Clinical Commissioning Policy:

Obesity surgery for young people (up to their 18th birthday) with severe complex obesity [16053/P]

Summary

Obesity surgery (also known as metabolic bariatric surgery (MBS) is recommended to be available as a routine commissioning treatment option for a small number of highly selected young people with severe and complex obesity within the criteria set out in this document.

The policy is restricted to certain age groups as this reflects the population for whom NHS England is the responsible commissioner.

Committee discussion

Please see Clinical Panel reports for full details of Clinical Panel's discussion.

What we have decided

NHS England has carefully reviewed the evidence to commission MBS as part of the treatment pathway for young people up their 18th birthday who have severe and complex obesity. We have concluded that there is enough evidence to make the treatment available at this time.

Links and updates to other policies

This document updates Clinical Commissioning Policy: Obesity surgery for children with severe complex obesity (NHS England: 16053/P).

Plain language summary

About obesity in children and young people

Obesity in children and young people is a major and growing health problem. People who have overweight or obesity, or who have a lot of body fat can be more likely to develop serious health problems such as:

- High blood pressure (called 'hypertension')
- A condition where the body produces insulin but does not use it effectively (called 'insulin resistance')
- A group of problems that can lead to heat diseases, stroke and type 2 diabetes (called 'metabolic syndrome')

- Lower life expectancy

About current treatment

For most people, eating a healthy, reduced-calorie diet and exercising regularly is the most effective treatment for obesity. Some patients may benefit from psychological support from a trained healthcare professional, to help change the way they think about food and eating.

Specialist weight management programmes are also available. If lifestyle changes alone are not successful, treatment with medicines may be considered.

All of the above treatments are 'non-invasive' – they do not require an operation.

About the new treatment

If patients do not respond to the above 'non-invasive' therapies, MBS may be considered. This refers to any surgical treatment or operation for obesity – this may include a sleeve gastrectomy, for example.

NHS England has carefully reviewed the evidence to treat young people who have obesity with obesity surgery. We have concluded that there is enough evidence to make the treatment available for a small number of highly selected young people, up to their 18th birthday, with severe and complex obesity.

Epidemiology and needs assessment

Children and young people living with obesity are at an increased risk of developing various health problems, and are also more likely to become adults with obesity. Childhood obesity is associated with obesity-related conditions, commonly hypertension, obstructive sleep apnoea, insulin resistance, metabolic syndrome, metabolic-dysfunction associated steatotic liver disease and dyslipidaemia. The cost of obesity to society was estimated in 2007 to be £16 billion, and if rates continue to rise could reach up to £50 billion in 2050 (NICE CG189, 2014).

Children and young people with obesity are currently managed predominately with lifestyle interventions, focusing on behavioural and dietary modifications, with evidence of short term success (Cochrane Review, 2009). Pharmacotherapy is less commonly used in young people: for children 12 years and older, NICE recommend treatment with orlistat off-label if physical comorbidities or severe psychological comorbidities are present (NICE CG246, 2024). Some young people with severe obesity who have significant and severe obesity-related complications such as hypertension, metabolic-dysfunction associated steatotic liver disease or uncontrolled diabetes and who have not responded adequately to specialist multi-component, intensive, non-invasive weight management programmes, may benefit from a surgical approach.

Currently there is no evidence based care pathway in utilising MBS in the population of young people. Primarily the types of MBS commonly performed in this population are: laparoscopic Roux-en Y gastric bypass (RYGB); sleeve gastrectomy (LSG).

The prevalence of children and young people with obesity has been increasing, and in 2023/24, 5.5%% of Year 6 children (4.5% of girls and 6.5% of boys) were identified as having severe obesity (greater than and including 99.6th centile). It is estimated that around 6-8 patients receive MBS each year, based on an average across the 30-40 undertaken over the last 5 years and data from the National Bariatric Surgery Registry (2023) that shows that 20 primary operations for patients aged 12-17 were undertaken between 2017-2021.

