Item Number: 7.1

Name of Presenter: Shaun O'Connell

Meeting of the Governing Body **1 September 2016**	NHS Vale of York Clinical Commissioning Group

Prevention and Better Health Strategy

Purpose of Report
For Decision

Rationale

One of our strategic priorities for 2016/17 is to focus on Prevention and Better Health. This is an area of focus as we believe that this is the best way of achieving maximum value from the limited resources available to us.

The *Prevention and Better Health* strategy has been developed to demonstrate how focusing our efforts on prevention, self-care and shared decision making can support a shift in the way health care resources are valued, and to empower patients in the Vale of York to become more active participants in shaping their health outcomes.

This paper develops a strategy for tackling the obesity and smoking – the two main lifestyle behaviours which are known to significantly impact health and treatment outcomes.

Strategic Priority Links

☐Primary Care/ Integrated Care	☒Planned Care/ Cancer
☐Urgent Care	☐Prescribing
☐Effective Organisation	☒Financial Sustainability
☐Mental Health/Vulnerable People	

Local Authority Area

☒CCG Footprint	☐East Riding of Yorkshire Council
☐City of York Council	☐North Yorkshire County Council

Impacts/ Key Risks

☒Financial
☐Legal
☒Primary Care
☒Equalities

Recommendations

1. Approve the proposed Prevention and Better Health Strategy
2. Direct the further development of the self-care and shared decision making aspects of the strategy, and patient support resources
3. Approve the intention to collaborate with local authority partners in the commissioning of weight management and smoking cessation services
4. Direct the further development of mechanisms for collaborative commissioning of further prevention services with partner organisations

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NHS
Vale of York
Clinical Commissioning Group

Vale of York Clinical Commissioning Group

Prevention and Better Health Strategy

Contents

1. Introduction

NHS Vale of York 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 we have signed up to with local authority partners[1,2,3]. To achieve this it must enable, and encourage, 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'll never be completely eliminated.

Other harms caused by, for example, smoking or becoming obese and inactive, 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 of CCGs in the NHS Five Year Forward View is to prioritise action on smoking, obesity and diabetes. We also have a requirement to prioritise financial sustainability, show leadership and reduce health inequalities. For the public this boils down to ensuring we all get the best value from our health services and that it's there for when we really need it.

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.
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

[1] City of York Council, *Improving Health & Wellbeing in York - Our strategy 2013-16*
[2] *East Riding Of Yorkshire Joint Health & Wellbeing Strategy 2016-19; Promoting Wellbeing, Preventing Ill-health*
[3] *North Yorkshire Health and Wellbeing Board, Joint Health and Wellbeing Strategy 2015-2020*

groups.

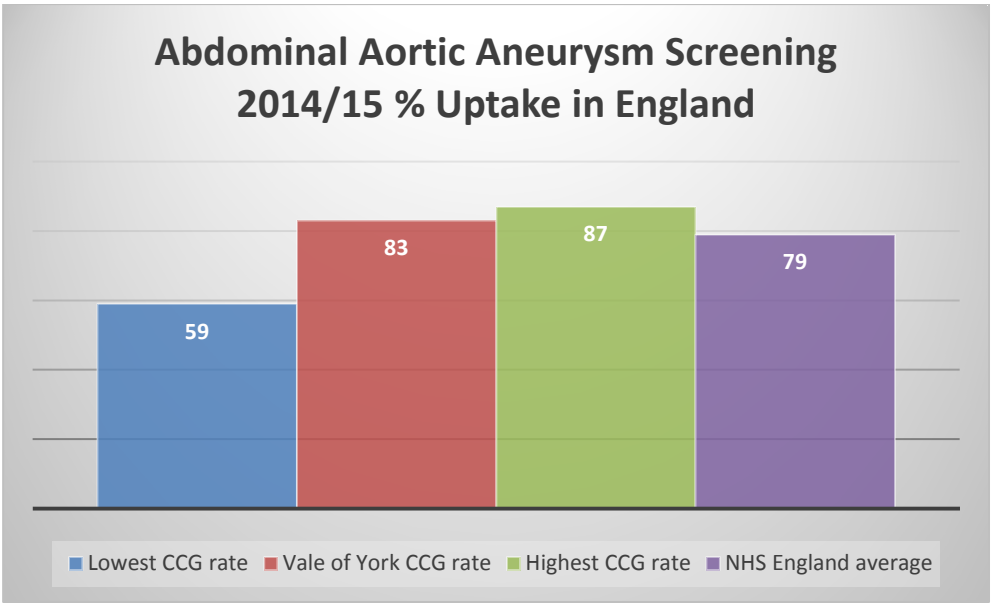
Smoking causes a range of diseases including cancer, cardiovascular disease and respiratory diseases. It causes many other debilitating conditions such as age-related macular degeneration, gastric ulcers, impotence and osteoporosis. Further, it can cause complications in pregnancy and is also associated with lower survival rates, delayed wound healing, increased infections, prolonged hospital stays and repeated admissions after surgery (Delgado-Rodriguez et al. 2003; Theadom et al. 2006).

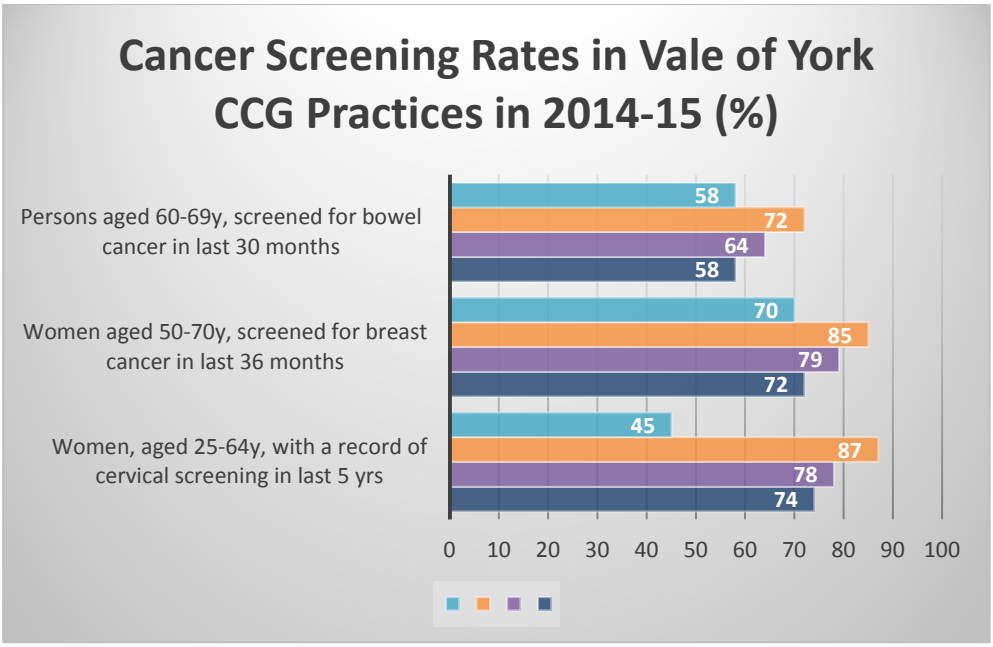
In England in 2011, an estimated 79,100 adults aged 35 and over died as a result of smoking (18% of all deaths) and nearly half a million hospital admissions adults aged 35 (5% of all admissions) were attributable to smoking. Treating smoking-related illnesses cost the NHS an estimated £2.7 billion in 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.

Obesity is a global problem. In the UK 23% of adults are obese (Body Mass Index > 30) and the estimated cost to the NHS in our CCG is £46million (2015). Obesity contributes to many illnesses. The development of diabetes as a result of obesity is said to be one of the largest ‘time bombs’ for the NHS with potentially one in ten people having Type 2 diabetes by 2034. Type 2 diabetes itself is a major cause of illness; preventable sight loss, heart disease, strokes, peripheral circulatory problems and renal failure. The national Pre-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.

There are national screening programmes for cervical, bowel and breast cancer and for abdominal aortic aneurysm. They are one of the key ways we try to prevent premature death. Uptake for these is generally good. Even so if some people miss out they risk developing serious illness that could have been prevented. Such occurrences are costly for the individual as well as the NHS. Whilst Public Health England are responsible for the screening programmes CCGs are responsible for the treatments that result from them and for the treatments that are needed when screening has not been taken up. In all screening programmes there is variation and therefore room for improvement in uptake. (see below).





Identifying and treating blood pressure should be the bread and butter of primary care prevention of heart disease and strokes but it appears we are not as good as it as others. Recent RightCare data suggests that within the Vale of York CCG there are some 5000 patients who have high blood pressure but are not diagnosed (and therefore treated). The same data indicates there are higher numbers of patients dying under the age of 75 than there are in comparable CCGs.

Data from the Quality and Outcomes Framework is known to show consistently lower rates of obesity in the adult population than other surveys. Although encouraged to 'make every contact count' we don't know if any interventions for obesity are being provided for those whose weight is not recorded or even for those it is.

2. Establishing a Prevention and Better Health Strategy

One of our strategic priorities for 2016/17 is to focus on Prevention and Better Health. We propose to achieve this aim through the development and implementation of a Prevention and Better Health (PBH) Strategy. The introduction details some of the ways we can do that. If we focus our efforts on prevention, self-care and shared decision making and take bold strategic decisions to do so we will secure the best value from the limited resources available and improve our population's health.

