

Statement 3. Children and young people, and their parents or carers, see healthy food and drink choices displayed prominently in local authority and NHS venues.

Statement 4. Children and young people, and their parents or carers, have access to a publicly available up‑to‑date list of local lifestyle weight management programmes.

Statement 5. Children and young people identified as being overweight or obese, and their parents or carers as appropriate, are given information about local lifestyle weight management programmes.

Statement 6. Family members or carers of children and young people are invited to attend lifestyle weight management programmes, regardless of their weight.

Statement 7. Children and young people, and their parents or carers, can access data on attendance, outcomes and the views of participants and staff from lifestyle weight management programmes.

Statement 8. (placeholder) Reducing sedentary behaviour.

Appendix 2: Obesity in Adults - prevention and lifestyle weight management programmes [In Development] – draft statements

Currently post-consultation.

Statement 1. Adults have access to a publicly available, up-to-date list of local lifestyle weight management programmes.

Statement 2. Adults identified as being overweight or obese are offered information about local lifestyle weight management programmes.

Statement 3. Adults identified as overweight or obese with comorbidities are offered a referral to a lifestyle weight management programme.

Statement 4. Adults about to complete a lifestyle weight management programme agree a plan to prevent weight regain.

Statement 5. Adults can access data on attendance, outcomes and views of participants and staff for local lifestyle weight management programmes.

Appendix 3: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
4.1 Identification					
Measuring height and weight					
001	Obesity Group of the British Dietetic Association	Regular measurement & recording of waist circumference in adults.	Distribution of body fat, in addition to total body fat, is a key aspect of risk. Although different cut-off points have not been recommended for different ethnic groups due to lack of evidence, differential risk at lower waist circumference cut off points for some ethnic groups is recognised.	Waist circumference is not routinely measured and therefore key opportunities to identify high risk individuals are being missed.	Waist circumference is not routinely measured (http://www.noo.org.uk/data_sources/adult/health_survey_for_england and http://www.nice.org.uk/guidance/ph46/resources/guidance-assessing-body-mass-index-and-waist-circumference-thresholds-for-intervening-to-prevent-ill-health-and-premature-death-among-adults-from-black-asian-and-other-minority-ethnic-groups-in-the-uk-pdf).
002	Obesity Group of the British Dietetic Association	Regular opportunistic weighing of adults.	Excess weight is recognised as a key modifiable risk factor for cardiovascular disease and other chronic conditions. Regular weighing will result in earlier identification of those who are gaining weight and therefore increasing their risk. Although different cut-off points have not been recommended for different ethnic groups due to lack of	Weighing adults was included in previous QOF guidance but is no longer included. Even so, maintenance of regular weight records is recognised as patchy, and opportunities to prevent problems are therefore being missed.	The Health Survey for England identified excess weight as a modifiable risk factor affecting a significant proportion of adults (http://www.noo.org.uk/data_sources/adult/health_survey_for_england).

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			evidence, differential risk at lower BMI cut off points for some ethnic groups is recognised.		Although this data is robust it is based upon a representative sample of the population and will therefore not identify individuals at risk. Regular recording of BMI is not always optimal and healthcare practitioners may not be aware of differential risk for different ethnic groups (http://www.nice.org.uk/guidance/ph46/resources/guidance-assessing-body-mass-index-and-waist-circumference-thresholds-for-intervening-to-prevent-ill-health-and-premature-death-among-adults-from-black-asian-and-other-minority-ethnic-groups-in-the-uk-pdf).
003	Royal College of Paediatrics and Child Health	Recognition increased obesity rates (40% vs 25% in mainstream children locally) in children with neurodevelopmental disorders	This leaves a vulnerable group of children at increased risk consequences of obesity	Children with special needs often excluded from monitoring eg special schools data not included in national data collected in yr R and yr 6. Also often excluded from obesity management programs as don't fit in group interventions	*No additional information was provided by the stakeholder.*

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
004	SCM 1	All children and adults engaging primary or secondary health care services should have their weight and height measured and documented. Patients with a BMI equal to and above 30 (or equivalent for children) should be given advice and if in secondary care their GP informed. This will need to be underpinned by training and education across the entire NHS.	The prevalence of obesity in adults and in children in the UK is amongst the highest in the developed world. Consequently, obesity is now so common that people do not realise that they are obese. If obesity is not raised as a concern when patients attend medical appointments with healthcare professionals this perpetuates the problem. All in-patients are currently weighed in order for thromboembolic risk stratification and dosing. However, there are no clearly sign posted pathways for people who are obese and these need to be incentivised akin to smoking cessation.	Obesity is the now one of the top three social burdens generated by human beings. All in-patients are weighed but the issue of high BMI is rarely raised with the patient on included in the discharge summary. Obesity is rarely addressed by healthcare professionals even when they are seeing patients whose co-morbidities that are due to obesity (e.g NAFLD or OSA). Advice from healthcare providers regarding weight can motivate patients to lose weight or at least seek out appropriate support. Education and training in raising obesity as a problem, screening for complications and subsequent management is needed across the NHS.	http://www.mckinsey.com/insights/mgi/in_the_news/the_global_obesity_threat Carrasco Sánchez FJ, Díaz Alcaide F, Marín Fernández Y, Chaparro Moreno I, Pujol de la Llave E. Prevalence of obesity in hospitalized internal medicine patients. Annales de Medicine Interne 2002;19(9):453–6. Healthcare Commission (UK). Obesity: Identification and management in secondary care. London: HC, 2006. http://ratings2006.healthcarecommission.org.uk/Indicators_2006Nat/Trust/Indicator/indicatorDescriptionShort. asp?indicatorId=1214 [accessed 13 December 2012]. https://www.rcplondon.ac.uk/sites/default/files/action-on-obesity.pdf
005	SCM 7	People (adults and children) seen in outpatients have	Despite multiple other measures of illness (eg NEWS score) BMI is not	Despite obesity being the cause of a disproportionate number of hospital attendances	RCP Action on Obesity: comprehensive care for all’

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		their BMI measured when they arrive	measured routinely in outpatients to my knowledge and it is an 'easy win' to get hospitals to document this in the notes	there is no measure of the actual rate of obesity in outpatients (to my knowledge), and it would be a prompt to offer specialised treatment if wished by the patient. The proportion of those seen in OPD with the score could be set at a certain target as not all patients can have this measured (eg those who can't stand)	Academy of Medical Royal Colleges. Measuring up. The medical profession's prescription for the nation's obesity crisis', a report of the Medical Royal Colleges'
006	Weight Watchers UK	Adopting an opt-in rather than opt out approach to assessing weight status	There is strong evidence that as overweight becomes the norm at population level, underestimation of weight is increasing. Weight misperception is a real concern and has potential to cause more harm than weight stigma.	Health care professionals (HCPs) relying on personal judgement before deciding to assess weight status is likely to be problematic. Assessing weight status and checking for associated co-morbidities should be standard practice with HCPs following standardised, recommended techniques for assessing weight status.	Weight misperception literature. For example: Johnson, F., Beeken, R. J., Croker, H., & Wardle, J. (2014). Do weight perceptions among obese adults in Great Britain match clinical definitions? Analysis of cross-sectional surveys from 2007 and 2012. BMJ open, 4(11), e005561.
Providing information					
007	SCM 2	Provision of good quality information and education for patients carers and families	To improve informed choice about treatment options and to improve outcomes from existing programmes.	There are areas of good practice around the country but this needs to be brought together and best practice shared.	*No further information was provided by this stakeholder.*
008	SCM 1	All children and adults engaging primary or secondary health care services should have their weight and height measured and documented.	The prevalence of obesity in adults and in children in the UK is amongst the highest in the developed world. Consequently, obesity is now so common that people do not realise that they are obese. If obesity is not	Obesity is the now one of the top three social burdens generated by human beings. All in-patients are weighed but the issue of high BMI is rarely raised with the patient on included in the discharge summary.	http://www.mckinsey.com/insights/mgi/in_the_news/the_global_obesity_threat

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		Patients with a BMI equal to and above 30 (or equivalent for children) should be given advice and if in secondary care their GP informed. This will need to be underpinned by training and education across the entire NHS.	raised as a concern when patients attend medical appointments with healthcare professionals this perpetuates the problem. All in-patients are currently weighed in order for thromboembolic risk stratification and dosing. However, there are no clearly sign posted pathways for people who are obese and these need to be incentivised akin to smoking cessation.	Obesity is rarely addressed by healthcare professionals even when they are seeing patients whose co-morbidities that are due to obesity (e.g NAFLD or OSA). Advice from healthcare providers regarding weight can motivate patients to lose weight or at least seek out appropriate support. Education and training in raising obesity as a problem, screening for complications and subsequent management is needed across the NHS.	Carrasco Sánchez FJ, Díaz Alcaide F, Marín Fernández Y, Chaparro Moreno I, Pujol de la Llave E. Prevalence of obesity in hospitalized internal medicine patients. Annales de Medicine Interne 2002;19(9):453–6. Healthcare Commission (UK). Obesity: Identification and management in secondary care. London: HC, 2006. http://ratings2006.healthcarecommission.org.uk/Indicators_2006Nat/Trust/Indicator/indicatorDescriptionShort. asp?indicatorId=1214 [accessed 13 December 2012]. https://www.rcplondon.ac.uk/sites/default/files/action-on-obesity.pdf
009	WLSinfo	Improving access to support groups with supported and trained peer group facilitators	Members believe that the best sustainable outcomes and quality of life are experienced by those who attend support groups.	Group provision is patchy around the country. People need appropriate training and support to run support groups.	*No further information was provided by this stakeholder.*
4.2 Assessment					
Clinical and psychological assessment					

