BOMSS PROFESSIONAL STANDARDS DOCUMENT

This document is an Appendix to and should be read in conjunction with "*Providing Bariatric Surgery – BOMSS Standards for Clinical Services & Guidance on Commissioning*".

The GMC's *Good Medical Practice* and the Royal College of Surgeons of England's *Good Surgical Practice* set standards for UK surgeons. This document aims to supplement these publications by defining Professional Standards relevant to the practice of Bariatric Surgery in the UK.

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A. Practitioner standards

1. Standards for surgeons

Bariatric surgery is challenging due to the large size of patients, restricted laparoscopic access and the unique physiology of the severely obese. Bariatric surgery is not for the occasional operator. It requires advanced skills and specific training.

Providing Bariatric Surgery – BOMSS Standards for Clinical Services & Guidance on Commissioning recommends that NHS provision of Bariatric Surgery should be commissioned in Bariatric Units and Bariatric Centres, and details minimum numbers of operations for Individual Surgeons and Units / Centres.

A bariatric surgeon should:

Be adequately trained and experienced as defined in Section A2 below.

Perform at least 40 bariatric cases per annum.

Be able to offer patients a range of procedures, including gastric banding, Roux en Y gastric bypass and Sleeve Gastrectomy according to individual patient's needs and circumstances. Surgeons offering only one type of operation should only work as part of a unit offering a full range of procedures. Single-handed, single-procedure practice is to be discouraged.

Be adequately trained and experienced in the recognition and management of bariatric surgery complications.

Be committed to continuing professional development, education and training in the field of Bariatric Surgery.

Be able to carry out revisional bariatric surgery.

Ensure that adequate Consultant-level cover is readily available for all patients in the post-operative period.

Be involved in the training of less-experienced bariatric surgeons and trainees.

Be committed to multidisciplinary team working with other healthcare professionals to best meet the needs of individual patients.

Be committed to the long-term follow-up of his / her patients. Bariatric surgeons should ensure that there are robust, reliable and realistic arrangements in place for the short and long term post operative follow up and care of all patients for whom they perform a bariatric operation. This should include appropriate levels of surgeon, dietitian, psychologist / psychiatrist, GP and nursing input.

Maintain a log of procedures, results and complication rates, ideally via a dedicated bariatric database, preferably the National Bariatric Surgery Registry (NBSR). Bariatric surgeons should ensure that there are reliable arrangements in place for follow up data for all their patients to be captured and entered onto such a database.

Regularly audit their individual and Unit's / Centre's results.

Perform bariatric surgery only in Units or Centres meeting BOMSS Facility Standards as defined below in Section B.

Be an active member of a Specialist Bariatric Professional Society, preferably BOMSS.

Ensure that they and any organization they work with in providing bariatric surgery adhere to the *BOMSS Statement on Current Advertising Practice for Bariatric Procedures*.

2. Standards of Training and Experience of Bariatric Surgeons

A bariatric surgeon should be adequately trained in bariatric surgery. International societies (ASMBS, IFSO) have already suggested curricula for bariatric training, and given the well-documented relationship between surgeon experience and the incidence of death and major complications after laparoscopic gastric bypass, BOMSS has adopted similar standards for the UK. It is mandatory that bariatric surgeons be trained in the management of the patient who is morbidly obese and has an understanding of all the surgical treatment options for morbid obesity, including early and late complications.

A bariatric surgeon should:

Have appropriate certification to perform General Surgery (CCT) and have had training in Upper Gastrointestinal, Laparoscopic and Emergency surgery.

Have completed a period of participatory training at a bariatric institution (not simply observing surgery). This period should be being long enough to gain experience of all common operative techniques, and management of their complications. The period should also include experience in the medium to long-term follow up of post-operative patients.

Have testimonials by mentors/proctors of satisfactory bariatric training.

Have a log book/maintain a database (preferably the NBSR) of bariatric cases during training.

It is recognised and recommended that for a surgical trainee an additional (post-CCT) fellowship for 6 or 12 months in a specialist bariatric unit or centre may be the best way of achieving the above skills and experience skills for independent bariatric surgical practice, e.g. those accredited by the Royal College of Surgeons according to the ISCP

By the end of their bariatric surgery training the trainee should aim to have fulfilled the requirements of the *BOMSS Bariatric Training Fellowship Core Curriculum* (published on the BOMSS website).

For an established Consultant Surgeon without previous bariatric training it is recognised that a prolonged period of participatory training may be impractical. In such cases it is recommended that a shorter period of participatory training should be augmented with an appropriate period of mentorship with an established bariatric surgeon, who should provide a testimonial of appropriate training and experience prior to commencement of independent practice.