Implementation

Inclusion criteria

Surgical intervention is not generally recommended in children or young people (NICE CG246, 2025). However, MBS may be considered in eligible individuals to achieve significant and sustainable weight reduction, if all the following criteria are fulfilled:

- The young person has been evaluated by the complex surgical obesity management (Tier 4) specialist multidisciplinary team (MDT) (see service specification for details) and deemed suitable for MBS based upon their obesity related complications and a risk-benefit analysis of short- and long-term risks of not operating versus the risks of surgery. Psychological factors, motivation/compliance, learning difficulty issues and impact on education will also be considered.
- The young person has a BMI ≥3.5 SD, or BMI ≥3.0 SD with at least one significant obesity-related complication.
- The young person has achieved physiological maturity (Tanner Stage 4 or above).
- The young person has engaged with intensive obesity management from an MDT (e.g., from a commissioned Tier 3 Weight Management service for children and young people).
- The young person has not had a clinically significant sustained response to lifestyle and/or appropriate pharmacological obesity management.
- The benefits of surgery are not outweighed by the risks of anaesthesia.
- The young person and their carers commit to the need for long-term follow up.
- Young people with syndromic or monogenic obesity will also be discussed by the MDT on a case by case basis and arrangements made by the MDT to seek further national expert advice/opinion on the suitability for surgery, though surgery for these children and young people is unlikely to be the most appropriate treatment option.

Patient pathway

Before being considered for MBS, the young person must have engaged with intensive obesity management from an MDT (for example, this may be provided by a Tier 3 weight management service for children and young people). It is expected that this will have identified, investigated and managed the associated obesity related complications prior to referral for surgical assessment to a Tier 4 service. The adequacy, intensity and duration of intervention/s will be determined by the specialist MDT: prior to referral to a Tier 4 service, all non-surgical avenues (including available pharmacological interventions) should

have been adequately explored and found to be ineffective or not tolerated; these approaches should be documented in the MDT discussions.

Young people eligible for MBS should have a comprehensive clinical, psychological, education, family and social assessment by an appropriate specialist MDT before undergoing surgery, this includes a full medical evaluation and genetic screening or assessment to exclude rare, treatable causes of obesity.

Surgical care and follow up should be coordinated around the patient and their family's needs, complying with the approaches outlined in the Department of Health's 'A call to action on obesity in England' to increase attendance and compliance. Lifelong follow up is advocated, with follow up at 3 months, 6 months and 12 months for the first year and annually for life, with a minimum 2 year follow up in the paediatric Tier 4 service. This should include:

- Monitoring nutritional intake (including protein and vitamins and mineral deficiencies)
- Monitoring for obesity related complications
- 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.

No child or young person should be discharged from follow up until their 18th birthday.

See the NHS service specification for more details.

Governance arrangements

Providers, surgeons, premises, on site services and obesity surgery throughput should at least meet International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) Guidelines for Safety, Quality and Excellence in Bariatric Surgery (2008).

There must be appropriate specialised MDT composition, co-option and support, specialist professional input and process design for all stages of the pathway (elective and emergency). In addition, organisational arrangements for patient safety (elective and emergency) should be risk assessed, regularly tested and improved. Protocols should be audited especially the use of questionnaires for clinical assessment, generic interdisciplinary roles and substitution and/or expansion of professional roles.

The surgical services should be seamless both pre- and post-operatively with the medical specialist service, and determined by local arrangements

The obesity surgical and medical provider will be responsible for the organisation of structured, systematic and team based follow up for a minimum of 2 years, including planned transition to adult services. The latter provider will make arrangements to hand over care to the adult service when the adolescent reaches 18 years if appropriate, with the option of continued follow up beyond 18 years of age in paediatric services or Tier 4 paediatric led services, where adolescents are within a few years of surgery, whilst transition to adult service provision is facilitated.

Follow up rates and nutritional and/or metabolic complications should be published.

Provider organisations must register all patients using prior approval software and ensure monitoring arrangements are in place to demonstrate compliance against the criteria as outlined.

Mechanism for funding

Specialised complex obesity services, including obesity surgery pre-assessment, peri-operative management, postoperative and longer term follow up where it occurs within the specialised service, will be funded by NHS England.

Audit requirements

Mandatory compliance by obesity surgery providers with National Bariatric Surgery Registry (NBSR) requirements, including 100% of provision of required data, and publication of long term follow up data.

Given the relative lack of evidence related to adverse effects (e.g., nutritional deficiencies) in the adolescent population, it would be beneficial for specific outcome requirements to be included in the NBSR dataset and published, to support longitudinal study. See service specification for suggested outcome measures.

Policy review date

This document will be reviewed when information is received which indicates that the policy requires revision. If a review is needed due to a new evidence base then a new Preliminary Policy Proposal needs to be submitted by contacting england.CET@nhs.net.

Our policies provide access on the basis that the prices of therapies will be at or below the prices and commercial terms submitted for consideration at the time evaluated. NHS England reserves the right to review policies where the supplier of an intervention is no longer willing to supply the treatment to the NHS at or below this price and to review policies where the supplier is unable or unwilling to match price reductions in alternative therapies.

