NHS
South West
Clinical Senate

Notes from Senate Council Meeting

Held on Thursday 18th May 2017
In Taunton Rugby Club

How best can weight loss and smoking cessation be encouraged through criteria for fitness for surgery and what is the evidence base for improved outcomes as a result?

Chair: Dr Phil Yates

1.1	**Welcome and introductions**
	PY welcomed Senate Council members including new members as well as CCG representatives and contributors. Round table introductions – attendance and apologies listed below. Due to the purdah restrictions, PY confirmed this meeting was being held as a closed meeting. It was agreed that the discussions from the day were to be kept confidential and the Senate's recommendations would not be shared until after the formation of a new government following 8th June.
1.2	**Setting the Scene**
	Public Health England (PHE) brought this question to the clinical Senate. It is a key area for policy discussion amongst Clinical Commissioning Groups (CCG) nationwide. At present there are different approaches being taken assess fitness for surgery and the role of weight loss and smoking cessation criteria. The South West Clinical Senate is keen that following the deliberation today, an agreed South West position on this including set guidance will be issued. Prior to this deliberation, the Royal College of Surgeons (RCS) were approached and have provided a statement to the Senate about 'fitness for surgery'. The statement confirms the RCS position that blanket bans on surgery based on BMI or smoking cessation contravene NICE clinical guidance and do not best serve patients. The RCS does however support weight loss and smoking cessation to support a healthy lifestyle and better surgical outcomes.
2	**Due Diligence - Warwick Heale, System Delivery Director, Wider Devon STP**
	This presentation explored the legality around using criteria for assessing fitness for surgery: • It is likely that if the objective is to optimise patient health and reduce the need for surgery rather than save money, the criteria will be lawful. • Patients have the right to access NHS treatment on an equivalent basis to other patients. Therefore, policies must be rationally supported by evidence. • Consider a comprehensive evidence review to back up policy and to support reasonable judgement/decision making. • At the point of accessing NHS services, patients are mostly receptive to making

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	lifestyle changes for health optimisation.
3	**The Evidence Base for Improved Outcomes - Debbie Stark, Consultant in Public Health, PHE**
	PHE are seeking a South West consensus around criteria for fitness for surgery. This should be founded on a strong evidence base considering the relevance of criteria as well as the drivers for them. • Current proposals for restricting access to surgery using weight loss and smoking cessation criteria are presented as driving better outcomes for patients. However, it is not clearly expressed whether this is in general (making changes for a healthy lifestyle) or only with regards to the current point in life (at the point of accessing elective surgery). • The question for debate is whether using fitness for surgery criteria is in fact rationing of services with the aim of saving money or is it about looking at the benefits associated with society as a whole and the promotion of a healthier population. Both long and short term gains must be considered as well as the opportunity of surgery to promote health improvement and intervention. • The implications for inequality must also be considered.
4	**National Tobacco Control Programme - Allan Gregory, PHE National Tobacco Control Manager**
	• Smoking causes the greatest number of preventable deaths and is the greatest cause of health inequalities. • Smoking cessation is the highest value intervention in the NHS. • Stopping smoking prior to surgery not only limits post-operative complications such as issues with wound healing but also benefits long term health and reduces the risk of disease development. • Smoking cessation is outlined as a priority in the 5 Year Forward View (5YFV) as well as in the 2017-18 NHS mandate and tackling tobacco dependency is a priority for Sustainability and Transformation Plans (STPs). • Patients in the hospital setting are receptive to challenge. This is a 'teachable' moment. Quit attempts started in hospital are most effective but require solid referral and support processes to include Nicotine Replacement Therapy (NRT) and counselling. • PHE is currently developing a menu of preventative intervention which includes smoking cessation as part of this wider intervention plan. This menu will outline the costs and gains of smoking prevention. • Vaping is currently not evidenced as being harmful and 'vapers' are deemed to be non-smokers. As the 'teachable moment' would not currently apply to vapers, there is arguably a lost opportunity to discuss other lifestyle choices with these patients. • There is some benefit to be gained from medicalising smoking by using the term 'tobacco dependency' and describing smoking as a relapsing condition. • Consider a baseline assessment using NICE guidance PH48 to make changes to smoking cessation procedures within the acute setting.
5	**Health and Wellbeing Programme Update - Justine Womack, PHE SW Health and Wellbeing Programme Lead**

