Safeguarding Adults Executive Board

Bariatric Care for Adults – Professionals Guide

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	Content	Page
1	Purpose and Context	3
2	Definition	3
3	Legal Frameworks	5
4	Multi-Agency Involvement	9
5	Multi-Agency Risk Assessment and Management	13
6	Engagement	14
7	Environment & Facilities	15
8	Care Planning	16
9	Bariatric Care Practitioner Toolkit – Appendices	17
10	Information on Local Services	18
11	Further Resources	19
12	Glossary of Terms used	19

1. Purpose and context

1.1 This Safeguarding Adults Executive Board (SAEB) guidance supports staff working in partner agencies across the Bi-Borough of Kensington and Chelsea and Westminster on how to address the challenges presented by adult bariatric care patients, who due to their size and weight, may struggle to access treatment and care in emergencies. This guidance includes the pathways and support that may be required by these people to prevent and/or reduce the risk of abuse and neglect, as well as ensuring that bariatric care patients are treated with respect, dignity and equality. It also aims to guide staff in these situations so that their safety, health and well-being is supported.

1.2 This guidance acknowledges the increasing numbers of overweight people within the UK population, particularly since the Covid pandemic and a rise of those seeking local health and social care services. Providing treatment, care, support and manual handling for these people represents unique challenges for staff compounded with the increased level of risk. It emphasises the need for all agencies to work together to ensure effective communication and appropriate settings for these people.

1.3 This guidance has been produced following learning from a multi-agency review of an incident involving Ms C who was a bariatric care patient who was cared for in the community. In line with the SAEB's commitment to continuous learning, this guidance seeks to share the learning with the aim of raising awareness and to prevent further occurrences. Other similar cases have taken place nationally and these are outlined in Appendix 2.

1.4 Risk assessment and careful planning across various settings, including community and hospital environments, are crucial. At the heart of this process is the involvement of adults and carers in the multi-agency planning process, ensuring their views are considered. Together, we can create a safer and more inclusive care system for this client group.

1.5 The SAEB would like to thank and acknowledge the work of Northumberland County Council and Lincolnshire Community Health Services NHS Trust upon whose work this guidance is based. The SAEB is happy for this guidance to be replicated and used in other areas providing a formal acknowledgement to this document is given.

2. Definition

2.1 In 2023 - 2024 a health survey in England found that 64.5% of adults aged 18 and over were estimated to be overweight or obese, with 26.5% of adults living with obesity, according to GOV.UK.[1] The prevalence of overweight or obesity in adults was higher among men (69.7%) than women (59.2%), and the prevalence of obesity in adults was higher among women (26.9%) than men (26.2%).

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[1] Obesity profile: short statistical commentary, May 2025 (GOV.UK)

Key findings from the survey:

- Prevalence of overweight or obesity: 64.5% of adults aged 18 and over.
- Prevalence of obesity: 26.5% of adults aged 18 and over.
- Higher prevalence in men: 69.7% of men were overweight or obese, compared to 59.2% of women.
- Higher prevalence in women: 26.9% of women were obese, compared to 26.2% of men.
- Increasing trend: There has been an upward trend in the prevalence of overweight and obesity since 2015 – 2016.

2.2 This guidance defines a bariatric care patient as a person who has a Body Mass Index (BMI) of 40 or more and who also has an associated health condition. It is recognised that overweight people may have difficulties not only because of their weight but also due to their physical width, body shape, and level of mobility. A bariatric care patient can be defined as a person whose weight, size and dimensions:

- Are over the safe working load of routine equipment.
- Restricts their ability to access health and social care due to:
    - Limitations on movement and the ability to travel to local or specialist centres.
    - Difficulty accessing buildings hindering timely and accurate assessments/treatment/intervention
    - A reluctance to seek advice from health and social care professionals

2.3 Professionals working with bariatric individuals must be sensitive to the complex and multifactorial causes of obesity. Obesity is not simply the result of personal choices or willpower, but rather the outcome of an interplay between genetic, biological, psychological, social, and environmental factors. These may include socioeconomic status, early life experiences, trauma, mental health, access to nutritious food, and opportunities for physical activity. By recognising this complexity, professionals can avoid blame-based or overly simplistic approaches and instead offer compassionate, evidence-informed care that supports sustainable health and well-being. Sensitivity to these diverse influences is essential in building trust and fostering positive, non-stigmatising relationships with individuals seeking support. There are also some specific conditions like Prada Willis, Hypothyroidism and Cushing's Syndrome which make people more susceptible to obesity.