Equality statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Definitions

Obesity	In children and young people, obesity is commonly defined as a body mass index z score of +2.05 SDs
Body mass Index (BMI)	a measure (kg/m²) of whether someone is a healthy weight for their height.
BMI SD	standard deviation score indicates how many units (of the standard deviation) a child's BMI is above or below the average BMI value for their age group and sex. Also referred to as a z score.
Co-morbidity	the presence of one or more additional diseases co-occurring with a primary disease (synergistic or coincidental); or the effect of such additional disease (clinically dominant).
Dyslipidaemia or high cholesterol	means that there is an imbalance of fats (lipids), circulating in the blood stream. Cholesterol is a fatty substance the body uses to make hormones and metabolise food.
Obesity surgery	also known as bariatric surgery, any surgical treatment for obesity.
Roux–en–Y gastric bypass (RYGB)	the most popular variation of gastric bypass operation conducted in the UK. During surgery, the top section of the stomach is divided off by a line of staples, creating a small 'pouch' stomach. A new exit from this pouch is made into a 'Y' loop from the small intestine so that food bypasses the old stomach and part (about 100-150cm) of the small intestine. The size of stomach pouch and the length of small intestine that is bypassed are carefully calculated to ensure that patients will be able to eat enough for their body's needs at normal weight.
Laparoscopic sleeve gastrectomy (LSG)	the sleeve gastrectomy reduces the size of the stomach by about 75%. It is divided vertically from top to bottom leaving a banana shaped stomach along the inside curve, and the pyloric valve at the bottom of the stomach, which regulates the emptying of the stomach into the small intestine, remains intact. This means that although smaller, the stomach function remains unaltered.

References

National Institute of Health and Care Excellence Clinical Guideline 249. Obesity: identification, assessment and management of overweight and obesity in children, young people and adults.

National Institute for Heath and Care Excellence Clinical Guideline 43. Transition from children's to adult's services.

Melissas, J. IFSO Guidelines for Safety, Quality and Excellence in Bariatric Surgery. Obesity Surgery 2008; 18: 497-500.

Change form for published clinical commissioning policies, commissioning policies and commissioning statements developed by Clinical Reference Group (CRGs)

Product name: Clinical Commissioning Policy: Obesity surgery for children with severe complex obesity
Publication number: 16053/P (2017)

Summary of the rationale and the change: A number of amendments to the published policy have been requested by the clinical community and signed off by the Specialised Surgery in Children Clinical Reference Group, chaired by the National Specialty Advisor for Specialised Surgery in Children.

Description of changes required

Describe what was stated in original document	Describe new text in the document	Section/Paragraph to which changes apply	Describe why document change required	Changes made by	Date change made
-	Reference to obesity surgery has been replaced by metabolic bariatric surgery (MBS) throughout.	All	To reflect preferred terminology.	Lead Commissioner	July 2025.
-	Person-centered language has been used throughout (e.g., 'young person with obesity').	All	To reflect preferred terminology.	Lead Commissioner	July 2025.
-	Reference to adolescents has been replaced by young person throughout.	All	To reflect preferred terminology.	Lead Commissioner	July 2025.

-	Content has been transferred to the latest clinical commissioning policy template. Associated changes have been made throughout in line with the new template.	All	To reflect current clinical commissioning policy methodology.	Lead Commissioner	July 2025.
The eligible population was defined as 'children 18 years and under'.	The eligible population is now defined as 'children up to their 18th birthday'	What we have decided	To reflect that children 18 and above would be treated within adult bariatric surgery services.	Lead Commissioner	July 2025.
The paragraph stated that specialist weight management programmes are also available, although they are often designed for adults.	Reference to specialist weight management programmes being designed for adults has been removed.	About current treatment	To reflect current models of care.	Lead Commissioner	July 2025.
The eligible population was defined as 'children 18 years and under'.	The eligible population is now defined as 'children up to their 18th birthday'	About the new treatment	To reflect that children 18 and above would be treated within adult bariatric surgery services.	Lead Commissioner	July 2025.
Reference was made to NICE Clinical Guideline 189.	This has been replaced with reference to NICE Clinical Guideline 249.	Inclusion criteria	NICE Clinical Guideline 189 has been superseded by NICE Clinical Guideline 249.	Lead Commissioner	July 2025.
The criteria specified that the adolescent was required to have been	The criteria has been revised to clarify that evaluation for suitability	Inclusion criteria	To reflect the intention to commission Tier 4	Lead Commissioner	July 2025.