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
010	Association for Dance Movement Psychotherapy UK	Inclusion of psychological screening for patients who present with obesity	There is growing evidence that in some cases, obesity and overweight are linked to 'emotional eating'. In such cases, approaches to treatment based solely on education about weight loss are likely to be, at best, temporarily effective; stressful life events are likely to trigger emotional eating as a coping strategy.	Recent research has found a significant relationship between basic need satisfaction and emotional eating, with a mediating effect of negative coping strategies. Thus, if treatments can be geared towards supporting the development of coping strategies for dealing with distress, this might enable to development of more successful weight management programmes.	Andrews, R., Lowe, R. & Clair, A. (2011). The relationship between basic need satisfaction and emotional eating in obesity *Australian Journal of Psychology*, 63: 207–213. doi:10.1111/j.1742-9536.2011.00021
011	SCM 3	Psychological Screening, Assessment and Interventions for obesity assessment and management	Individuals with severe and complex obesity have a high incidence of psychological morbidity including mood disorders and disordered eating, with psychological factors being linked to both the cause and consequence of obesity. ('Obesity in the UK; A Psychological Perspective. British Psychological Society, 2011) NICE guidance recommends multi-component assessment including of psychosocial distress, psychological problems, disordered eating and underlying causes of obesity. The guidance also advocates comprehensive assessment of psychological factors that may affect adherence to post surgery diet and care. NICE guidance recommends intervention approaches which incorporate cognitive and behavioural	National Obesity Observatory Report on Obesity and mental health (2011) recommends that intervention strategies should consider physical and mental health of patients and should routinely monitor mood and weight to facilitate early detection and intervention for mental health across the age range. The report suggests that encouraging healthy eating and physical activity will be ineffective where individuals are experiencing low self-esteem or low mood and that a focus on psychosocial factors is particularly important when working with obese children. Because there is varied and patchy access to multidisciplinary obesity services this will affect the confidence, skills and knowledge to screen and assess for psychological factors linked to obesity and the ability and knowledge to refer for appropriate interventions either as part of weight management services or from specialist mental health or eating disorder services as appropriate and available.	NCEPOD 'Too Lean A Service' (2012) recommends a greater emphasis on psychological assessment and support at an earlier stage in the care pathway for obese patients(i.e. before being referred through for surgery) and recommends the routine use of psychological screening tools. See BPS report 'Obesity in the UK; A Psychological Perspective' (2011) for a review of the evidence base and examples of psychological screening, assessment, intervention and consultation in obesity services. The Cochrane Review (Shaw, K.A. et al, 2005 'Psychological Interventions for overweight or obesity. Cochrane Database of Systematic Reviews, 3. Art no. CD003818. DOI: 10.1002/14651858.CD003818.pub2) ; suggests that behavioural and cognitive-behavioural interventions (combined with dietary and exercise strategies) are effective in enhancing weight reduction.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			interventions and recommends psychological support after surgery as well as referral for more specialist interventions as needed as part of lifestyle change programmes..	Psychological assessment and evaluation can guide therapeutic interventions to optimise the safety and efficacy of weight loss interventions. One of the key findings of the NCEPOD report ('Too Lean A Service?' 2012) evaluating pre and post bariatric surgery care was that less than a third of patients had any documented evidence of receiving psychological support.	A service evaluation showing positive weight loss and improvements in psychological morbidity from a tier 3 level long term lifestyle intervention programme; *Evaluation of the 'Live Life Better Service', a community-based weight management service, for morbidly obese patients* Dean Wallace; Puja Myles; Rachel Holt; Jonathan Nguyen Van-Tam Journal of Public Health 2015; doi: 10.1093/pubmed/fdv103
012	SCM3	Patient engagement and motivation to make sustainable lifestyle change	NICE guidance recommends the following to promote engagement and motivation; • assessing an individual's readiness and confidence to make lifestyle change • discussing options for treatment with patients • tailoring weight loss interventions to personal needs and preferences • offering repeat consultations and support for those not yet ready to change. NICE guidance advocates that clinical services are multi-component and multi-disciplinary with a range of treatment components on offer. Clinical services are advised to actively involve patients as key	Promoting true patient choice and engagement can be challenging when clinicians do not feel confident to discuss matters with patients and/or there is a restricted range of service options on offer locally. Clinicians may struggle to bring up the issue of weight and obesity with individuals due to the complexity of factors involved e.g. seeking to highlight clinical risk factors whilst trying to engage and motivate clients and manage emotional responses such as anger, denial or disbelief in a positive way. A Royal College of Practitioners Report 'Action on Obesity: Comprehensive Care for All' (RCP 2013) concludes that there is varied and patchy availability of multi-component, multi-disciplinary services which limits treatment options and choice. This report also recommends that multidisciplinary teams have specialist and experienced clinical professionals at primary and	RCP report 'Action on Obesity: Comprehensive Care For All' (2013) recommends training in MI principles and approaches for all clinicians to be incorporated when taking clinical history BPS Report 'Obesity in the UK: A Psychological Perspective' (2011)

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			players in choosing when, how and with what components of support their obesity is assessed and managed. This recognises that all obesity/weight loss interventions, at all levels of intensity, require the engagement with and adherence of individuals to long term cognitive and behavioural changes and that continual promotion and enhancement of patient involvement and motivation is crucial.	secondary care and promotes joined up care with consistent messages and support for patients as they move through services. BPS Report 'Obesity in the UK: A Psychological Perspective' (2011) reports three things that might undermine patient engagement and motivation to change (pg 11); • a lack of confidence amongst clinicians in implementing behaviour change and motivation strategies • short term duration of intervention programmes undermining the ability for real sustainable change to take place programmes do not promote 'intrinsic motivation' (i.e. support the development of autonomy, relatedness and competence) which may affect adherence issues.	
013	SCM 5	Clinical assessment of obesity in children included in the NICE guideline CG189 indicates areas of measurement and assessment for comorbidities however are not specific to trigger many services in primary care and secondary care to necessarily investigate children specifically for these.	Looking proactively for markers and evidence of comorbidities of obesity in children is important as it may have longer term effects in stemming the progression to type 2 diabetes, preventing obstructive sleep apnoea and improving learning and screening for psychological sequelae may prevent further escalation of poor quality of life and worsening of obesity. Improved screening for comorbidities will lead to more effective treatment and addressing of specific difficulties and risks caused by obesity.		Reilly & Kelly. Long-term impact of overweight and obesity in childhood and adolescence on morbidity and premature mortality in adulthood: systematic review. IJO 2011; 35:891-898. August et al., Prevention and Treatment of Pediatric Obesity: An Endocrine Society Clinical Practice Guideline Based on Expert

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					Opinion. JCEM 2008 93:12, 4576-4599. Prevention of Type 2 diabetes – Tuomilehto et al., for the Finnish Diabetes Prevention Study Group 2001.
Follow-up to assessment					
014	SCM 3	Patient engagement and motivation to make sustainable lifestyle change	NICE guidance recommends the following to promote engagement and motivation; • assessing an individual's readiness and confidence to make lifestyle change • discussing options for treatment with patients • tailoring weight loss interventions to personal needs and preferences • offering repeat consultations and support for those not yet ready to change. NICE guidance advocates that clinical services are multi-component and multi-disciplinary with a range of treatment components on offer. Clinical services are advised to actively involve patients as key	Promoting true patient choice and engagement can be challenging when clinicians do not feel confident to discuss matters with patients and/or there is a restricted range of service options on offer locally. Clinicians may struggle to bring up the issue of weight and obesity with individuals due to the complexity of factors involved e.g. seeking to highlight clinical risk factors whilst trying to engage and motivate clients and manage emotional responses such as anger, denial or disbelief in a positive way. A Royal College of Practitioners Report 'Action on Obesity: Comprehensive Care for All' (RCP 2013) concludes that there is varied and patchy availability of multi-component, multi-disciplinary services which limits treatment options and choice. This report also recommends that multidisciplinary teams have specialist and experienced clinical professionals at primary and secondary care and promotes joined up care	RCP report 'Action on Obesity: Comprehensive Care For All' (2013) recommends training in MI principles and approaches for all clinicians to be incorporated when taking clinical history BPS Report 'Obesity in the UK: A Psychological Perspective' (2011)

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			players in choosing when, how and with what components of support their obesity is assessed and managed. This recognises that all obesity/weight loss interventions, at all levels of intensity, require the engagement with and adherence of individuals to long term cognitive and behavioural changes and that continual promotion and enhancement of patient involvement and motivation is crucial.	with consistent messages and support for patients as they move through services. BPS Report 'Obesity in the UK: A Psychological Perspective' (2011) reports three things that might undermine patient engagement and motivation to change (pg 11); • a lack of confidence amongst clinicians in implementing behaviour change and motivation strategies • short term duration of intervention programmes undermining the ability for real sustainable change to take place programmes do not promote 'intrinsic motivation' (i.e. support the development of autonomy, relatedness and competence) which may affect adherence issues.	
015	Weight Watchers UK	Ongoing follow up for patients for who are identified as overweight but who state they are not ready to change	To ensure that support is available when patients are ready	Attitudes and beliefs about weight and health are amenable to change. Therefore if a patient is initially reluctant to adapt their lifestyle continued, sensitive encouragement from their HCP may be beneficial. HCPs should be kept up to date with the local obesity pathways and remain informed of any changes to services available.	*No further information was provided by this stakeholder.*
4.3 Tier 3 services					
Referral to tier 3 services					
016	Johnson & Johnson Medical Limited	Tier 3 specialist weight management services	There is good evidence that appropriate tier 3 specialist weight management services can drive significant improvements in the	Tier 3 specialist weight management services are commissioned by CCGs and are usually administered by a clinician-led multi-disciplinary team. The quality and accessibility of tier 3	Clinical Obesity (2014), Evaluation of a multidisciplinary Tier 3

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			overall health of people with obesity, particularly for those who have not responded to previous tier interventions. NICE clinical guideline (CG189) recommends referral to tier 3 services if bariatric surgery is being considered. The guidance further states that bariatric surgery should only be offered "if the person has been receiving or will receive intensive management in tier 3 service".	specialist weight management services are highly variable across the country, with the absence of these services in some localities. Where these services are not commissioned, patients are more likely to deteriorate and are then unable to access other interventions in the later stages of the obesity pathway such as bariatric surgery. Uniform availability of tier 3 services will be required to improve access to bariatric surgery, where clinically indicated.	weight management service for adults with morbid obesity, or obesity and comorbidities, based in primary care http://onlinelibrary.wiley.com/doi/10.1111/cob.12066/abstract NICE Clinical Guideline 189 (2014), Obesity: identification, assessment and management of overweight and obesity in children, young people and adults https://www.nice.org.uk/guidance/cg189 BOMSS (2014), Commissioning Guide: Weight Assessment and Management Clinics (Tier 3) http://www.bomss.org.uk/commissioning-guide-weight-assessment-and-management-clinics-tier-3/
017	Obesity Group of the British Dietetic	Referrals to lifestyle weight management services are considered at lower BMI	Asian (South Asian and Chinese) populations are at increased risk of ill-health at lower levels of body fat	Commonly used cut-off points for diagnosis of overweight (BMI≥25kg/m2) and obesity (BMI≥30kg/m2) are likely to underestimate risks	Regular recording of BMI is not always optimal and healthcare practitioners