2.4 Living with being overweight is linked to a wide range of physical health problems including co-morbidities like high blood pressure and diabetes. It is important to highlight that a high majority of bariatric care patients are on Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BIPAP) for sleep apnoea and respiratory failure. Cardiac and respiratory failure should be stressed as critical issues in this population. Additionally, lymph oedema in the legs is usually caused by cardiac failure, which in turn can lead to cellulitis and skin infections requiring tissue viability support. All of these can lead to an increased use of healthcare services. It is also associated with poor psychological and emotional health and poor sleep. Bariatric care needs may not present until later in the court of their illness when specialist transportation or equipment or services are required.

2.5 Due to experiences of stigma from members of the public and healthcare professionals, bariatric patients can feel great shame in accessing health care and as such can be reluctant to seek help and attend appointments. It is important that professionals do not make assumptions but approach each individual with empathy and curiosity and explore what difficulties they may have in accessing care. Some individuals may fear that a consultation

about an apparently unrelated issue may lead to a discussion about their weight, and this can add to feelings of self-blame and shame.

2.6 Bariatric care patients can present with several complex issues in regard to their treatment and management including manual handling and transportation. It is the responsibility of health and social care to make reasonable adjustments for people who require increased healthcare or social care interventions. It is also the role of professionals to be aware of what adjustments may look like (e.g. specialist equipment) and the individual themselves may be unaware of the support that is available. Similarly, it is important that professionals are proactive in gently exploring and offering equipment, as individuals may be too embarrassed to ask. For example, if a patient with poor mobility is attending a hospital appointment they may benefit from the use of a bariatric wheelchair whilst in hospital so that they can safely and comfortably navigate hospital buildings, wait for and attend appointments and have blood tests.

3. Legal frameworks

All guidance in this section should be read in conjunction with individual agency policies, procedures, and guidance

Care Act 2014

3.1 The Care Act 2014[2] sets out the framework for local authorities to assess needs for care and support. The Care Act highlights prevention as a key responsibility for agencies, with clear links to the principles of wellbeing and empowerment.

3.2 Section 1(2) of the Care Act states that “well-being”, in relation to an individual, means the person’s well-being so far as relating to any of the following:

- Personal dignity (including treatment of the individual with respect)
- Physical and mental health and emotional well-being
- Protection from abuse and neglect
- Control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided)
- Participation in work, education, training or recreation
- Social and economic wellbeing
- Domestic, family and personal relationships
- Suitability of living accommodation
- The individual’s contribution to society.

3.3 In the context of bariatric care, precenting is about the care and support system actively promoting a person’s well-being in a holistic way. In practice this means that practitioners should take a trauma-informed and strengths-based approach to intervene at the earliest

[2] Care Act 2014.GOV.UK

opportunity and consider a range of different approaches and services to meet the individual's needs.

3.4 Key to working in a person-centred and sensitive way with bariatric patients is to understand the impact of their condition upon their mental health, including their emotional, psychological, and social well-being.

Safeguarding Adults – Section 42 Care Act 2014

3.5 In the context of this guidance, it is important to consider that in specific circumstances issues relating to bariatric care patients may meet the criteria for a response under safeguarding adult procedures as 'adults at risk.'

3.6 In accordance with the Care Act safeguarding adults' arrangements apply to adults aged 18, or over, whom:

- Have needs for care and support (whether or not those needs are being met); and
- are experiencing, or are at risk of, abuse or neglect; and
- as a result of those needs are unable to protect themselves against the abuse or neglect or the risk of it.

3.7 Under section 42, Local Authorities must make whatever enquiries they think necessary where the above criteria are met.

3.8 Examples where safeguarding procedures may apply for bariatric patients include where the person is at increased risk of self-neglect (see section below), or be subjected to physical or emotional abuse, linked to factors such as weight-based discrimination, history of trauma and difficulty coping emotionally.

