HARROGATE AND RURAL DISTRICT CLINICAL COMMISSIONING GROUP

LINKING PREVENTION AND BETTER HEALTH TO ELECTIVE CARE

OCTOBER 2016

1. PURPOSE

This paper seeks Governing Body approval for the introduction of a period of health optimisation before referral and commencement of non-urgent elective surgery as part of the strategic approach to improving the health and wellbeing of the population of Harrogate and Rural District.

2. INTRODUCTION

NHS Harrogate and Rural District Clinical Commissioning Group's (CCG) vision is to achieve the best health and wellbeing for everyone. We have made this commitment in our five year strategic plan, and through the local health and wellbeing strategies and boards we have signed up to with local authority and fellow CCG partners. To achieve this, the CCG must enable, encourage and support the people it serves to live the healthiest lives possible; and it must do so within the resources available. Only by doing so will we ensure we get the very best value from the NHS. Exceeding the CCG's resources risks the ability of the NHS to be there when people really need it.

The life choices we make will affect our long term health. We know smoking harms us. We know being active is good for us. As individuals we live with our decisions and the lifestyle we choose. However if those choices impact on the ability of the NHS to provide services for everyone, the CCG should act - to preserve the ability to get the best value from NHS resources.

Being harmed while playing sport or in a road traffic accident is an inevitable risk of living an active life! We would never discourage that and whilst rules in sport and safety laws on the road try to minimize such events they will never be completely eliminated.

Other harms caused by, for example, smoking; obesity and inactivity; and alcohol are potentially preventable. In light of the current financial pressures on the NHS we believe that to preserve the ability to get the best value from NHS resources the CCG should try to prevent any *avoidable use* of NHS resources.

One of the many expectations on CCGs in the NHS Five Year Forward View is to prioritise action on preventable ill health including smoking, obesity and diabetes. We also have a requirement to prioritise financial sustainability, show leadership and reduce health inequalities. For the public this means we need to ensure that we all get the best value from our health services and that it is there for when we really need it.

3. OPPORTUNITIES

One way of fulfilling such expectations is for the CCG to prioritise the promotion of a healthy lifestyle and to prevent as much ill-health as possible. We can do that in a wide range of ways – tackling smoking and obesity, detecting pre-diabetes and high blood pressure, reducing inactivity and alcohol consumption, increasing immunisation and uptake of cancer screening and helping people to understand their options and manage

their own health through self-care and shared decision making. Whilst local authorities have responsibilities towards prevention they are not responsible for the health costs of unhealthy lifestyles. The CCG should therefore collaborate with local authorities, as well as other partner organisations to prevent ill-health and prevent any *avoidable use* of NHS resources.

4. CONTEXT OF OBESITY

Public Health England report that the prevalence of obesity among adults has increased sharply during the 1990s and early 2000s. The proportion who were categorised as obese (BMI 30kg/m2 or over) increased from 13.2% of men in 1993 to 24.3% in 2014 and from 16.4% of women in 1993 to 26.8% in 2014 (HSE). By 2050 obesity is predicted to affect 60% of adult men and 50% of adult women.

As the prevalence of obesity in England increases, it has become a major public health concern due to its association with serious chronic diseases and related morbidity and mortality.

The national Diabetes Prevention Programme is tackling the progression from Pre-Diabetes to Diabetes and the CCG is part of a Sustainability and Transformation Plan (STP) area wide bid to join the programme's second wave.

4.1. IMPACT OF OBESITY ON HEALTH

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[1].

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[1]

Obesity increases the risk of the development of other disease including angina, gall bladder disease, liver disease, ovarian cancer, osteoarthritis and stroke.

The impact of obesity stretches to cancer survival rates with both survival and recurrence being linked to obesity. For example, it is understood that substantial weight gain after diagnosis and treatment is adversely associated with breast cancer prognosis. Obesity has been shown to increase the risk of recurrence and death among breast cancer survivors by around 30%[1].

4.2. OBESITY AND IMPACT ON JOINT REPLACEMENT AND OTHER SURGERY

Obesity is an increasing problem in the population and also a significant risk factor for osteoarthritis. It is often associated with comorbidities such as diabetes, ischaemic heart disease, hypertension and sleep apnoea. An Arthritis Research Campaign Report[2] stated that joint surgery is less successful in obese patients because:-

1. Obese patients have a significantly higher risk of a range of short-term complications during and immediately after surgery (eg longer operations, excess blood loss requiring transfusions, DVT, wound complications including infection).
2. The heavier the patient, the less likely it is that surgery will bring about an improvement in symptoms for joint replacement surgery (eg they are less likely to regain normal functioning or reduction in pain and stiffness).
3. Within joint replacement surgery the implant is likely to fail more quickly, requiring further surgery (eg within 7 years, obese patients are more than 10 times as likely to have an implant failure).
4. People who have joint replacement surgery because of obesity-related osteoarthritis are more likely to gain weight post-operatively (despite the new opportunity to lose weight through exercise following reduction in pain levels).