This paper is about the first step we will take in the Prevention part of our strategy. Outline proposals on Self-Care and Shared Decision Making aspects of the strategy are included as Appendix A.

The overall strategy will guide the way in which the CCG enables residents and patients to take greater responsibility for their health. It has a wide remit including:

1. Tackling the common risk factors for many of the main diseases affecting people in the Vale of York;
2. Improving the appropriate use of health and care services;
3. Ensuring patients gain the most benefit from the interventions they receive;
4. Support local people and patients to engage with and take responsibility for their own health; increasing levels of shared decision making between patents and clinicians.

The Wanless report in 2002on the future funding of healthcare services in UK[4]envisaged three different scenarios, each with its own resource implications. The 'fully engaged' scenario in which people took active ownership of their own health, and engaged with health and healthcare services through a dramatically increased use of information and technology, was associated with better health outcomes and a lower increase in costs.

The report indicated that developing a local strategy to promote prevention and self-care should help to address the impacts of poor health and contribute to a more sustainable financial position for the local economy. The review estimated that if the public were fully involved in managing their health and engaged in prevention activities £30 billion could be saved across the UK.

2016/17 finds the health and social care system in the Vale of York, if not across most of England, in a period of unprecedented stress. The services currently used by the local population exceed the resources available to fund them. There are no additional funds available to meet this gap, so the way we design and commission services needs to change.

While the strategy has been produced by Vale of York CCG, it aligns to the aims and objectives set within the health and wellbeing strategies of each of our local authority partners[1,2,3]. The health and wellbeing strategies recognise the important role of working together to support our local populations in achieving better health, and this strategy outlines how the CCG is developing its approach.

[4]Wanless, D, *Securing our Future Health: Taking a Long-Term View, 2002* http://www.yearofcare.co.uk/sites/default/files/images/Wanless.pdf, accessed 22/8/2016

3. Strategic Objectives

Vale of York CCG's Prevention and Better Health Strategy aims to optimise prevention with a variety of areas to reduce the overall morbidity and mortality for amendable diseases.

To support achievement of this, we will be measuring achievement against the following objectives:

- A reduction in smoking prior to surgery
- Reduction in smoking rates in our population
- Increasing rate of weight reduction prior to surgery
- Reduction in rates of obesity in our population
- Increased primary prevention of disease (e.g. immunisation and cancer screening)
- Increased secondary prevention of disease (e.g. detection and high quality treatment of diabetes, hypertension, cardiovascular and renal disease)
- weight recording of patients in primary care
- Increase in levels of self-care amongst Vale of York residents.
- Increase in self-management support for patients with long-term conditions.
- Increase use of shared decision making

We will develop more detailed measurable objectives as we build and implement the strategy.

4. Context and Drivers

We are responsible for commissioning health services which meet the requirements of our population, and these include acute, community, mental health, maternity and children's health services. Our overall goals are to improve health outcomes, maximise health efficiencies and ensure that people are seen in the right place and the right time. Where possible this should be close to home.

Our priority areas for 2016/17 as outlined in our '*Operational Plan 2016-17*[5]'are:

1. Integration of community based-services (incorporating the Better Care Fund)
2. Urgent Care programme
3. Planned Care and Cancer Programme
4. Primary Care Programme
5. Prescribing Programme
6. Prevention and Better Health
7. Mental Health and Learning Disabilities
8. Children and Maternity

This is the strategy for our sixth priority 'Prevention and Better Health'. Including self-care and shared decision making should help to create better understanding of individual's choices and develop community resilience, the ability to consider and manage health conditions with less direct contact with health professionals.

[5] http://www.valeofyorkccg.nhs.uk/data/uploads/publications/update-june-16/nhs-vale-of-york-ccg-operational-plan-2016-17-final.pdf

The strategy should be everybody's business in the Vale of York. We need to ensure that the limited public sector budget achieves the maximum value for our population, and this means allocating greater focus and resources on services that help people to live healthier lives, prevent illness or, when it does occur, diagnose illness early, prevent it from getting worse, and optimising treatment outcomes.

A preventative approach should be taking place alongside treatment and service provision at all levels. Patients need to be involved in decisions relating to their health whenever possible. Local people must be supported in caring for themselves and their families, and in using services appropriately–in taking more responsibility for their health. Not doing so deprives others of NHS resources when they need them.

There has been relatively little focus on healthy lifestyles in the local health service in recent times and no specific strategic objectives to address it. The CCG is keen that should change.

a) Finance

This strategy is going to be implemented during a period of severe financial constraints. During 2016/17 the CCG has set a provisional overall savings target of 3.1% for 2016/17 (£12.2m). Despite such savings the CCG has a challenging deficit financial plan. Our local authorities are facing larger cuts in their budgets and therefore service provision. Yet we know we could potentially save the local health and care economy millions of pounds by reducing the number of people who smoke and reducing the number of people who are obese.

b) Population

At the same time, there is a rising demand for services. This is partly due to changes in the population, with greater numbers of older people and children, both groups requiring more care than the general population.

However a significant part of this increase is due to the inappropriate use of services–for example accessing urgent care services, when only advice or information is needed. One aspect of this strategy is about developing ways to manage this demand.

Lifestyle and behaviour impact on the risk of developing disease (see section 3)

c) Technology

Technology has an important role to play. Communicating via email, text message and mobile phone is now commonplace with 81% of UK adults in Q1 2016 with broadband in the UK (fixed & mobile) and 93% owning or using a mobile phone[6]. Despite this, the adoption and use of new technologies by health care providers has lagged far behind that of other sectors, even though this can often be achieved at low or even no cost.

There are numerous apps, software programmes that can be used on smartphones, which can be down loaded free of charge such as NHS Quit Smoking app, One You Couch to 5K, One You Easy Meals, One You Drinks Tracker, NHS24's MSK help and various NHS

[6] http://media.ofcom.org.uk/facts/

Right Care shared decision aids

All Vale of York CCG pathway redesigns will assess the utility of using such technology and will incorporate text, mobile, e-comms and social media whenever benefits are likely.

d) Mental Health

Vale of York CCG recognises that a Prevention and Better Health Strategy is as much about mental health and wellbeing and social needs as it is about physical health, and that these areas are all interdependent. For example depression caused by debt can inhibit self-care resulting in weight gain. Not surprisingly suffering a stroke is associated with an increased risk of depression. If services are to be effective then they will need to address mental, physical and social health needs. There is good evidence to show that increasing activity can improve depression and anxiety symptoms as much as medication.

Vale of York CCG will ensure that: all relevant commissioning decisions enhance the protective factors for mental health; the mental health services that it commissions also support self-care and prevention for physical health; frontline behaviour change interventions, particularly amongst service users with risk factors for poor mental health, include the five ways of promoting wellbeing.

5. The Case for Change

Many of the diseases affecting Vale of York residents – cardiovascular disease (CVD),chronic obstructive pulmonary diseases, type 2diabetes and cancer – are linked by common and preventable risk factors such as high blood pressure, high blood cholesterol and overweight and obesity, and by related major behavioural risk factors: unhealthy diet, physical in activity, tobacco and alcohol use.

Supporting our population to take a proactive approach to increasing physical activity, maintaining an optimal weight through healthy eating and stopping smoking, will improve their quality of life, reduce health inequalities across our area and reduce the long-term health burden.

A Kings Fund[7] report identifying priority areas for Clinical Commissioning Groups states that expenditure on prevention is ‘an excellent use of resources’. Ina review of more than 250 studies published on prevention in 2008, nearly 80% were within the National Institute for Health and Care Excellence’s threshold for cost effectiveness.

While specific prevention services can be commissioned e.g. a smoking cessation or weight management service, Vale of York CCG aims to embed prevention interventions within encounters between Vale of York’s service providers and service users wherever possible. These can include brief interventions around diet, physical activity, smoking, alcohol and drug use, and promoting well being

If we are to provide high quality healthcare that meets patient’s expectations, then Vale of York residents must be supported to be fully engaged with their health.

[7]http://www.kingsfund.org.uk/publications/articles/transforming-our-health-care-system-ten-priorities-commissioners

a) Our priorities

There are many areas a prevention strategy could address – smoking, obesity and inactivity, diabetes prevention, alcohol consumption, immunisation, cancer and abdominal aneurysm screening, diabetic retinal screening, unwanted pregnancies, illicit drug use, social isolation and activity in the elderly. While all are important smoking and obesity should be our priority now because the impact on health from these is great and there is evidence it can be reduced. The other areas will be addressed in due course.

b) Smoking

Smoking is internationally accepted as one of the greatest harms to health that can be avoided. We have already taken steps to address this and we need to do more.

In October 2013 the CCG developed a 'stop before your op' policy aimed at highlighting to patients who may be about to undergo surgery the risks of smoking and the benefits of stopping. The policy requires patients who smoke to consider stopping or signing a waiver form acknowledging the risks of continuing to do so. The policy is enacted at the time a patient is being considered for surgery because there is good evidence that smokers are more receptive to the need to stop and are more likely to do so at this time.

We do not know how many patients stop as a consequence of the policy or how many continue to smoke despite being made more aware of the risks. We know all such 'brief interventions' help move people towards stopping earlier than they would otherwise have done so.

We know the harms of smoking are grave, both for an individual and their family but also for everyone else in our community. There is a list of harms from smoking in Appendix B. Reducing rates of smoking reduces the impact on individuals, their families, the health service and society as a whole from smoking. It will free up resources to improve services for everyone.