3.9 For further information and guidance, refer to the London Multi-Agency Adult Safeguarding Policy and Procedures.[3]

Self-neglect

3.10 Self-neglect covers a wide range of situations and behaviours such as neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

3.11 Whilst the Care Act recognises 'self-neglect' as a type of abuse or neglect, the Care and Support Statutory guidance (14.17)[4] states that "self-neglect may not prompt a Section 42 enquiry. An assessment should be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support".

3.12 As such in the first instance, agencies should refer to pathway set out in the SAEB Self-Neglect and Hoarding Strategy, which sets out that in the first instance the Self-Neglect and Hoarding Pathway should be used, in which responses and support sit outside of the Section 42 process. Regardless of whether the support provided is under Section 42 or not, the same approach should apply involving close partnership working across all agencies involved.

3.13 Self-neglect is a critical factor to consider within bariatric care for patients, as these behaviours can significantly impact a person's ability to access and benefit from necessary medical and

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[3] London Multi-Agency Safeguarding Adults Policy and Procedures.
[4] Care Act 2014.GOV.UK

social support services. Addressing these issues is essential to ensure comprehensive and effective care for adults with complex health needs.

3.14 Professionals should be aware that difficulties in self-care can be a cause of great embarrassment for bariatric individuals and, as such, may find it very difficult to volunteer this information to staff. A lack of completion of self-care tasks may not be due to an unwillingness to complete these tasks, but rather an inability to do so due to mobility and equipment at home; for example, it may be too difficult to climb into a bathtub, or an individual may feel at risk of falling and being unable to stand up again.

3.15 Some bariatric individuals may be at higher risk of hoarding, but professionals can be curious as to whether this is driven by an urge to hoard, or physical difficulty in picking up items and being able to dispose of them.

3.16 Professionals working with bariatric patients should hold in mind that apparently small changes in mobility and lifestyle can have a significant impact on ability to self-care, and as such professionals should encourage individuals to keep up their current level of mobility as much as possible. The Covid pandemic had a profound impact on the mobility of individuals with obesity, often intensifying existing health challenges. Lockdowns, closure of pools and community leisure centres and social distancing reduced opportunities for physical activity. Some individuals living with obesity related health conditions (e.g. respiratory difficulties and joint pain) experienced rapid deconditioning during this time, which in turn led to a loss of independence. With this knowledge professionals should approach bariatric care patients understanding the importance of maintaining mobility and the risk of deconditioning.

3.17 Supporting people who self-neglect or hoard often requires longer-term involvement to build relationships, identify and work on any past trauma, and support the person to understand and manage any specific risks where possible. It is important for workers to understand that people have the right to choose their lifestyle, balanced with their mental health or their capacity to understand the consequences of their actions. In some cases, it may be a care or risk management issue rather than a safeguarding concern and may require a social care assessment. However, it is not always appropriate to refer to the local authority straight away, as there may be initial support that other agencies can provide.

3.18 In some areas of public health there are approaches taken to maximise the chance for individuals to access health care knowing the presence of stigma can impact this. For example, in the context of HIV individuals are able to access care without giving details of their GP. As professionals we should understand and anticipate possible barriers to accessing care and proactively remove them – for example, having more flexible Did Not Attend (DNA) policies for bariatric care patients and working to find out how we can make attendance easier and more likely. **See Appendix 6: Sensitive Approaches for Supporting Bariatric Care Patients for how you can ask sensitive questions**.

Mental Capacity Act 2005

3.19 The Mental Capacity Act 2005[5] and its key principles provide a vital framework for decision-making, helping to balance respect for individual autonomy with the need for protection. This can be challenging in practice, particularly when distinguishing between a person making a capacitated choice to live in a certain way (even if deemed unwise) and a person lacking the mental capacity to make the relevant decision.

3.20 Concerns about a person's mental capacity must be clearly documented. Any capacity assessment related to self-neglect should be time-specific and focus on the specific decision or action in question.

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[5] MentalCapacityAct2005.GOV.UK

3.21 Depending on the individual's circumstances, other legal frameworks may also need to be considered to determine appropriate action.

3.22 **Mental Capacity Act (MCA) 2005: Key Principles and Assessment Process Statutory Principles (s.1 MCA 2005)**

1. A person must be presumed to have capacity unless proven otherwise.
2. All practicable steps to assist the person in making a decision must be taken before concluding they lack capacity.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done or decision made for someone lacking capacity must be made in their best interests.
5. Consideration must always be given to whether the goal can be achieved in a way that is less restrictive of the person's rights and freedom of action.

