right care
right place
right time
right outcome

NHS
Merton
Clinical Commissioning Group

MERTON CLINICAL COMMISSIONING GROUP
GOVERNING BODY

Date of Meeting: 15 December 2016

Agenda No: 3.3 **Attachment:** 04

Title of Document: Surgery Readiness Option	**Purpose of Report:** Commence review
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Executive Summary:

The report sets out the case for Merton CCG to examine expanding the application of a 'Surgery Readiness' policy to elective treatments.

If the governing body approves the recommendation, the CCG will commence a period of stakeholder engagement to develop a specific recommendation and any required safeguards with some key stakeholders and to clarify the process for implementing the policy.

Once a specific proposal has been developed, the governing body will be presented with a formal option and process for consultation to implement that change.

Key sections for particular note (paragraph/page), areas of concern etc: Nil

Recommendation(s): The governing body authorise development and engagement on a proposal that would guide relevant patients through a funded and well structured stop-smoking or weight management process before undertaking elective surgery.

Committees which have previously discussed/agreed the report: This proposal has been discussed at a high level by the Clinical Reference Group, Executive Management Team and Finance Committee

Financial Implications: Depending on the option finally adopted, a more restrictive criteria for access to these treatments would be expected to release resources for re-investment in 2017-18

How has the Patient voice been considered in development of this paper: As the paper is seeking approval to commence a review of current policy there has been no patient engagement or consultation to date. Some patient involvement and engagement will be sought as part of the review. If the recommendation arising from the review is to change the access more extensive consultation with the local population will be undertaken**.**
Other Implications: (including patient and public involvement/Legal/Governance/Risk/Diversity/ Staffing) There is no particular legal implication of commencing a review. Any recommendations for change will include examination of legal and governance risks.
Equality Assessment: As the paper is seeking approval to commence a review of current policy an equality impact assessment has not been carried out.
Information Privacy Issues: N/A
Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution) – Engagement plan detailed below

1. Context and introduction

The South West London Sustainability and Transformation Plan (SWL STP) highlights increasing prevention as a key theme to improve outcomes of patients and address the load on the whole system.

One area which the CCG notes that has been examined in other CCGs and for which there is an emerging evidence base, is the policy of increasing patients' fitness before elective surgery is undertaken in particular addressing smoking and excess weight.

Using the moment when a patient is being referred for elective hospital treatment to direct a patient to services aimed to make them fitter before their surgery and take an active role in their care and hopefully to make a long-term lifestyle change is a key opportunity to improve the health of the population of Merton.

There are clear benefits to the patient in terms of risk reduction during the procedure, short-term recovery improvements and long-term health outcomes. There may be some financial gains for the NHS as well, as patients will encounter less complications, will stay in hospital for less time, will recover faster and will live healthier lives if they can maintain the change in behaviour – with the potential costs of more referrals to smoking cessation and weight management services off-setting to some extent.

2. The case for change

The CCG proposes to examine introducing a policy on the management of overweight patients or smokers requiring routine elective surgery who may require a general or spinal/epidural anaesthetic.

The new policy would build upon Body Mass Index (BMI) and Smoking elements of the existing hip and knee arthroplasty[1] and IVF policies already adopted by the CCG (see existing SWL ECI Policies at 14.8. 14.10 and Appendix 1[2]). A number of 'cosmetic' procedures covered by the SWL ECI policies also include a BMI Threshold.

[1] *Busato A, Roder C, Herren S et al. Influence of high BMI on functional outcome after total hip arthroplasty. Obesity Surgery, May 2008: 18/5 (595-600); 0949-2658*

[2] http://www.wandsworthccg.nhs.uk/newsAndPublications/Publications/Documents/Effective_Commissioning_Initiative%202014-2015.pdf

For example, section 14.10 of the SWL ECI policy – Knee replacement surgery (primary) includes the following steps that should be followed prior to referral:

> *"Any other pre-existing medical conditions have been investigated and optimised*
>
> ***If appropriate the patient should have been advised to reduce their BMI to less than 30 and all reasonable attempts made to reduce their weight to this level prior to surgery**. Exceptions include patients whose pain is so severe and/or mobility so compromised that they are in immediate danger of losing their independence and where joint replacement would relieve this threat. An exception would also be patients in whom destruction of the joint is of such severity that delaying surgical correction would increase the technical difficulty of the procedure."*

Section 13.5 which relates to IVF includes criteria:

Body mass index of woman	19 – 30 kg/m^2, weight to be maintained for the last 6 months prior to application.
Smoking status of couple	Both partners should have been non-smokers for at least six months prior to commencement of treatment.

After initial discussions with stakeholders, a review of the evidence for the risks of surgery in smokers and obese patients and the benefits of addressing these issues, this paper sets out a recommendation to commence a review about some options that might be a suitable basis for starting to build consensus around possible changes in policy.