To encourage adult smokers to stop smoking we propose to postpone elective surgery for conditions that are not life threatening for six months or until they've stopped smoking for eight weeks.

Patients undergoing surgery for cancer will not be affected and the CCG clinicians will identify other groups of patients who should be exceptions to the policy. An example exception is patients recommended to have a cholecystectomy for gallstones as delaying such surgery can risk potentially life threatening pancreatitis.

Many NHS stopping smoking services measure success 4 weeks after a planned 'quit date' Clinicians have expressed scepticism that this short time interval enables a sufficiently engrained new non-smoking habit. We have proposed 8 weeks to enable the patient's commitment to a new lifestyle to be more firmly embedded.

Information about local authority resources currently available within the CCG area are on the Referral Support Service (RSS) website here and information for the public are available here on the CCG website. Appendix G details further information for patients on support for stopping smoking.

c) Obesity

Obesity is defined as a Body Mass Index (BMI)(weight in kg / height in m^2) of more than 30.

BMI ranges	Weight status
18 to 24	Normal
25 to 29	Overweight
30 to 39	Obese
40 to 49	Morbidly obese

BMI is an established measure of weight though it is recognized that muscular people will have a higher BMI that is not thought to be a risk to health (muscle is denser than fat) and adults of Asian origin may have a higher risk of health problems at BMI levels below 25[8].

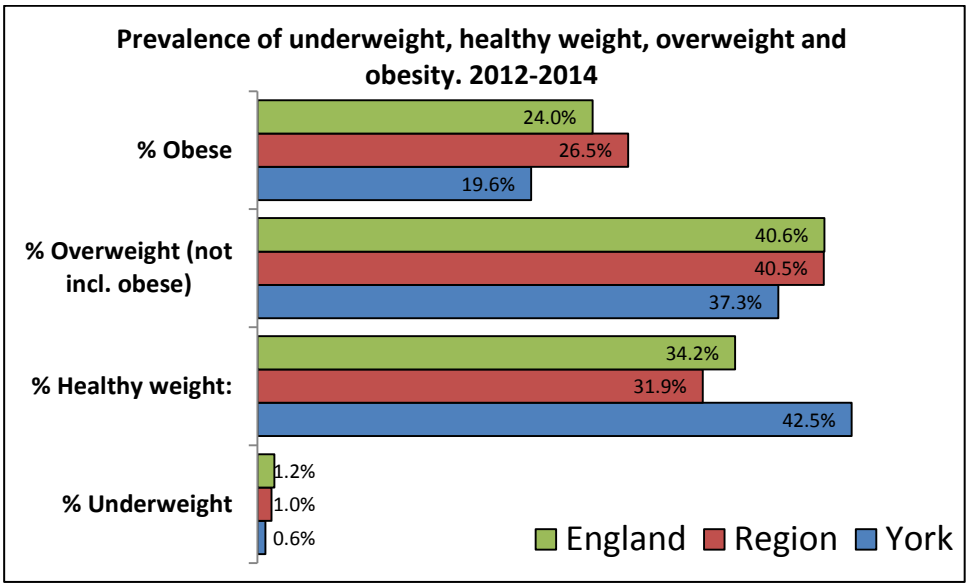
Obesity can be measured by waist measurements but that is not yet established in UK clinical practice. NHS Choices website states individuals have a higher risk of health problems if waist size is:

- more than 94cm (37 inches) if you're a man
- more than 80cm (31.5 inches) if you're a woman

Risk of health problems is even higher if your waist size is:

- more than 102cm (40 inches) if you're a man
- more than 88cm (34.5 inches) if you're a woman

Prevalence of underweight, healthy weight, overweight and obesity. Active People Survey 2012-2015. York v Region/England



[8] NHS Choices Website

The prevalence of obesity (BMI ≥30) as measured by practices using 2014/15 QOF Obesity register (patients aged 16 or over with a BMI ≥30 in the preceding 12 months) ranges from 2.1% to 15.2% with an average of 8.6%. It is accepted that QOF data is not a proxy for population prevalence of obesity.

Being obese and overweight is becoming a societal norm that threatens our health in a multitude of ways. Appendix C details these. Whilst there is a plethora of ways of addressing weight loss within the local health economy there has not been a specific NHS strategy to help patients (or support their clinicians to help them to) lose weight and get healthier.

Anecdotal evidence about the readiness of clinicians to address obesity varies. Whilst some patients report the doctor is ‘always banging on about my weight’ others report ‘he never mentions my weight’. Is it surprising with a lack of supporting services and limited time sometimes doctors feel unable to broach the problem. To make every contact count that needs to change as there is good evidence that brief interventions for obesity are effective in leading to short term changes. To build these into long term changes the CCG intends to support patients to access weight management services. North Yorkshire County Council already has an activity and weight loss service as does East Riding of Yorkshire Council. City of York Council will soon be starting its Health and Wellness Service.

We know the harm to physical and mental health from obesity can be serious, and can impact on family members too. Reducing rates of obesity will reduce the impact on individuals, their families, the health service and society as a whole from smoking. It will free up resources to improve services for everyone. If our strategy can encourage all patients who need elective surgery to lose weight that will have a positive benefit for them and the NHS.
There is good evidence that shows that obese patients are more likely to experience:

- post-operative complications after elective breast procedures
- infection at the surgical site (especially with major abdominal surgery or elective colon and rectal surgery)
- bleeding and infections after abdominal hysterectomy
- peri-operative deep venous thrombosis and pulmonary embolism
- complications after elective lumbar spine surgery
- poor outcomes after joint replacement surgery such as
    - Component loosening and failure
    - Dislocation of the replacement joint, especially in the hip
    - Needing a second "revision" surgery to remove failed implants and replace them with new ones.

It is more difficult to give anaesthesia to a patient with obesity. It is more difficult to insert needles and cannulas to give vital medication and fluids, to ventilate obese patients under general anaesthetic and it is more difficult getting needles in the right place for spinal and epidural nerve blocks and other types of regional anaesthesia. All of these combined with the technical challenges associated with performing surgery on a patient with obesity, mean operation times are often longer. In general, the longer patients are in surgery, the greater the risk of developing complications.

Recovery from surgery takes longer in obese patients and rehabilitation to the same extent as normal weight patients may not be achieved. In joint surgery for example this will limit the potential gain from having a new joint.

To minimise the risks of surgery and maximise the benefits of surgery the CCG proposes to encourage adults who are obese to lose weight before being listed for surgery. A ten percent weight loss is a serious yet attainable target. If patients can achieve this it shows a firm commitment to a new lifestyle of activity and consuming fewer calories that will benefit overall health. Commercial slimming clubs (such as Weight Watchers and Slimming World) encourage members to lose 10% of their body weight. Tier 3 services aim for a weight loss of 5-10% over a twelve week period so persistence with the changed lifestyle for longer should enable most patients to achieve 10%. The table below indicates some of the health benefits from 10% reduction in weight.

Mortality	20-25% fall in total mortality 30-40% in diabetes-related deaths 40-50-% fall in obesity-related cancer deaths
Blood Pressure	Fall of approximately 10mmHg in both systolic and diastolic values
Diabetes	Reduces risk of developing diabetes by > 50% Fall of 30-50% in fasting glucose Fall of 15% in HbA1c
Lipids	Fall of 10% in total cholesterol Fall of 15% in LDL Fall of 30% in triglycerides Increase of 8% in HDL

Where BMI is 30kg/m^2 or more we propose to postpone elective surgery for conditions that are not life threatening for twelve months or until 10% of weight loss is achieved, whichever is the sooner. (The baseline weight, the assessment weight will be regarded as that at the time of presentation to their primary care clinician for the condition that is to be treated by surgery).

The Council of Representatives supported the development of a strategy based on the specific BMI and twelve months postponement of elective surgery at its April meeting.

Patients undergoing surgery for cancer will not be affected and the CCG clinicians will identify other groups of patients who should be exceptions to the policy. An example exception is patients recommended to have a cholecystectomy for gallstones as delaying such surgery can risk potentially life threatening pancreatitis.

Implementation

It is beyond the scope of this paper to detail the process of implementation. The CCG will ensure patients who are ready to be listed for surgery are supported to access a variety of services to help them lose weight. See examples in Appendices F and G. We will work with our local authority partners to maximise access to and capacity of Tier 2 services. Tier 3 services are normally traditionally available when BMI > 40 or 35 and patients have co-morbidities or if they had not managed to lose weight with the support of Tier 2 services. Access to Tier 3 services costs around £600 per patient. Hip or knee replacement surgery costs around £6000. Details on the Tier Terminology are in Appendix D.

We recognise GPs have GMC obligations[9] to '*refer a patient to another practitioner when this serves the patient's needs'* and '*to support patients in caring for themselves to empower them to improve and maintain their health. This may, for example, include:*

a) *advising patients on the effects of their life choices and lifestyle on their health and well-being*
b) *supporting patients to make lifestyle changes where appropriate'.*

The CCG does not want doctor patient relationships to be harmed by the implementation of this policy and so will work with primary and secondary care providers to implement the policy with minimal bureaucracy so that patients are supported while they lose weight, and doctors can adhere to GMC expectations and patients can be referred back in with the least impact on primary care. Information on weight loss options will be available to primary care clinicians, the Referral Support Service and secondary care clinicians.

