Engagement Report for Service Specifications	
Unique Reference Number	1758
Specification Title	Specialised services for women with complications of mesh inserted for urinary incontinence and vaginal prolapse
Lead Commissioner	Anthony Prudhoe
Clinical Reference Group	Specialised Women's CRG
Which stakeholders were contacted to be involved in service specification development?	All registered stakeholders with the Specialised Women's CRG. CRG members, including PPV members.
Identify the relevant Royal College or Professional Society to the specification and indicate how they have been involved	Royal College of Obstetricians and Gynaecologists British Association of Uro-Gynaecologists (BSUG) British Association of Urological Surgeons (BAUS) RCOG/BSUG are represented as an affiliate organisation on the CRG and have been involved development of the specification. BAUS have also been represented as part of the specification development.
Which stakeholders have actually been involved?	Clinicians, patients, commissioners, BSUG, Association of Coloproctology.
Explain reason if there is any difference from previous question	Stakeholder decision to participate in stakeholder feedback.
Identify any particular stakeholder organisations that may	Limited patient responses, so as part of the public consultation the patient support groups around vaginal

be key to the specification development that you have approached that have yet to be engaged. Indicate why?	mesh will be directly contacted.
How have stakeholders been involved? What engagement methods have been used?	7 responses, from standards Stakeholder testing email to registered stakeholders.
What has happened or changed as a result of their input?	Some wording in specification amended as per table below. Groups referred to will be contacted to highlight consultation launch and encouraged to respond.
How are stakeholders being kept informed of progress with specification development as a result of their input?	Stakeholder messages, and specific engagement once public consultation is launched.
What level of wider public consultation is recommended by the CRG for the NPOC Board to agree as a result of stakeholder involvement?	A 60 day consultation was recommended by PPVAG, and there have been no concerns raised around this following stakeholder feedback. The CRG recommend that patient groups are specifically contacted as part of the public consultation, as are services providing this (contact via professional organisations).

Stakeholder/CRG Feedback

Organisation Responding	Feedback Received	SWG response	Resulting Action
Sian Summers **Service Specialist** **Specialised Commissioning – NHS England South.** No declarations of interest. No comments re consultation.	**Do you agree with the detail of Section 2 of the service specification – "The patient pathway and dependencies"?** □ Partially - X **Please detail any changes that you think should be made to this section?** There is a lack of clarity as to which element of the pathway the specification covers. It could read as if the non-complex URO- MDT element is included. I understand that this needs to be described but need greater clarity as to what is within the scope of the spec and what is not. It is unclear if patients do not choose the surgical pathway option after the first outpatient appointment whether they are then are no longer under the scope of the specification. Is this the intention? The coding detail is good but how would commissioners differentiate between the non-complex surgery and the complex in the data that is received from providers to ensure only the relevant providers are undertaking the complex activity? **Please detail any other changes that you think should be made to the service specification, and explain why the**	TBC. Specification states referral back to Uro MDT if surgery not progressed. Commissioners will be aware of who the commissioned providers are for complex mesh removal – activity can be monitored.	Specification wording amended to clarify this if for complex mesh removal and the Uro-MDT is covered under a separate service specification. None. None.

	changes are necessary. Address queries above – ned to be clear on what is actually being commissioned under the specification. **Please describe any equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts identified?** Small numbers of patients and the high level of requirement for meeting the infrastructure / staff elements of the contract mean that there are unlikely to be many centres for mesh surgery. Will distance to travel and lack of awareness in areas that do not have this service impact on referrals made and ability to attend, especially taking into account the impact the problems patients are likely to have will have on ability to endure long distance travel? How can we ensure geographically equitable distribution of centres? Will Mesh MDTs need to be developed / encouraged in some trusts to accomplish this? **Are there any other comments you wish to make about this service specification?** Has the funding of the activity and possible shifts from one region to another for provision been taken into account both in activity and budget. Is there a commissioning/ procurement plan to accompany this specification? As the number of women undergoing mesh insertion has	Quality considerations require consolidation, with clear pathways to be in place between these providers and local units. Centres will be aligned with VVF centres to ensure competency and workforce availability. To be addressed in the commissioning plan.	None. None.

