BRITISH OBESITY & METABOLIC SPECIALIST SOCIETY

PROVIDING BARIATRIC SURGERY

BOMSS Standards for Clinical Services & Guidance on Commissioning 2026

for and on behalf of BOMSS Council, April 2026

BOMSS Service Standards and Commissioning Advisory Working Party

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Introduction

The British Obesity and Metabolic Specialist Society (BOMSS) Commissioning Guidance *('Providing Bariatric Surgery – BOMSS Standards for Clinical Services & Guidance on Commissioning'*) and the accompanying BOMSS Professional Standards Document were first published in 2012 and revised in 2019 (1, 2). These were comprehensive documents setting out a consensus view of what at that time constituted the principles that underpin safe, high quality metabolic bariatric surgical practice. The guidance in these documents has been used by multiple stakeholders including clinicians, NHS Commissioners, independent sector providers, regulatory bodies and indemnity providers.

It was the stated intention, of the 2012 guidance that standards should be reviewed and updated regularly in order to maintain its relevance. The last review was in 2019; and therefore in line with the principle that these guidelines should be a living document the updated version of these commissioning standards is presented below.

Background

Since the 2019 update there have been a number of changes in both the clinical and commissioning arenas.

There has been a shift towards recognising obesity as a chronic complex multifactorial disease (3). Metabolic bariatric surgery (MBS) has now become an established standard approach for the management of severe and complex obesity and is now a part of the general surgical curriculum (4). However, there have been several challenges related to the delivery of surgery as a consequence of the COVD pandemic (5). Moreover there has been significant changes in the type of surgical procedures performed, including a reduction in the number of gastric banding procedures and a rise in the proportion of revisional cases (6). In addition, there has been an expansion in the number of cases undertaken in the private sector over the last decade with patients choosing undergo surgery in private hospitals in the United Kingdoms as well as abroad. Finally a significant number of NHS bariatric patients are having the surgical part of their care routinely "outsourced" to the private sector (6).

There have also been new publications on benchmarked expected clinical outcomes following MBS (7, 8) as well as the release of new National Institute for Care Excellence (NICE) clinical guidance and quality standards on the management of severe and complex obesity (9, 10)**.**

Finally, there have been changes in therapeutic options for complex obesity including new endoscopic therapies, and the emergence of effective Obesity Management medications (OMM) which are having an impact of the demographics on the patients being referred for MBS (9)**.**

This review addresses these issues and specifically updates BOMSS commissioning guidance and supersedes the previous commissioning documents.

Facilities

As detailed in the 2012 guidelines, there is a need for all institutions undertaking MBS to have appropriate outpatient, ward, radiology and theatre facilities. These are detailed in the in the 2012 as well as the NICE guidance (1,9) and represents the minimum expected for any institutions undertaking MBS. However in line with the update from 2019, there is no longer a requirement for MBS to be undertaken in an institution with Level 2 (HDU) or Level 3 (ICU) facilities.

Multidisciplinary team (MDT) assessment

BOMSS wishes to re-enforce the importance of service delivery through a process based on a multidisciplinary team (MDT) (11-14).

The BOMSS 2012 guidelines recommended the following core professions / disciplines within the MDT:

1. Specialist Bariatric Surgeon
2. Bariatric Clinical Nurse Specialist
3. Specialist Bariatric Dietitian

In addition to these core members of the MDT, there was acknowledgement in both the 2102 and 2019 guidelines for the need for standing access to a number of specialities. Whilst the 2019 guidelines were somewhat proscriptive in listing additional core members of the MDT (specifically a psychologist and a bariatric anaesthetist) the latest NICE criteria advocate individualised assessment for all patients referred for MBS (9). This approach emphasises the importance of appropriate MDT screening for all patients; and the ability to refer onto other specialist healthcare professionals and services (e.g. psychology and eating disorders services) should this be indicated.

The updated BOMSS view reflects the approach advocated by NICE and recommends that all patients should undergo a formal review by a Specialist Bariatric Surgeon, a Bariatric Clinical Nurse specialist and a Specialist Bariatric Dietitian, and additional specialists (e.g. psychologists, endocrinologists, and physiotherapists) as required based on patient requirements. In addition there is a need for MDT involvement following surgery particularly in situations where complications have occurred following MBS.