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	Association	and/or WC cut-off points in Asian populations.	than Caucasians. Type 2 diabetes and cardiovascular disease are more prevalent at BMI <25kg/m2 in these groups. However due to the heterogeneity of these groups, specific cut-off points for overweight and obesity have not been identified. However given their increased risks, a pragmatic approach is to use the WHO cut-off points for populations as a trigger for referral of individuals to lifestyle weight management services (23 kg/m2 for increased risk and 27.5 kg/m2 high risk).	of ill-health in these populations.	may not be aware of differential risk for different ethnic groups (http://www.nice.org.uk/guidance/ph46/resources/guidance-assessing-body-mass-index-and-waist-circumference-thresholds-for-intervening-to-prevent-ill-health-and-premature-death-among-adults-from-black-asian-and-other-minority-ethnic-groups-in-the-uk-pdf).
018	Royal College of Paediatrics and Child Health	Lack obesity management services for children with special needs	Despite high incidence obesity in this group very limited access to help even where available for typically developing children for example programs like MEND often exclude children with additional needs eg autism as “won’t fit in group”.	Often needs individual approach, or geared towards needs of children Access to tailored holistic programs for obesity management for children with neurodisability there needs to be agreement over ownership of this provision eg CCG and public health both argue the other should fund program.	*No additional information was provided by this stakeholder.*
019	SCM 1	People with severe and complex obesity should have access to Tier 3 obesity services that comply with RCS Commissioning Guide	A tier 3 obesity service is for obese individuals (usually with a body mass index ≥35 with co- morbidities or 40+ with or without co-morbidities) who have not responded to previous tier interventions. A tier 3 service is comprised of a multi-disciplinary team of specialists, led by a clinician and typically including: a physician	The provision of tier 3 services is variable, with the absence of such services in many areas. In the absence of tier 3 services patients cannot access appropriate care and they cannot ordinarily access bariatric surgery. The RCP has recently undertaken a survey examining provision of Tier 3 services in London and less than 10% of CCGs have commissioned tier 3 services.	Obesity: identification, assessment and management of overweight and obesity in children, young people and adults (2014) NICE guideline CG189 NHS England and Public

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			(consultant or GP with a special interest); specialist nurse; specialist dietitian; psychologist or psychiatrist; and physiotherapist/physical activity specialist/physiology. These services are critical in the management of patients and in particular identifying and treating co-morbid conditions and optimising patient health. In addition, patients need to have participated in a tier 3 service before they are able to access bariatric surgery.	NHS England commissioning policy recognises that patients completing tier 3 support who pro-actively manage their diet and exercise are more likely to subsequently succeed in the dietary control required post-surgery, and therefore maximise the outcomes of their surgery. Some services that have been commissioned do not comply with recommended service specification in terms of expertise of their MDT.	Health England (2014) Joint report on commissioning obesity services NHS England (2013) Service specification: severe and complex obesity (all ages) NHS England (2013) A05/P/a Clinical Commissioning Policy: complex and specialised obesity surgery RCS Commissioning Guidance on Weight Assessment and Management Clinlcs https://www.rcseng.ac.uk/healthcare-bodies/docs/weight-assessment-and-management-tier-3-services
020	SCM 3	Tier 3 Assessment and Management for Obesity	NICE guidance recommends considering referral to Tier 3 services for those individuals requiring more specialist and intensive assessment and interventions and as part of the pathway through for bariatric surgery.	Clarity is needed about when and who to refer and what a Tier 3 approach will offer. What is a Tier 3 Service ? Definitions for a Tier 3 MDT Service and remit can be found in the following reports; NHS England Report 'Joined up Clinical	*No additional information was provided by this stakeholder.*

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				Pathways for Obesity' (2014) Clinical Commissioning Policy:Complex and Specialised Obesity Surgery http://www.england.nhs.uk/wp-content/uploads/2013/04/a05-p-a.pdf But the existence of Tier 3 Services is still patchy; NHS England Report 'Joined up Clinical Pathways for Obesity' (2014) 'The provision of tier 3 services is variable, with the absence of such services in many areas' (pg 7) East Midlands Academic Health Science Network Obesity Programme Report (2015) 'in relation to tier 3 services, the guidelines would seem to be aspirational at best'	
021	SCM 4	Access to both Tier 2 and Tier 3 weight management services within every CCG	NICE CG 189,and NICE PH 53 guidelines reviewed the evidence for these interventions and recommended effective interventions. . Access should be universal to ensure equity.	In many areas there is either a lack of Tier 2 services, or a lack of awareness of the services available, with no coherent obesity pathway. Tier 2 is commissioned by Public Health. CCGs have not all commissioned specialist Tier 3 services, and as assessment in a Tier 3 service is a prerequisite for bariatric surgery this may deny patients access to that effective treatment, as well as LELD and new drug treatments for obesity as they emerge. CCCs need to work with Public health to develop comprehensive pathways. This can be achieved	RCP Action on Obesity (as above) National Institute for Health and Clinical Excellence (NICE) CG 189 (2014) Obesity: identification, assessment and management of overweight and obesity in children, young people and adults. National Institute for Health and

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				by setting up local obesity networks (e.g. Norfolk Obesity network) and appointing obesity champions in community and secondary care (see powerpoint presentation attached) Levers may be required to encourage the commissioning of these services.	Clinical Excellence. Available from: http://www.nice.org.uk/guidance/CG189 NICE-accredited RCS Weight Assessment and Management Clinics Commissioning Guidance https://www.rcseng.ac.uk/healthcare-bodies/docs/weight-assessment-and-management-tier-3-services RCP survey in progress
022	SCM 6	Consistent services offered across all postcodes - particularly commissioning of tier 3 services	There is variability in the commissioning and provision of tier 3 and 4 services across England, particularly clinical multi-disciplinary team interventions (commonly referred to as 'tier 3' services) as per recommended in (NICE CG43.	Reflecting the principles of the NICE guidance, intensive and multidisciplinary assessment and support should be provided for individuals to enable them to have trialled and exhausted all non-invasive treatment options prior to potentially higher risk surgical approaches	NICE CG43 recommendations NHS England Report of the working group into: Joined up clinical pathways for obesity
023	SCM 6	Development and implementation of obesity pathways	There is a range of existing guidance available to support an integrated approach to practice and care throughout the obesity care pathway – this includes guidance from Department of Health5 and the National Institute for Health and Clinical Excellence (NICE)	Potential for increased efficiencies with regards use of financial resources. Good tier 3 services can reduce the need for consideration of surgery, so pooling the budgets for tiers 3 and 4 could have intrinsic benefits.	Obesity Care Pathway. CG189

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024	SCM 7	People with severe obesity (BMI 40 or 35 plus obesity-related disease) are offered referral to weight assessment and management clinics (Tier 3) by their GP especially if they wish to consider bariatric surgery	GPs should refer obese patients with BMI 40 or 35 + comorbidity who are difficult to manage to Tier 3 weight assessment and management clinics if they wish specialist advice in their care GPs do not have access to Very Low Energy Diets or potential new pharmacotherapies for obesity	Practices should be assessed according to the level of obesity for the proportion of patients they refer to Tier 3 clinics. Eg a specific proportion of severely obese patients should be engaged with per year and offered onward referral	Same as the above plus NICE CG189 NICE-accredited RCS Weight Assessment and Management Clinics Commissioning Guidance https://www.rcseng.ac.uk/healthcare-bodies/docs/weight-assessment-and-management-tier-3-services
025	SCM 7	People with severe obesity (BMI 40 or more or 35 plus obesity-related disease are availed of Tier 3 clinics by their local CCG	Tier 3 clinics must be commissioned by each CCG so that every patient above has access if they wish specialist care or the GP feels they need it	Currently many CCGs are not commissioning Tier 3 services (eg most of London) sot that patients cannot access care. CCGs are putting resources into prevention instead (or not at all) so that those needing treatment (the groups mentioned) are left with treatment	A05 document NHS England RCP document Action on Obesity RCS Commissioning Guidance on Weight Assessment and Management Clinlcs https://www.rcseng.ac.uk/healthcare-bodies/docs/weight-assessment-and-management-tier-3-services
026	SCM 7	People who wish to consider bariatric surgery are offered referral to the	Currently the provision of bariatric surgery (which is the only successful long term (more than 10 year)	Potential health improvement with surgery far outweighs anything else that can be offered and rates of referral for surgery are/have been	A05 document NHS England RCP document Action on

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		local Tier 3 clinic	treatment for severe obesity is offerd to <1% of those who could benefit; the rate of provision is much less than many other western European countries	subject to widespread post code variation, for non-clinical reasons	Obesity RCS Commissioning Guidance on Weight Assessment and Management Clinlcs
027	SCM 7	Patients with onset of type 2 diabetes within 10 years and BMI 35 or more are offered referral to a Tier 3 clinic	Diabetes is an unremitting disease and only bariatric surgery offers a chance of long term remission	Treatment of diabetes (which is mostly type 2) is 10% of the NHS budget and bariatric surgery offers the only potential for remission and possibly reduction long term in healthcare costs	NICE CG189
028	SCM 7	People (adults and children) admitted to hospital with severe obesity (BMI 40 and 35 + etc) are identified and offered a community lifestyle weight management programme and/or a clinic appointment for assessment in Tier 3 before discharge	If the admission is obesity-related it would be a spur to offer help for the patient's weight management if the patient wishes it; successful weight management might reduce further admissions	The proportion offered clinic appointments could easily be measured with respect to a specific target	Academy of Medical Royal Colleges. Measuring up. The medical profession's prescription for the nation's obesity crisis', a report of the Medical Royal Colleges'
029	SCM 7	People attending Tier 3 have outcome measures from the process	Tier 3 weight assessment and management clinics have been introduced wholesale with no evidence that there is health benefit above what can be achieved by the GP. There is no database and no set of agreed outcome measures. Tier 3 is potentially excellent but we need outcome measures of their activity – their absence stands out, so there should be a quality standard(s) for what they achieve.	BMI / weight loss achieved at entry to and exit from Tier 3 unknown (target 100% known; the weight loss target could be eg >50% patients achieve 5% weight loss, target known in 100%) BMI at discharge from Tier 3 either back to the GP or on to surgery unknown (target 100%) Change / improvement in diabetic control unknown (target 100%) Prevalence of comorbidities unknown (target 100% recorded)	A05 Policy NHS England NICE CG189 RCS Commissioning Guidance on Weight Assessment and Management Clinlcs https://www.rcseng.ac.uk/healthcare-bodies/docs/weight-

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				Referral rates on to surgery vary widely, for non-clinical reasons – eg 10% suitable for surgical assessment in some to most in others (target % unknown but rewards / risks of surgery should be discussed in 100%) For diabetes – % with HbA1c recorded at beginning and end (target 100%); % type 2 diabetics of recent onset referred on to bariatric surgery assessment (target 100%); microvascular risk and % with end-organ damage from diabetes should be assessed (target 100%) For people with BMI>50, the target for referral for surgical assessment should be 100% for those who have failed previous lifestyle weight management; the measure could be % referred on for surgical assessment or reason why not documented (target 100%) Obesity risk – % with Edmonton Obesity Scoring System (EOSS) (or similar mortality risk instrument) target 100% recorded; % with Obesity Surgery-Mortality Risk Score (OS-MRS) recorded before referral to surgery (target 100%). The EOSS and OS-MRS are documented for patients having surgery already. A screening tool for psychiatric / psychological comorbidity should be documented as being used (target 100%).	assessment-and-management-tier-3-services Padwal RS, Pajewski NM, Allison DB and Sharma AM. Using the Edmonton obesity staging system to predict mortality in a population-representative cohort of people with overweight and obesity. Canadian Medical Association Journal. 2011; 183(14): E1059-66. DeMaria EJ, Portenier D, Wolfe L. Obesity surgery mortality risk score: proposal for a clinically useful score to predict mortality risk in patients undergoing gastric bypass. Surgery for Obesity & Related Disease. 2007; 3(2): 134-40.

