Engagement Report for Service Specification

Unique Reference Number	A05-S02
Title	Severe and Complex Obesity Surgery for Children
Accountable Commissioner	Sue Sawyer
Clinical Reference Group	Severe and Complex Obesity (all ages)
Which stakeholders were contacted to be involved in policy development?	The severe and complex obesity clinical reference group and stakeholders and paediatric surgery were contacted on 08.02.16 for a 1 week stakeholder engagement exercise.
Identify the relevant Royal College or Professional Society to the policy and indicate how they have been involved	Royal College of Physicians Association of Physicians specialising in Obesity British Dietetic Association British Obesity and Metabolic Surgery Society - Have been involved as stakeholders in the clinical reference group.
Which stakeholders have actually been involved?	The clinical reference group formed a policy working group which was a sub-set of the main CRG; some stakeholders were informally consulted during this process.

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Explain reason if there is any difference from previous question	No
Identify any particular stakeholder organisations that may be key to the policy development that you have approached that have yet to be engaged. Indicate why?	We have received responses from relevant stakeholders and expect more comments during the wider public consultation. The relevant professional body has commented as part of the stakeholder feedback. The PWG recommends that we would wish to specifically engage with British Association of Paediatric Surgeons, British Obesity and Metabolic Surgery Society, NHS England Paediatric Surgery Clinical Reference group to review the recommendations around surgeon specific requirements.
How have stakeholders been involved? What engagement methods have been used?	Following development of the draft service specification stakeholders were contacted for feedback via email correspondence.
What has happened or changed as a result of their input?	The service specification is being reviewed by the PWG to identify if any of the comments/suggests would constitute a material change and would need amendment prior to wider public consultation. Minor typing errors have been corrected.
How are stakeholders being kept informed of progress with policy development as a result of their input?	An email response will be sent to the stakeholders describing the feedback in the engagement report on individual comments.
What level of wider public consultation is recommended by the CRG for the NPOC Board to agree as a result of stakeholder involvement?	It is suggested by this clinical reference group that this service specification should run for four weeks. There were two respondents who felt this should be extended for to a three month consultation. However to coincide with the public consultation for A05X03 Severe and complex obesity surgery for children policy it is suggested that these documents follow the same process which is for 4 weeks public consultation.

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Appendix One - Stakeholder Feedback

Organisation Responding	Feedback Received	PWG response	Resulting Action
1. Individual Clinician	-Changes would benefit from a 4 week consultation.	Noted	No action required
	1.0 This section should include the emotional and psychological impacts of childhood obesity as well as the impact on educational attainment. We know that the heaviest children will lead us to complex families with multiple health and social care needs.	Noted and a reasonable point	Noted for review and return to PWG for amendments prior to public consultation
	1.1 & 1.2 In clinical practice we would use the 91st centile as the cut off for overweight (rather than the 90th)	In clinical practice we would use 91st centile for overweight and 99.6th for obesity. This document relates to obesity sufficient to consider surgery see section 1.6	No changes made.
	1.3 Small typo; They are *thought* cumbersome	Noted	Changed
	1.4 This section is confusing and potentially non-workable. It seems sensible to use the 99.6th centile for BMI cut-off point1.5	Noted but the PWG have made an attempt to note the recommended definitions. This	No changes made

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	Establishing the pubertal stage of a child should be assessed ***after*** the initial identification of being above the 99.6th centile, rather than being used as initial criteria.	is an alternative approach than that used in the USA	
	1.6 Unfortunately this is far too confusing and would prove unworkable. We should use the 99.6th centile to identify children to denote 'severe obesity' and to gain access to medical assessment.	Noted but the PWG does not concur with this approach The PWG agrees with the level of 99.6 centile for tier three services but this document is specifically related to surgical care.	No changes made No changes made
	1.9 It is imperative that the specialist MDT include representation from children's social care and from education. We know that the heaviest children lead us to families with complex health and social needs and that having childhood obesity impacts on educational attainment. Any child undergoing medical intervention for obesity will require intensive and long-term follow-up with social care often having significant influence on behaviour.	This is covered in the document	Specification has been reviewed to ensure there is appropriate representation of these roles.
	The treatment plan should include domiciliary visits rather than be centred on a clinical environment and should extend to a 24 month	This would not be possible for economic reasons and is outside of the scope of this	No Changes made

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	period.3.2.1 Surgery should be reserved for paediatric and adolescent patients ***whose families*** have undergone an extensive behavioural change programme. Other considerations are;	specification Social worker should be the liaison with education	 No Changes made
	Likelihood of the ***patient/family*** adhering to a follow-up programme	Points noted but PWG feel this is highlighted later in the specification	No changes made
	4.2 Local Tier 3 services are not widely commissioned but must be available to support the Tier 4 services	PWG agree with this point but this is outside the scope of this specification.	No Changes made
	4.4Access to social worker and child protection assessment ***must always*** be included in the assessment	PWG note this comment and feel that this is covered in the document but furthermore clarify that where appropriate the paediatrician will be the lead for this.	No changes made
	6.2 Related services NHS Safeguarding teams Education services	Noted – covered in section 6.2	No changes made
2. British Dietetic Association	-Changes would benefit from a 4 week consultation	Noted	No action required.