MDT Meetings

Previous guidelines mandated face to face MDT meeting to discuss all patients. This would still be regarded as the gold standard, however following the COVID pandemic there has been an increase in remote working and formal face to face MDT meetings are often no longer undertaken. Given the literature has demonstrated that MDT assessment (as opposed the actual provision of a meeting) is the key determinant of better care (12), BOMSS no longer mandates a face to face MDT meeting provided there is robust documented evidence of a MDT assessment of a patient prior to surgery.

Recording of clinical outcomes

There is a need for robust governance arrangements to allow transparent and verifiable recording of clinical outcomes.

In terms of data recording, in alignment with the NICE guidance submission of peri-operative data for all bariatric cases to the National Bariatric Surgical Registry (NBSR) has been; and remains a mandatory requirement for both NHS and private cases.

The GMC "Good Medical Practice" require clinicians to provide accurate, up to date information about their clinical practice to ensure patient safety. The Medical Director of the NHS has made it clear that the responsibility for maintaining and providing accurate data rests with individual clinicians both in terms of coding of their work and the submission of clinical activity data to national audits (15).

The Registry publishes a publicly available yearly report on Consultant volume and outcomes in MBS. This Consultant Outcome Report (COP) report now includes all recorded bariatric surgical activity in both the NHS and private sectors and this report should be used as the verified record of surgical volume and peri-operative outcomes for surgeons (https://nbsr.e-dendrite.com).

As many complications following MBS occur after discharge from hospital (7) patients may re-present to their local hospitals as opposed to their bariatric unit; and hence these complications may not be automatically recorded through the NBSR.

As such BOMMS recommends that all bariatric units have a robust governance system to monitor and record the 90 day complication rates of both the unit and individual surgeons.

Based on international published benchmarked data, units and surgeons should aim to achieve a 90 day overall complication rate of less than 10%; and an overall 90 day major complication rate (Clavien-Dindo 3A or above) of less than 5% (7, 8).

Classification of Surgeons and Institution

Both the International Federation of Surgical Obesity (IFSO) and BOMSS have long and consistently recognised that surgical volume is a critical pre-requisite of a high quality bariatric surgical service (1, 2, 16).

IFSO recognises two classes of institutions and surgeons- a primary bariatric institution/ surgeon undertaking low complexity cases; and institutions/ surgeons "of excellence" who undertake more complex surgery and mentorship of trainee surgeons (16).

In the United Kingdom, NHS England criteria also distinguishes between those surgeons and institutions which undertake primary bariatric surgery, and "specialist" surgeons and institutions which undertake more complex elective revisional surgery (17). The latest NICE guidance also recommends that elective complex revisional surgery should only be performed by "experienced surgeons" in specialist institutions (9).

To standardise nomenclature, BOMMS recommends recognition of two types of institutions and surgeons:

1. An accredited institution/surgeon undertaking independent elective primary bariatric surgery; and achieving clinical outcome results within expected international benchmarked standards.
2. A "specialist" institution/surgeon undertaking independent elective primary and revisional MBS; and achieving clinical outcome results within expected international benchmarked standards.

Number of Surgeons per institution

Previous BOMSS commissioning guidance (1, 2) recommended the presence of at least two bariatric surgeons in each institution offering MBS. By contrast the IFSO guidelines (16) did not mandate a minimum number of accredited bariatric surgeons per unit but rather focused on the total activity of the unit and the surgeon undertaking the procedure. BOMSS accepts that in an era of super-specialisation, where within upper GI units individual surgeons often focus their practice on cancer resection or MBS, a "mixed" practice is becoming less common. As such BOMSS now prefers the adoption of the approach advocated by IFSO.

BOMSS therefore recommend that MBS should be undertaken in an institution, and by a surgeon, **each** of whom can demonstrate a verified recent track record of undertaking a minimum volume of MBS as evidenced by the NBSR; and as defined below.

Definitions of minimum surgical volumes

Whilst previous recommendations proposed minimal annual volumes for both institutions and surgeons, it is important to recognise that for various reasons there may be a temporary reduction in activity due to unforeseen circumstances (e.g. the COVID pandemic). Similarly in the case of individual surgeons, there may be changes in personal circumstances (e.g. parental leave) which may temporarily impact surgical volume. As such it is important to review a track record over a longer period as this is a more reliable indicator of safe practice. That said, there is also a need for relative recency of data as the rapid evolution of MBS (e.g. the reduction in gastric banding nationally and the increase in the number of revisional surgery) means that historical data may not be relevant in providing assurance for the current safety of a service.