It also concluded that "Weight loss and exercise combined have been shown to achieve the same level of symptom relief as joint replacement surgery". A study of obese patients with knee osteoarthritis found that those 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[3].

A recent extensive literature review advises assessment of "timely weight loss as a part of conservative care"[4]. It confirms in detail the increased risk of many perioperative and postoperative complications associated with obesity (as well as increased costs and length of stay), such as wound healing/infections; respiratory problems; thromboembolic disease; dislocation; need for revision surgery; component malposition; and prosthesis loosening.

Across other surgical specialities, there is good evidence that shows that obese patients are more likely to experience:

- a nearly 12-fold increased risk of a post-operative complication after elective breast procedures[5]
- a 5-fold increased risk of surgical site infection (SSI)[6]
- 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 [7]
- an increased risk of bleeding and infections after abdominal hysterectomy[8]
- a higher incidence of peri-operative deep venous thrombosis and pulmonary embolism[9]
- increased risk of complication after elective lumbar spine surgery[10]

4.3. LOCAL CONTEXT

In conjunction with our Public Health colleagues Harrogate and Rural District CCG commit to improving the health of our population. It is understood that obesity is a national concern and itself is a burden on the health economics of a population. Treatments directly relating to diabetes currently cost approximately £10 billion of the NHS budget. With incidence of Type II diabetes rising in line with obesity levels this is adding to financial pressures[11].

	Harrogate and Rural District	National Average
Percentage of Adults Classified as Overweight or Obese[12]	64.9%	64.6%
Percentage of Children ages 4-5 Classified as Overweight or Obese[12]	20.1%	21.9%
Percentage of Population Diagnosed with Hypertension[12] (High Blood Pressure)	14.8%	13.8%

The links between obesity and Type 2 diabetes are clear. The estimated prevalence of diabetes within Harrogate and Rural District area (registered population) for people aged 16 years and over is 8.1%, rising to 9.3% by 2030[13].

4.4. OVERVIEW OF CURRENT WEIGHT MANAGEMENT SERVICES

The local Tier 2 Weight Management service for adults is commissioned by North Yorkshire County Council and delivered by Harrogate Borough Council. The aim of the "Active Health" programme is to deliver evidence based accessible service for adults over 18 years of age who would benefit from a structured physical activity programme in a safe, supervised environment. The service supports people in making lifestyle changes especially in those people who are physically inactive or have a limiting lifelong illness. The scheme will promote long-term participation in regular physical activity through goal setting and developing confidence therefore improving the person's mental, social and physical well-being. Eligibility for the programme is as follows:

Eligible to access the service	Excluded from the service
Sedentary or physically inactive (less than 30 minutes activity per week)	Unstable angina
Low to moderate risk health conditions	Unstable hypertension
Aged 18 years or above	Unstable diabetes
Severe coronary heart disease or early post myocardial infarction/coronary artery bypass graft/angioplasty**.** **NB. Cardiac rehab classes only.**	Unstable and/or severe mental health problem
Mild to moderate mental health problems (e.g. depression, anxiety or stress)	Pregnant, post natal prior to attending post-natal check, or breastfeeding
Diabetes I and II	Have a BMI >35 with significant, unmanaged co-morbidities **(Fit 4 Life)**
Post physiotherapy musculoskeletal conditions e.g. knee, hip, shoulder etc	Have had bariatric surgery in the last 2 years **(Fit 4 Life)**
Living in the Harrogate district	
Individuals identified within the NHS health check as BMI greater than 25 should be referred into the Programme. **(Fit 4Life)**	
BMI 25+ without comorbidities or managed comorbidities **(Fit 4 Life)**	

The local Weight Management service for children is called the 'North Yorkshire Healthy Choices Programme' and is delivered by North Yorkshire County Council.

Tier 3 weight management services are not currently commissioned and are being explored with West Yorkshire colleagues as part of the CCG's Sustainability and Transformation Planning footprint.

5. CONTEXT OF SMOKING

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].

5.1. IMPACT OF SMOKING ON HEALTH

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. Further, it can cause complications in pregnancy and is also associated with lower survival rates, delayed wound healing, increased infections, prolonged hospital stays and repeated admissions after surgery[16].

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 of adults aged 35 and over (5% of all admissions) were attributable to smoking. Treating smoking-related illnesses cost the NHS an estimated £2.7 billion in 2006. The overall financial burden of all smoking to society has been estimated at £13.74 billion a year.

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.

5.2. LOCAL CONTEXT

Smoking is the primary cause of premature mortality and preventable illness in North Yorkshire[17]. 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[18].