3. Standards of Training and Experience of Non Surgeon members of the MDT

Providing Bariatric Surgery – BOMSS Standards for Clinical Services & Guidance on Commissioning addresses the make-up of the individual multidisciplinary teams (MDTs). Bariatric surgeons should work as part of Multidisciplinary teams in which each participant is expected to maintain registration with their relevant Professional Regulatory Body and to be a member of the relevant specialist society e.g. the Society of Bariatric Anaesthetists (SOBA) or the British Dietetic Association. All participants should be suitably trained and experienced in the care of bariatric surgery patients and committed to continuing professional development in their field.

4. Patient advocacy

A bariatric surgeon must ensure that all decisions taken concerning a patient are taken with the full involvement and understanding of the patient. All such decisions should always be in the individual patient's best interest.

A bariatric surgeon should ensure that all patients are given access to all relevant healthcare professionals both within and without of the MDT, in order to ensure that their needs in terms of pre operative assessment and optimisation, perioperative care and post operative management are fully met.

A bariatric surgeon should assess all patients individually prior to the day of surgery in order to ensure that patients have been appropriately assessed, advised, any comorbidities optimised and that decisions regarding surgery have been taken in the patients best interests.

5. Obtaining consent for bariatric procedures

A bariatric surgeon should ensure that the patient has all the necessary education and advice required to give informed consent for their bariatric / metabolic procedure. A deferred two-stage consent process should be used with a sufficient time lapse. The details of benefits and risks should be explicit and should be supported with written documentation. Specifically the whole consent process should not be undertaken in one stage on the day of

surgery. Throughout the process the bariatric surgeon should consider the patient's capacity to give informed consent, being mindful of their literacy skills and any learning / cognitive disability.

6. Ethics statement

A bariatric surgeon should adhere to the *BOMSS Code of Ethics.*

7. Working in Teams

The decision on whether or not a patient is suitable for surgery needs to be made with the input of advice from a number of different health professionals. Surgeons cannot work alone and it is imperative that they work with a multidisciplinary team as outlined in *Providing Bariatric Surgery – BOMSS Standards for Clinical Services & Guidance on Commissioning*; preferably by the use of MDT meetings.

Bariatric surgeons should ensure that all patients have access to a full MDT and any other healthcare professionals and specialists, as their individual care requires. Many patients will not need to be seen by more than a few members of the MDT. Typically every patient will need to be comprehensively assessed by the bariatric surgeon and ***at least*** one other professional – usually the Specialist Dietitian (or occasionally Nurse Specialist, but preferably both). Psychological support should be available to all patients from an early stage and as required throughout the care pathway pre and post surgery. Screening tools should be employed to identify and appropriately refer patients who may require such help.

8. Audit

BOMSS is committed to national data collection and to audit through the National Bariatric Surgery Registry (NBSR).

Bariatric surgeons should commit to long term data collection and audit of their individual and Unit's / Centre's results, ideally via a dedicated bariatric database, preferably the NBSR. Bariatric surgeons should ensure that there are reliable arrangements in place for short and long term follow up data of all their patients to be captured, entered onto such a database and regularly audited.

B. Facility Standards

1. Equipment & Safety

Bariatric surgery must only be undertaken in facilities that are adequately equipped. Such requirements are significant, but essential for the safe conduct of bariatric surgery.

Each bariatric surgery facility should have a clearly documented and agreed Institutional weight limit, taking the capacity of equipment (outpatient, diagnostic, surgical, manual handling, ward care & hygiene) on the local treatment pathway into account. The lack of suitable equipment should at no time stigmatise or single out a bariatric patient.

All personnel dealing with bariatric patients must be conversant with the use of such equipment and deal respectfully and sensitively with the vulnerabilities of bariatric patients.

Where institutional escalation policies also require inter-hospital transfer, the facilities of the available ambulance service must be known and agreed.

Scales
In all areas where patients need to be weighed (Outpatient clinics, wards etc.) there should be readily available weighing scales that are capable to accurately weighing obese patients, that are easily accessible to obese patients both standing and seated and which are situated in a area providing privacy and dignity for patients.

Hoisting and transfer equipment
Most bariatric patients are mobile and able to transfer with minimal aid. However, all bariatric surgery institutions must have a range of equipment readily available in all relevant areas to allow for obese patients to be transferred easily and safely, both in the ward and theatre environments.

Outpatient clinics
All patients will require pre-operative assessment and it is essential that outpatient facilities offer the same level of care and dignity to bariatric patients that are provided to other patients. Outpatient facilities must therefore have chairs and examination couches that not only have the requisite weight limits, but that are also adequately sized to allow the patient to sit and/or lie comfortably. Wheelchairs of appropriate dimensions must be made available and doorways must be large enough to accommodate the same.