This approach of utilising a surgeon's recent track record in assuring quality is one which has been adopted by the National Adult Cardiac Surgery Audit (18) and the National Vascular Registry (19).

In line with the above principles the NBSR now publishes an updated validated summary of surgeons recorded totality of practice (i.e. NHS and private activity) over the previous four years as part of the COP report (https://nbsr.e-dendrite.com).

Minimum volume of activity for an accredited bariatric surgeon

Current IFSO guidance mandates that primary bariatric surgery should only be undertaken by surgeons performing at least 50 procedures per year (16). This approach does not take into account a surgeon's recent track record; and in the current commissioning environment BOMSS feels that achieving this volume on a consistent annual basis may prove challenging.

BOMSS therefore advocates that accredited surgeon i.e. surgeons independently performing primary MBS should have undertaken a minimum of 160 cases in the previous four years as verified by the published annual Consultant Outcome report from the NBSR (https://nbsr.e-dendrite.com).

The same minimum volume requirement i.e. 160 cases in the previous four years as documented in the NBSR also applies to any institution undertaking primary MBS.

Minimum volume of activity for a specialist bariatric surgeon undertaking revisional surgery in a NHS hospital

Guidance from NHS England criteria mandate that complex revisional bariatric surgery should only be undertaken in a unit performing 100 cases year over the previous 5 years, and by surgeons with a cumulative volume of over 500 cases (17).

In the current commissioning environment, BOMSS feels that achieving this number will be unrealistic for most surgeons and institutions. Therefore, these guidelines may prevent competent surgeons and institutions from undertaking this work for many years.

As such we advocate that a "specialist" surgeon i.e. one who independently performs elective revisional MBS within a NHS hospital should have undertaken a minimum of 240 cases in the previous four years as verified by the published annual Consultant Outcome report from the NBSR (https://nbsr.e-dendrite.com).

The same minimum volume requirement (i.e. 240 cases in the previous four years as documented in the NBSR) also applies to any institution undertaking elective revisional bariatric surgery.

On Call arrangements

As many complications following MBS occur after discharge from hospital (7), discussions must be undertaken with patients prior to discharge. These discussion should ensure that patients have a clear understanding of alarm features relevant to the surgery they have had; the timeframe over which emergencies may occur; and the appropriate actions to take should they occur. The MDT must

establish, in concert with the institution, an appropriate pathway to ensure patient access to expert care can be facilitated in the event of a deviation from a standard post-operative recovery. Whilst this often means expeditious return to the hospital where surgery was undertaken, BOMSS recognises there may be situations where it may be more clinically appropriate for a patient to undergo urgent treatment at a local hospital to avoid delays in their treatment pathway.

Previous BOMSS guidance (1, 2) mandated the presence of continuous consultant bariatric surgeon on-call availability. This requirement has however proven logistically impractical for many units. In addition, since the publication of the original guidelines in 2012 there has been a focus within the NHS on emergency surgery provision nationally; and MBS has now become a recognised part of the General Surgical Curriculum (4). Surgical management of bariatric emergencies (such as a leak or small bowel incarceration within an internal hernia) should therefore be within the scope of practice of any general surgeon covering the emergency on call, even in hospitals which do not offer elective bariatric surgery.

As such, BOMSS no longer advocates a requirement for a bariatric unit to have a dedicated bariatric on-call rota to manage post-operative or emergency bariatric patients.

BOMMS does however recommend the presence of a dedicated on-call specialist service in the following cases:

1. For institutions which are starting MBS for the first time (see below), BOMSS does not believe that sole reliance on an on-call service who will not have had no significant experience of managing routine bariatric surgical patients is appropriate

2. BOMSS recognises that revisional surgery has a higher in patient complication rate compared with primary surgery. These complications often occur "out of hours" during a patient's in-hospital stay and require specialist input.

For both of the above situations, BOMSS mandates a secondary on call service led by "specialist" bariatric surgeons; available to guide and support the on call general surgical team.

Expansion of bariatric surgical activity

BOMSS notes that even in the era of effective OMMs there remains a significant underprovision of MBS in the United Kingdom (20). BOMSS therefore strongly advocates for an expansion of bariatric surgical activity throughout the United Kingdom.

