Vale of York
Clinical Commissioning Group

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Dear Colleague

Body Mass Index and Smoking Thresholds

1. I am writing to confirm that the Vale of York CCG's BMI and smoking thresholds for elective surgery, described in the Optimising Outcomes from All Elective Surgery Commissioning Statement will come into effect from **16th January 2017**.

2. It is proposed that the restrictions apply across all elective surgical operations under general and local anaesthesia unless otherwise stated in the policy.

3. The restrictions being implemented for elective surgery that

    a. patients with a BMI > 30 should
        i. lose 10% of their weight, or
        ii. sufficient weight to get below a BMI of 30 or
        iii. wait up to one year.

    b. if patients are current smokers they must
        i. stop smoking for two months
        ii. or wait six months before surgery.

4. BMI assessment will be by clinicians' height and weight measurements and smoking status is from patient reporting. Exhaled breath carbon monoxide testing will not be used.

5. It is hoped that the implementation of the restrictions will contribute to efforts to raise awareness of the real impact that smoking and obesity have on individual's health and to stabilise the CCG's finances. Obesity is thought to cost the NHS locally about £46m a year. Smoking is thought to cost the NHS and Social Care in York alone around £7m. You will be well aware of the clinical benefits to individuals from weight loss and smoking cessation.

6. The CCG's Clinical Executive do not consider that the thresholds are there only to reduce the risks of surgery. There is evidence that recovery is enhanced and post-operative complications are reduced by weight loss and smoking cessation. We know that smoking and obesity have a massive impact on health and NHS costs generally and it is for these reasons that the CCG feels it is justified in implementing the threshold at this time, even for patients having operations under local anaesthetic and even for patients whose operation is not exacerbated by smoking or being obese.

7. Whilst every effort has been made to identify the appropriate clinical exceptions we expect that in the early weeks of the policy the exclusion list will be updated regularly and we will communicate this via email to General Practice and provider colleagues each week that a change occurs.

8. The CCG is mindful of the GMC expectation of doctors and the contractual requirements that the LMC has written to colleagues about. There are two pathways that referring clinicians should follow. These are attached and are described below.

    a. When a GP or nurse practitioner refers to a specialist and is clear their patient requires an operation the RSS will advise obese and smoking patients that their referral cannot proceed until they fulfil the commissioning criteria and send them the CCG's standard letter about the policy and sources of help for weight loss and stopping smoking.

    b. When a GP or nurse practitioner refers a patient for an opinion, the RSS will warn the patient about the CCG's policy and that, having seen the surgical team, they may not be able to proceed to surgery straight away.

9. GPs should use the attached Optimising Outcomes From All Elective Surgery Referral Form with all surgical referrals starting from the 9th January. Referrals received from 21st January onwards without this will be returned by the RSS to practices.

10. GPs should now warn patients who are obese or who are smokers that their referrals will be delayed (unless they are in an exclusion category).

11. We expect referrals from the MSK service to go through the RSS from early February and as most of these patients will be being referred from the MSK service into secondary care for specific procedures these referrals will be stopped by the RSS where patients do not meet the thresholds. MSK patients will then be discharged back to their GP until they fulfil the thresholds (ie lose 10% of their weight, reduce their BMI to < 30 or wait a year, or if smokers, stop smoking for 2 months or wait six months).

12. **It will be in patients' interests for GPs to be recording weight and BMI and giving brief interventions on every possible occasion** because if patients have lost 10% of their weight or stopped smoking for two months by the time they are seen in outpatients they can then be 'listed'. As the paper in the Lancet recently showed such interventions are worthwhile. Colleagues can then decide when it is appropriate to regard 'time zero'. This enables GPs and patients to address obesity and smoking as early as possible. This helps individuals and the whole population. It enables patients who have lost weight to proceed through to surgery more quickly than if the weight measurements and brief interventions are delayed until patients present with symptoms that require surgery.

13. If the specialist feels the patient may benefit from surgery but they do not meet the commissioning thresholds then specialists will discharge them back to their GP. Secondary care providers cannot 'hold' patients who do not meet commissioners' thresholds.

14. When patients do meet the thresholds they will be encouraged to inform their GP by telephone. We advise that GPs should then write a short letter directly to the specialists informing them their patient is now ready to be listed and detailing any significant changes to their health in the interim or any changes to their medication. If local providers are able to establish fast routes back into surgical pre-assessment we will inform local GPs and patients of these and what to do.

15. We do not expect the majority of patients to need a second GP appointment or a second outpatient appointment.

16. At pre-assessment providers need to record smoking status and BMI and assure themselves that patients fulfil the commissioning threshold or have confirmed IFR approval to be paid for surgical procedures. Without this providers risk undertaking surgery that will not be reimbursed.