Obesity is a major contributory factor to premature death and ill health in England and this policy change would aim to ensure the use of medical triggers to inform patients of the benefits of losing weight and support them in doing so. Patients who successfully lose weight will benefit from fewer complications and will achieve wider health benefits.

The new policy could be applied to routine referrals to all surgical specialities (perhaps excluding cardiology, cardiothoracic, neurosurgery and fracture related procedures) that may require a general or spinal/epidural anaesthetic.

A possibility is that the referring GP may refer overweight patients for an opinion, but patients with a BMI >40 OR with a BMI between 30 - 40 with metabolic syndrome could be expected to lose weight and will not be referred surgery until,

1. (i) they reduce their weight by at least 10% over 9 months
2. (ii) or to a BMI less than 30,

unless there are exceptional circumstances. GP's should advise their patients of this policy and provide them with education material and referral to weight management support service, as appropriate.

The CCG also proposes to examine a policy on the management of smokers requiring surgical referrals.

All smokers requiring a surgical referral to ALL surgical specialities should be referred to an appropriate Smoking Cessation Services in order that they are aware of the risks associated with smoking and surgery and have the opportunity, and are supported, to quit in advance of their surgery.

Depending on the final form of the option, patients might not be required to have quit smoking for a period of time before having have surgery but ALL patients should be in a position to make an informed choice about the risks of proceeding.

The proposal could suggest that smokers should have been smoke-free for a specific period of time prior to referral to surgery, or smoke-free for a period before surgery (without impacting the date of referral for surgery).

3. Key considerations

It is not proposed to ban any patients receiving treatment on the basis of their smoking or weight.

The highest impact of the likely proposals there would be a firm requirement (with relevant safeguards) that patients have made genuine supported steps, or achieved a particular goal, over a period of time, to address smoking or excess weight before referral and/ or approval to operate is given. This would need to be supported by appropriate access to relevant services and a clear criteria for where exceptions could be considered – which could be similar to the existing exceptions in section 14.10 as noted above.

At the lower end of the impact scale, the proposal could be set as ‘guidance only’. This option could be focussed on a programme of informing patients about the benefits of being more surgery ready, the risks of undergoing surgery without addressing known risk factors, assistance to make better decisions about whether to agree to undergo an elective procedure and support to address these areas, but without the force of formal guidance or the ability of the referrer to ensure that all patients have undertaken relevant steps before surgery is booked.

A key issue to be determined is what should occur if a patient does not take up the offer of a referral to a weight-management or smoking cessation service and whether patients should be referred for surgical treatment in parallel with the ‘fitness’ services – which may reduce the take-up or successful completion rate of those services. This would need to be balanced with the impact to patients and the system of introducing a delay in the elective procedure.

The final form of the option is to be developed in the period before the governing body is asked to make a decision on the final form of any change in existing policy.

4. Proposed process and next steps

The requested decision is to put the proposal under review and to commence engagement, leading to development of a draft policy and future governing body review of whether to proceed with any change

The governing body is asked to agree to the principle underpinning the possible change, and to approve the commencement of further work and engagement to refine our proposals.

We have informally shared our plans with the GP membership and have their support in principle. We recommend that the governing body approve a period of stakeholder engagement to further develop our proposals, and then with well formed policies, subsequently make a decision whether or not to proceed, with formal public consultation to take place if required.

Purpose of engagement and consultation
In order to undertake effective engagement and consultation a range of robust activities must be undertaken to:

- Identify patients and/or groups of patients who may be disproportionally affected by any service changes
- Assess any potentially negative (or positive) impacts on populations sharing protected characteristics (Equalities Impact Assessment - to be published to coincide with any public consultation)
- Gather and assess existing patient experience data, working closely with Healthwatch and other patient groups

This will help us to:

- Discover potential solutions and scenarios developed through processes with clinicians, patients and the public
- Set patient and public priorities for future service models of affected services in Merton, for example what would good look like?

How will we do this?
The CCG wants to ensure that members of the public, patients, carers, providers and those who have an interest in the proposals we are developing have the opportunity to inform them at an early stage. We need to talk through these proposals with local people and discuss with them how we prioritise the CCG's spend on health services to inform our resilience plans.

The CCG will utilise a range of methods for involving people which could include working closely with HealthWatch and other local voluntary or community organisations to reach into local communities as well as ensure we act on the sound and insightful local intelligence supplied by them. Existing forums such as the CCG's community involvement group and patient engagement group (PEG) network will be also used as a sounding board to ensure that if the CCG makes a decision to proceed to consultation that our plans will ensure that the patient voice is sufficiently

taken into account.

As part of an equalities impact assessment we will be able to identify any potential impacts on specific communities and groups and will work with local voluntary and community organisations to test and discuss our proposals with these communities.

If after an initial period of engagement, the governing body considers that it is appropriate to propose a significant change to the current access criteria, we will undertake a more extensive formal consultation with the local population.