	drastically reduced in recent years how will the reduction in numbers needing this surgery in future years be managed? How do we support competency and possibly fewer centres. Are there minimum numbers for surgeons? Is there a decommissioning plan? It looks as if there will be a need to cope with a peak of demand and then deal with a lessening demand – can we describe this and make sure it is clearly defined from other gynae activity in contractual terms?	To be addressed in the commissioning plan. To be addressed in the commissioning plan.	None. None.
Mark Chapman **Chair Clinical Reference Group for Specialised Colorectal Services (also clinician and Chair of External Affairs for the Association of Coloproctology)** Declaration of interest: Was chair of governance committee of the Pelvic Floor Society No comments on consultation	**Do you agree with the detail of Section 2 of the service specification – "The patient pathway and dependencies"?** □ Partially **Please detail any changes that you think should be made to this section?** Colorectal surgeons have inserted mesh into rectovaginal septum for recto recto intussusception and ext rectal prolapse for about 10years. There is now a significant problem with this causing mesh erosion in up to 4% of cases. Although numbers are smaller than for TOT, TVT the problems are significant and the difficulty in managing these patients as great as for the gynae group- perhaps with more morbidity. This group of patients could easily be included in this service spec. and will prevent the need to develop a further one which would have considerable overlap with similar expertise resource etc.	TBC – competency differences of approaches need to be considered. Where indicated, colorectal surgeons are included in the MDT where mesh involves in gynaecology/ urology and colorectal indications.	TBC

	I urge you to include this group of patients in this service spec. V. little change would be needed to the document or to the requirements of the service. I am sure the professional colorectal associations would support this. It would also help to unite and consolidate the somewhat fragmented pelvic floor services that the NHS offers. **Please detail any other changes that you think should be made to the service specification, and explain why the changes are necessary.** Section 2:1 the phrase "good working" is meaningless – needs to be more specific. Proctogram spelt incorrectly. "Simple excisions could be done locally" needs tightening so that simple is defined. Perhaps should be about competency. **Please describe any equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts identified?** A complex mesh removal service needs to be co-located with a functioning colorectal pelvic floor team	TBC – unclear if more detail is needed. Acknowledged TBC Colorectal surgery interdependency already included.	None. Amended. TBC.
James Hill **Manchester University**	**Response to Mark Chapman's comments**		

NHS Foundation Trust No declarations of interest. No comments on consultation.	I agree with your comments. As the deadline is 6th Dec, there is no merit in discussion it at Executive but I think it is worth sending to Exec for information Mark are you happy with this, just wanted to check that it is permissible to circulate the document I am impressed that this is going to be set up and is a good response to the problem.	Acknowledged.	None.
Miss Victoria Cook **Consultant Obstetrician and Gynaecologist** **Divisional Director for Surgery** **Hillingdon Hospital NHS Foundation Trust** No declarations of interest. No comments on consultation.	I have read through the proposal and as a district general urogynaecologist I am happy with the proposals. My main comment would be that I would wish to have a choice as to which specialist service to send my patients to.	Anticipated that local units will build relationships and pathways with local complex mesh removal service, but patients are able to be referred to any commissioner provider.	None.
Professor Jonathan Duckett MB ChB, MD(Res), FRCOG **Consultant Obstetrics and Gynaecology** **Directorate of Women's Health** **Medway NHS Foundation Trust** Declarations of interest: Chair of BSUG Member of Specialised	**Do you agree with the detail of Section 2 of the service specification – "The patient pathway and dependencies"?** X Partially **Please detail any changes that you think should be made to this section?** The term secondary or tertiary care is somewhat dated **Please detail any other changes that you think should be made to the service specification, and explain why the changes are necessary.**	TBC	TBC