3.23 **Assessing Capacity**

The MCA outlines a three-stage test for assessing capacity:

1. **Functional Test:** Is the person unable to make the decision? This involves assessing if they can do any one of the following:
   - Understand relevant information
   - Retain relevant information
   - Use or weigh relevant information
   - Communicate their decision.

2. **Diagnostic Test:** Does the person have an impairment or disturbance in the functioning of their mind or brain (e.g., due to a condition, illness, or substance use)?

3. **Causative Nexus:** Is the person's inability to make the decision directly caused by the identified impairment or disturbance?

3.24 **Decisional vs. Executive Capacity**

The distinction between the capacity to make a decision (decisional capacity) and the ability to actually carry out the decision (executive capacity) can create challenges in practice. Where decisional capacity is not accompanied by the ability to carry out the decision, overall capacity is impaired and interventions by professionals to reduce risk and safeguard wellbeing may be legitimate.

3.25 Using a 'Pyramid Model of Awareness' (Crosslon et al., 1989) helps to assess not just the person's factual understanding but deeper levels of awareness and executive function. The pyramid model sets out three levels of awareness:

1. Recognising facts and risks.

2. Understanding how actions influence risks.

3. Modifying or planning actions based on understanding risks

3.26 This model aids in evaluating deeper levels of awareness and executive function, helping assess the person's ability to understand, retain, Use or weigh and communicate the decision.

Human Rights Act 1998

3.27 All public sector bodies have a duty under the Human Rights Act 1998 [6] to discharge the State's positive obligations under the European Convention on Human Rights. For adult safeguarding the following are especially relevant:

- Article 2 – to protect life
- Article 3 – to protect against torture, inhuman or degrading treatment
- Article 5 – to protect against unlawful interventions with liberty, including by private people
- Article 8 – to protect physical and moral integrity of the individual (especially, but not exclusively) from the acts of other persons.

3.28 In practice professionals need to balance their duty to protect a client (Article 2) with a duty to protect their rights to choose how to live their life (Article 8).

3.29 In complex cases, it may be necessary to seek legal advice and consider other relevant legal frameworks depending on the individual's circumstances.

4. Multi-Agency Involvement

4.1 It is recognised that a wide range of agencies can be involved with bariatric care patients, in a variety of circumstances and settings. There is a need for all agencies to work together to effectively safeguard and meet the needs of these people. When a bariatric care patient is identified consent should be obtained to share their details with partners for the purpose of ensuring they are offered the appropriate support when needed.

[6] TheHumanRightsAct1998.GOV.UK

Roles and responsibilities

4.2 Whilst several agencies may be involved, the lead agency will be dependent on the issues presented.

Community Care Services	
Adult Social Care	The role of Adult Social Care is to support adults who need help due to their care and support needs related to age, illness or disability, enabling them to live as independently as possible. These teams, which include social workers and occupational therapists, support bariatric care patients by promoting health activities, providing advice and education, and making onward referrals to community resources and supports. They also lead on risk management which impacts on identified care needs.
Local Authority Safeguarding Adults	Oversee Section 42 safeguarding enquiries where the criteria under the Care Act is met.
Primary Care (GPs)	GPs act as a bridge between specialist care and community health, ensuring that patients receive continuous and holistic care throughout their bariatric journey including: • Follow-up and overall patient management: conduct annual reviews to monitor progress, assess nutritional status, and order blood tests to check for deficiencies or complications. • Manage pre-existing conditions related to obesity, such as diabetes and high blood pressure, and address any new conditions that may arise after surgery. • Collaborate with bariatric surgeons and other specialists to provide comprehensive care and facilitate the transition of patients from specialist care to primary care after the initial follow-up period. • In the UK several licensed GLP-1 medicines exist (known as ‘weight loss injections’ including semaglutide (sold under the brand names Wegovy, Ozempic and Rybelsus), tirzepatide (Mounjaro). There is a changing picture in terms of eligibility and commissioning agreements but staff working with bariatric care patients should be aware of this option such that patients can be supported to speak to their GP should they wish to consider this option. • Support people with complex obesity by providing tailored advice on diet, physical activity, and behaviour change. They involve multidisciplinary teams, including dietitians, psychologists, and physiotherapists, to help patients achieve sustainable weight loss and improve overall health.