The CCG will work with secondary care providers to ensure that they adhere to the policy and inform the CCG of dated baseline weights and dated weight at the time of surgery. Providers will not be reimbursed for surgery where the policy is not adhered to unless patients fall into an exception category or prior approval for funding from the IFR panel.

Appendix E details the proposed implementation pathway.

6. Self-Care and Shared Decision Making

To support the strategy for reducing smoking and obesity the CCG needs to prioritise work to promote self-care and shared decision making. Both are key to helping patients succeed in achieving better health and the NHS maximise the best use of its resources. Much of this work will take place in the CCG's Out of Hospital strategy.

Self-care has numerous benefits. It prevents disease, slows progression and reduces demand for specialist services. Up to 39% of GP consultations relate to minor ailments that could be treated by the patient and their family or by pharmacies. Up to 8% of adult attendances to inner-city A&E departments could be dealt with by a pharmacist. The CCG's policy on medicines that can be purchased supports this approach.

Self-management is a sub-set of self-care. For people diagnosed with long term conditions, self-management involves following complex medical regimens and making changes in lifestyle such as losing weight and increasing physical activity.

An increasing number of patients in Vale of York are being diagnosed with long term conditions and for them to be supported effectively the local health and social care system needs to develop services that are in line with models of best practice. The development of the integrated hubs and the out of hospital care models are designed to address optimising self-management.

Shared Decision Making is a process in which service providers and users work together to choose test, treatment, management or support packages, based on evidence and the service user's informed preferences. Shared Decision making can be supported through the use of specially designed information resources called Patient Decision Aids (PDAs).

[9] General Medical Council Good Medical Practice 2013

The Vale of York CCG has been promoting the use of Patient Reported Outcome Measures and Shared Decision Making Tools for over two years and has links to these on the home page of our website. The CCG and MSK provider have agreed to incorporate shared decision making in the MSK service.

Further outline on Self-Care, Self-Management and Shared Decision Making are in Appendix A.

Our communications team will ensure effective communication of this strategy and its implementation to the public.

Communications to both professionals, and patients, families and carers, will play an essential role in developing the Prevention and Better Health strategy in Vale of York. Vale of York's health and care system needs to increase its use of now common mediums such as text messages and social media. PBH messages can be embedded as matter of course in other communications. In order to bring about behaviour change for health improvement and more effective service use amongst priority groups, there is a need for communications campaigns based on social marketing principles such as generating service user insights and segmenting markets.

To ensure effective communications around the Prevention and Better Health strategy, Vale of York CCG will:

- assess ways for increasing the use of text messages, email and social media for Prevention and Better Health strategy;
- embed PBH messages within other communications where this is possible;
- promotethesystematicuseofnationalhealthsocialmarketingcampaigns;

7. Engagement with Partners and the Public

The Vale of York Prevention and Better Health strategy is relevant to many different local organisations including NHS Trusts, local councils, major employers and voluntary and community sector organisations. We will engage with our partners and the public to develop and implement the strategy. A summary of our local authority partners strategies and that of other CCGs with the Sustainability and Transformation Plan area are detailed in Appendix H.

8. Commissioning Principles around the Prevention and Better Health strategy

When commissioning services, we will consider the following:

1. Are there opportunities to support people to make healthy lifestyle choices the new service

2. How can the service promote and support prevention, self-care and shared decision making within encounters between service users and service providers?

3. Ensure that providers are made aware of and put in place mechanisms that support the provision of the common core principles of prevention, self-care and shared decision making.

4. Increase the uptake of new technologies–mobile phone, web-based, social media, telemedicine to improve prevention, self-care and shared decision making

5. How will services be targeted so that health inequalities in the area are addressed, and those people that need the most support receive it?

9. Recommendations

1. Approve the proposed *Prevention and Better Health Strategy*

2. Direct the further development of the self-care and shared decision making aspects of the strategy, and patient support resources

3. Approve the intention to collaborate with local authority partners in the commissioning of weight management and smoking cessation services

4. Direct the further development of mechanisms for collaborative commissioning of further prevention services with partner organisations

10. Appendices

Appendix A – Outline Proposals on Self Care, Self-Management and Shared Decision Making

Self-Care

The Department of Health has defined self-care as:

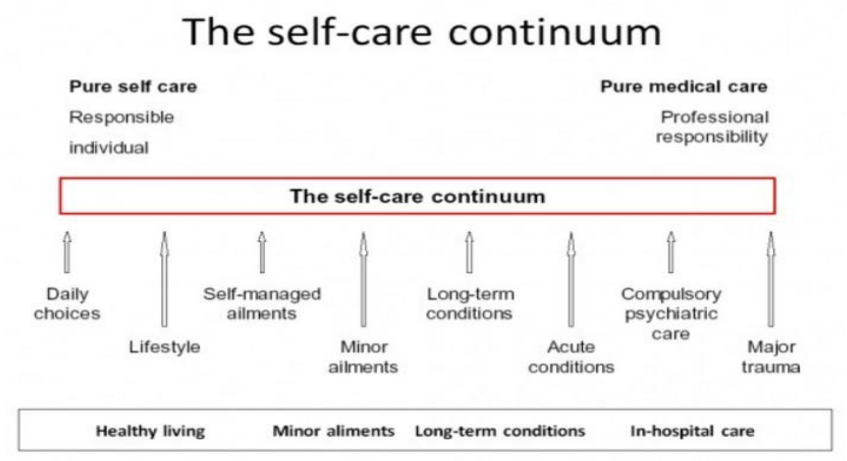
> '*The actions that people take for themselves, their children and their families to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long term conditions; and maintain health and well-being after an acute illness or discharge from hospital'*(Department of Health,2005).[10]

International evidence from some approaches to self-care support also suggests that investment could reduce:

- visits to GPs by up to 40%
- visits to outpatient clinics by up to 17%
- visits to A&E units by up to 50%
- drug expenditure

Patients are the health service's biggest untapped resource. If patients and the health service are to benefit, then services need redesigning so that patients and the public are truly partners and co-producers in their care. (Department of Health, 2005).[7]

Effective self-care empowers patients and so improves quality of life through preventing disease, slowing or minimising deterioration, and reducing the severity of symptoms. The model outlined by the Self-Care Forum (Figure below) shows self-care as taking place on a continuum, from individuals making choices about living healthily, via self-caring for minor ailments to self-managing long term conditions and finally to in-hospital care.



[10] http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4130868.pdf accessed 22/8/2016

An important aspect of self-care is enabling people to use services appropriately and resources effectively. One of the most significant challenges currently facing Vale of York's health care system is the large number of residents that are not engaging with the care best placed to address their needs (Analysis of NHS 111 calls for Vale of York and Scarborough and Ryedale CCGs in 2015)

This includes: seeking advice and treatment for minor ailments that could be treated at home; making GP appointments for minor ailments that could be treated in pharmacy; attending A+E or making 999 calls when telephone advice from NHS 111or booking a GP appointment would do. Vale of York CCG will support residents in developing their knowledge around making use of the right service at the right time.

It is estimated that approximately £1million worth of medicines prescribed in Vale of York are not taken as the prescriber intended and this can lead to poorer patient outcomes as well as wasted resources. Vale of York CCG's Medicines' Waste Campaign aims to address this area.

Self-care includes supporting patients to improve their health prior to specified treatments and interventions, to optimise the treatment's outcomes. This involves encouraging patients to lose weight or stop smoking prior to some elective procedures, where there is clinical evidence that this is appropriate to do so.

Self-management

Self-management is a sub-set of self-care. For people with long term conditions, self-management commonly involves understanding and following complex medical regimens, and making challenging changes in lifestyle, such as weight loss or increasing exercise.

Self-management involves three different kinds of tasks:

- care of the body and management of the condition,
- adapting everyday activities and roles to the condition, and
- dealing with the emotions arising from having the condition.

To support people with long term conditions so that they are able to self-care can have a dramatic impact on their quality of life, as well as reducing their need for emergency health and social services and the incidence of unplanned hospital admissions.

There are a rapidly increasing number of patients in Vale of York diagnosed with long term conditions, conditions that last a year or longer, impact on a person's life, and may require on-going care and support. These include cardiovascular disease, dementia, COPD, diabetes and HIV. Many patients have been diagnosed with two or more. Much of this is being driven by greater numbers of older people, but the increasing prevalence of obesity is also a significant risk factor for cardiovascular disease and diabetes.

Effective patient education begins immediately on diagnosis; thereafter people need access to regular updates in best practice in managing their long-term condition.For example, diabetes self-management education that educates patients as to the nature of the condition and its management, sets specific behavioural objectives, and supports a repeated process of attempting new self-management practices, monitoring their success, and then attempting revised plans has been shown to improve self-management

behaviours and metabolic control.

Wherever there is the evidence to support it, people diagnosed with other long-term conditions should be provided with similar patient education programmes to support them in developing the necessary knowledge and skills to self-manage their condition/s.

Shared Decision Making- Definitions and Best Practice

Shared decision making is a process in which service providers and users work together to choose test, treatment, management or support packages, based on evidence and the service user's informed preferences. Within the context of a user centred care system, the term 'shared decision making' is used more broadly to describe all aspects of people's involvement in their own health, wellbeing and care.

