NHS
Harrogate and Rural District
Clinical Commissioning Group

General Commissioning Statement

Condition or Treatment	Linking Prevention and Better Health to Elective Care: Referral for non-urgent, routine Elective Surgery
Background	CCGs in England have been provided with a number of expectations in the NHS Five Year Forward View. Amongst these priorities are actions on smoking and obesity, which the CCG recognise as playing an important role in individual's health and wellbeing. The point of referral for non-urgent elective surgery provides an opportunity for health optimisation. **The Challenge from Obesity[1]:** Overweight and obesity is a global problem. The World Health Organization (WHO; Obesity and overweight: fact sheet 311[2]) predicts that by 2015 approximately 2.3 billion adults worldwide will be overweight, and more than 700 million will be obese. Obesity is directly linked to a number of different illnesses including type 2 diabetes, fatty liver disease, hypertension, gallstones and gastro-oesophageal reflux disease (NICE guideline CG184), as well as psychological and psychiatric morbidities. The Health and Social Care Information Centre reported that in 2011/12 there were 11,740 inpatient admissions to hospitals in England with a primary diagnosis of obesity: 3 times as many as in 2006/07 (Statistics on obesity, physical activity and diet – England, 2013). There were 3 times as many women admitted as men. In the UK obesity rates nearly doubled between 1993 and 2011, from 13% to 24% in men and from 16% to 26% in women. Overall, a total of 23% of adults are obese (with a body mass index – BMI – of over 30); 61.3% are either overweight or obese (with a BMI of over 25). In 2011, about 3 in 10 children aged 2–15 years were overweight or obese. Public Health England's Active People Survey[3] identified that 22.8% of adults (16 yrs and above) in Harrogate were obese (BMI greater than or equal to 30kg/m2). Obesity poses risks for surgery with increased risk of deep vein thrombosis; more difficult intubation for general anaesthesia; lower oxygen levels during surgery; more difficult cannulation or regional local anaesthetic injection; increased risks of wound infection; and longer recovery from general anaesthesia.

Harrogate and Rural District CCG is committed to ensure that people who are obese are given an opportunity to reduce their risk factors for surgery by ensuring they have a period of health optimisation. Lifestyle change is more likely to be made in the context of the medical trigger of getting fit for surgery.

The Challenge from Smoking

Smoking causes a range of diseases including cancer, cardiovascular disease and respiratory diseases. It causes many other debilitating conditions such as age-related macular degeneration, gastric ulcers, impotence and osteoporosis.

Smokers are 38% more likely to die after surgery than non-smokers. Following surgery smokers:

- have higher risks of lung and heart complications
- have higher risks of post-operative infection
- have impaired wound healing
- require longer hospital stays and higher drug doses
- are more likely to be admitted to an intensive care unit
- have increased risk of emergency re-admission

('Joint Briefing: Smoking and Surgery' (April 16). ASH)

In England in 2011, an estimated 79,100 adults aged 35 and over died as a result of smoking (18% of all deaths) and nearly half a million hospital admissions adults aged 35 (5% of all admissions) were attributable to smoking.

There were 1,671 smoking attributable hospital admissions in the period 2014 – 15 in Harrogate, which is comparable to the national average.

The prevalence of smoking for Harrogate is 12.2% against an England average of 16.9% in 2015.

The CCG aims to support smokers to maximise their health outcomes by encouraging patients to quit smoking prior to surgery. Hopsitilisation has been identified as an opportune time to encourage smokers to quit.

This policy requires patients with a confirmed smoking status to be referred for Smoking Cessation service with the aim of optimising health prior to referral for elective surgery.

Commissioning statement	All non-urgent, routine referrals to surgical specialties for patients who smoke and/or have a BMI of ≥ 30 are to be offered a period of health optimisation for 6 months before commencement of referral for surgery. This may include a referral to Smoking Cessation services or Tier 2 Weight Management services. **Exclusions: (NB: Use Clinical Discretion at any time)** • Any urgent or non-routine procedures • Patients undergoing surgery for cancer • 2WW Referral for suspicion of cancer • Patients with a BMI of 30 or greater but who have waist measurement less than 94cm in males or 80cm in females • Patients with severe mental health illness, Learning Disability or significant cognitive impairment • Referrals for interventions of a diagnostic nature e.g. endoscopy • Children under 18 years • Frail Elderly (As a guide – 3 or more of the following: unintentional weight loss, self-reported exhaustion, weakness (grip strength), slow walking speed, low physical activity). • NB Does not currently apply to ophthalmology or dentistry/oral surgery Although people excluded in the policy will not be expected to complete a 6 month health optimisation period if they smoke or are obese, they will be supported to address lifestyle factors. Patients who only use electronic cigarettes will be classified as a non-smoker for the purposes of this policy. If a clinician feels that there are exceptional circumstances then the patient may be referred to the Individual Funding Request panel for consideration. <u>Patients Who Do Not Engage</u> Patients who are unable or unwilling to attempt any type of smoking cessation or weight loss programme will be required to enter a Health Optimisation period of 6 months. The GP should discuss with the patient the process for reviewing patient suitability for referral following the health optimisation period. This is with the expectation that this may provide time for reflection and consideration. When a health optimisation period has been completed for one condition, the health optimisation policy need not be applied for another condition requiring surgery within 12 months after completion of the original health optimisation policy (tick health optimisation period complete on referral letter).