17. When patients with a BMI > 30 have waited a year from the time they were first advised to lose weight their referral can proceed again whether they have lost weight or not.

18. When smokers have waited six months from the time they were first advised to stop smoking their referral can proceed again whether they have stopped smoking or not. The real impact on patients whose BMI and smoking status was recorded in the past and who had a brief interventions will then be minimised.

19. The Individual Funding Review Panel (IFR) Process will continue to apply for patients who are currently excluded but wish to apply for funding due to exceptional circumstances. There is a best practice guide on how to make an IFR application on the Referral Support Service website. Feedback from IFR team will aid the review of the whole process and exceptions list.

20. There will be no delay in surgery for patients who have been listed for surgery by the 21st January 2016 or who were placed on a waiting list prior to January 20th 2016.

21. The policy does apply to patients who are not on a waiting list by 20th January 2016

22. The CCG has posted information on weight loss and support for smoking cessation on its website at www.valeofyorkccg.nhs.uk/your-health There is a BMI calculator here too that patients can use. North Yorkshire County Council's Move it and Lose it programme is in operation in Selby and Tadcaster and there is a programme called 'Everyone Active' in Ryedale. City of York Council's physical activity programme HEAL (Health, Exercise, Activity and Lifestyle) is still running and its new Wellbeing service is expected to start soon. East Riding of Yorkshire has a health trainer service for patients and an exercise on referral scheme.

23. GPs and practice nurses should note that the LMC now support GPs referring patients for assessment for an exercise programme.

24. If you have further questions do not hesitate to contact Dr Shaun O'Connell; for more clarification.

Yours faithfully,

Phil Mettam
Accountable Officer – Vale of York CCG

Enclosed:

1. Optimising Outcomes from All Elective Surgery Commissioning Statement
2. Pathway diagram
3. Letters to patients for surgery and surgical opinion
4. Optimising Outcomes from All Elective Surgery Referral Form

Exclusions to the policy (as of 6th January 2017) are:

Exclusions apply to enable access to urgent care, but all patients must be offered access to smoking cessation and/or weight management concurrently regardless of urgency.

Exclusions include:

- Patients requiring emergency surgery or with a clinically urgent need where a delay would cause clinical risk:
    1. Cholecystectomy
    2. Surgery for arterial disease
    3. Anal fissure
    4. Hernias that are at high risk of obstruction
    5. Anal fistula surgery
    6. Revision hip surgery which is clinically urgent AND where delay could lead to

significant deterioration/acute hospital admission. Includes infection, recurrent dislocations, impending peri-prosthetic fracture, gross implant loosening or implant migration.

7. Revision knee surgery which is clinically urgent AND where delay could lead to significant deterioration/acute hospital admission. Includes infection, impending peri-prosthetic fracture, gross implant loosening/migration, severe ligamentous instability.

8. Primary hip or knee surgery which is clinically urgent because there is rapidly progressive or severe bone loss that would render reconstruction more complex.
9. Nerve compression where delay will compromise potential functional recovery of nerve.
10. Surgery to foot/ankle in patients with diabetes or other neuropathies that will reduce risk of ulceration/infection or severe deformity.
11. Orthopaedic procedures for chronic infection.
12. Acute knee injuries that may benefit from early surgical intervention (complex ligamentous injuries, repairable bucket handle meniscal tears, ACL tears that are suitable for repair).

- Referrals for interventions of a diagnostic nature:
    13. Gastroscopy
    14. Colonoscopy
    15. Nasopharyngolaryngoscopy
    16. Laparoscopy
    17. Hysteroscopy
    18. Cystoscopy
- Patients with advanced or severe neurological symptoms of Carpal Tunnel Syndrome such as constant pins and needles, numbness, muscle wasting and prominent pain AND that are significantly affecting activities of daily living
- Patients who despite having a BMI >30 have a waist circumference of:
    - Less than 94cm (37 inches) male
    - Less than 80cm (31.5 inches) female
- Children under 18 years of age
- Patients receiving surgery for the treatment of cancer or the suspicion of cancer
- Any surgical interventions that may be required as a result of pregnancy
- Patients with tinnitus
- Patients requiring cataracts surgery
- Vulnerable patients who will need to be clinically assessed to ensure that, where they may be able to benefit from opportunities to improve lifestyle, that these are offered. (Please note that deferring elective interventions may be appropriate for some vulnerable patients based on clinical assessment of their ability to benefit from an opportunity to stop smoking/reduce their BMI/improve pre-operative fitness.) This includes patients with the following:
    - learning disabilities
    - significant cognitive impairment
    - severe mental illness**

**Adults with a serious mental illness are persons who currently or at any time during the past year, have a diagnosable mental, behavioural, or emotional disorder of sufficient duration that has resulted in functional impairment which substantially interferes with or limits one