Wards
All bariatric surgery patients should be managed on designated wards in order to concentrate nursing and medical experience, and the necessary equipment. Wards should be equipped with everything that is needed to safely care for a bariatric patient with dignity. This includes having the following items available with a suitable weight capacity and/or size:

Beds allowing the patient to sit up to at least 45% angle
Pressure relieving mattresses
Chairs
Toilets
Wheelchairs

Commodes
Hoists
Weighing scales of suitable range
Zimmer frames
Anti-embolism stockings (bariatric size), which should be used as part of the locally agreed regimen for DVT prophylaxis
Adequate space around each bed space to accommodate bariatric size chairs

As several members of staff may be required to help transfer patients, it is important that this is taken into account when deciding on staffing numbers and duty rosters. The hospital must give consideration as to how it would evacuate bariatric patients in case of an emergency such as a fire. Consideration must be given to transfer arrangements, should they be required, in conjunction with the local ambulance service.

Theatres
Operating theatres should be equipped with suitable tables, manual handling devices and anaesthetic equipment.

These should include:

- Suitable transfer facilities, e.g. hoist and / or hover mattress
- Electric operating table that allows steep reverse Trendelenburg position
- Operating table leg extensions
- Operating table footplates
- Appropriate arm supports and padding
- Difficult intubation equipment including availability of fibre□optic laryngoscopy
- Suitable ventilator
- Availability of central lines catheters
- Availability of invasive arterial pressure monitoring
- Provision for maintaining normothermia
- Blood gas analysis must be onsite.
- Readily available blood for transfusion according to local protocols.
- Beds that allow patients to sit up to 45%, and to be woken and extubated on the bed.

The majority of bariatric surgery is laparoscopic and it is the view of BOMSS that high definition video equipment with ergonomic availability of monitors is mandatory. Appropriate instrumentation for laparoscopic and open bariatric surgery should be available at all times and as a minimum, there must be an adequate supply of instruments kept ***available to enable emergency re-operation,*** the preceding elective case-load notwithstanding. ***Equipment for emergency re-operation must include a bariatric grade static retractor system for open surgery.***

Post-operative Recovery and High Dependency / Intensive care
It is the overwhelming rule that elective bariatric surgery patients, properly prepared, anaesthetised, operated on and recovered are independent of advanced recovery facilities. Nevertheless, no patient should spend the initial post-operative hours, usually the night, in a lower than Level 1 ward facility. On-site Level 2 Critical Care facilities certified to the CQC standards are an essential prerequisite for units undertaking any bariatric surgery other than straightforward gastric banding operations in low risk patients.

It is not recommended that any unit undertake a practice limited to gastric banding but BOMSS recognizes that there are safe UK Institutions operating with this practice. The decision to undertake such a limited practice without any on-site Level 2 facility *is not advised* but is a matter for a clear and robust understanding of responsibility between the Service Lead and Head of Clinical Governance and will depend on transfer distances and the reliable availability of Level 2 care facilities elswhere.

For uncomplicated cases undergoing gastric bypass or sleeve gastrectomy (excluding Super-Super-Obese and High risk superobese patients) It may equally be appropriate for Service Lead and Head of Clinical Governance to accept only a limited period of service at Level 2 (12 hours minimum), but *only* where transfer distances and Service Level Agreements allow for rapid access to continuously available off-site Level 2 facilities.

No patient outside the above risk category should be operated in a facility without continuous (and actually available) on-site level 2 availability. In all cases, not only should the appropriate equipment and monitoring be immediately available and functional, but also there should be appropriately trained staff. Nursing staff should have documented training in caring for Level 2 patients and in managing and recognizing specific clinical scenarios relating to bariatric surgery patients.

Robust postoperative care pathways, observation and escalation policies appropriate and specific to bariatric patients should be available and all relevant staff, including night staff and resident doctors must be familiar with and trained in them.

Resident Medical Officers with some critical care/anaesthesia experience are recommended, but as a minimum standard all RMO's must be supported by the availability of 24/7 consultant bariatric surgical and anaesthetic cover. Where such RMO cover is not available there is an additional front-line responsibility on the Consultant bariatric surgeon and anaesthetist.

Depending on the experience of the team (and on the responsibility of Service Lead and Head of Clinical Governance), patients undergoing Duodenal Switch procedures, all super-super-obese patients and all patients undergoing revisional surgery (except re-banding) should only be operated on in facilities with on-site level 3 critical care, unless the latter is reliably and continuously (actually) available close at hand. This will be partly dependent upon the clinical experience of the unit performing the surgery. Although data on the relationship of surgical volume to outcome may be crude and subject to publication bias, there is some evidence that groups performing higher volumes per year have better outcomes than those performing under 50. MDTs with long experience or experience of 100 or more cases per year and who have validated outcomes, should be at liberty to decide which patients can be operated on safely without the requirement for an onsite Level 3 critical care unit. However, robust postoperative observations and, critically, the availability of senior doctor review should be demonstrated.