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				The structure of the clinic can be assessed by % containing a bariatric physician (target 100%, if no physician it is, by definition, not Tier 3); the same could be assessed for the other team members.	
030	SCM 7	Additional developmental areas of emergent practice	BME groups have very high rates of obesity and very few receive bariatric surgery, probably as a reflection of very poor referral rates into Tier 3	The referral rates could be assessed for each GP practice as above	*No additional information was provided by the stakeholder.*
031	The Royal College of Pathologists	Provision of specialist, multidisciplinary, non-surgical ("Tier 3") adult weight management services	Specialist "Tier 3" multidisciplinary adult weight management intervention is recommended in NICE guidance, for obese people who require further weight management input after engagement with earlier tiers, and also as a prerequisite to progression to bariatric surgery.	There is significant geographical variation in provision of Tier 3 services across the country. This variation has become much more pronounced in England recently as a consequence of the Health and Social Care Act, with variation in commissioning of these services.	Report of the working group into: Joined up clinical pathways for obesity: http://www.england.nhs.uk/wp-content/uploads/2014/03/owg-join-clinc-path.pdf
032	Weight Watchers UK	Once a patient has been identified as overweight or obese, HCP's should have a clear pathway of what action to take and where to refer on. These pathways should be published and made publically available.	A lack of shared knowledge of local services and care pathways that are not joined up increase inequalities. Patients should receive the very best evidence based services across the board. Awareness among potential obesity management service users, and thus those most in need, is often very low. It is recommended that Local Authorities, in partnership with Clinical Commissioning Groups, publish their care pathways for weight management services across	To identify gaps in care pathways and ensure that appropriate support is available for based on patient need. To ensure that the management of overweight is driven by clinical expertise and pragmatically what is available at a community level It may be useful to developing treatment algorithms based on local availability of services. It would enable health professionals to signpost effectively to local services. It would also ensure public accountability for engagement in their own health and services, ultimately improving equality of access for people.	National Audit Office (2001) Tackling Obesity in England, The Stationery Office, London. Royal College of Physicians (2013) Action on Obesity: Comprehensive care for all, London, RCP Dixon K, Shcherba S, and Kipping R. Weight Loss from Three Commercial

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			all tiers, enabling signposting across public health, primary and secondary care touch points and professionals and promote self-referral access routes into tier 2. This would enable the many people who are overweight or obese and highly motivated to lose weight to identify for themselves what is available and how it can be accessed. Improving access for all is a key area for quality improvement.	Engaging 'hard to reach' overweight/obese families, particularly those from the most deprived communities is challenging. Numerous reports have identified primary care as the key NHS setting for screening, management and prevention of obesity in families (National Audit Office, 2001, Royal College of Physicians, 2013, Academy of Medical Royal Colleges, 2013). On an individual basis 90% of NHS contact is with primary care. Signposting and referrals from primary care is essential. It is becoming increasingly prevalent, but not yet best practice, to enable self-referrals into tier 2 services. Self-referrals are screened by providers to ensure eligibility under locally agreed terms, but vastly facilitates engagement and uptake from service users and minimises burden on NHS and Local Authorities. Promoting and enabling self-referral pathways has the potential to improve access and ultimately the quality of care received by the service user.	Providers of NHS Primary Care Slimming on Referral in North Somerset: Service Evaluation. J Public Health. 2012 May 18. Lloyd A and Khan R (2011) Evaluation of Healthy Choices: a commercial weight loss programme commissioned by the NHS, Perspective. Public Health, 131, 177-83. Wrieden W.I Et al (2012) NHS referral to a commercial, community-based lifestyle modification programme. Does area of deprivation make a difference? Proceedings of the Nutrition Society (2013); 72 / Issue OCE2
4.4 Surgical interventions					
Assessment for bariatric surgery					
033	Johnson & Johnson Medical Limited	Bariatric surgery	There is a significant amount of evidence supporting the cost and clinical effectiveness of bariatric	Bariatric surgery is one component of the obesity service pathway and is commonly referred to as 'tier 4' services. NHS England currently	NICE Clinical Guideline 189 (2014), Obesity: identification, assessment

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			surgery, particularly in preventing and improving the long-term health conditions associated with obesity. Bariatric surgery is recommended within NICE clinical guideline (CG189) for people with a BMI over 40, or over 35 for people with obesity-related health conditions such as type 2 diabetes or high blood pressure. In November 2014, the guideline was amended to reflect a lower BMI threshold of 30 for people with recent-onset type 2 diabetes, or even lower for those of Asian family origin.	commissions these services, which are delivered by a number of NHS providers. HSCIC figures indicate that the NHS performed 6,384 bariatric surgery procedures in 2013/14, compared to 8,024 in 2012/13. This represents a 20% decline in the number of procedures performed, despite a collective desire to increase the volume of surgical procedures due to their clinical and cost effectiveness for appropriate patients. Commissioning responsibility for bariatric surgery services is due to be transferred from NHS England to Clinical Commissioning Groups (CCGs) in April 2016. The transfer presents an excellent opportunity to join up clinical pathways for obesity and provide collective oversight of the co-morbidities related to obesity. However, the scale of the challenge should not be underestimated and a clear set of NICE quality standards will help maximise the chances of a successful transition.	and management of overweight and obesity in children, young people and adults https://www.nice.org.uk/guidance/cg189 Parliamentary Office of Science and Technology research briefing (2014), Obesity Treatments http://researchbriefings.parliament.uk/ResearchBriefing/Summary/POST-PN-0495#fullreport HSCIC (2015), Statistics on Obesity, Physical Activity and Diet http://www.hscic.gov.uk/catalogue/PUB16988/obes-phys-acti-diet-eng-2015.pdf NHS England (2014), Report of the working group into: Joined up clinical pathways for obesity. http://www.england.nhs.uk/wp-

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					content/uploads/2014/03/owg-join-clinc-path.pdf
034	SCM 1	People with severe and complex obesity who are eligible for bariatric surgery based upon NICE guidance should have access to specialist obesity surgical centres.	Bariatric surgery services have been subject to specialist commissioning since 2007 and only designated centres have been commissioned to undertake surgery. In response to the NCEPOD (2012) report the Service Specification which clearly stated the requirements on the infrastructure and clinical expertise of the team was developed. When bariatric surgery was under local commissioning there was a post-code lottery with many regions e.g. East of England developing their own criteria for referral for bariatric surgery and only commissioning from specific providers. Central commissioning removed these inequalities. Commissioning of bariatric surgery will be devolved back to CCGs who may not have the adequate expertise to evaluate surgical centres. CCGs may refuse to commission bariatric surgery or they may commission services that do not comply with the current specification (substandard but cheaper).	Prior to central commissioning there was a wide inequality with respect to access to bariatric surgery service around the UK with waits of > 2years in some areas or with criteria raised above that set by NICE (e.g. only patients with a BMI > 50 with type 2 diabetes). Prior to the NHS England Commissioning Policy there was a wide variation in team composition, experience and provision of appropriate infrastructure 24-hour specialise cover. We need to plan for these services to be devolved back to CCGs and ensure that the improvements in quality, care and access to surgery that have taken place over the last 5 years and not reversed leaving patients unable to access safe and appropriate services.	Obesity: identification, assessment and management of overweight and obesity in children, young people and adults (2014) NICE guideline CG189 NHS England (2013) A05/P/a Clinical Commissioning Policy: complex and specialised obesity surgery NCEPOD (2012) Bariatric surgery: too lean a service?

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035	SCM 1	People with type 2 diabetes with a BMI of 35 of greater should receive verbal advice and written information from their diabetes care provider (primary or secondary) regarding the beneficial effects of bariatric surgery and offered an expedited referral. All healthcare professionals in primary and secondary care should be aware of the benefits of bariatric surgery for patients with T2D and the need for early referral.	Type 2 diabetes (T2D) accounts for 25,000 preventable deaths a year in the UK. I in 10 hospital beds are occupied by patients with complications of T2D and there are 125 amputations a week due to T2D. Bariatric surgery is the most effective treatment for T2D for patients with a BMI>35 kg/m2. The vast majority of patients who are 10 years or less from diagnosis exhibit marked improvement in their glycaemic control with a reduction of diabetes medications and in most cases complete remission of their T2D. Patients with T2D who undergo bariatric surgery have reduced microvascular complications. Remission rates and improvements in microvascular complications are greater in patients who undergo bariatric surgery as close to diagnosis as possible.	The vast majority of patients with T2D with a BMI of 35 or greater are not aware of the health benefits of surgery. Diabetes specialists and GPs managing T2D are not informing patients about bariatric surgery or suggesting referral. Patients who are referred are often delayed due to lack of tier 3 services whereas the new NICE guidelines states that patients with T2D need an expedited referral as long as they receive tier 3 or equivalent whilst being assessed. In many areas the wait for surgery is >1year reducing the patients chance of remission.	Obesity: identification, assessment and management of overweight and obesity in children, young people and adults (2014) NICE guideline CG189 NBSR Second Registry Report 2014 (data for UK 2011-13) NEJM 370;21 May 22 2014 JAMA 2014;311(22):2297-2304
036	SCM 4	Adults with BMI >35 kg/m2 with obesity related co-morbidity, or BMI >40 kg/m2 should be offered assessment for bariatric surgery. Adults with new onset T2D and BMI. 30 kg/m2 should be considered for bariatric	NICE CG 189 reviewed the evidence and this is a very cost-effective treatment, proven to extend life and reduce co-morbidities such as T2D, OSA, hypertension and IHD. NICE CG 189 reviewed and updated the guidance to incorporate new evidence on the effectiveness of	Due to the lack of clear obesity pathways and local Tier 3 services many GPS are unable to refer patients for assessment. This inequity is iniquitous. These patients with severe and complex obesity are responsible for a disproportionate economic burden on the NHS, so effective treatment is cost-effective as well as clinically important	National Institute for Health and Clinical Excellence (NICE) (2014) Obesity: identification, assessment and management of overweight and obesity in children, young people

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		surgery (both after assessment at a Tier 3 service)	bariatric surgery in treating T2D.	CCGs should be encouraged to commission Tier 3 services and bariatric surgery. Clear guidance on assessment and management of these services is available for commissioners (RCS)	and adults. National Institute for Health and Clinical Excellence. Available from: http://www.nice.org.uk/guidance/CG189 The disproportionate economic burden associated with severe and complicated obesity: a systematic review E. Grieve, E. Fenwick, H-C. Yang and M. Lean Obesity Reviews 2013 doi: 10.1111/obr.12059 NICE-accredited RCS Weight Assessment and Management Clinics Commissioning Guidance https://www.rcseng.ac.uk/healthcare-bodies/docs/weight-assessment-and-management-tier-3-services
037	SCM 7	People with severe obesity (BMI 50 or more) who have tried to lose weight unsuccessfully through	Despite the reiteration in CG189 that, for patients who have tried and failed previous attempts at losing weight, a referral for bariatric surgery	The referral rates to Tier 3 as a proportion of patients in a GP practice with BMI 50 or more especially with obesity-related disease should be assessed	NICE CG189 RCS Commissioning Guidance on Weight