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	The figures in domain 1 (p3) that are quoted for total weight loss for each procedure are underestimated and do not represent the research data or NBSR report 2014. It should be postoperative not preoperative weight loss as stated.	PWG agree with this comment however the specific point here is to performance manage centres on weight loss and the PWG feels that these are realistic figures in children's surgeryThe targets are to indicate minimum targets of weight loss rather than expected average	No action required
	Section 4.1 should also include specialist dietetic pre and post bariatric surgery dietary assessment and advice from an experienced dietitian. All patients should have pre-operative nutritional blood tests/screening and advised appropriate micronutrient supplementation, as per BOMSS nutritional guidance 2014.	PWG noted this and feel it is covered in the specification but will clarify the point.	Specification amended
	Section 4.1 should also include providing access to a support group (face to face or online) and access to a physical activity therapist or physiotherapist	PWG feels that this is outside the scope of this policy and should be provided as part of tier 3 weight management services. Agree that physiotherapist should be part of the post-operative team to support mobilisation. PWG agrees with this point	No action required Specification has been updated to include this

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	Section 4.1 Regular post-operative assessment needs defining.	Noted – these definition are taken from the adult service specification.	clarity. No changes required.
	Section 4.3 The descriptions for the bariatric procedures are inaccurate and require revising	The PWG note this comment but it is their view that this is covered in a tier 3 weight management service and in the post-operative period this will be up to individual local policy for MDT engagement.	No Changes made
	Section 4.4 Pre-operative preparation should include a full dietetic assessment and advice/monitoring with a full nutritional screen. Post-operative care should specify who should be part of the surgical MDT (surgeon, dietitian, nurse, psychologist, physician)	Noted and amendments made	Specification updated Specification reviewed and amended
	Section 4.4 the advice for follow up with the gastric band is incorrect and does not reflect current UK practice in terms of frequency of follow up should occur. Gastric band patients should still require life-long follow up as with all other bariatric procedures, not 5 years as stated	The specification has been reviewed by the PWG and the references are supplied by for information at the end of this document.	No Changes made
	Section 4.5 The risks and complication rates of surgery are inaccurate and are not	It is the experience of this PWG that scales up to 300kg are	No changes made

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	representative of current NSBR data	sufficient but an alternative arrangement would need to be sourced if this was not the case	
	Section 4.7 weighing scales should be up to 500kgs not 300kgs.	This is covered in the specification.	No changes made.
	Section 4.8 staffing should read 'A specialist dietitian with experience and knowledge of obesity surgery and obesity management	NICE CG189 (Nov 2014) recommends that surgical services offer information on or access to plastic surgery where appropriate. This is out of scope of this specification but information will be given as part of the package of care.	No changes made
	Section 4.9 this does not reflect current NICE commissioning guidance 2014	The PWG feel that this should be the surgeon in the outpatient setting but acknowledge that other members of the MDT will be part of the assessment.	No Changes made
	Section 6.1, point 5 should include a specialist dietitian and nurse to discuss bariatric surgery and provide appropriate written information, resources and support		

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3. Individual NHS doctor response I am a Consultant Child and Adolescent Psychiatrist in a Specialist Eating Disorders Service for Children and Young People.	Changes would benefit from a four week consultation I am concerned that Binge Eating Disorder (BED) has not been listed as an exclusion criterion for surgery. Although many centres do not screen for it currently, the presence of BED in patients who undergo weight loss surgery can lead to poor outcomes, especially in the long term http://www.ncbi.nlm.nih.gov/pubmed/24347539) I would propose that children and young people with severe obesity are screened for BED using the Eating Disorders Examination Questionnaire. If BED is suspected, they should be referred to the local Children Young People's ED service for an assessment and possible treatment of the BED prior to any surgery taking place.	Noted PWG reviewed the paper submitted and noted that binge eating disorder was not listed as an exclusion for surgery which is in line with the PWG assumptions. All Patients have a psychological screen as part of the pathway management and work up and will be referred as appropriate.	No changes made No changes made
4. British Obesity and metabolic surgery society (BOMSS)	Changes would benefit from 12 week consultation In line with the recommendations of the American Society of Bariatric and Metabolic Surgery (ASMBS) *"pediatric best practice guidelines"* the bariatric surgeon should be an experienced bariatric surgeon. There is no mention in those guidelines of need for a pediatric surgeon to work alongside an	Noted The PWG acknowledges and welcomes the comments from BOMMS on this important matter. The consensus view represented in the draft service specification is based on managing the safety and quality	To support the debate around this important aspect of the service specification the PWG will actively seek views from the following organisations British