Research shows strong proven benefits from shared decision making, including:

- better treatment adherence, creating greater effectiveness and value
- improved confidence and coping skills
- fewer patients choosing major surgery, creating cost savings
- improved health behaviours such as greater exercise and reduced smoking
- more appropriate service use, particularly fewer emergency admissions

The use of specially designed information resources called Patient Decision Aids (PDAs) support patients in making their decisions[11]. These contain information on specific conditions that is accurate and balanced, ask questions that allow patients to think about the ways in which treatment consequences might affect them, and summarise the reasons for choosing, or not choosing, an option.

NHS RightCare have produced patient decision aids for 36 different conditions, each decision aid having been produced by an advisory group made up of clinicians, patients, voluntary and community sector organisations and Department of Health policy leads. They can be accessed at www.sdm.rightcare.nhs.uk.

Given that PDAs have been shown to reduce hospital activity and associated costs — up to38%fewer procedures and savings of 12% to 21%in a study of patients eligible for hip and knee replacements[12]- Vale of York CCG will incorporate PDAs within pathway redesign when possible.

[11] http://sdm.rightcare.nhs.uk/
[12] N Engl J Med 2013; 368 6-8, 'Shared Decision Making to Improve Care and Reduce Costs'

Appendix B The challenge from smoking

It is generally well known that and smoking has both individual and population level risks from reduced life expectancy and increased morbidity.

Harms caused by smoking

People who smoke are at greater risk of the following conditions when compared with those who do not smoke[13]:

- All-causes of death (mortality)
- Blindness, cataracts, age-related macular degeneration
- Congenital defects
- Periodontis
- Aortic aneurysm, early abdominal aortic atherosclerosis
- Type 2 diabetes
- Coronary heart disease
- Stroke
- Pneumonia
- Atherosclerotic peripheral vascular disease
- Osteoarthritis (a breakdown of cartilage and bone within a joint)
- Chronic obstructive pulmonary disease, tuberculosis, asthma and other respiratory effects
- Reduced fertility
- Male sexual dysfunction
- Rheumatoid arthritis
- Immune function
- Some cancers (mouth, larynx, oesophagus, trachea, bronchus and lung, acute myeloid leukemia, stomach, liver, pancreas, kidney and ureter, cervix, bladder, and colorectal)
- Low quality of life
- Mental illness such as clinical depression, anxiety, and other mental disorders
- Body pain and difficulty with physical functioning

The costs of smoking to the City of York

The annual cost to the NHS of smoking-related illness for York is on average £3.8 million and the costs to social care for York are £3.4 million.[14]

Smoking support before surgery

A review was undertaken to assess the effect of pre-operative smoking intervention on smoking cessation at the time of surgery and 12 months post-operatively and on the incidence of post-operative complications. Eight random controlled trials were included. The analysis demonstrates both intensive and brief intervention significantly increase smoking cessation at the time of surgery. Interventions that begin four to eight weeks

[13]https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/

[14] ASH http://www.ash.org.uk/information/ash-local-toolkit/cost-to-social-care

before surgery, include weekly counselling, and use nicotine replacement therapy are more likely to have an impact on long-term smoking cessation.[15]

The effects of smoking on the outcomes of surgery

A review was undertaken to determine the risks or benefits of short-term (less than four weeks) smoking cessation on postoperative complications. Based on an analysis of 25 studies, it reports that smokers who quit more than four weeks before surgery had lower risk of respiratory and wound-healing complications than current smokers. Quitting less than four weeks before surgery did not appear to increase or decrease postoperative respiratory complications.[16]

Surgery as a teachable intervention

In a large nationally representative longitudinal study of 5,498 patients conducted in the US, researchers found that undergoing major surgery approximately doubled the chances that a smoker would quit.[17]

Smoking and wound healing

A large 2012 systematic review was undertaken to clarify how smoking and nicotine affects wound healing processes and to establish if smoking cessation and nicotine replacement therapy reverse the mechanisms involved. In total, 177 articles were included. The author concludes that smoking has a prolonged effect on inflammatory and reparative cell functions leading to delayed healing and complications. Smoking cessation restores the tissue microenvironment rapidly and the inflammatory cellular functions within four weeks.[18]

Smoking and surgical outcomes

The surgical outcomes of current smokers and never smokers were examined in a large US cohort comparison involving a sample of 520,795 non-cardiac surgical patients. The researchers found that smoking was associated with a 40% greater chance of 30-day

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[15] Thomsen T, Villebro N, & Møller AM. *Interventions for preoperative smoking cessation.* Cochrane Database of Systematic Reviews 2010; Issue 7. Art. No.: CD002294. DOI: 10.1002/14651858.CD002294.pub3.

[16] Wong J, Lam DP, Abrishami A, Chan M, & Chung F. *Short term preoperative smoking cessation and postoperative complications: a systematic review and meta-analysis.* Canadian Journal of Anesthesia 2012; 59: 268-279.

[17] Shi Y, & Warner DO. *Surgery as a teachable moment for smoking cessation.* Anesthesiology 2010; 112(1):102-7.

[18] Sorensen LT. *Wound healing and infection in surgery. The pathophysiological impact of smoking, smoking cessation and nicotine replacement therapy.* Annals of Surgery 2012; 255: 1069-1079.

mortality and a 30-100% greater chance of major morbidity including surgical site infection, pneumonia, unplanned intubation and septic shock.[19]

[19] Turan A, Mascha EJ, Roberman D, et al. *Smoking and perioperative outcomes*. Anesthesiology 2011; 114: 837-46.

Appendix C -The challenge from obesity[1]

Overweight and obesity is a global problem. The World Health Organization (WHO; Obesity and overweight: fact sheet 311) 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.

The costs of obesity

The cost of being overweight and obese to society and the economy was estimated to be almost £16 billion in 2007 (over 1% of gross domestic product). The cost could increase to just under £50 billion in 2050 if obesity rates continue to rise, according to projections from the Department of Health. A simulated model reported in the Lancet predicted that there would be 11 million more obese adults in the UK by 2030, with combined medical costs for treatment of associated diseases estimated to increase by up to £2 billion per year.

The estimated cost of obesity to the NHS annually for the Vale of York CCG was £46.6 million in 2015.[20]

The challenge from diabetes[2]

Obesity is a leading cause of type 2 diabetes, from which around 22,000 people die early every year. People who are overweight or obese are more likely to develop type 2 diabetes – and the risk rises as body weight increases[3]. Evidence suggests that a 1 kg/m^2 increase in BMI increases the risk of developing new-onset type 2 diabetes by 8.4%[3]. One in six of all people in hospital have diabetes – while diabetes is often not the reason for admission, they often need a longer stay in hospital, are more likely to be re admitted and their risk of dying is higher.

There are currently 2.6 million people with Type 2 diabetes in England, with around 200,000 new diagnoses every year, and 5 million people at high risk of developing Type 2 diabetes. If current trends persist, one in three people will be obese by 2034 and one in ten will develop Type 2 diabetes. However, evidence exists which shows that type 2 diabetes is largely preventable through lifestyle changes.

[20] Swanton, K. "Healthy Weight, Healthy Lives: A toolkit for developing local strategies." (2008) National Heart Forum/CrossGovernment Obesity Unit/Faculty of Public Health

Diabetes is a major cause of preventable sight loss in people of working age and a major contributor to kidney failure, heart attack, and stroke. As well as the human cost, Type 2 diabetes treatment currently accounts for just under 9% of the annual NHS budget. This is around £8.8 billion a year. There is also strong international evidence which demonstrates how behavioural interventions, which support people to maintain a healthy weight and be more active, can significantly reduce the risk of developing the condition.

NHS England is leading the Healthier You: NHS Diabetes Prevention Programme (NHS DPP) which will identify those at high risk and refer them onto an evidence-based behaviour change programme to help reduce their risk. It is a joint commitment from NHS England, Public Health England and Diabetes UK. The programme has started this year with a first wave of 27 areas covering 26 million people, half of the population, and making up to 20,000 places available. Those referred will get tailored, personalised help to reduce their risk of Type 2 diabetes including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes, all of which together have been proven to reduce the risk of developing the disease. An Humber Coast and Vale STP wide area bid is currently being drafted for funding as part of the second wave of the programme.

The effects - adults

Excess weight is associated with a number of long term conditions that place a significant burden on the health and social care system. Alongside the serious ill-health it provokes, it can reduce people's prospects in life, affecting individuals' ability to obtain and hold down work, their self-esteem and their underlying mental health.

There is a lot of evidence now linking obesity with a wide range of health issues. The Department of Health report Healthy Lives, Healthy People: A call to action on obesity in England, (2011)[4] announced the Government's new national ambitions for a downward trend in excess weight in both children and adults by 2020 and set out how, by working together, a wide range of partners will be able to make these ambitions a reality. It issued a new 'calorie reduction challenge', calling on the food and drink industry to play a key role - alongside Government and others - in reducing the population's calorie intake by 5 billion calories a day to help close the crucial imbalance between energy in and energy out.

England has one of the highest rates of obesity in Europe, with more than 60% of adults and a third of 10 and 11 year olds overweight or obese. "Reducing the number of calories we consume is essential. It can happen if business continues action to reduce calories in everyday foods and drinks, and if all of us who are overweight take simple steps to reduce our calorie intake. If we collectively rise to the challenge we have set in the Call to Action, we can create an environment that helps people make informed, balanced choices about their health and reduce the burden of obesity."

The Chief Medical Officer said "Most of us are eating or drinking more than we need to and are not active enough. Being overweight or obese is a direct consequence of eating more calories than we need. Increasing physical activity is a part of the equation, but reducing the amount of calories we consume is key.