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		community-based programmes are referred by the GP to a Tier 3 clinic for consideration of bariatric surgery	assessment should be made, the rate of surgery has continued to decrease in the English NHS over the last 3 years		Assessment and Management Clinlcs https://www.rcseng.ac.uk/healthcare-bodies/docs/weight-assessment-and-management-tier-3-services
038	The Royal College of Pathologists	Provision of bariatric surgery for individuals who 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.	There is a robust evidence base for the effectiveness of bariatric surgery in bringing about significant weight loss, with maintenance at the lower weight achieved, and consequent improvement in comorbidities such as type 2 diabetes. Bariatric surgery is recommended in NICE guidance	Across the UK, provision of bariatric surgery falls very significantly below the level that would be required to offer surgery to all willing patients who, by NICE criteria, would be expected to benefit from it. Estimates of the proportion of patients each year who undergo bariatric surgery as a percentage of those who could potentially benefit from it range from 1.5-3.5%.	Clinical Commissioning Policy: Complex and Specialised Obesity Surgery: http://www.england.nhs.uk/wp-content/uploads/2013/04/a05-p-a.pdf
Psychological assessment					
039	The Royal College of Pathologists	Psychological assessment of patients being considered for bariatric surgery	NICE guidance recommends comprehensive pre-operative psychological assessment of people being considered for bariatric surgery.	Pre-operative psychological assessment of patients being considered for bariatric surgery is an essential component of assessment for bariatric surgery, both to identify psychological contraindicators and also potential issues that may affect compliance with appropriate post-operative dietetic modification. There is significant variation in provision of psychological support, with a recent NCEPOD report showing that only 17.6% of patients were assessed by a psychologist or psychiatrist prior to surgery.	Too Lean a Service? A review of the care of patients who underwent bariatric surgery. http://www.ncepod.org.uk/2012report2/downloads/BS_fullreport.pdf
040	WLSinfo	Improving access to	Many of our members believe that	Services vary across the country. Standards for	*No further information was*

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		psychological support services pre operatively	there is a huge level of unmet need which can prevent the best outcomes of surgery. Members believe that good quality support before the decision about surgery can improve outcomes after.	best practice should be identified, and implemented. This should inform how services are planned and delivered. Commissioners of Tier 3 and Tier 4 should ensure these services are included in service specifications.	*provided by the stakeholder.*
Outcome auditing					
041	Obesity Group of the British Dietetic Association	Outcome data from weight management interventions is collated and shared.	Optimal strategies for weight management need to be identified and shared so that best practice is adopted and rolled out. Although there is clear guidance on what lifestyle weight management interventions should include, a pathway for sharing robust outcome data is not in place.	Sharing of outcome data is not widespread, with the risk that less helpful strategies may continue to be utilised. In order to develop a robust evidence base, outcome data sharing is necessary.	The importance of evaluating and reporting outcome data for weight management is recognised and a standard evaluation framework has been developed (http://www.noo.org.uk/uploads/doc721_2_noo_SEF%20FINAL300309.pdf). An evaluation data collection tool exists on the National Obesity Observatory website (https://www.noo.org.uk/core), but the data it contains is in many cases incomplete and patchy.
042	SCM 3	Holistic Audit, evaluation, research and monitoring of Obesity Interventions	NICE guidance recommends multi-component approaches as well as different types of specific interventions (e.g. pharmacological, surgical)	Audit and evaluation is key for evaluating the impact of obesity services, for adding to research knowledge and for quality assurance. Yet there is a lack of published data evaluating long term outcomes, using similar outcome	Chapter on audit and research in 'Action on Obesity: Comprehensive Care For All (RCP, 2013)

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			NICE recommends prospective audit to monitor short and long term outcomes and complications from different procedures and also 'impact on quality of life and nutritional status' (1.10.5) NICE guidance also made research recommendations to improve future NICE guidance and patient care. These included; • considering whether post-operative lifestyle management care improves outcomes • obesity mgt for people with a condition associated with an increased risk of obesity To continue to learn more about what works for whom quality standards can consider how to promote long term robust and comparative data gathering, analysis and publication	measures and an holistic framework. NCEPOD report 'Too Lean a Service' (2012) found that less than half of the cases they assessed had their data reported to the National Bariatric Surgery Register. The adoption of a standard holistic set of outcome measures could allow data sets to be matched and compared across different models and levels of service delivery. The National Obesity Observatory's Standard Evaluation Framework can be used to evaluate obesity interventions along the lines of multi-component models of intervention as advocated in NICE guidance but does not specify measuring quality of life outcomes or long term outcomes. http://www.noo.org.uk/core/frameworks The Bariatric Obesity and Metabolic Surgeons Society has developed guidance for outcomes and a database for surgical procedures and outcomes for up to 2 years, but does not measure quality of life, nutritional status, complications or outcomes beyond 2 years. (http://www.bomss.org.uk/wp-content/uploads/2014/04/Extract_from_the_NBSR_2014_Report.pdf) Measuring outcomes for quality of life, psychological morbidity and disordered eating as well as changes in weight and BMI and physical	

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				and nutritional status would allow multi-component evaluation of services at all levels and cross –centre comparisons. National Obesity Observatory Report on Obesity and mental health (2011) reports an 'urgent need for evaluations of weight management interventions both in terms of weight loss and psychological benefits'	
Reconstructive surgery					
043	WLSinfo	Improving access to reconstructive surgery	Many members complain that after surgery the loose skin can be physically and psychologically debilitating.	The current services are a postcode lottery. These procedures should be a key part of the bariatric surgery package. Commissioning needs to be informed about this.	Royal College of surgeons report.
4.5 Follow-up care after bariatric surgery					
Follow-up care within the bariatric service					
044	Johnson & Johnson Medical Limited	Bariatric surgery follow up	Studies have shown that follow up care is essential to ensuring the longer term success of bariatric surgery procedures. Follow up care is recommended within NICE clinical guideline (CG189) for a minimum of two years after bariatric surgery, and includes: monitoring nutritional intake, monitoring for comorbidities, medication review, dietary, physical activity and psychological support, and information about professionally-led or peer support groups.	While the service standards for pre-operative care are relatively well-defined in England, there have been significant variations at the local level in relation to both the service components and funding arrangements for follow-up care. Where follow-up care is conducted in primary care settings, there have been concerns that GPs often lack the relevant expertise to identify surgery-associated complications in a timely manner and to raise these concerns to the relevant bariatric clinicians. Given its relevance to surgical outcomes, the inclusion of follow up care in the quality standard will be useful to improving the long-term health	NICE Clinical Guideline 189 (2014), Obesity: identification, assessment and management of overweight and obesity in children, young people and adults https://www.nice.org.uk/guidance/cg189 BOMSS (2014), Guidelines on perioperative and postoperative biochemical

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				outcomes of those requiring bariatric surgery.	monitoring and micronutrient replacement for patients undergoing bariatric surgery http://www.bomss.org.uk/bomss-nutritional-guidance/
045	SCM 1	People who have undergone bariatric surgery should be managed by their specialised surgical provider team for 2 years post-surgery with appropriate support and nutritional monitoring (as per BOMSS guidelines) and monitoring of co-morbidities. They should receive appropriate mineral and vitamin supplements. Subsequently, patients should have yearly nutritional monitoring. If any problems arise after 2 years referral back to a specialist surgical centre should occur.	Nutritional deficiencies (in particular iron, B12, Vit D), are common after bariatric surgery. Failure to identify deficiencies can result in neuropathy, night blindness, rare life threatening complications (e.g. beri beri) and death. Patients can develop post-operative complications for example hypoglycaemia, excessive weight loss and pain which require appropriate specialist management.	Duration of follow up by the surgical provider centre is highly variable with many patients being discharged back to GP without appropriate follow up in place. Nutritional monitoring. The BOMSS survey undertaken by Mary O'Kane highlighted the variability in nutritional assessment and supplementation across the England and Wales.	Obesity: identification, assessment and management of overweight and obesity in children, young people and adults (2014) NICE guideline CG189 NCEPOD (2012) Bariatric surgery: too lean a service? www.bomss.org.uk/bomss-nutritional-guidance https://www.rcseng.ac.uk/healthcare-bodies/docs/weight-assessment-and-management-tier-3-services
046	SCM 3	Psychological Screening, Assessment and Interventions for obesity assessment and management	Individuals with severe and complex obesity have a high incidence of psychological morbidity including mood disorders and disordered eating, with psychological factors being linked to both the cause and	National Obesity Observatory Report on Obesity and mental health (2011) recommends that intervention strategies should consider physical and mental health of patients and should routinely monitor mood and weight to facilitate early detection and intervention for mental health	NCEPOD 'Too Lean A Service' (2012) recommends a greater emphasis on psychological assessment and support at an earlier stage in the

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			consequence of obesity. ('Obesity in the UK; A Psychological Perspective. British Psychological Society, 2011) NICE guidance recommends multi-component assessment including of psychosocial distress, psychological problems, disordered eating and underlying causes of obesity. The guidance also advocates comprehensive assessment of psychological factors that may affect adherence to post surgery diet and care. NICE guidance recommends intervention approaches which incorporate cognitive and behavioural interventions and recommends psychological support after surgery as well as referral for more specialist interventions as needed as part of lifestyle change programmes..	across the age range. The report suggests that encouraging healthy eating and physical activity will be ineffective where individuals are experiencing low self-esteem or low mood and that a focus on psychosocial factors is particularly important when working with obese children. Because there is varied and patchy access to multidisciplinary obesity services this will affect the confidence, skills and knowledge to screen and assess for psychological factors linked to obesity and the ability and knowledge to refer for appropriate interventions either as part of weight management services or from specialist mental health or eating disorder services as appropriate and available. Psychological assessment and evaluation can guide therapeutic interventions to optimise the safety and efficacy of weight loss interventions. One of the key findings of the NCEPOD report ('Too Lean A Service?' 2012) evaluating pre and post bariatric surgery care was that less than a third of patients had any documented evidence of receiving psychological support.	care pathway for obese patients(i.e. before being referred through for surgery) and recommends the routine use of psychological screening tools. See BPS report 'Obesity in the UK; A Psychological Perspective' (2011) for a review of the evidence base and examples of psychological screening, assessment, intervention and consultation in obesity services. The Cochrane Review (Shaw, K.A. et al, 2005 'Psychological Interventions for overweight or obesity. Cochrane Database of Systematic Reviews, 3. Art no. CD003818. DOI: 10.1002/14651858.CD003818.pub2) ; suggests that behavioural and cognitive-behavioural interventions (combined with dietary and