Referral guidance	See pathway flow diagram: http://www.harrogateandruraldistrictccg.nhs.uk/data/uploads/health-information/bmi-smoking-flow-chart-final.pptx If the patient is to be referred for non-urgent, routine elective surgery and smokes and/or has a BMI of 30 or more, the GP should:- • Consider if excluded or an exceptionality as detailed above If no exclusion or exceptionality applies, GP to discuss with patient:- • Support options available for smoking cessation and tier 2 weight management and refer if applicable / print Patient Information Sheet Weight Management: Service Details https://www.harrogate.gov.uk/fit4life ○ Referral Form for use from 1 January 2018 (being developed): In the meantime, referrals should be emailed via a secure link to: ihl.wigan@nhs.net / 01942 404799 giving the patient's name and contact number. ○ Patient Information Sheet (under development): Smoking Cessation Service Details http://www.northyorks.gov.uk/article/24109/Stop-smoking Referral Form https://www.smokefreelifenorthyorkshire.co.uk/ReferralForm.aspx • Set individualised goal (if appropriate). The GP should discuss with the patient the process/arrangements for reviewing patient suitability for referral following the health optimisation period.

	Gatekeeping & Policy Management When referral to surgical speciality is appropriate, all referrals to secondary care should include the following information regarding a patient's BMI status: **Option 1:** Non-Smoker & BMI under 30 **Option 2:** Active Smoker or BMI 30 or above with applicable exclusions (see list of exclusions) or has been approved by the IFR panel **Option 3:** 6 month health optimisation period complete **Option 4:** Active Smoker or BMI 30 or above (not eligible for referral) Referrals received by RSS which identifies a patient under **Option 4 - BMI 30 or above or does not include Options 1-3** will be returned to the referring GP in order that the patient can be offered health optimisation prior to referral. Referrals for exceptional circumstances are to be submitted by way of an IFR referral form for decision by the IFR panel. The referral form is available through the following link: http://www.harrogateandruraldistrictccg.nhs.uk/data/uploads/rss2/ifr/hard_exceptional_circumstances_submission_form_revised_02.06.16.doc Frequently Asked Questions in relation to the policy / referrals can be found through the following link: http://www.harrogateandruraldistrictccg.nhs.uk/data/uploads/commissioning/gp-faq-health-optimisation-policy_18-12-17.pdf
Effective from	1 November 2016
Summary of evidence / Rationale	Compared with a healthy weight man, an obese man is: • Five times more likely to develop type 2 diabetes • Three times more likely to develop cancer of the colon • More than two and a half times more likely to develop high blood pressure – a major risk factor for stroke and heart disease[4]. Compared with a healthy weight woman, an obese woman is: • Almost thirteen times more likely to develop type 2 diabetes

	• More than four times more likely to develop high blood pressure • More than three times more likely to have a heart attack[4] Obesity increases the risk of the development of other disease including angina, gall bladder disease, liver disease, ovarian cancer, osteoarthritis and stroke. An Arthritis Research Campaign Report[5] stated that joint surgery is less successful in obese patients because of a higher risk of a range of short-term complications during and immediately after surgery; the heavier the patient, the less likely it is that surgery will bring about an improvement in symptoms for joint replacement surgery; the implant is likely to fail more quickly, requiring further surgery and those who have joint replacement surgery because of obesity-related osteoarthritis are more likely to gain weight post-operatively. It also concluded that "Weight loss and exercise combined have been shown to achieve the same level of symptom relief as joint replacement surgery". The study "Effects of intensive diet and exercise on knee joint loads, inflammation, and clinical outcomes among overweight and obese adults with knee osteoarthritis: the IDEA randomised controlled trial Messier et al JAMA 310(12) 1263-73 (2013)" found that obese patients with knee osteoarthritis who dropped their weight by 10% after a combination of diet and exercise reported less pain, better knee function, improved mobility and enhanced quality of life[6]. A literature based review[7] advises assessment of "timely weight loss as a part of conservative care" and confirms the increased risk of many perioperative and postoperative complications associated with obesity. Other evidence found that obese patients are more likely to experience: Chen CL et al. (2011)[8]; a nearly 12-fold increased risk of a post-operative complication after elective breast procedures. Waisbren E et al (2010)[9]; a 5-fold increased risk of surgical site infection (SSI) Hourigan JS (2011)[10]; an increased risk of SSI as much as 60% when undergoing major abdominal surgery and up to 45% when undergoing elective colon and rectal surgery. Osler M et al. (2011)[11]; an increased risk of bleeding and infections after abdominal hysterectomy. DeMaria EJ, Carmody BJ. (2005)[12]; a higher incidence of peri-operative deep venous thrombosis and pulmonary embolism. Elgafy H et al. (2012)[13]; increased risk of complication after elective

	lumbar spine surgery. Tobacco smoking remains the single greatest cause of preventable illness and premature death in England. It is also the largest single cause of inequalities in health and accounts for about half of the difference in life expectancy between the lowest and highest income groups. Deaths caused by smoking are 2 to 3 times higher in low income than in wealthier groups[14]. Harrogate and Rural District CCG is committed to the Tobacco Harm Reduction Strategy in conjunction with our Public health Colleagues. The recent 'Joint Briefing: Smoking and Surgery' (April 16) document produced by ASH and 5 Royal Colleges as well as the Faculty of Public Health, provides a powerful summary of the significant risks associated with smoking and surgery and the benefits of achieving smoking cessation pre-operatively[15]. Smoking is the primary cause of premature mortality and preventable illness in north Yorkshire[16]. Only 6% of smokers currently access a smoking cessation support service when they try to quit however when they do their chances of success are four times more likely. The annual cost of smoking to the NHS across Harrogate and Rural District is estimated to be £5.4 million[17]. The strong association between smoking and both physical and mental ill-health means that many people who use secondary care services are smokers. When smokers use these services, it presents a valuable opportunity to use interventions of proven effectiveness and cost effectiveness to initiate and support stop smoking attempts.
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