London Ambulance Service	Has two dedicated 24/7 ambulances who will attend to bariatric care patients in an emergency situation such as heart attack, stroke or sepsis. They are also called for healthcare professional (HCP) transport such as catheter issues and cellulitis where hospital treatment is identified by the HCP. The vehicles are based at Richmond and Ilford ambulance stations and are led by two Clinical Team Managers. They can attend non-emergency bariatric care calls, but these would be chargeable to the borough.
London Fire Brigade	Should only be called when the patient's life is immediately threatened or where technical rescue is required. Please see Appendix 8: Contingency Planning for Admission from Home to Hospital Flow Chart for details of specialist support provision.

Community Care Services and Mental Health **Community health services are provided by Central London Community Healthcare NHS Trust (CLCH) and Central and North West London NHS Foundation Trust (CNWL)**	
Community Health Services (District Nurses)	Provide healthcare and support to adults in their own homes or community settings, like residential care homes. They help manage chronic conditions, wound care, palliative care, medication administration, and rehabilitation, aiming to prevent hospital admissions and promote independence. Adult Community Nursing Teams also provide care for bariatric patients, ensuring their complex needs are met at home. This includes pressure area care, mobility support, specialist equipment provision, and coordination with other healthcare professionals to promote comfort, dignity, and overall well-being.
Community Tissue Viability Nurses	Specialise in preventing and managing complex wounds, such as pressure ulcers and leg ulcers. They provide expert advice, treatment plans, and education to patients and healthcare professionals to promote wound healing and prevent complications. People with a larger body size are more susceptible to pressure ulcers due to poor circulation. • It is important to use the appropriate equipment that accommodates their size and width to prevent pressure damage. In bariatric care patients there are skin challenges such as difficulty in reaching to certain areas of the body, pressure ulcer, venous insufficiency, lymphoedema, intertrigo, friction (skin rubbing together), skin folds and poor physical mobility.

	• Skin infection varies from local infection to life threatening i.e. necrotising fasciitis. There is an increased risk for skin infection for bariatric care patients due to excessive skin folds that trap humidity and encourages microbial growth, lymphatic flow is hindered, increased tension on wound edges and skin pH tends to be higher.
Community Specialist Weight Management Services	Support people with complex obesity by providing tailored advice on diet, physical activity, and behaviour change. They involve multidisciplinary teams, including dietitians, psychologists, and physiotherapists, to help patients achieve sustainable weight loss and improve overall health.
Central and North West London NHS Foundation Trust (CNWL)	Both from the community and in-patient services, particularly if the adult is detained under the Mental Health Act or requires psychiatric treatment. In Emergency Departments of local acute hospital settings e.g. Chelsea and Westminster and Imperial Trust, CNWL runs Psychiatric Liaison Services.

Acute Care including hospital admissions, consultants, tissue viability, dieticians, physiotherapists, occupational therapists and specialist mobility teams	
Bariatric Clinics Service at Imperial College Healthcare NHS Trust	Offers two specialised clinics at St Mary's Hospital. The first clinic is dedicated to new patients who are referred for bariatric surgery. The second clinic caters to patients who have previously undergone bariatric surgery and require follow-up care.
Chelsea and Westminster Hospital NHS Foundation Trust	Offers comprehensive bariatric care, including surgery and psychological support, as a major UK centre for bariatric surgery. They offer a range of surgical options like gastric banding, bypass, sleeve gastrectomy, and intragastric balloons. The hospital also provides dietetic and psychological support before and after surgery through group workshops and individual assessments.

4.3 Professionals across all areas and agencies of the care sector should recognise the importance of a multiagency approach. They should involve the relevant Local Authority departments and external providers within multiagency meetings, including:

- Environmental Health, Planning Departments, Housing, Contracts and Commissioning
- Social Housing Providers and Private Housing Organisations / Landlords
- Legal Representatives
- Care Providers.

5. Multi-Agency Risk Assessment and Management

5.1 There are various risk factors to consider when caring for bariatric care patients in different settings, such as community and hospital environments. Robust risk assessment is essential to support the adult, preventing harm and to avoid unnecessary risks for staff. The individual should be involved throughout the process, with their views and wishes central to the planning. See Appendix 1: BE SAFER LAS Guidance (20.2).