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	experienced bariatric surgeon. Based on above guidelines we request to be removed from the service specification *"….paediatric surgeon. The latter surgeon will be working alongside the adult obesity surgeon or be a paediatric surgeon with sufficient and current experience in obesity surgery and the range of procedures."* There is no evidence or consensus that a pediatric surgeon is required to provide expertise within an MDT team with regards to bariatric surgery in adolescents. On the contrary there is consensus and guidelines that the bariatric surgeon involved in adolescent bariatric surgery should be an "expert" bariatric surgeon. In Chapter 4.3 with regards to Type of Surgery: *"The type of procedure selected will depend upon a range of clinical factors, including…. the experience of the surgeon who will perform the operation."* Chapter needs amendment as it implies that the surgeon would be only proficient in some of the bariatric procedures listed, hence is not an experience bariatric surgeon. We feel Bariatric Surgery in Adolescents should be performed only by an established	aspects of this of surgery in children. The decision to support joint procedures is an attempt to combine the clinical expertise in both the adult obesity surgery area and the paediatric service which this proposed service would be a part of. This proposed approach will support the development of paediatric expertise over time, combine good clinical practice to support the NCEPOD recommendations for younger patients (under 16 years old) and supports the facilitation of emergency out of hours care particularly if required especially at a children's hospital,	association of paediatric surgeons, the NHS England paediatric surgery clinical reference group and BOMMS and will facilitate a specific discussion to take this forward. If required.

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	bariatric surgeon proficient in all bariatric procedures and that service specification should also define Surgeon's credentials for a provider of Bariatric Surgery in Adolescents and this should include: 1. Established bariatric surgeon with at least 5 years of experience at Consultant level 2. Proficient in all laparoscopic bariatric procedures, including revisional 3. Annual caseload of at least 40 laparoscopic bariatric surgery cases/year (excluding gastric band) with at least 20 cases/year involving a gastro-entero anastomosis (i.e. Gastric Bypass) 4. NBSR (National Bariatric Surgery Registry) contributor 5. Regular attendance at National and International Conferences 6. Full member of BOMSS		
	Further suggested amendments as follow: Page 3: Domain 1. Is percentage preoperative weight loss at 1 year post surgery an appropriate measure given that there may be continued growth in height? Page 8: 4.1 The specialised multidisciplinary team needs to include psychology/ psychiatry	PWG do not agree as selection for surgery will be based on patients who are post pubertal and this is expressed as a target Noted- this is covered within the document	No changes made No changes made

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	Page 8: 4.1 The specialised multidisciplinary team needs to include a family social worker	Noted-this is covered within the document	No changes made
	Page 10: 4.4 pre-operative assessment needs to include psychological assessment	Noted – this is covered within the document	No changes made
	Post-operative care - the regular follow up and support needs to be emphasised rather than saying "Post-operative care should be available to manage complications as they occur." Good dietetic and psychological support can help with the prevention of complications.	This is a mandatory as part of the post-operative follow up.	Specification amended
	The dietitian is an essential member of the multidisciplinary team and therefore must be provided. The dietitian must be specialised in obesity management including surgical management regardless of where the patient is seen.	Noted – this is covered in the specification	No changes made
	Pages 12 add protein malnutrition to complications of gastric bypass.	Noted and amended	Specification amended
	The risks arising as a result of vitamin and mineral deficiencies need to be highlighted.	PWG feel this is covered in section 10 vitamin and micronutrient depletion needs to be regularly monitored.	No changes made
	Page 14 Specialist dietitian with expert knowledge in obesity and bariatric surgery	Noted – this is covered in the specification	No changes made.

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5. Individual Clinician NHS Trust	The changes are material and significant and would benefit from wider and full public consultation of 12 weeks. Please note that in section 3.1 the reference for the 'Joined up Pathways in Obesity' is incorrect or missing. NHS England however appears to be devolving responsibility to CCGs for the commissioning and provision of feeder services, namely Tier 3 services, which will require similar MDT functioning and funding for a much larger population of patients, of which only a select few would move on to require bariatric surgery, as listed in section	Noted Noted – this appears as a footnote on the page. NHS England is not the commissioner of tier 3 weight management services. Tier 4 services for adults is being transferred to CCGs during 2016/17 The ethos of this policy is that all medical management's aspects of weight management have been tried and been unsuccessful and that only a small group of patients would go forwards for a surgical assessment. We agree that there is a lack of tier 3 provision in england but NHS England is not the commissioner of this service. An expert reference group will provide advice on the commissioning of tier 3 services.	.See above Reference section reviewed. No changes made.

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References	Complications  AMOS 2y IJO.pdf  Inge et.al. 2015 NEJM.pdf  LAGB Complicatons.pdf  complication of surgical procedures T		

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