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					exercise strategies) are effective in enhancing weight reduction. A service evaluation showing positive weight loss and improvements in psychological morbidity from a tier 3 level long term lifestyle intervention programme; Evaluation of the 'Live Life Better Service', a community-based weight management service, for morbidly obese patients Dean Wallace; Puja Myles; Rachel Holt; Jonathan Nguyen Van-Tam Journal of Public Health 2015; doi: 10.1093/pubmed/fdv103
047	SCM 4	People who have had bariatric surgery should be followed up at the surgical centre for 2 years post –op according to NICE and BOMSS guidelines	The NCEPOD report Too Lean a Service (2012) was critical of the initial post-operative care and recommended; ensuring that the patient received clear post-operative dietary guidance; the GP received a timely discharge summary and plan and there was a clear, continuous	Inadequate follow-up increases the risk of malnutrition, or recognising surgical complications. Due to bariatric surgery units often being geographically distant from patients homes there is tendency for people to drop out of follow-up They may then not get appropriate treatment or an organised long term follow-up plan	BOMSS guidelines National Confidential Enquiry into Patient Outcome and Death.Too Lean a Service? A review of the care of patients who underwent bariatric

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			long term follow-up plan involving all the appropriate health care professionals NICE CG 189 evidence	The NBSR which requires recording follow-up data from NHS bariatric services may formalise this, and assist audit.	surgery. London: Dave Terrey; 2012. The British Obesity and Metabolic Surgery Society (BOMSS) has produced "Guidelines on perioperative and postoperative biochemical monitoring and micronutrient replacement for patients undergoing bariatric surgery" and "GP Guidance: Management of nutrition following bariatric surgery".
048	SCM 4				Additional evidence sources for consideration - Obesity CRG is currently working on post surgical follow up guidelines including examples of shared care follow-up and this document may be available in september
049	The Royal College of Pathologists	Nutritional follow-up after bariatric surgery	NICE guidance recommends a minimum of 2 years of nutritional follow-up after bariatric surgery, followed by long-term annual monitoring of nutritional status using a shared care model.	Patients are at risk of nutritional deficiencies after bariatric surgery if they do not have appropriate follow-up. A recent survey of members of the British Obesity and Metabolic Surgery Society revealed significant variation in practice with regard to nutritional follow-up after	BOMSS Guidelines on peri-operative and postoperative biochemical monitoring and micronutrient replacement for patients undergoing

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				bariatric surgery.	bariatric surgery http://www.bomss.org.uk/wp-content/uploads/2014/09/BOMSS-guidelines-Final-version1Oct14.pdf
050	WLSinfo	Improving access to psychological support services post operatively	Many of our members believe that there is a huge level of unmet need which can prevent the best outcomes of surgery.	Services vary across the country. Standards for best practice should be identified, and implemented. Early identification of people with psychological problems after surgery and swift treatment will improve outcomes.	*No additional information was provided by the stakeholder.*
051	WLSinfo	Improving follow up in years 3-5 post operatively	Many of our members believe that the current practice of discharge from specialist services at 2 years is inappropriate.	Members believe that many serious problems occur in years 3-5. Regain is a major worry at this time. Improved communication with GP's at discharge and support for problems when they occur is needed.	*No additional information was provided by the stakeholder.*
Follow-up care after discharge from bariatric surgery service follow-up					
052	SCM 1	People who have undergone bariatric surgery should be managed by their specialised surgical provider team for 2 years post-surgery with appropriate support and nutritional monitoring (as per BOMSS guidelines) and monitoring of co-morbidities. They should receive appropriate mineral and vitamin supplements. Subsequently, patients should have yearly	Nutritional deficiencies (in particular iron, B12, Vit D), are common after bariatric surgery. Failure to identify deficiencies can result in neuropathy, night blindness, rare life threatening complications (e.g. beri beri) and death. Patients can develop post-operative complications for example hypoglycaemia, excessive weight loss and pain which require appropriate specialist management.	Duration of follow up by the surgical provider centre is highly variable with many patients being discharged back to GP without appropriate follow up in place. Nutritional monitoring. The BOMSS survey undertaken by Mary O'Kane highlighted the variability in nutritional assessment and supplementation across the England and Wales.	Obesity: identification, assessment and management of overweight and obesity in children, young people and adults (2014) NICE guideline CG189 NCEPOD (2012) Bariatric surgery: too lean a service? www.bomss.org.uk/bomss-nutritional-guidance https://www.rcseng.ac.uk/h

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		nutritional monitoring. If any problems arise after 2 years referral back to a specialist surgical centre should occur.			ealthcare-bodies/docs/weight-assessment-and-management-tier-3-services
053	SCM 4	People who have had bariatric surgery and are discharged from the surgical centre after 2 years should have an annual review every year including recommended blood tests and nutritional monitoring via a shared care protocol between a specialist unit and their GP	NICE CG 189 reviewed the evidence.	This is a new recommendation. Formal shared care protocols have yet to be established or agreed There is little evidence on the safety of this proposal. There are serious concerns raised by general practitioners with respect to the expertise, facilities and resources to do this. There is a serious risk of malnutrition if the patient is unable to comply with the nutritional guidelines, follow-up and aftercare. Patients may be at risk of protein malnutrition ,chronic diarrhoea/malabsorption . The incidence of iron deficiency anaemia , vitamin B12 deficiency and Vit D defficiency is increased following the gastric bypass, sleeve gastrectomy and duodenal switch. Patients who undergo a duodenal switch are at additional risk of developing deficiencies in fat soluble vitamins and protein. Nutritional deficiencies are not an inevitable outcome of bariatric surgery and can be avoided with correct follow-up.	RCGP Top ten tips for the management of patients post bariatric surgery in primary care http://www.rcgp.org.uk/clinical-and-research/clinical-resources/nutrition/~/media/Files/CIRC/Clinical%20News/Top-Ten-Tips-Leaflet-2013.ashx The British Obesity and Metabolic Surgery Society (BOMSS) has produced “Guidelines on perioperative and postoperative biochemical monitoring and

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				Patients may also require specialist psychological support in some cases. There is a requirement for the bariatric surgeons to submit data to NBSR; however, as patients are no longer under the bariatric surgeon after two years, it is difficult to collect long term data unless it is part of the shared care protocol.	micronutrient replacement for patients undergoing bariatric surgery" and "GP Guidance: Management of nutrition following bariatric surgery". O'Kane M, Pinkney J, Aasheim ET et al (2014) Management of nutrition following bariatric surgery: GP guidance. Available from: http://www.bomss.org.uk/nutritional-guidelines/ Ten Top Tips for the management of patients post-bariatric surgery in primary care Helen Mary Parretti, Carly Anna Hughes, Mary O'Kane, Sean Woodcock, Rachel Gillian Pryke BJO 2015 vol 1 2 68-73 http://www.britishjournalofobesity.co.uk/
054	SCM 7	People who have had bariatric surgery should be offered adequate nutritional	The CCGs are currently refusing in many instances to allow GPs to perform post-op nutritional bloods as	Due to the confusion mentioned	A05 document RCS Commissioning

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		follow up in a shared care arrangement with the GP, the bariatric surgery service and the CCG	a cost-saving measure		Guidance on Weight Assessment and Management Clinlcs https://www.rcseng.ac.uk/healthcare-bodies/docs/weight-assessment-and-management-tier-3-services
055	The Royal College of Pathologists	Nutritional follow-up after bariatric surgery	NICE guidance recommends a minimum of 2 years of nutritional follow-up after bariatric surgery, followed by long-term annual monitoring of nutritional status using a shared care model.	Patients are at risk of nutritional deficiencies after bariatric surgery if they do not have appropriate follow-up. A recent survey of members of the British Obesity and Metabolic Surgery Society revealed significant variation in practice with regard to nutritional follow-up after bariatric surgery.	BOMSS Guidelines on peri-operative and postoperative biochemical monitoring and micronutrient replacement for patients undergoing bariatric surgery http://www.bomss.org.uk/wp-content/uploads/2014/09/BOMSS-guidelines-Final-version1Oct14.pdf
Antenatal care following bariatric surgery					
056	SCM 1	Women who have undergone bariatric surgery should have access to specialist antenatal care with appropriate expertise regarding bariatric surgery	The number of women of childbearing age who are undergoing bariatric surgery is increasing. Still birth/miscarriage rates are higher in this group. Assessment of glycaemic control using a standard OGTT is not appropriate after bariatric surgery as	Lack of provision or advice regarding management of pregnant women who have undergone bariatric surgery.	Outcome of pregnancy after bariatric surgery http://www.nejm.org/doi/full/10.1056/NEJMoa1405789

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			glucose excursion are altered and standard glucose load can cause dumping. Band slippage and internal hernias may occur during pregnancy,		
4.6 Additional areas					
Issues of engagement, inequalities and family involvement					
057	Royal College of Paediatrics and Child Health	Inequality access to sport/physical activity for children with neurodisability	One of reasons for increased obesity in children with special needs is lack opportunity to participate in physical activity. Our local data shows 2:1 ratio opportunities to participate in sport in school or outside, and 10:1 for representative sport. School picture has improved recently post Paralympics (we are currently analysing post Paralympic data) but outside school little change. Paralympics does seem to have increased interest in participating- lack opportunity is big problem	Potential to reduce obesity Self esteem Potential careers Equal opportunities	*No further information was provided by this stakeholder.*
058	SCM 3	Patient engagement and motivation to make sustainable lifestyle change	NICE guidance recommends the following to promote engagement and motivation; • assessing an individual's readiness and confidence to make lifestyle change • discussing options for treatment with patients • tailoring weight loss interventions to personal	Promoting true patient choice and engagement can be challenging when clinicians do not feel confident to discuss matters with patients and/or there is a restricted range of service options on offer locally. Clinicians may struggle to bring up the issue of weight and obesity with individuals due to the complexity of factors involved e.g. seeking to highlight clinical risk factors whilst trying to engage and motivate clients and manage	RCP report 'Action on Obesity: Comprehensive Care For All' (2013) recommends training in MI principles and approaches for all clinicians to be incorporated when taking clinical history BPS Report 'Obesity in the