5.2 When we work with people during the risk assessment process it is important to remember that a person's ability to engage can fluctuate either as a result of a cognitive impairment of the mind or brain or due to physical or emotional difficulties. In such circumstances it will be necessary to arrange conversations at times that are appropriate for them and/or provide additional support if required such as an:

- Appropriate Person
- Independent Advocate, or
- Independent Mental Capacity Act Advocate.

5.3 Given the complex and challenging situations that are often presented when supporting bariatric care patients, coordinating risk assessment and a management plan across a range of organisations is likely to be more effective than a single agency response. Multi-agency meetings are often the best way to ensure effective information sharing and communication, and a shared responsibility for assessing risks and agreeing an action plan.

5.4 Any professional can request and convene a multi-agency meeting in relation to concerns about the level of risk a bariatric care patient is facing. Consent should be sought from the individual for a meeting to take place, and they should be involved as far as possible, but where the person may have been assessed to lack capacity to understand the risks their bariatric care needs present to them, a decision to hold a professional's meeting in their best interests may be necessary. In situations in which the individual has mental capacity, but the level of risks presented to themselves are significantly high, then professionals can override the person's consent and convene a meeting.

5.5 A multi-agency meeting aims to offer support for professionals by providing a risk enablement approach to offer advice and support in cases where single or multi-agency responses have been unable to reduce the level of risk, whilst empowering the adult and recognising their human rights. The objective is to address risk issues at the lowest possible level.

5.6 The use of multi-agency meetings can support escalation in relation to high-risk cases where:

- When one or more identified risks cannot be resolved satisfactorily, meaning a risk remains that, in the assessor's judgement, is deemed too high to accept and outweighs any potential benefits.
- When an acceptable solution is not available or sustainable in the long term.
- When there is a dispute or disagreement between interested parties regarding the acceptable level of risk.
- When there is a dispute or disagreement between interested parties regarding proposed solutions to one or more aspects.
- When the level of risk is particularly complex, and the Assessor/Manager would value endorsement from all partner agencies involved.

6. Engagement

Building trust is crucial. Use a non-judgemental approach and discuss concerns honestly. If an adult declines support but significant risks are evident, assess their mental capacity. Assume capacity unless proven otherwise and support them in decision-making. Involve key professionals if needed. If they lack capacity, act in their best interests and in the least restrictive way. Remain persistent, patient, and professionally curious, even if the adult is not engaging.

Identify a trusted professional to offer support. Some services, like medical staff, Environmental Health, or Fire Services, may be more welcomed due to their universal nature. If an adult avoids medical services, consider involving other relevant professionals.

Multiple visits/conversations rather than one-off contacts are valuable to build relationships. Demonstrate interest and concern for someone's experience. Be respectful and patient, and remember that people can be agitated, aroused, and angry when experiencing a stressful situation.

Named contact / Making dedicated time

6.1 Ensure the patient knows who their named contact is and what their role is. Prioritise time to engage with adults at risk, as well as their families and other key people in their lives. Creating opportunities to listen increases the chance of people trusting you and sharing important information. Provide privacy and consider how comfortable people might be speaking in front of others.

Relationship and rapport building

6.2 Multiple visits/conversations rather than one-off contacts are valuable to build relationships. Demonstrate interest and concern for someone's experience. Be respectful and patient, and remember that people can be agitated, aroused, and angry when experiencing a stressful situation. All health and social care providers should begin with neutrally rated terms around the patient’s weight and ask their language preferences when speaking with people.

Family and advocacy involvement

6.3 Health and social care professionals should discuss with the individual whether they want their family, carer, or advocate involved in decision-making about their care and support. This

discussion should happen more than once in case the individual changes their mind or their capacity is compromised. Involving families and carers in decisions about services and systems they use is important, but it should not negate the adult's autonomy and rights. If someone has legal status as a Lasting Power of Attorney or Deputy, make sure you understand what their role entails and remember you must share relevant information and consult them.

Tailoring communication to people and families

6.4 Use an interpreter if the person concerned is not fluent in English. Check the person understands what you have said, ask them to explain what they have heard from you, and what they think about it. Check you understand what a person has said to you by summarising and paraphrasing what you have heard and asking whether you have it right.