In principle, expansion of bariatric surgical capacity can be achieved through: :

1. The establishment of new units offering MBS.
2. Increase in activity in existing bariatric units.

Although BOMMS does regard the expansion of MBS activity in the NHS as a public health priority, this must be undertaken in a safe way underpinned by transparent governance processes as detailed below.

i. Support for newly established bariatric units

BOMSS wish to re-emphasise previous advice from the 2019 update that newly established units should be supported by a more experienced bariatric MDT as part of a local network. The period of mentorship for a unit should be at least one year, with extended informal mentorship as needed. In addition, new units should not undertake elective complex revisional surgery until the volume of primary MBS as stated above has been reached.

For those Consultant surgeons operating in a newly established unit, with minimal recent track record, BOMSS guidance mandates a formal mentorship process with the new surgeon operating jointly with an accredited specialist surgeon for a minimum of 40 cases. This mentorship process should last a minimum of one year, with extended informal mentorship as needed.

ii. Increasing primary bariatric surgical activity in established units

BOMMS strongly supports the expansion of surgical activity within existing bariatric units as a method of increasing patients' timely access to bariatric surgery. BOMSS does however recognise the constraints on the availability of in-patient hospital beds within the NHS. BOMSS therefore strongly supports the exploration of novel service delivery models including same day discharge protocols as recommended by Get it Right First Time (GIRFT) (21) as a method of addressing these constraints.

In terms of individual surgeons' activity, as previously outlined BOMSS expects that an accredited surgeon undertaking primary bariatric surgery will be performing at least 40 cases per year. It is acknowledged that some surgeons within established bariatric units will not be achieving this figure. BOMSS strongly advocates that these surgeons are afforded the opportunity to increase their activity to achieve this minimum level of activity.

For experienced surgeons whose individual volumes are only slightly lower than the BOMSS minimum standards, this expansion of activity may be achieved without the need for formal additional governance safeguards.

However, there will be surgeons working within an established unit who have a limited recent track record of independent bariatric surgical activity. This would include, for example, recently appointed Consultants; and those for whom bariatric surgery comprises a small component of their job plan. Whilst BOMSS supports the expansion of these surgeons' bariatric surgical activity, this needs to be managed within a governance structure which priorities patient safety.

Therefore, for surgeons whose four year track record, as published by NBSR, falls below half of the threshold required for accreditation (i.e. 80 cases or fewer over the preceding four year period), BOMSS recommends these surgeons increase their activity under the guidance of formal governance process. This would include mentorship by a "specialist" surgeon and regular monitoring of their clinical outcomes.

Complex Revisional surgery

Given the relative rarity of revisional procedures and the increased incidence of complications in these cases, complex elective revisional surgery should only be independently undertaken by "specialist" surgeons within "specialist" units (as previously defined).

For lower volume surgeons, BOMMS strongly supports the principle of two Consultant operating for elective complex revisional cases, with "specialist" surgeons acting as mentors. This approach maximises patient safety, provides a degree of medicolegal protection and allows training and mentorship for less experienced surgeons. Such joint operating also aids in terms of the delivery of robust specialist out of hours cover which is a requirement for any service undertaking complex revisional surgery.

For surgeons who fulfil the criteria as accredited surgeons, but do not fulfil the criteria as specialist surgeons (i.e. surgeons performing between 160-240 cases over a four year period) BOMSS advocates these surgeons should undergo formal mentorship including joint operating with a "specialist" surgeon (i.e. one who fulfils the minimum standards needed to undertake revisional cases independently).

For surgeons who do not fulfil the criteria of an accredited surgeon (ie less than 160 recorded cases over the preceding four year period) BOMSS guidance mandates two Consultant operating with a "specialist" surgeon taking the role of the lead operator in all cases.

Long term clinical follow-up

Previous BOMSS guidance emphasises the importance of long term follow up for all patients who have undergone MBS, with responsibility for care residing with the bariatric team for the first two

years after surgery. Thereafter the expectation is that routine postoperative and annual monitoring should be transferred to; and remain within the remit of primary care. However concerns regarding late complications related to surgery should prompt timely referral to a Bariatric Centre for specialist assessment.

BOMSS has developed a dedicated online GP Hub (BOMSS GP Hub) to support primary care clinicians in the management of patients following bariatric (metabolic) surgery. The GP Hub is intended to support clinicians in delivering safe, evidence-based long-term follow-up, ensuring that patients receive appropriate surveillance and ongoing care in line with national recommendations. The GP Hub also contains guidance to support the first line management and treatment of nutritional deficiencies in primary care, as well as guidance on when referral to a specialist bariatric unit related to micronutrient deficiency is recommended. Where referral to alternative specialties may be required; the GP Hub also offers guidance to support these decisions.