Clear guidelines for transfer to a critical care bed in a neighbouring facility should be demonstrated, usually in the form of a Service Level Agreement either with a nearby facility or with a critical care network. This requires that the local ambulance service can provide an emergency ambulance within a guaranteed transfer time agreed between Service Lead and Head of Clinical Governance. The responsibility for

ensuring this is in place rests jointly with the Surgeon, Anaesthetist and Hospital Manager/Director of Nursing. Appropriate equipment to manage a transfer of a critically ill bariatric patient (including transfer ventilators) should be available. The final risk assessment and location of surgery for each patient is the responsibility of the operating surgeon and anaesthetising anaesthetist, but only in concert with agreed MDT standards and with Service Lead and Head of Clinical Governance.

Patients should be encouraged and able to bring in their own CPAP (Continuous Positive Airway Pressure) / BIPAP (Bilevel Positive Airway Pressure) machines and use them pre- and post- operatively as required. All units should have the ability to provide oxygen enriched CPAP acutely in an emergency situation and at least one nurse at any one time conversant with the principles of CPAP.

Imaging

Bariatric facilities should have the availability of cross-sectional imaging and fluoroscopic imaging of the upper GI track suitable for the majority of their patients. However it is recognised that there is a national lack of certain types of imaging equipment with adequate weight-capacity. If these facilities are not available in house, there must be clear protocols and Service Level Agreements that will ensure safe transfer to a nearby facility that can provide such imaging in a timely manner should the need arise.

The weight limitation of available imaging equipment should be explicit.

A senior radiologist should report the images the same day and he/she should be available to discuss the imaging with the surgeon.

2. Staffing

Bariatric surgery facilities should ensure that all members of their bariatric surgery multidisciplinary team meet the relevant standards of experience and training as defined in this document and those of other relevant Professional Societies.

All patients must have access to the full range of specialist professionals appropriate for their needs in line with NICE guidelines. Patients need access to a team of surgeons, bariatric physicians / endocrinologists, anaesthetist, nurses and dietitians who have specialist experience in assessing morbidly obese patients. In addition, patients should have easy access to psychological support where this is indicated. Access to other specialities (eg. sleep studies, respiratory medicine, cardiology) should be available when required.

Resident Medical Officers with some critical care/anaesthesia experience are recommended, but as a minimum standard all RMOs must be supported by the availability of 24/7 consultant surgical and anaesthetic cover.

3. Staff education

It is important that all members of the bariatric team commit to lifelong learning.

All surgeons need to commit to continuing medical education as required for revalidation with the GMC. Continuing Medical Education opportunities afforded by specialty society membership allows members to keep up to date with advances in bariatric and metabolic surgical techniques. We would suggest that all bariatric surgeons should belong to at least one of the specialist bariatric and metabolic societies receive at least one of the bariatric and metabolic journals and attend at least one of the annual society meetings.

Robust postoperative care pathways, observation and escalation policies appropriate and specific to bariatric patients should be available and all relevant staff, including night staff and resident doctors must be familiar with and trained in them. Appropriate sensitivity training should be available to all hospital and clinic staff that care for bariatric patients.

4. Governance

Care pathways, escalation polices and protocols should be agreed with health professionals for all major aspects of service delivery. It is advisable to have clearance of such policies and protocols from the local/regional governance committees.

Clear continuous long-term follow-up plans must be made for every patient including input from all relevant health professionals.

It is essential that arrangements be in place for cover at all times throughout a patient's inpatient stay.

5. Follow Up of patients and Audit

Facilities and / or organisations undertaking bariatric surgery should be committed to the long-term follow-up of their patients. They should ensure that there are robust, reliable and realistic arrangements in place for the short and long term postoperative follow up and care of all patients. This should include appropriate levels of surgeon, dietitian, psychology/ psychiatric, GP and nursing input.

Facilities and / or organisations undertaking bariatric surgery should commit to long term data collection with local and national audit of their results, ideally via a dedicated bariatric database, preferably the NBSR. They should ensure that there are reliable arrangements in place for short and long term follow up data of all their patients to be captured, entered onto such a database and regularly audited. Such audit data should be publically available.

6. Advertising Standards

Bariatric facilities should employ an advertising policy which adheres to the *BOMSS Statement on Current Advertising Practice for Bariatric Procedures*.

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