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			needs and preferences • offering repeat consultations and support for those not yet ready to change. NICE guidance advocates that clinical services are multi-component and multi-disciplinary with a range of treatment components on offer. Clinical services are advised to actively involve patients as key players in choosing when, how and with what components of support their obesity is assessed and managed. This recognises that all obesity/weight loss interventions, at all levels of intensity, require the engagement with and adherence of individuals to long term cognitive and behavioural changes and that continual promotion and enhancement of patient involvement and motivation is crucial.	emotional responses such as anger, denial or disbelief in a positive way. A Royal College of Practitioners Report 'Action on Obesity: Comprehensive Care for All' (RCP 2013) concludes that there is varied and patchy availability of multi-component, multi-disciplinary services which limits treatment options and choice. This report also recommends that multidisciplinary teams have specialist and experienced clinical professionals at primary and secondary care and promotes joined up care with consistent messages and support for patients as they move through services. BPS Report 'Obesity in the UK: A Psychological Perspective' (2011) reports three things that might undermine patient engagement and motivation to change (pg 11); • a lack of confidence amongst clinicians in implementing behaviour change and motivation strategies • short term duration of intervention programmes undermining the ability for real sustainable change to take place programmes do not promote 'intrinsic motivation' (i.e. support the development of autonomy, relatedness and competence) which may affect adherence issues.	UK: A Psychological Perspective' (2011)
059	SCM 3	Accessing and engaging with services for those who are 'hard to reach'	There are particular issues of equality of access and meeting challenges of engagement for populations at high risk of obesity who may struggle to access services and/or prioritise the	Social Deprivation is strongly associated with risk and incidence of obesity (Foresight Report 2007, Health Survey for England, 2013) and sedentary behaviour.	*No further information was provided by this stakeholder.*

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			management of their health and wellbeing amongst a complexity of other biopsychosocial factors e.g. those from areas of high social deprivation, individuals with enduring mental health conditions or a learning disability.	There is a bi-directional relationship between mental health and obesity (NOO report 'Obesity & Mental Health 2011, BPS Report 'Obesity a Psychological Perspective 2013) and higher incidence obesity in children and adults with a learning disability (See refs in research rec of NICE CG 189). Making a quality standard encouraging services to consider how best to engage and offer assessment and intervention (as recommended by NICE) to the hard to reach including the monitoring and reporting of outcomes and engagement by social deprivation index (postcode, as advocated in NOO SEF tool) will allow us to learn more about getting service to those who stand most chance of benefitting from a risk and health equality point of view.	
060	Slimming World	Services should encourage a family approach in the successful management of obesity.	It is vital that services supporting adults encourage and adopt a family approach in terms of dietary and physical activity support which will positively benefit the wider family – aiding prevention in future generations.	A family based approach is vital due to the continuing evidence base of an association between overweight and obesity in children and parental overweight and obesity.	Scottish Intercollegiate Guidelines Network. (2010) Report No.115: Management of Obesity: A National Clinical Guideline. Available at: http://www.sign.ac.uk.
061	Weight Watchers UK	Take into account personal choice preference but balance this with what is proven to be effective	To ensure care decisions are patient centred but also rooted in the evidence Different weight management interventions and services have	Patients and HCPs may have preconceived beliefs about what will be effective for weight management which are not proven to be effective and / or not evidence based and therefore less likely to be successful on an individual level.	For guidance on weight loss, providers should refer to NICE Guideline CG43 "On the prevention, identification, assessment

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			different approaches and different outcomes. The level of evidence underpinning different interventions also varies. Some services (such as Weight Watchers) has good quality efficacy data from randomised controlled trials published in high impact peer reviewed journals, in addition to real world evaluative data. Others have little or no evidence. Commissioners should prioritise commissioning services which are known to work with proven outcomes. Out of small pilot or evaluative work on emerging innovations, commissioned services should have already been proven to work.	Weight Watchers has frequently encountered providers at a local level offering exercise referral schemes (ERS) to individuals as an alternative intervention for weight management (despite ERS not being proven to be effective for weight loss). In such cases individuals are often asked to choose between ERS and an evidence based behaviour change intervention tier 2 service. There is now good evidence that for overweight and obese patients who present in primary care, referral to a provider such as Weight Watchers is more effective and costs the taxpayer less (Jolly et al, 2011; Jebb et al, 2011; Fuller et al, 2012) than the usual care that GP practices are able to provide. Yet few commissioners seem to refer to this evidence and commission on this basis. Services for individuals provided by health professionals or by providers with little or no evidence of efficacy (simply claiming their services or programmes are 'evidence based') remain a popular option. However, there is often little evidence for either the rationale for these interventions, or any clinical outcomes, at best evaluation usually consists of self-reported data/anecdotal responses. There is huge variability across the country in terms of the type, duration, level of quality and provider of services commissioned to manage obesity in adults; local nuances, innovation and choice are vital to provide high quality care to the	and management of overweight and obesity in adults and children." NICE Public Health Guideline 53, 'Managing overweight and obesity in adults – lifestyle weight management services' May 2014 Comparison of Range of Commercial or Primary Care Led Weight Reduction Programmes with Minimal Intervention Control for Weight Loss in Obesity: Lighten Up Randomized Controlled Trial. K Jolly, A Lewis J Beach, J Denley, P Adab, JJ Deeks, A Daley, P Aveyard. http://www.ncbi.nlm.nih.gov/pubmed/22053315 - # BMJ 2011; Nov 3; 343. Primary Care Referral to a Commercial Provider for Weight Loss Treatment versus Standard Care: a

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				public. However, it is not acceptable to commission services that are not yet proven to be effective or indeed have been proven to be ineffective. Service specifications such as the publication by the Department of Health (now Public Health England) 'Development of a specification for lifestyle weight management services: Best practice guidance for tier 2 services.' have an essential role to play in quality commissioning processes. They are a key tool that enables a commissioning organisation to set out the need, expectations of service quality, outputs and outcomes of the service being sought. They are the key source of information from which a service provider will shape the design and delivery model for the service that they are proposing. Producing a good quality service specification is crucial in securing market interest during the tendering process and in helping to secure an intervention that is fit for purpose.	Randomised Controlled Trial SA Jebb, AL Ahern, AD Olson, LM Aston, C Holzapfel, J Stoll, U Amann-Gassner, AE Simpson, N Fuller, S Pearson, NS Lau, AP Mander, H Hauner, I Caterson. Lancet. 2011. September 7. Weight Loss from Three Commercial Providers of NHS Primary Care Slimming on Referral in North Somerset: Service Evaluation. K Dixon, S Shcherba, and R Kipping. J Public Health. 2012 May 18. [Epub ahead of print] Weight Watchers on Prescription: An Observational Study of Weight Change among Adults Referred to Weight Watchers by the NHS. AL Ahern, AD Olson, LM Aston, SA Jebb. BMC Public Health 2011; 11:434.

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					Developing a specification for lifestyle weight management services. Department of Health, Obesity and Food Policy Branch, PHD. March 2013
Provision of training					
062	SCM 2	Education of health care professionals in raising the issue of weight and weight management	Many health care professionals are unskilled in this area and need assistance to raise these issues in consultation in a non confrontational way	Issues need addressing in pre and post graduate education. If improved will encourage more people to seek assistance.	*No further information was provided by this stakeholder.*
063	SCM 4	Education for doctors, nurses and healthcare professionals on how to raise the topic of obesity, health risks of obesity and benefits of weight loss and then incentivised to record this discussion and the outcome	Many doctors and healthcare professionals lack confidence in how to raise the subject of weight, and opportunities to offer help are missed. Obesity was emphasises in medical training in the past, and some professionals are unaware of the extent of the health risks, and also the effective treatments available Once trained doctors in both primary and secondary care should be monitored to ensure that patients who are overweight or obese are being offered advice and/or referral until it becomes established standard practice	Obesity is a major contributor to NCDs, especially T2D. The cost of obesity related illness is huge, and it affects large numbers of people so a comprehensive NHS response is important. People may be embarrassed or ashamed to raise the topic themselves, but often welcome the offer of help. People presenting with a new diagnosis such as T2D or OSA may be receptive to advice and treatment to help them lose weight if linked to an improvement in their health. A systematic review and meta analysis showed that advice from a physician encouraged behaviour change and weight loss.(Rose et al 2012) Referral to evidence based treatments is cost effective (NICE CG 189 and PH 53). To establish this as standard practice incentives	The RCGP nutrition group has produced leaflets, e-learning and a one day workshop on raising the subject, and managing obesity., but GPs have so many educational requirements to fufill that many have not yet accessed this. RCGP Top ten tips raising the topic of weight http://www.rcgp.org.uk/clinical-and-research/clinical-resources/nutrition/~/media/Files/CIRC/Clinical%20News/Top-Ten-Tips-Leaflet-

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				or levers may be required such as adding to the QoF indicators keeping a register of those with BMI > 30 kg/m2 and providing written advice or referral.This is similar to the indicator on LARC added to contraceptive indicator which encouraged GPs and nurses to introduce this new discussion. Indicators could be put into hospital contracts or contracts with other providers such as stop smoking services.	2013.ashx RCGP Introductory Certificate in Obesity, Malnutrition and Health.The RCGP Introductory Certificate in Obesity Malnutrition and Health is a self-directed learning package suitable for individual learning or small group cascade training. It involves completion of the 6 e-learning modules plus attendance at hands-on practical sessions based on the accompanying interactive workbook and slide set. This can be run locally in small groups with or without specialist input. Introductory Certificate in Obesity, Malnutrition and Health Workbook RCGP e-Learning topics World Obesity SCOPE e-learning modules Especially the 5 A's model http://www.worldobesity.or

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					g/scope/ Addressing barriers for GP's in obesity management: the RCGP Nutrition group Pryke R, Hughes C, Blackburn M BJO 2015 vol 1 1 9-13 http://www.britishjournalofobesity.co.uk/ Physician weight loss advice and patient weight loss behavior change: a literature review and meta-analysis of survey data. Rose SA, Poynter PS, Anderson JW, Noar SM, Conigliaro J. Int J Obes (Lond). 2012 Mar 27. doi: 10.1038/ijo.2012.24. NICE PH53 RCP Action on Obesity: comprehensive care for all' Academy of Medical Royal Colleges. Measuring up. The medical profession's

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					prescription for the nation's obesity crisis', a report of the Medical Royal Colleges' NICE is developing an e-learning module on obesity, BMJ learning has module and the National obesity observatory has good information. www.noo.org.uk
064	Slimming World	Training for all health professionals to ensure confidence in raising the issue of weight with patients in a sensitive and supportive manner when assessing someone's weight and discussing weight management options.	We feel that there should be consistent training for health professionals to help them to sensitively raise the issue of weight with patients, to recognise the need for compassion and care when supporting people in weight management and to ensure they are familiar with options for signposting/referring people to.	A key recommendation in the NICE guideline (PH53) is that health professionals should be aware of the stigma adults who are overweight or obese may feel or experience, and should ensure that the tone and content of all communications is respectful and non-judgemental. In line with this we would suggest that all professionals who interact with families receive training to equip them with the skills to sensitively and confidently raise the issue of weight with patients.	Research has shown that making people feel bad about their weight is counterproductive and is more likely to cause people to gain weight than lose it (Jackson et al, 2014. Obesity). Therefore if initial conversations are not handled in a supportive manner it may hinder someone's weight loss attempts rather than improve them. Talking to health professionals on a regular basis this is an area which many feel

