Bariatric surgery pathway

General surgery, June 2026

GETTING IT RIGHT FIRST TIME

Referral and assessment

Referral from medical practitioner (1)

Initial consultation with patient by appropriately skilled medical practitioner, with access to a core MDT member, based on clinical history, NICE guidance and patient preference

- Refer back to primary care
- Start medical therapy
- Start surgical pathway
- Other weight loss interventions

Clinical Assessment for Bariatric Surgery

- Review of obesity duration and weight-loss history
- Standardised obesity staging using Edmonton Obesity Staging System or King's Obesity Staging Criteria
- Comorbidity assessment and functional status (including OSA screening with STOP-Bang to guide sleep studies/CPAP)
  - Optimisation of other conditions such as anaemia, diabetes, hypertension, respiratory disease
- Bloods and key investigations (sleep studies/CPAP compliance if OSA present, ECG/ echo, other specialist letters)
- Weight-loss pharmacotherapy use reviewed and documented
- Specialist dietetic assessment and input
- Physio or exercise assessment
- Psychological assessment
- Support network assessment
- Surgical optimisation assessment
- Alcohol/NAFLD screening
- Smoking cessation
- Provide patient with information leaflet outlining pathway

Pre-MDT preparation and coordination (2)

MDT and listing

One-stop bariatric MDT clinic (3)

Formal MDT decision. Patient suitable for surgery?* (4)

- No: Defer pending further optimisation, considering referral for medical management
- Yes: Supply patient written information regarding procedure, pre and post-op care where appropriate

Shared decision-making completed

Patient signs consent form. Add to waiting list. Pre-op screening assessment. (5)

Validate and prioritise waiting according to locally and nationally agreed criteria. Ensure all meet criteria. Re-confirm suitability at intervals for long waits.

Pre-operative

Pre-op preparation (6)

- Anaesthetic screening assessment
- Dietitian review including nutritional and micronutrient evaluation
- Psychological support and preparation
- Consider safeguarding and capacity
- Patient education on post-operative diet, need for nutritional supplementation and lifestyle changes
- Peri-operative VTE prophylaxis plan for all patients
- Refer to latest guidance on specific protocols, e.g. type 2 diabetes medicines
- Analgesia assessment

Formal pre-op assessment. Consideration high and low risk features and appropriate level of post-op care, and use of robotics and elective hubs. (7)

Liver reduction diet pre-op according to local policy

Admission

Admit to designated hub centre where appropriate (8)

VTE risk assessment

Confirmation of consent

WHO checklist completed

Analgesia as agreed at pre-op assessment

Surgery and post-operative

Surgery

Operation note with post-operative instructions (9)

Monitor for complications and record all data on NBSR

DrEaMing enhanced recovery

TTO medication and supplements.
Pain control.
Fit to work certificate.
Patient information leaflet.

Discharge and follow up

Discharge from hospital if criteria met in line with local policy (10)

Specialist nurse/dietitian phone call within 1 week of surgery:

- Clinical review: complications, diet progression, hydration, medication.
- Identify need for physician review.
- Confirm blood test schedule.

6-8 weeks follow-up with specialist nurse/dietitian

3 month follow up with dietitian

6 month follow up with dietitian

12 month follow up with dietitian

18 month follow up with dietitian

24 month follow-up with specialist nurse

Discharge to primary care for lifelong annual monitoring. Re-referral triggers clearly communicated at discharge. Correspondence to GP and patient specifying lifelong follow-up and micronutrient supplementation

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(1) GP referral letters should include height, weight, BMI, and obesity-related disease. Referrals missing this information should be returned to the referring practitioner before progressing through the pathway.

(2) A dedicated bariatric coordinator is recommended to manage referral screening, collation of external results, pre-clinic questionnaire and dietetic group education documentation. By the time the patient attends clinic, the coordinator should ensure all routine information has been gathered and is available to the clinical team.

All assessment data should be current at the time of referral and recommended that all investigations and assessments are completed within optimal time frame prior to referral, to ensure clinical decisions are based on up-to-date information.

NICE referral criteria for surgical bariatric pathway:
Offer adults a referral for a comprehensive assessment by specialist overweight and obesity management services providing multidisciplinary management of obesity, to see whether bariatric surgery is suitable for them if they:

- have a BMI of 40 kg/m2 or more, or between 35 kg/m2 and 39.9 kg/m2 with a significant health condition that could be improved if they lost weight and
- agree to the necessary long-term follow up after surgery (for example, lifelong annual reviews).