For patients who are within two years of surgery and who are not under the care of a specialist bariatric surgery (e.g. patients who have surgery abroad) there is a need for locally agreed pathways to support the triage, assessment and management of these patients. These pathways need to be designed to ensure that these patients have access to clinicians with the appropriate expertise to undertake routine early to mid-term post-operative follow-up; and to identify early to mid-term surgical complications. Such a pathway would promote a consistent and proactive approach to post-operative care with the aim of reducing the incidence of emergency readmissions.

BARIATRIC SERVICE PROVISION WITHIN THE PRIVATE SECTOR

BOMSS recognises and welcomes the important contribution of private sector in the delivery of MBS both for self- funding, and (rarely) insured patients; as well as those who are "outsourced" as part of a NHS pathway.

BOMSS acknowledges that there are additional specific challenges in service delivery within the private sector. For example, private hospitals often do not have on site Level 2 (HDU) or Level 3 (ICU) facilities. There is also potentially additional clinical and medicolegal responsibilities on clinicians undertaking MBS in the private sector as compared to delivery within an NHS hospital.

It therefore remains the view of BOMSS that private hospitals providing MBS to any class of patient should at all times meet, and in some areas exceed, the minimum standards set out above for NHS services as detailed below.

Facilities

Private hospital undertaking MBS require the same minimum standards of facilities as an NHS hospital as detailed in the 2012 and 2019 guidelines.

In addition, as the majority of private hospital do not have an site HDU/ICU facilities, there is a need for private hospitals undertaking MBS to have robust protocol for transfer; and a service level agreement (SLA) with an appropriate NHS or private hospital with ICU facilities.

Governance

The governance arrangement for MBS in private hospitals should be the same as those detailed for NHS hospital, with the NBSR being used to verify the surgical volume and peri-operative outcome for surgeons.

Similarly, there is a need for all private hospitals to have a robust governance and recording system to monitor individual surgeons 90 day complication rates and ensure these are within international benchmarked standards.

As per previous 2012 guidelines, where NHS services are outsourced, BOMSS recommends that the body with responsibility for outsourcing should pay special attention to ensure the BOMSS standards met prior to commissioning such services.

Multidisciplinary team (MDT) assessment

The MDT assessment requirements in terms of personnel and logistics are identical to those required for the NHS.

BOMSS also recognises that the nature of private practice means there may be specific commercial influences on both the surgeon and hospital which are not present in the NHS. In order to prevent the perception of conflicts of interests and maintain an MDT principle of a "cabinet of equals" BOMSS recommends that the bariatric clinical nurse specialist and specialist bariatric dieticians be directly employed by the private hospital. In addition, there may be a role for supra-regional bariatric MDT hubs to allow input from clinicians from outside the private hospital.

Cross cover and emergency arrangements

As with the NHS guidelines, there is no longer a requirement for a hospital to engage two or more accredited bariatric surgeons; nor is there a requirement for cross cover to be provided by an accredited bariatric surgeon. Such cover can be provided by a surgeon who is qualified and able to participate in an NHS general surgical emergency on call service.

As with NHS guidelines, patients must have a clear understanding of alarm features relevant to the surgery they had; and of the timeframe in which emergencies may occur. The MDT must establish, in concert with the institution, an appropriate pathway to ensure patient access to expert care can be facilitated in the event of a deviation from a standard post-operative recovery.

Revisional surgery

For private hospitals undertaking revisional bariatric surgery, the same volume criteria as detailed for the NHS applies to both the hospitals and surgeons (i.e. a track record of having performed 240 cases over the previous four years as demonstrated in the yearly published NBSR Consultant COP).

In addition, given the higher risk of complications associated with these procedures, there is a need for cross cover for any revisional surgery by a second specialist bariatric surgeon in order to ensure robust emergency cover for these patients.

Long term clinical follow-up

As per previous 2012 guidelines BOMSS deplores the promotion of bariatric care packages in the independent sector that either ignore the provision of proper multidisciplinary follow-up over appropriate periods of time, and/or fail to inform patients of the importance of long-term follow-up.

Notwithstanding poor practices in this regard there are also genuine cases whereby patients self- fund for treatment, fully recognising the follow-up issue but are unable to fund this ongoing aspect of their care. BOMSS recommends that those who cannot self-fund follow up (particularly the cost of the routine blood tests) should not be denied access to treatment in the NHS on the grounds of the previous private operation.

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