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					uncomfortable working in due to a lack of training/perceived skill in raising the issue.
Lifestyle weight management programmes					
065	SCM 2	Changes in commercial slimming clubs where patients are referred	The current commercial slimming product is aimed at people with a BMI averaging less than 32. It is a difficult environment for people with a BMI > 35	This should inform commissioners so more appropriate user friendly services can be commissioned.	*No further information was provided by this stakeholder.*
066	SCM 7	People with obesity (BMI 30 or more especially if they have type 2 diabetes of onset within 10 years) are offered lifestyle weight management programmes (Tier 2) by their GP	Obesity is increasing and NICE PH53 states the importance of losing 3-5% weight to improve health. GPs and primary care staff eg nurses / dietitians / physiotherapists to engage with obese people with eg motivational interviewing	GPs are tasked only to maintain a register of the obese and not to do anything more for them. GPs should be offered a QOF for treating obesity eg referring to a Tier 2 lifestyle weight management clinic and/or referral to a Tier 3 clinic. Eg a specific proportion of patients per practice are offered engagement about their weight at least once a year	NICE PH53 RCP Action on Obesity: comprehensive care for all' Academy of Medical Royal Colleges. Measuring up. The medical profession's prescription for the nation's obesity crisis', a report of the Medical Royal Colleges'
067	Slimming World	Equal access to effective and evidence based weight management services for adults should be available across the country.	Services (provided through the NHS or local authorities) are currently not consistent across the country meaning that some adults have access to evidence based weight management services while others have no/much fewer options.	Currently there are health inequalities across the UK for both adults and children in terms of the provision of services for weight management. It is vital that health professionals have the ability to offer patients the suitable service for their needs once an assessment and conversation with the patient has taken place.	For example, at present, if you live within the Nottingham City Council area and have a BMI>30 and would like support with weight management then you can be referred to attend a local, evidence based, weight management group free of charge for 12 weeks. Yet

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					if you live in the neighbouring council area and you have a BMI>30 this is not an option.
068	Weight Watchers UK	Equality of access and availability of obesity management	HCPs should have clear clinical reasons for not referring on, rather than only referring on under pressure from patients or based on assumptions on what a patient might find acceptable HCP's basing referral on personal judgement of what a patient might find acceptable or useful rather than offering patients a full range of possibilities narrows treatment options There is currently a postcode lottery for access to obesity treatment and for quality standards of obesity treatment, with disjointed commissioning of the stepped care model. Lifestyle weight management services (tier 2) currently sit within the remit of Public Health, where clinically led services sit is with CCGs, (tier 3 and tier 4). Numerous reports (HOOP and RCP) illustrate the lack of access to quality local services; describing access as "patchy". It is thought that very little is invested in weight management services in	Weight Watchers have recent insights that men are less likely to be offered weight management on referral (WRS) by their GP than women as there is an assumption that men would not be interested in this option. However, when men are written to directly by GP surgeries and offered WRS uptake increases Additionally, generally, presently obesity services throughout the public system, are restricted and do not meet volume needs. In 2013, the American Medical Association (AMA) reclassified obesity as a disease, to enable improvements in treatment planning, access and outcomes. Whilst it is consensus that obesity is complex and requires multilevel actions, improving access and quality standards for treatment across tiers 2-4 would play one part in offering significant benefits. The Darzi Review recommended that 'systematic and industrial scale' interventions are needed to make any meaningful impact on obesity and the resultant long term conditions like type 2 diabetes and coronary heart disease.	Male engagement insights, currently unpublished data. Darzi A (2008) High Quality Care for All: NHS Next Stage Review (Final Report). Department of Health London. HOOP (Helping Overcome Obesity Problems) (2014) Tackling obesity: all talk, no action Royal College of Physicians. Action on obesity: comprehensive care for all. Report of a working party. London: RCP, 2013.

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			comparison to other public health issues, disproportionally when impact on health and social care and wellbeing is considered. Greater emphasis should be placed on commissioning tier 2 lifestyle weight management Services on a scale that meets demand, in order to reduce the need for progression into more costly and higher risk tiers of treatment and potentially more invasive surgical procedures and in order to enhance the entire care pathway.		
Suggestions for commissioning arrangements					
069	Cambridge Weight Plan	Provision of interventions for the overweight and obese	Cambridge Weight Plan would like to thank NICE for this opportunity to comment on the development of a Quality Standard (QS) on obesity. It is hugely important that there is sufficient provision of interventions to help the 67.1% and 57.2% of men and women respectively in England who are overweight or obese. Millions of people therefore need assistance to lose weight, yet too often resources are directly almost solely at preventing obesity – a worthy aim, but not one that can help all of those who already need assistance.	An important point that this QS should consider is encouraging the use of effective and cost-effective private providers to help people lose weight. Treating conditions related to obesity and being overweight is expensive. Recent estimates by the charity Diabetes UK have suggested that NHS expenditure on tackling diabetes is nearly £10bn a year alone. Yet the resources available to help people lose weight, and so avoid these crippling costs to the NHS, are severely limited. Neither the NHS nor local authorities have large amounts to spend on healthcare as a whole – spending is either rising more slowly than previously, or is being cut altogether.	*No further information was provided by this stakeholder.*

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				Even when money is available, funding programmes that help people lose weight is often both not a priority and not a popular recipient for funding: it is assumed that being overweight is a personal problem that people should take responsibility for solving themselves. Hence the need for private providers to support efforts to help individuals lose weight. These private providers must operate according to existing NICE/NHS guidance and they must be backed up by credible evidence. This QS must insist on quality assurance, but is should also recommend that commissioners consider effective and cost-effective private provision across the different tiers of weight management.	
070	LighterLife	Provision of interventions for the overweight and obese	LighterLife would like to thank NICE for the opportunity to consult on this Quality Standard (QS). The provision of interventions to help the obese and overweight lose weight is hugely important: two thirds of people in the UK are overweight in some way. Despite this, resources are too often focused on preventing people from becoming obese, a worthy aim in itself but not one that will help those already overweight or	It is undeniable that public resources to help the overweight and obese lose weight are limited. Both NHS and, crucially, local authority spending is to either increase at a slower rate in the coming years or be cut altogether. Furthermore, spending on helping individuals with what many see as a “lifestyle” issue such as losing weight is not a priority for many local authorities or NHS bodies; nor is it popular with local populations. This underscores the need for a QS to encourage the greater use of effective and cost-effective private providers of weight	*No further information provided by this stakeholder.*

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			obese.	management services, such as LighterLife. Quality can be assured by mandating that only services that operate to existing NHS/NICE guidance are able to operate within an NHS framework. Once this quality has been assessed and assured, then this QS should recommend private provision at all tiers of the obesity pathway – private providers are able to deliver effective, cost-effective solutions for individuals who range from mildly overweight to hospital-bound and severely obese.	
071	SCM 6	Development and implementation of obesity pathways	There is a range of existing guidance available to support an integrated approach to practice and care throughout the obesity care pathway – this includes guidance from Department of Health5 and the National Institute for Health and Clinical Excellence (NICE)	Potential for increased efficiencies with regards use of financial resources. Good tier 3 services can reduce the need for consideration of surgery, so pooling the budgets for tiers 3 and 4 could have intrinsic benefits.	Obesity Care Pathway. CG189
072	SCM 6	Services to be commissioned on outcomes other than just weight change.	Weight or BMI change alone is a crude indicator of 'health outcomes'. A modest weight loss with an increase in physical activity or functional ability, or dietary improvements may also be very desirable outcomes. National Obesity Observatory's (2009) Standard Evaluation Framework. This framework recommends collecting data on diet, physical activity and QoL in addition	Obese patients often have complex psychological and medical conditions. They may have little self-confidence and poor self-esteem. Given time and expert help through dietitians, exercise experts and psychologists, it is common to see make permanent changes in lifestyle, though these may not always be reflected by their weight loss	National Obesity Observatory's (2009) Standard Evaluation Framework. This framework recommends collecting data on diet, physical activity and QoL in addition to weight loss data.

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			to weight loss data.		
073	Weight Watchers UK	Encourage the commissioning of longer term open services	Currently predominantly commissioned services are of standard term at only 12 weeks. This general commissioning practise is largely driven by cost requirements and restraints. However, new emergent models of longer term services should be explored due to the developing evidence base to support their role in weight management. We believe that a change in commissioning practices can have a positive impact on longer term outcomes. Obesity interventions for adults at a tier 2 level should be of longer term.	Qualitative data from a cohort of severely obese patients, with complex social and medical problems, who were referred by GP practices in Worcester for a year-long Weight Watchers intervention suggested that many reported tangible medical benefits such as: Ceasing blood pressure medication, a reduction in HbA1c from 8.6% to 6.2% in a patient with type II diabetes, increased level of stamina/energy, reduction in back and joint pain, a reduction in medication to control blood glucose. Additionally, a randomised controlled trial carried out in 2003 evaluated two weight loss methods; Weight Watchers and self-help. After 1 and 2 years, body weight, BMI and waist circumference were more significantly decreased in participants assigned to the Weight Watchers group. Regular meeting attendance was significantly correlated with both weight loss and weight loss maintenance (Heshka et al 2003).	Heshka S, Anderson JW, Atkinson RL. et al. Weight loss with self-help compared with a structured commercial program: a randomized trial. JAMA. 2003;289:1792-1798
Developing a patient support network and other resources					
074	SCM 2	Development of standalone packages of information and support for bariatric patients in years 3-5	It appears that this is a key time for deleting problems including but not limited to regain	It will improve the outcomes of a high cost intervention. It will also help patients recognise problems and seek help earlier	(Declaration of interest) I have just be involved in developing and delivering a problem in Liverpool.
075	SCM 2	Development of a good quality patient led support network across the country	Patients need to speak to others in the same situation in groups facilitated by trained peer group facilitators.	There are examples of good practice but this needs to be developed across the country	*No further information was provided by this stakeholder.*

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Further interventions					
076	Association for Dance Movement Psychotherapy UK	Inclusion of Dance Movement Therapy as one possible treatment for those obese patients who engage in emotional eating	Dance Movement Therapy (DMT) is unique in its ability to address both psychological and physical coping strategies / behaviours. It is non-stigmatising, and allows participants to participate at all levels of fitness.	DMT has a growing evidence base and high levels of acceptability.	Vaverniece, I., Meekums, B., Majore-Dusele, I. & Rasnacs, O. (2012). Dance movement therapy for obese women with emotional eating: A controlled pilot study. The Arts in Psychotherapy, 39, pp. 126– 133.
077	Royal College of Paediatrics and Child Health	Effective strategies for preventing and managing excess weight in disabled children and young people		Disabled children and young people are an overlooked group	The BACD and James Lind Alliance priority setting partnership identified the top 10 research priorities for disabled children and young people in 2014. The number 8 priority identified was: What strategies are effective to improve engagement in physical activity (to improve fitness, reduce obesity etc.) for children and young people with neurodisability? www.bacdis.org.uk/research/psp.htm
No comment					
078	Royal College of	This is to inform you that the RCN has no comments to submit to inform on the above quality standard consultation at his time.			

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	Nursing				