"We all have a role to play, from businesses to local authorities, but as individuals we all need to take responsibility. This means thinking about what we eat and thinking about the number of calories in our diets to maintain a healthy weight."

It made the health risks for adults with obesity (BMI over 30) very clear. For example, compared with a non-obese 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.

An obese woman, compared with a non-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.

Risks of other diseases, including angina, gall bladder disease, liver disease, breast and ovarian cancer, osteoarthritis and stroke, are also increased

What do we know works – the evidence[4]

1. **NICE and Cochrane**

The most recent rigorous and systematic reviews of the evidence for tackling obesity have been undertaken by (NICE)7 and the Cochrane Collaboration.8-14 The NICE review contains evidence from primary research published up to 2005 while the Cochrane reviews contain evidence up to 2004 or 2007, depending on the individual review.

The Cochrane review focuses solely on high quality data from randomised controlled trials (RCTs). NICE reviews acknowledge that a strict focus only on RCTs may produce insufficient evidence of effectiveness, and in many cases may be inappropriate for the types of interventions being considered. NICE reviewers therefore extract data from a variety of sources, with the evidence weighted according to its quality.

Overall, the evidence summarised in this briefing shows that there is sufficient evidence to justify well-targeted action to manage and treat adult obesity (further details available)

2. **Arthritis Research Campaign report 2009**

Some years ago, an Arthritis Research Campaign Report[6] stated that joint surgery is less successful in obese patients because

a. **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).
b. The heavier the patient, the **less likely** it is that surgery will bring about **an improvement in symptoms** (eg they are less likely to regain normal functioning or reduction in pain and stiffness)
c. 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);

d. 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[7].

3. **From Sebastian Hinde (**Research Fellow, Centre for Health Economics, CLAHRC, Yorkshire and Humber)

'Evidence exists that tier 3 services are likely to be highly cost-effective (and indeed potentially cost-saving in a diabetic population). This is due to the significant long term cost and health benefits derived from even a modest reduction in the level of obesity, and the high cost of bariatric surgery.

While there is limited clinical evidence justifying the withholding of elective surgeries, such as hip operations, in those with BMI>30, there are demonstrable cost and health benefits to be realised if the temporary withholding of such surgery can motivate weight loss. Estimates of the potential long term health and cost benefits are shown in the table below.'

Use of EConDA to inform the benefits of weight loss

The EConDA toolkit can be used to inform the health and cost benefits that would be expected if patients who have their hip operations delayed lose weight. The table below reports some of the primary outputs of the toolkit for a range of weight loss percentages. The cohort is all those with BMI>30 (the toolkit does not allow for greater granularity), all ages, both genders, and a lifetime analysis horizon.

% becoming healthy weight	Cost saving from reduced treatment, per person	QALY gain from improved health, per person	Reduction in peak diabetes, per 100,000 persons	Reduction in peak CHD, per 100,000 persons
5%	£174	0.01	772	153
10%	£345	0.03	1,532	306
20%	£687	0.05	3,055	612
50%	£1,721	0.12	7,720	1,531
100%	£3,439	0.24	15,449	3,063

4. Other comments and actions

The proposed10% weight loss goal fits with Slimming World goals and to achieve this "in a year" is consistent with other CCGs. A BMI of 30 is widely defined as "obese" and consistent with the current threshold for IVF. The intention is for this approach to be a "wake-up call" for the local population and individuals – to promote a culture change and support GPs in raising the subject of weight loss.

Dr Alison Forrester
Healthcare public health advisor
22.8.16

References

1. NICE Guidelines CG 189Obesity: identification, assessment and management November 2014 https://www.nice.org.uk/guidance/cg189/chapter/Introduction

2. NHS England Diabetes Prevention Programme https://www.england.nhs.uk/ourwork/qual-clin-lead/diabetes-prevention/

3. NICE Guideline PH38: Type 2 diabetes: prevention in people at high risk July 2012 https://www.nice.org.uk/guidance/PH38/chapter/2-Public-health-need-and-practice

4. Healthy Lives, Healthy People: A call to action on obesity in England. Department of Health report 2011

5. A briefing paper for commissioners National Obesity Observatory (NOO) http://www.noo.org.uk/

6. Arthritis Research Campaign: "Osteoarthritis and Obesity" (2009) http://www.arthritisresearchuk.org/external-resources/2012/09/17/15/29/osteoarthritis-and-obesity-a-report-by-the-arthritis-research-campaign.aspx

7. 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) http://www.ncbi.nlm.nih.gov/pubmed/2406501

8. Obesity and total joint arthroplasty: a literature based review. Journal of Arthroplasty May 2013 http://www.arthroplastyjournal.org/article/S0883-5403(13)00174-5/abstract

Appendix D - Tier Terminology

Weight management services are considered according to tier, based on severity of condition or need (WHO classification system). The levels of service are based on a 4-tier model:

There is a wide range of service from various providers, depending on the tier, with primary care and private providers at the Tier 1 and 2 levels, and secondary/specialist care at Tier 4, but currently without community provision at the intermediate stages where standard weight loss programmes are insufficient.

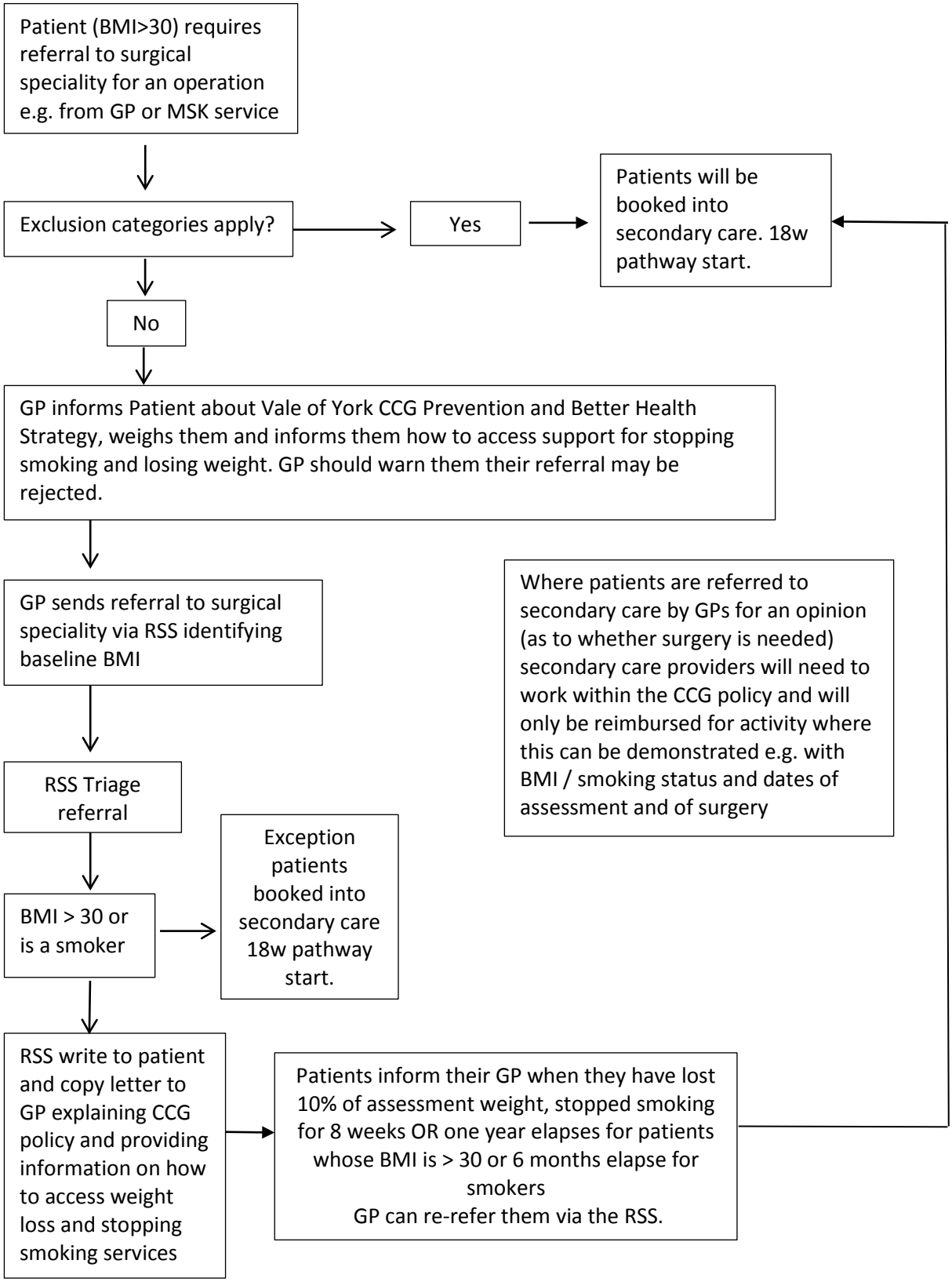
Tier	Primary Care	Public Health	Local Authority	Private/Commercial Providers	Community Services	Secondary Care
1 BMI 25-29	Identification of weight issues, advice, direction towards weight loss services	Promotion of healthy lifestyle messages Specific messages e.g. on breast-feeding	Sports/ active leisure provision, open spaces, schools advice, child measurement programme	(e.g. Weightwatchers, Slimming World) Provision of weight loss programmes	x	x
2 BMI 30-35	Identification of weight issues, advice, direction towards weight loss services	Promotion of healthy lifestyle messages	As above	As above	x	x
3 BMI 35-45	Referral to Tier 3 services - limited	x	x	x	x	x
4 BMI >45	Referral to secondary care	x	x	x	x	Bariatric surgery

This is the position as at 1 April 2016. Tier 4 services are currently commissioned by NHSE though expected to transfer to CCGs (originally in April 2016).