	• There is general consensus on the importance of the 'teachable moment' when an obese patient is accessing NHS services within hospital setting. • PHE has not yet completed formal comprehensive review of the literature on this topic. However, in general, evidence around weight loss and obesity for surgical outcomes is complex with outcomes dependant on procedure. • There is good evidence that patients who are obese are at greater risk of surgical site infections (SSI) during surgery, are more difficult to anaesthetise and may be at increased risk of airway complications as a result. • Evidence is unclear on exactly how much weight patients need to lose to make a difference to surgical outcomes. NICE PH 53 emphasises the importance of making gradual, long term changes to diet and exercise in order to lose weight sustainably and suggests those completing a lifestyle programme will average losing around 3% of their body weight over a 6 to 9 month period. The PHE Menu of Preventative Interventions states a patient persisting with a tier 2 weight management programme for 12 months might reduce their body mass index by 2.46 kg/m2. • Osteoarthritis, hernia, gallstones and degenerative spinal disease do have a significant relationship with obesity but losing weight will not prevent the need for surgery • There is evidence around the link between childhood experiences and obesity which should be taken into account in relation to interventions. • There is fear that implementing criteria for surgery polices could widen the inequalities between population groups. • Services need to be in place to support patients with weight management.
6	**Perioperative Medicine Celia Ingham-Clark, Medical Director for Clinical Effectiveness, NHS England**
	• There are two aspects to this debate: reducing obesity and smoking cessation and moderating demand for elective surgery. • 5YFV Next Steps – planning to deprioritise 18 week wait for elective surgery but expects demand and activity to continue to rise. • Consider practical difficulties with operating on obese patients eg. access. • Whittington hospital as an example that uses opt out rather than opt in for support to quit smoking and NRT medication prescribed on admission. • Overall aim is to provide the right procedure for the right person at the right time to ensure best use of resource and best outcome. • Efficiency – cooling queues for low risk common procedures by looking at what can be done before referral in primary care. • Referral: once a patient is referred and begins on the 18 week pathway, the whole process is aimed at pushing the patient through to surgery. Ideally the fitness check would be prior to referral. • Enhanced recovery principles should be implemented to improve the patient experience and reduce length of stay and re-admissions • Intervention rates should be mapped to highlight variations - data is available from the national surgical commissioning centre website. • Monitor and benchmark efficiency of theatre usage to enable assessment of getting the right number of cases through. • Use of World Health Organisation (WHO) surgical safety check list to improve efficiency.

	• Important to undertake shared decision making properly – value patient opinion even if different to surgical opinion or is the 'do nothing' option. • Bariatric surgery is an exception as potential candidates have to go through 6 months tier 3 support before being operated on. • Referral centres only work if set up well and supported by good administration. • Get it right first time (work out where inefficiencies and over provision and commissioning taking place). • Rightcare is rolling out over elective areas of care. Where can appropriate savings be made to raise quality of care and reduce costs? • Assess commissioning along the whole pathway of care rather than individual procedures. Include options to discuss lifestyle changes. • Personalised risk assessment before referral and throughout the pathway. Provide patient with information about options to encourage proper shared decision making.
7	**The NEW Devon Experience - Adam Carrick, Head of Planned Care and Programmes, NEW Devon CCG**
	• NEW Devon considered the rational for assessing fitness for surgery including using weight and smoking status as criteria. This was followed by developing a consensus guideline, rather than a CCG policy which has been reviewed and supported within the STP Clinical Cabinet and is currently awaiting sign off by each of the constituent organisations. • Consider obesity in the context of metabolically unhealthy patients and provide weight loss as part of treatment for metabolic syndrome. Ensure availability of weight loss interventions, and with a realistic weight loss target. Make health improvement interventions a positive offer on the treatment pathway leading to surgery. Integrate within or run in parallel to surgical assessment. • Risk where patients are unable to take up support eg. patients with mental health problems or those with learning disabilities. Further discussion required to asses against vulnerability. • These guidelines would apply to the whole pathway so GPs are expected to manage patient referrals in primary care and in secondary care the patient is assessed using the criteria.
8	**Public and Patient Perspective - Kevin Dixon, Chair of the Citizens' Assembly**
	A survey was designed by Healthwatch Torbay in conjunction with PHE and following a focus group with patients and the public to decide which questions should be included. The survey was designed to use clear and understandable language. The survey was circulated amongst the South West Healthwatch networks. Responses to date confirm the following: • Smoking should be referred to and treated as an addiction not a lifestyle choice • Weight loss should centre around appropriate targets not a set weight – conern about unrealistic targets. • Concerns these criteria would exclude vulnerable groups eg. for those with mental health issues or with learning disability. • Criteria will lead to the poor being punished and middle class people accessing surgery privately. • Health shock is key to getting peer and family support to quit smoking.