6.5 **Supporting bariatric neurodivergent adults**

Care professionals should focus on personalised care, clear communication to include understanding individual needs, offering flexible support and collaborating with the individual and their support network. Recognising the potential for sensory sensitivities and communication differences associated with neurodiversity is crucial. **Please see Appendix 7: Supporting Bariatric, Neurodivergent Adults – 7-minute briefing.**

Think about the time of the day / location that is best to speak to someone

6.6 Things like dementia, substance abuse, and certain physical conditions can impact how able people are to communicate at different times of the day. Remember that heightened emotions and stress can reduce people's ability to process information. Speak slowly, in small chunks of information, and repeat important points if you are not confident you have been understood. Take account of sensory impairment or speech impediment, ask what helps them, consider specialist advice, and ask people who know them what will help.

Multi-agency involvement

6.7 Identify a trusted professional to offer support. Some services, like medical staff, Environmental Health, or Fire Services, may be more welcomed due to their universal nature. If an adult avoids medical services, consider involving other relevant professionals.

7. Environment and Facilities

7.1 Relevant care environments, including community and hospital settings, should be thoroughly risk assessed to ensure they meet the needs of bariatric care patients. These assessments should consider the suitability of the environment, equipment, and overall systems of work. The design and delivery should incorporate the views of service users. Risk assessments should identify equipment deficiencies and necessary environmental adjustments. Specialist advice, such as from moving and handling specialists, may be required.

7.2 There may be specific community clinics that have suitable equipment and space for bariatric care patients. Planning should include appropriate ambulance services and staffing to manage patient handling safely.

7.3 Agencies should ensure that all equipment used for patient moving and handling is regularly inspected and maintained to meet safety standards. Staff should be trained in the proper use of this equipment to prevent injuries and ensure patient safety.

7.4 Care environments may also include community care provision and an individual's own home, which also need to be risk assessed accordingly.

7.5 The Central London Community Healthcare (CLCH) NHS Trust Patient Moving and Handling Risk Assessment Form is designed to assess the risks associated with moving and handling patients. **Please See Appendix 2.**

7.6 Within any risk assessment, it is important that the perspectives of all people involved are considered involving the individual, carers and staff. The following factors should be considered in the risk assessment:

Access Requirements

- General access requirements to include widths of doorways and corridors
- Location of the service for the adult (upstairs/downstairs and access)
- Safe evacuation routes and access in the event of an emergency.

Equipment Requirements

- Weight limits and suitability of equipment and furniture, for example suitable seating/wheelchairs
- Weight limits and suitability of toilet/welfare facilities (standard floors in homes have a weight limit of 150 kg/m2)
- Room layout and the positioning of furniture and equipment
- Availability of specialist equipment
- Number of staff required to safely conduct manual handling.

8. Care Planning

Contingency planning for admission from home to hospital

8.1 A contingency plan for bariatric transfers from home to hospital should detail procedures for safe patient handling, equipment requirements, and communication protocols. This involves assessing the patient's weight-bearing ability, mobility, and environment to determine necessary resources such as hoists, appropriate wheelchairs or stretchers, and adequate staffing. Clear communication channels between home care, ambulance services, and the receiving hospital are essential for a smooth transfer. A comprehensive plan addresses the unique needs of bariatric patients, including specialised equipment, trained staff, and appropriate environmental considerations. **Please see Appendix 8: Contingency Planning for Admission from Home to Hospital Flow Chart**.

9. Bariatric Care Practitioner Toolkit

9.1 This toolkit is intended for use by all agencies supporting adults with bariatric care needs. It provides a range of resources, including the appendices referenced throughout this document, to assist professionals in delivering effective, coordinated care for individuals requiring bariatric support.