There are multiple routes into weight loss services at Tiers 1 and 2, and many people do not require the intervention of primary care services but self-refer to commercial providers. However at Tiers 3 and 4, GPs provide the initial referral.

Identification of at-risk individuals can be made via health checks, which in York will be part of the Integrated Wellness Service offer, or primary care visits for other causes.

Appendix E – Draft Implementation Pathway



Appendix F – Sample Patient Information

Weight loss to improve outcomes after surgery

Obesity is a recognised risk factor in surgery and surgical procedures. Research shows that obese patients are more likely to experience:

- infection at the surgical site;
- poor wound healing;
- bleeding and blood clots in limbs and lungs;
- breathing problems;
- loosening, failure or dislocation of a new joint.

The NHS wants you to be aware of these risks so that you can take steps to minimise them before your procedure. If you need surgery and your weight is significantly higher than it should be, your doctor will explain the importance of losing weight before your operation or procedure can take place.

Even though you may feel fit and healthy at your current weight, studies show that patients with a higher body mass index (or BMI) are more likely to experience potentially serious complications both during and after surgery.

Patients in the Vale of York that require surgery, but have a BMI of 30 or above, must reduce their weight by at least 10% before they can go on to a surgeon's waiting list. As soon as the target weight loss is achieved, or following a year of actively trying to achieve the target, patients will then be added to the waiting list.

The complications of an increased risk

It is important to be in the best possible health before surgery. Patients with obesity are more likely to have certain diseases and conditions that increase the risks of surgery. If you have one of the following conditions, you will be asked to work with your GP to manage the condition so that it is kept under control before your procedure.

- Cardiovascular disease, including high blood pressure
- Type 2 diabetes
- Obstructive sleep apnoea
- Metabolic syndrome—a group of health conditions that increase your risk for developing cardiovascular disease and type 2 diabetes.

There are risks associated with every surgery. However, some risks are greater for patients with obesity.

Complication	Reason	Risk
Anaesthesia	It is more difficult to give anaesthesia to a patient with obesity. Complications may be due to the patient's body shape and anatomy, or linked to health conditions that can affect breathing.	More difficulty and pain putting in needles to give necessary medications. Lack of sufficient oxygen and airflow. Problems with getting needles in the right place for spinal and epidural nerve blocks and other types of regional anaesthesia.
Length of time for the operation	There are technical challenges associated with performing surgery on a patient with obesity, so operation times are often longer.	The longer in surgery, the greater the risk of complications.
Complications after surgery	Compared with a patient of normal weight, someone with obesity is more likely to experience complications after surgery.	Infection. Poor wound healing. Difficulty breathing. Blood clots. Pulmonary embolism (a blood clot in the lungs).
Other outcomes that can be affected	Joint replacement will help relieve your pain and enable you to live a fuller, more active life. However, if you have obesity, you may never achieve the increased mobility and range of motion experienced by a patient of normal weight.	Component loosening and failure. Dislocation of the replacement joint, especially in the hip. In some cases, a second 'revision' surgery may be necessary to remove failed implants and replace them with new ones.

Losing weight

The key elements to losing weight are diet and exercise and better lifestyle changes.

Reduce your fat and calorie intake

Based on your BMI and age, your GP may be able to give you some calorie restriction guidelines to aim for. Try to eat smaller portions of meals that include fruits, vegetables

and whole grains, lean meats, and low-fat dairy. Drink plenty of water and avoid sugary drinks that are high in calories. Weight loss groups provide lots more motivation than losing weight on your own.

Get more physical activity and exercise

If you have constant pain, you may not be as active as you were before. Low-impact activities such as swimming or cycling will put less strain on your joints but still be effective in helping you to lose weight.

Make the change now!

There is great value in establishing a healthier lifestyle before surgery. Losing weight and reducing your BMI decreases the risk of complications and increases the likelihood of a successful surgical outcome. You will be healthier and reduce the risk of diabetes too. In some cases, losing weight before surgery can decrease pain to the point where surgery such as joint replacement may no longer be needed, or postponed to a number of years down the line.

Although reaching and staying at a healthy weight can be a long-term challenge, the payoff is significant. If you need help losing weight and lowering your BMI before surgery, talk to your GP. He / she can recommend specific low-impact exercises and signpost you to activities and weight-loss plans that fit your individual needs and lifestyle. Resources are also available on the CCG's website www.valeofyorkccg.nhs.uk

Frequently asked questions

What is BMI?
BMI is a very important calculation that health professionals use to measure body fat. It is based on an individual's height and weight. Typically, the higher the BMI, the more body fat there is.

$$\text{BMI} = \frac{\text{Weight (lb.)}}{\text{Height}^2\text{ (in.)}} \times 703 \quad \text{or} \quad \frac{\text{Weight (kg)}}{\text{Height}^2\text{ (m)}}$$

For an adult, the following BMI ranges apply.

BMI ranges	Weight status
18 to 24	Normal
25 to 29	Overweight
30 to 39	Obese
40 to 49	Morbidly obese

Why are patients asked to wait a year?

We know it takes time to lose weight and for positive lifestyle changes to become firm habits. It's not possible, or healthy, to lose a lot of weight rapidly. We want patients to have time to adopt a new lifestyle with a steady, healthy weight loss that will benefit them for many years to come. Once a weight loss of 10% is achieved if patients feel they still need

an operation they will be added to the surgical waiting list. Sometimes as weight comes down and people get more active they feel they don't need an operation just now.

Why is the target weight loss set at 10%?

10% weight loss is a serious target. If patients can achieve this then that shows a commitment to a new lifestyle of activity and consuming fewer calories that will benefit overall health.

Popular slimming clubs encourage its members to lose 10% of their body weight.

Appendix G - Draft Information for Patients on Support for Stopping Smoking and Losing Weight

Stop smoking advice from the CCG

This is available on the CCG's website

Smoking – the facts and where to get help

Smoking – why you should stop if you are pregnant

Smoking – why you should stop if you before surgery

Mobile device apps

Please note:
If you have an Apple device, download on the App Store.
If you own an Android device, download at Google Play.

One You Couch to 5km

The Couch to 5km app has been designed to get you off the couch and running in just nine weeks. Grab your trainers, download the app and follow the step-by-step instructions.

One You Drinks Tracker

Drinking a bit too much can sneak up on you. This free drinks tracker app makes it easy to keep an eye on the booze you drink and take control with daily tips and feedback.

One You Easy Meals

This free easy meals app is a great way to eat foods that are healthier for you. If you're ever short of inspiration you'll find delicious, easy meal ideas.

NHS Smoke Free App

The Smokefree app can help you stop smoking by providing daily support and motivation. If you stay smokefree for the four week programme, you're up to five times more likely to stay quit for good. Join the thousands who have already quit with this support.

There's lots of other free support on offer including a Quit Kit, emails and texts.

Local authority partner resources

Selby and Tadcaster Move It, Lose It

'Move It and Lose It' is an exciting programme that gives you the support and encouragement to achieve a new healthier, happier you.

This 12-week programme gives you the best of both worlds, but the best news is it's free (if you meet the eligibility criteria).

At the weekly Slimming World meetings you'll learn everything you need to know to help you to lose weight without ever feeling hungry and banishing the guilt of eating out. Participants can access Slimming World classes at Selby Leisure Centre on Wednesdays from 7.30pm-9pm.

While you're part of the 12-week programme you'll be able to exercise with like-minded people at Selby Leisure Centre, Tadcaster Leisure Centre or in a local community venue.

Referral is through a health professional or through self-referral if your BMI is 25 or above, you live in Selby or Tadcaster, are over 18 and not pregnant. Contact the team on 01942 488 481 or emailleisureenquiries@wlct.org

Ryedale's Change Point Programme

'Everyone Active', in partnership with Ryedale District Council, offers an adult weight management programme in the Ryedale District.

The programme is a 12 week multi-component course, run on a rolling enrolment basis. Each participant is invited by the team to an initial meeting before they begin the course. They then enter onto a 12 week programme consisting of a 90 minute session per week. The session is split into a 45 minute physical activity session (low intensity) and 45 minute nutritional information session. Referrals are periodically assessed with one of the 'Everyone Active' trained professionals that takes starting measurements and monitors these throughout the programme and beyond.

Referral is either through your GP or through self-referral. To be eligible you must have a BMI greater than 25. Individuals with a BMI greater than 35 will be assessed on an individual basis.

You can self-refer too. Email scarboroughscinfo@everyoneactive.com or phone 01723 360 262.

Hambleton 'Take That Step'

Take That Step is a 12 week weight management and lifestyle programme for people with a Body Mass Index (BMI) of 25 and above or those who have a medical condition that could be improved with more positive lifestyle choices.

The programme consists of weekly one hour weight management and lifestyle workshops and open access to gym based exercise, fitness classes and swimming activities.