Women's CRG. As a researcher I have received funds from commercial organisations to perform research on vaginal meshes for prolapse and continence procedures for stress incontinence. No comments on consultation.	1.2 description – last sentence page 1; surgery is not performed by the MDT but usually members of the MDT.	Acknowledged	Amended.
	Page 3 IUGA/ICS (not ISC!) please use the full classification if you are going to include in the document. There are 3 other sections including time pain and site.	Acknowledged	Amended.
	Mesh MDT core membership. You mention a formally accredited subspecialist. The subspecialist training scheme has been in place for the last 20 years – some of our most experienced consultants are not subspecialists as they completed training before this. They should be able to lead an MDT.	TBC	TBC
	I think it is unrealistic that patients can be offered a date for surgery at an outpatient visit. Scheduling is usually more complex than this, especially if a team of surgeons are needed.	Acknowledged	Wording revised: *If they decide on surgery they will be counselled and consented, and contacted to offer a date and pre-assessment.*
	Codes – you do not seem to have included the codes for TOT surgery or the new codes for removal of vaginal mesh inserted for prolapse.	TBC	
	There is no real mention of assessing outcome after treatment in the document – this is clearly very important to both surgeons and patients.	Covered in specification and quality indicators (not shared in stakeholder testing).	None
	You mention that surgeons need to demonstrate competency – how do aim to achieve this? There is currently no training scheme to assess competency.	TBC	TBC
	The document links with the fistulae centres. You need to be certain that there are sufficient centres spread	Alignment of centres linked to	None, but will await feedback

	geographically so that patients can access services. I am not convinced that there will be enough centres. 3.2 Population needs – I do not recognise the figures that you use for the development of frequency and urgency (15%) and 20-30% will not need further surgery for stress incontinence. Also these figures are not esp. relevant to this document on mesh centres. Not all asymptomatic vaginal exposures are easily treated and some will need referral to a mesh centre. The document relies on a network of specialist urogynaecology MDTs – these are currently not in place and will need commissioning **Please describe any equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts identified?** As above you need sufficient centres to allow ease of access.	maintaining competency. TBC Any complex mesh exposures can be referred to complex mesh referral centres for MDT discussion. Being addressed separately. As above.	from consultation. TBC None. None. None, but will await feedback from consultation.
Lesley Briggs **Patient Representative on the Specialised Women's CRG** Declaration of interest: Public and Patient Member on Specialist Women's	**Do you agree with the detail of Section 2 of the service specification – "The patient pathway and dependencies"?** □ Fully **Please detail any changes that you think should be made to this section?**		

Clinical Reference Group	No changes necessary **Please detail any other changes that you think should be made to the service specification, and explain why the changes are necessary.** No changes necessary **Please describe any equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts identified?** Those ethnic minority groups were seeking and/or accessing services for incontinence and mesh removal as in this particular specification is difficult due to language barriers or cultural differences. I recommend in Section 9 that the consultation could be circulated to these groups through local contacts to gain comments, opinion or their perceptions on the care being suggested **We are planning on conducting a 60 day consultation on the service specification. Do you have any suggestions about consultation approach and are there any specific groups that we should reach out to as part of the public consultation? (please provide contact details where possible)** Due to the sensitivity around the subject of vaginal mesh, I feel it is crucial that the consultation and the details of how to be involved are transparent to ensure that people are	Acknowledged.	Will be fed into consultation plan.

	able to offer their comments and/or opinion. I am confident it will happen anyway, but I think it is crucial that the Mesh groups listed in *Support Groups* are consulted for their opinion to ensure they can say they have been engaged in the process. I am enclosing the details of the groups listed in: • *Synthetic Vaginal Mesh Tape Procedure for the Surgical Treatment of Stress Urinary Incontinence in Women PATIENT INFORMATION LEAFLET Version 24.0 - date: May 2017* **Useful Resources** Bladder and Bowel Foundation: www.bladderandbowelfoundation.org The Pelvic, Obstetric and Gynecological Physiotherapy Professional Network of the Chartered Society of Physiotherapy: Email: pogp.csp.org.uk Self-help groups in the UK: www.scottishmeshsurvivors.com www.tvtinfo.wordpress.com	Acknowledged.	Will be fed into consultation plan.