Consider referral for people of South Asian, Chinese, other Asian, Middle Eastern, Black African or African–Caribbean background using a lower BMI threshold (reduced by 2.5 kg/m2) to account for the fact that these groups are prone to central adiposity and their cardiometabolic risk occurs at lower BMI.

Offer an expedited assessment for bariatric surgery to people:

- with a BMI of 35 kg/m2 or more who have recent-onset (diagnosed within the past 10 years) type 2 diabetes and
- as long as they are also receiving, or will receive, assessment in a specialist overweight and obesity management service.

Consider an expedited assessment for bariatric surgery for people:

- with a BMI of 30 to 34.9 kg/m2 who have recent-onset (diagnosed within the past 10 years) type 2 diabetes and
- who are also receiving, or will receive, assessment in a specialist overweight and obesity management service.

Consider an expedited assessment for bariatric surgery for people of South Asian, Chinese, other Asian, Middle Eastern, Black African or African–Caribbean background using a lower BMI threshold (reduced by 2.5 kg/m2), to account for the fact that these groups are prone to central adiposity and their cardiometabolic risk occurs at lower BMI.

(3) **MDT should include:**

- Bariatric surgeon
- Physician
- Dietitian
- Clinical nurse specialist
- Anaesthetist (early input to facilitate proactive preoperative optimisation, including any diagnostic gaps are addressed and surgical readiness confirmed
- Clinical psychologist
- Other allied professionals as indicated (e.g. sleep medicine)

(4) Formal decision MDT should include the following:

- Assessment of surgical risk and readiness
- Choice of bariatric procedure
- Prioritisation for listing for surgery

(5) NBSR registration is discussed and patient is informed.

At the time a patient is added to an elective waiting list (at the latest) a screening assessment should be undertaken (this is not the same as a full preoperative assessment). For further information guidance on early risk assessment, screening and optimisation, refer to the Operational implementation and support guide for early screening, risk assessment and optimisation for adult patients.

Document any specific requirements linked to anti-obesity medication use including:

- Obesity management medications (OMMs) associated weight loss lowering BMI below threshold
- Perioperative drug management
- Need to re-confirm eligibility

Where significant pharmacotherapy-induced weight loss reduces BMI below the standard surgical threshold, the MDT should review the indication and local eligibility criteria, and undertake shared decision-making with the patient regarding the advantages, disadvantages, and clinical appropriateness of proceeding with surgery.

Apply a prioritisation framework including highest risk of comorbidity progression, very high BMI, severe OSA, brittle diabetes, surgical risk against expected benefit, and duration on pathway.

(6) **Red-flags indicative of urgent clinical review and deferral of elective surgery:**

- Decompensated heart failure
- Inadequately controlled diabetes with recurrent DKA admissions
- Severe obstructive sleep apnoea without CPAP or poor CPAP adherence

(7) For detailed best practice standards in pre-operative assessment, refer to the Pre-operative assessment services guidance.

Whilst not a mandatory requirement, it is recommended that a clinical nurse specialist conducts the final pre-operative review to confirm completion of all MDT assessments and investigations, deliver consolidated patient education, ensure the pathway checklist is fully completed, and act as a consistent point of contact for the patient prior to surgery.

(8) Confirm receipt of all pre-operative assessments and MDT documentation prior to admission.

Operational standard: 85% bariatric theatre list utilisation.

(9) **Post-operative information should include:**

- Emergency contact information
- Pregnancy planning guidance
- Alcohol safety guidance
- Dumping syndrome education
- Body contouring/reconstructive surgery referral criteria
- Access to mental health support
- Signposting to patient support groups

(10) Same day discharge where appropriate.

Routine annual blood monitoring panel for primary care as per BOMSS guidance:

Re-refer to bariatric service if:

- Poor weight maintenance or recurrent weight regain.
- New or worsening comorbidities.
- Nutritional deficiency requiring specialist oversight.
- Complications related to surgery (stricturing, reflux, sleeve dilation).
- New or recurrent symptoms of dumping, hypoglycaemia, or nutritional complications.
- Early pregnancy following bariatric surgery.
- Significant psychological distress or concerns regarding eating behaviours.