Appendix	Title / Description	Link
1	**LAS BESAFER Guidance** for all staff assigned to Bariatric Ambulances, Emergency Operations Centre personnel, including those in the Clinical Hub, Clinical Team Managers, Incident Response Officers and other professionals who may lead or coordinate incidents involving bariatric patients.	BESAFER LAS Guidance
2	**Central London Community Healthcare (CLCH) NHS Trust Patient Moving and Handling Risk Assessment Form:** designed to assess the risks associated with moving and handling patients	CLCH Patient Moving and Handling Risk Assessment
3	**SAEB Multiagency Checklist** of areas to consider during intervention and support for Bariatric Care Patients.	Multiagency checklist
4	**Learning from Bariatric Care Case Studies**: this document includes learning from various cases extending the focus beyond the Case of Ms C to encompass a broader cohort of patients facing similar issues and aims to identify systemic challenges and opportunities for improvement in the care and support provided to adults with complex healthcare needs.	Learning from Bariatric Care Case Studies
5	**Sunderland SAB – Safeguarding Adults Review 7-minute briefing:** Joseph was a 20-year-old man with a learning disability, Prader-Willi syndrome (PWS), obesity hyperventilation syndrome and type II diabetes. Joseph died during a hospital admission.	'Joseph'
6	**Sensitive Approaches for Supporting Bariatric Care Patients:** this guidance document provides recommended approaches for engaging in sensitive discussions and offering support.	Sensitive Approaches for Supporting Bariatric Care
7	**Supporting Bariatric, Neurodivergent Adults – 7-minute briefing:** This document provides a guide for care professionals on how to support adults who are both bariatric and neurodivergent and includes the case study of Ms A.	Supporting Bariatric, Neurodivergent Adults
8	**SAEB Contingency Planning for Admission from Home to Hospital Flow Chart:** This document is a comprehensive flow chart and guidance resource for professionals involved in the care and transfer of patients with bariatric needs. It is designed to support multi-agency collaboration, ensuring safe, dignified, and effective care, especially during hospital admissions and emergency transfers.	Contingency Planning for Admission from Home to Hospital Flow Chart
9	**SAEB Bariatric Care for Adults - Professionals Guidance Launch & Learning Event:** This webinar aims to: • Increase understanding about the specific needs and challenges faced by bariatric patients. • Enhance understanding of psychologically informed and sensitive approaches to supporting bariatric patients. • Raise awareness about the different pathways and specialist support services across the SAEB multiagency partnership.	SAEB Bariatric Care for Adults - Professionals Guidance Launch & Learning Event

10. Local Services

Bariatric Care Patients are at risk of malnutrition due to illness, medication, reduced mobility, and fluid retention. It is important to seek advice from a dietician early and follow an appropriate dietary management plan. Services available in Kensington, Chelsea, and Westminster include:

Nutrition and dietetics: Central London Community Healthcare NHS Trust

Chelsea and Westminster Hospital offers comprehensive bariatric care, including surgery and psychological support, as a major UK centre for bariatric surgery. They offer a range of surgical options like gastric banding, bypass, sleeve gastrectomy, and intragastric balloons. The hospital also provides dietetic and psychological support before and after surgery through group workshops and individual assessments

Bariatric Clinics Service at Imperial College Healthcare NHS Trust offers two clinics at St Mary's Hospital: One for new patients who are referred for surgery, and another for patients who are referred to us having had a previous bariatric surgery.

Clinics | Imperial College Healthcare NHS Trust

Information on how to refer to the bariatric surgery service **Refer to this service | Imperial College Healthcare NHS Trust**

CNWL have a Single Point of Access 24/7 which can offer advice , information and access to crisis services **https://www.cnwl.nhs.uk/services/mental-health-services/adult-and-older-adult/single-point-access** there is also Hub of hope on the same page which provides where people can search for local services

11. Further Resources and Reading

11.1 Engagement Resources

Communication Tips (Video from RNID)
How to communicate with a person with dementia | Alzheimer's Society
Communicating with people with a learning disability | Mencap
Newcastle SAB Principles of Engagement Video
Neurodiversity: let's change a culture | Social Work Week 2021

11.2 Mental Capacity

Mental Capacity Act: making decisions - GOV.UK
Consent to treatment - Assessing capacity - NHS

12. Glossary of Terms Used

Appendix	Title
BMI	Body Mass Index
CPAP	Continuous Positive Airway Pressure
BIPAP	Bilevel Positive Airway Pressure
GLP-1	Glucagon-Like Peptide-1 (medication class)
HCP	Healthcare Professional Transport
DNA	Did Not Attend (missed appointment)
MCA	Mental Capacity Act
SAR	Safeguarding Adults Review