	www.tvt-messed-up-mesh.org.uk Bladder and Bowel Foundation, 0845 345 0165 www.bladderandbowelfoundation.org The Cystitis & Overactive Bladder Foundation, 0121 702 0820 www.cobfoundation.org PromoCon, 0161 607 8219 www.disabledliving.co.uk/PromoCon/About **Multiple Sclerosis Resource Centre:** Information on Multiple Sclerosis including symptoms, treatments and latest news. Telephone: 0800 783 0518 Email: http://www.ms-uk.org/ It would also be prudent to contact those ethnic minority groups were going and seeking help for this sort of thing might be difficult due to language and cultural differences. Regrettably, I do not have contact details to provide for you but maybe the local ***Healthwatch*** schemes will be in contact with relevant groups and would know where to circulate the consultation to. **South Asian Health Foundation** Telephone: 07807069719 Email: raj.gill@sahf.org.uk		

	Thought this would be a good starting point for information on South Asian community health groups? Patient and Involvement Teams within local Health Trusts could also be a useful point of reference? I am not sure if you do contact these, but the Royal College of Obstetricians and Gynaecologists has active Public and Patient involvement – a Network of members and a wider network known as the Women's Voices Involvement Panel. The contact is Matthew Miles, Head of Public and Patient Involvement at the RCOG (mmiles@rcog.org.uk) which could be a rich source of representative feedback from across the UK. I was a patient representative on the NHS England Vaginal Mesh Working Group, and part of our work was to develop leaflets to go in hand with the recommendations to ensure that women received appropriate, and moreover, accurate information at the time of consultation inherent within the consent process. I am aware that work is going to be undertaken to prepare a leaflet to go with this specification on Mesh Removal; would it be worth during the public consultation process to ask about the leaflet provision / format, and see if there is a need to prepare a leaflet in the same format as with the previous leaflet for the use of mesh in urinary incontinence		

	to be used in the consent process (which ran to 16/17 pages), or a more concise leaflet. As a patient representative, and having been involved in Mesh Working Group and the development of the specification in question I realise this is going to be complex surgery and the woman needs to be fully aware of all aspects of the process, and wish to avoid any criticism from groups as in the past regarding the provision of information. In setting this out in the consultation, it would demonstrate recommendations – and patient's voices – have been taken on-board and addressed.		
Dr Karen Brown **Karen.Brown@nuth.nhs.uk** Clinician**,** Newcastle Hospitals Foundation Trust No declarations of interest	**Do you agree with the detail of Section 2 of the service specification – "The patient pathway and dependencies"?** □ Partially **Please detail any changes that you think should be made to this section?** Agree almost wholly. Only addition would be code for suburethral fascial sling (Aldridge type) under urethral mesh complication codes as we sometimes insert a sling instead of a Martius fat pad for concurrent stress incontinence. Some units may insert a 'sling on a string' type fascial sling. **Please describe any equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts identified?** Geographical inequalities but 5-6 centres around the	TBC Acknowledged	TBC Will await

	country should suffice to give access within a reasonable distance **Are there any other comments you wish to make about this service specification?** No more currently Overall happy with it **We are planning on conducting a 60 day consultation on the service specification. Do you have any suggestions about consultation approach and are there any specific groups that we should reach out to as part of the public consultation? (please provide contact details where possible)** To all BAUS and BSUG members Need to include Pelvic Floor Society Members UKCS membership Pelvic Pain Society Membership Mesh Oversight Group members organisations including standing, associate and GPs	 Acknowledged	consultation feedback Will be fed into consultation plan.