5.3. SMOKING AND IMPACT ON SURGICAL OUTCOMES

There is strong evidence that smokers who undergo surgery[15]:

- have a higher risk of lung and heart complications

- have higher risk of post-operative infection
- have impaired wound healing
- are more likely to be admitted to an intensive care unit
- have an increased risk of dying in hospital
- are at higher risk of readmission
- remain in hospital longer

Also, there is evidence to suggest that quitting smoking before having surgery:

- reduces the risk of post-operative complications
- reduces lung, heart and wound-related complications
- decreases wound healing time
- reduces bone fusion time after fracture repair
- reduces length of stay in hospital

5.4. OVERVIEW OF CURRENT SMOKING CESSATION SERVICES

The local Smoking Cessation service is commissioned by North Yorkshire County Council and delivered by Solutions4Health. The aim of the 'Smokefree Life North Yorkshire' programme is to deliver evidence-based accessible service for anyone who would benefit from structured support to quit smoking. The service supports people in a one-to-one setting, running sessions within community venues, as well as offering online or telephone appointments. Access to the service is via a health professional or self-referral.

6. BMI NON-URGENT ELECTIVE SURGERY OPTION FOR CONSIDERATION

The Governing Body is asked to consider the adoption of the following Commissioning Policy in relation to BMI before elective surgery.

NHS Harrogate and Rural District CCG does not routinely commission referral to secondary care for routine, non-urgent elective surgery for patients whose BMI is 30 or more. Patients with a BMI of 30 or more are to be offered a referral to Tier 2 weight management to enable completion of a period of health optimisation for 6 months before commencement of surgery, offering an opportunity for weight loss to improve health and surgical outcomes.

If a clinician feels that there are exceptional circumstances then the patient may be referred to the Individual Funding Request Panel for consideration.

6.1. EXCLUSIONS TO THIS POLICY

The following group/patients with the following conditions will not be subject to this policy:

- 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

- Any urgent procedures

7. SMOKING OPTION FOR CONSIDERATION

NHS Harrogate and Rural District CCG does not routinely commission referral to secondary care for routine, non-urgent elective surgery for patients who are active smokers. Patients who are active smokers are to be offered a referral to Smokefree Life North Yorkshire to enable completion of a period of health optimisation for 6 months before commencement of surgery unless a quit status is confirmed by Smokefree Life North Yorkshire, whichever is sooner. A confirmed quit means that a person has been smoke free for 4 weeks after their individual quit date. This will allow a period of health optimisation.

If a clinician feels that there are exceptional circumstances then the patient may be referred to the Individual Funding Request Panel for consideration.

7.1. EXCLUSIONS TO THIS POLICY

It is suggested that patients with the following are excluded from this policy:

- Patients undergoing surgery for cancer
- 2WW Referral for suspicion of cancer
- 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
- Any urgent procedures

Patients who only use electronic cigarettes will be classified as a non-smoker for the purposes of the policy.

8. IMPLEMENTATION PLAN

As part of the implementation process a clear and comprehensive communications and engagement process will take place with Primary Care colleagues, and information will be produced to inform the public regarding this strategy.

Clinicians will be provided with clear guidance regarding the process of implementation and the effectiveness of this will be monitored through the CCG Committees (for example, Clinical Executive Committee). GPs in Harrogate and Rural District will be supported with materials to educate patients and inform them of the benefits of their health optimisation period.

We believe that any potential short term impacts on people with lifestyle risk factors will be balanced by a more long term reduction in health inequalities. 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.

9. RISKS

<u>Financial</u>

- Financial risk incurred through increased numbers of referrals (for exceptional circumstances) sent through the IFR panel.
- Financial risk incurred through patients attending urgent care during Health Optimisation period.
- Additional GP appointments will be required (pre and post Health Optimisation period).

Stakeholder

- Increase in the number of referrals to Fit4Life and associated capacity issues.
- Increase in referrals to Smokefree Life North Yorkshire (Solutions4 Health).

Strategic

- These proposals support the delivery of HaRD CCG's strategic objectives.

Reputational

- The public and other key stakeholders e.g. Health watch, OSC may have concerns that these proposals are driven solely by financial imperatives.

10. RECOMMENDATIONS

The Governing Body is asked review the contents of this paper and approve the following commissioning policies as part of a wider holistic approach to ensure patients have optimised their health prior to surgery:

1. All non-urgent referrals to surgical specialties with a BMI of ≥ 30 to be offered a referral to Tier 2 weight management to enable completion of a period of health optimisation for 6 months before commencement of surgery.

2. All non-urgent referrals to surgical specialties where the patient is a smoker to be offered a referral to Smokefree Life North Yorkshire for smoking cessation to enable completion of a period of health optimisation for 6 months before commencement of surgery. If Smokefree Life North Yorkshire confirm a positive quit to the patients GP within this period then the referral could be expedited.

These will be in addition to advice on wider lifestyle behaviours (eg alcohol reduction) and optimisation of long term condition management.

The agreement of these policies will give the individuals the opportunity, and provide the incentive, to make changes to their lifestyle which will directly improve health outcomes. With the current spend on obesity and smoking related ill-health increasing, by acting to reduce the prevalence locally this will also protect the future finances of the local health economy.

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