evaluated by the appropriate specialised MDT and deemed appropriate for surgery.	for surgery should be carried out by the Tier 4 specialist MDT. This now includes reference to ensuring that the evaluation should be based upon their comorbidities and a risk benefit analysis.		services and reflect current practice.		
The criteria specified that the adolescent had a BMI equal to 35 kg/m^2 (BMI SD greater than or equal to 3.5) with significant associated comorbidities that are both predicted to have the potential to progress and are amenable to improvement/resolution by weight loss. Obesity should have been present for several years.	The criteria has been revised to reflect current definitions of obesity, in line with current NICE guidelines. We have removed the requirement for obesity to have been present for several years as it was felt that it was unlikely a child would present with obesity for less than this, given the need to have completed management in a specialist weight management service prior to referral.	Inclusion criteria	To reflect current definitions of obesity in children and young people.	Lead Commissioner	July 2025.
The criteria outlined the need for an adolescent to have completed clinical assessment and	The criteria has been revised to reflect that a person should have completed intensive	Inclusion criteria	To reflect current models of care and variation in the models	Lead Commissioner	July 2025.

management within a Tier 3 service.	weight management treatment from a multidisciplinary team such as a Tier 3 Weight Management service.		of care commissioned across England.		
The criteria specified that the decision of the MDT regarding surgery will depend on the individual's engagement and response to weight management services, their comorbidities and risk benefit analysis.	The criteria has been removed. The need to consider a risk benefit analysis as part of assessment for suitability for surgery has been included in criteria 1. An additional criteria has been included to outline that the person must not have had a clinically significant response to lifestyle and/or appropriate pharmacological weight management treatments.	Inclusion criteria	To improve wording and clarify treatments that should have been completed prior to consideration for surgery.	Lead Commissioner	July 2025.
The adolescent and their family commits to the need for long term follow up.	The person and their carers commit to the need for long term follow up.	Inclusion criteria	To reflect that carers may be from outside the family unit.	Lead Commissioner	July 2025.
The criteria specifies that people with syndromic or	The criteria has been amended to reflect the role of the MDT and to	Inclusion criteria	To reflect the role of the MDT and provide further clarify on the	Lead Commissioner	July 2025.

monogenic obesity could be considered for surgery by the MDT and arrangements made by the MDT to seek national expert advice/opinion on the ethical issues and supporting research.	acknowledge that surgery for this group of young people is unlikely to be the most appropriate treatment option.		most appropriate treatment options for this group.		
The section outlined the need for the adolescent to have completed clinical assessment and management within a commissioned Tier 3 service.	The section has been revised to reflect that a person should have completed intensive obesity management from a multidisciplinary team such as a Tier 3 Weight Management service.	Patient pathway	To reflect current models of care and variation in the models of care commissioned across England.	Lead Commissioner	July 2025.
The section highlighted that adolescents should remain in Tier 3 until all non-surgical avenues have been adequately explored.	The section has been revised to remove reference to Tier 3 services and to reflect that all non-surgical avenues should have been explored prior to referral to a Tier 4 service.	Patient pathway	To reflect current models of care and variation in the models of care commissioned across England.	Lead Commissioner	July 2025.
Reference to IFSO guidelines.	Updated reference to IFSO guidelines on safety in bariatric surgery.	Governance arrangements.	Updated to reflect recent publications.	Lead Commissioner	July 2025.

	Reference to Tier 3 services has been replaced with 'Specialised Weight Management' services to reflect variation in the models of care commissioned across England.	Governance arrangements	To reflect current models of care.	Lead Commissioner	July 2025.
The glossary previously defined typical models of care for managing obesity, including definitions of Tier 1, 2, 3 and 4 services.	These definitions have been removed to reflect variation in the models of care commissioned across England.	Glossary	To reflect current models of care.	Lead Commissioner	July 2025.
The glossary defined Obesity in adults (as a BMI of 30 or more) and children and young people (as per the British 1990 growth reference charts).	The definition of obesity in children and young people have been revised to reflect current practice (i.e., a BMI Z score of +2SDs).	Glossary	To reflect current clinical practice.	Lead Commissioner	July 2025.
Definitions were included for gastric balloon and Laparaoscopic adjustable gastric band.	Definitions for gastric balloon and Laparaoscopic adjustable gastric band have been removed as these types of surgery are no longer used in children and young people.	Glossary	To reflect current clinical practice.	Lead Commissioner	July 2025.

-	The reference list has been updated. The list now includes references to current NICE guidelines and other references included in the updated policy. References which were included in the evidence review, included in the original policy document, have been removed. The evidence review, included references, has been published alongside the revised clinical commissioning policy.	References	To reflect references included in the updated policy and to reflect current clinical commissioning policy methodology.	Lead Commissioner	July 2025.