You may be eligible if you have a BMI of 25 or above, a long term medical condition, a mild to moderate mental health condition, musculoskeletal (joint problems), at risk of a fall, post physiotherapy or require support with medical conditions. If you feel you meet the criteria and are ready to make positive lifestyle choices just ask your GP or health professional to make a referral.

For most people the programme is free; however there is a one off charge of £36 for:

- people referred for post physiotherapy with no long term condition and a BMI of less than 25;
- individuals referred for a long term condition with a BMI less than 25 living in the NHS Vale of York CCG footprint of the Easingwold area.

East Riding 'Healthtrainer' Service and Exercise Referral Scheme (Pocklington)

Healthtrainers provide personal support and motivation to adults across the East Riding of Yorkshire. The service offers direct support, guidance and motivation to individuals who want to make a change to their lifestyle. Individuals can also be signposted to other services, groups and organisations in the local area.

You may want to get fitter, control your weight, have a healthier diet, reduce your alcohol consumption or quit smoking. Or you may want to reduce your stress levels or just feel better about yourself. If you want to become healthier but don't know where to start a Healthtrainer will be able to help you work out exactly what you want and how to go about it.

Healthtrainers will provide guidance, support and motivation with:

- Healthy Eating
- Losing Weight
- Physical Activity
- Stopping Smoking and Substances
- Reducing Alcohol Consumption
- Sexual Health
- Reducing Stress and Anxiety
- Self Care

Healthtrainers can spend up to an hour with you at each meeting and you can meet with your personal health trainer weekly or fortnightly. The team also offers telephone support if you find it difficult to get out.

Healthtrainers are currently in the Pocklington Health Centre on Thursdays from 9am to 12noon and Fridays from 9am to 5pm.

For further information about the Healthtrainer Service phone 0800 917 7752.

East Riding of Yorkshire Council exercise referralscheme

The exercise referral scheme is an introduction to physical activity that enables GPs and other health professionals to recommend a course of exercise for people who they believe would benefit from it.

The scheme entitles you to join an activity programme at East Riding of Yorkshire Council leisure facilities that are linked to your GP surgery. Throughout the programme you will have the help and guidance of specially qualified exercise professionals.

Referrals are made by your GP or health professional. The scheme is based on a recommended two sessions per week over a period of 10 weeks. The cost is £33.00 and payable on registration. It is understood that in exceptional circumstances, the £33.00 fee may not be possible. In this circumstance please advise a member of the Exercise Referral Team.

City of York Council Sponsored HEAL / physical activity programme

HEAL (Health, Exercise, Activity and Lifestyle) is a programme of activities designed to help people with specific long-term medical conditions to start exercising safely and improve their health. These conditions include:

- diabetes
- heart disease
- arthritis
- cancer
- multiple sclerosis
- Parkinson's disease
- chronic obstructive pulmonary disease (COPD)
- mental health issues such as depression and anxiety

The HEAL exercise referral scheme uses specialist qualified instructors to help participants become more active through safe, targeted condition-specific exercises. Instructors deliver specific exercise programmes for the management, or prevention of many medical conditions including:

- gym-based sessions
- specialist classes for musculoskeletal conditions, osteoarthritis, rheumatoid arthritis, cardiac rehabilitation, cancer and neurological conditions
- diabetes and exercise workshops.

Referral to the HEAL Programme is through your GP or heath professional.

The council also manages a physical activity programme where you can obtain information about opportunities in York. Most are free but some incur a small charge. For details of available activities and the HEAL programme go to https://www.york.gov.uk/info/20244/sport_and_physical_activities/431/heal_programme

Other online resources

ONE YOU

One You supports you to make simple changes towards a longer and happier life. You can make small changes yourself, or with friends and family. It provides tools, support and encouragement every step of the way and help you improve your health.

Take the free One You health quiz to see how you score and start the fight back to a healthier you. Read more at https://www.nhs.uk/oneyou/about-one-you#Esej5Qcxo516Yi3q.99

NHS Choices Weight Loss Plan

NHS Choices offers a diet and exercise plan which will help you lose weight in a safe and sustainable way.

The plan will support you to adopt a healthier lifestyle and learn how to keep the weight off in the long term. A 12 week guide to weight loss is delivered through weekly information packs full of diet, healthy eating and physical exercise advice. The plan also includes a food and exercise chart where you can track progress, calories, exercise and weight loss. You can also calculate your BMI and calorie intake on the website and get support through the online community from others who are trying to lose weight.

Get started at http://www.nhs.uk/Livewell/weight-loss-guide/Pages/losing-weight-getting-started.aspx

Live Well: This scheme is a free 12 month healthy lifestyle programme that addresses weight management and physical activity for individuals (over 18 years) with a BMI (Body Mass Index) of 45 and over.

The programme aims to provide tailored advice and support to reduce calorie intake, increase sustainable physical activity and reduce sedentary behaviour.

Individuals get:

- 12 months personal support and tuition from qualified instructors
- An individual analysis of their needs and expectations
- A tailored programme of exercise, nutrition and psychological support to promote increases in levels of physical activity, healthy eating and motivation to support lifestyle changes
- Support to exercise at a leisure centre (seated if necessary) or at home

- Free access during the 12 months to the programmed exercise activities and to all other activities at the leisure centre
- A free pass for a family member/friend to access the leisure centre activities with them, to provide support to the individual on the Live Well programme.

Individuals can only access Live Well through their GP- not available to VoY patients.

Change4Life

Modern life is resulting in people being a lot less active and eating more convenience and fast foods. This is having a negative impact on the health of both adults and children. Nine out of ten children today are likely to grow up with dangerous amounts of fat in their bodies which could cause life threatening illnesses such as cancer, type 2 diabetes and heart disease.

Change4Life is the first step to helping you and your children eat more healthily, get moving more and live longer. The site includes recipes, information about local activities and advice about drinking less alcohol.

Go to http://www.nhs.uk/change4life/Pages/change-for-life.aspx

Appendix H - Local Authority and STP strategies

The North Yorks Joint Health and Wellbeing Strategy (JHWBS) focuses on a life-course approach, and includes a number of priorities related to weight management: under "Start Well", one target is to reduce the percentage of children who are obese or overweight, while another is to increase the number of babies who are breast-fed "Live Well" includes aspirations towards a greater number of people encouraged to manage their own conditions, with increased opportunities for fitness.

The strategy includes an increased emphasis on the responsibilities of the individual:

"What do we expect from people living in North Yorkshire?

- You will take on more responsibility for your own health and wellbeing
- You will make more healthy choices to improve your health and wellbeing"

The **City of York Council JHWBS** (and Integrated Wellness Strategy) is currently in development, but will contain an increased focus on self-management and the ability to make healthy choices.

It is well documented in the **Joint Strategic Needs Assessment** (JSNA) that lifestyle issues contribute to poorer health outcomes in York:[21]http://www.healthyork.org/what-is-a-joint-strategic-needs-assessment.aspx

York's Joint Health and Wellbeing Strategy (City of York Council, Health and Wellbeing Strategy, *Improving Health and Wellbeing in York* (2013-2016))- aims to improve health and wellbeing through greater focus on integration, improving quality and efficiency, addressing the wider determinants of health and focusing on prevention and early intervention. The CYC JHWBS is currently being updated, and consultation and engagement sessions are being held during the summer and autumn of 2016.

The JSNA core dataset provides further data on health and wellbeing in York: http://www.York.gov.uk/_layouts/search.aspx?k=jsna%20core%20dataset

The CYC Integrated Wellness Strategy defines wellness as:

' a proactive, preventive approach that emphasises the whole person and which works to achieve optimum levels of physical, mental, social and emotional health. Good nutrition, healthy weight, exercise, increased resilience, active social networks and avoiding risk factors such as tobacco use and alcohol misuse, all play a role in wellness. Individuals who manage their lifestyles are healthier, more productive, have fewer absences from work, and make fewer demands for medical and social services.[22] The wellness approach goes beyond looking at single-issue, healthy lifestyle services with a focus on illness, and instead aims to take a whole-person and community approach to improving health.'

The **ERYC JHWBS** contains the following on obesity : While both adult and childhood obesity occur at a lower rate than the national average, recorded diabetes in the East

[21]Joint Strategic Needs Assessment (JSNA, 2011)

[22] From illness to wellness, NHS Confederation briefing Oct 2011, issue 224

Riding (6.8% in 2013/14) is higher than that for England (6.2% for the same period) and is increasing at a greater rate than England.

Type 2 diabetes (approximately 90% of diagnosed cases) is partially preventable – it can be prevented or delayed by lifestyle changes and earlier detection followed by effective treatment reduces the risk of developing diabetic complications. As the risk of developing type 2 diabetes increases with age and the East Riding has an older population structure than the England average, the area can be expected to have a higher proportion of people with diabetes. Targets include: “Encourage and promote healthy behaviours and modify risk factors especially for those at risk of developing diabetes; Promote and enable the take-up of physical and cultural activities to improve health and wellbeing.”

The strategy also includes a focus on self-care: “Self-care is about the lifestyle choices people make, which help them stay well - both physically and mentally. This includes taking care of minor illnesses and injuries as well as avoiding health hazards, such as smoking or drinking too much alcohol. Better self-care also includes exercising and eating well to prevent poor health. “

The STP for the 6-CCG footprint includes priorities around prevention and patient activation, with each CCG contributing towards the achievement of overall goals to reduce avoidable illness. Weight management and diabetes prevention form part of the shared goals within the prevention strand.