	• Need to break the stereotype to address smoking cessation: perceived fatalism amongst smokers and cultural resistance is high. The survey is currently being left open to continue to capture responses. Final report of responses will be provided to PHE in due course.
9	**Group Work**
	The Senate Council split into 4 working groups: • Vale of York Case Study – Phil Yates • Evidence around obesity – Justine Womack and Adam Carrick • Smoking – Allan Gregory • Inequalities issues – Debbie Stark Each group discussed the evidence and discussed the following questions taking into account pre-reading sent out ahead of the meeting and the presentations heard: 1. What evidence is there for improved outcomes? 2. How should clinicians encourage patients to stop smoking or lose weight before and/or after surgery? 3. Is there any merit in denying/delaying surgery to smokers/the obese? 4. What key recommendations should the Senate make? There was much consensus between the groups and key points fed back were as follows; • Consensus in group that blanket ban is not supported • Success of the interventions – need to have smoking cessation and weight management services available • Need to consider smoking and obesity separately • Mandating an offer to patients but not mandating uptake • Evidence for improved surgical outcomes as a result of weight loss is mixed and depends on procedure. • Mixed evidence for obesity interventions. • Some minor complications at surgery don't equate to poor outcomes long term from surgery • Primary care to give information early to patients • Adopt metabolic approach rather than just weight • Post-operative support to maintain change • Normalise smoking interventions into everyday clinical practice throughout pathway and across all health providers eg pharmacy (success of NHS Healthy Living Pharmacy project) • Consistency of approach nationally – 1 set of regulations backed by PHE Full notes from the Groups are available.
10	**Recommendations**
	Each group fed back and the common themes/recommendations were drawn out and agreed. See final recommendations.

*All presentation slides available from the clinical Senate website.

Attendance:

Marion Andrews-Evans	Executive Nurse	Gloucestershire CCG	Senate Council member
Tim Burke	Chair	NEW Devon CCG	Invited
Adam Carrick	Head of Planned Care & Programmes	NEW Devon CCG	Presenter
Diane Crawford	Clinic Biomedical Scientist al Senate Manager	University Hospital Bristol	Senate Council member
Ellie Devine	Senate Manager	South West Clinical Senate	Senate Management Team
Kevin Dixon	Chair of Citizens' Assembly	Citizens' Assembly	Senate Council member
Anna Field	Associate Director – Planned Care and Cancer Commissioning	Swindon CCG	Invited
Nadine Fox	Head of Medicines Management	Wiltshire CCG	Invited
Caroline Gamlin	Area Team Medical Director	NHS England South Region, South West	Senate Council member
Allan Gregory	National Tobacco Control Manager	Public Health England	Presenter
Will Harris	Chair of Clinical Operations Group	Somerset CCG	Invited
Warwick Heale	System Delivery Director	Wider Devon STP	Presenter
Matthew Hibbert	Public Health Specialist	Somerset County Council	Invited
William Hubbard	Consultant Physician and Cardiologist	Royal United Hospital Bath	Senate Council member
Nicky Hughes	RMS General Manager & Elective Care Lead	Kernow CCG	Invited
Celia Ingham-Clark	Medical Director for Clinical Effectiveness	NHS England	Presenter
Georgia Jones	Head of Penninsular Foundation School	HEE	Senate Council member
Emma Kain	Specialty Registrar in Public Health	Devon County Council	Invited
Joanna Kasznia-Brown	Consultant Radiologist	Taunton and Somerset NHS Foundation Trust	Senate Council member
Nick Kennedy	Consultant Anaesthetist and Intensivist	Taunton and Somerset NHS Trust	Senate Council member

Bettina Kluettgens	Director of Patient Safety	SWAHSN	Senate Council member
Ben Lankester	Consultant Trauma and Orthopaedic Surgeon and Clinical Director	Yeovil District Hospital	Senate Council member
Andria Merrison	Consultant Neurologist	North Bristol NHS Trust	Senate Council member
Dave Partlow	Clinical Development Manager	South Western Ambulance Service NHS FT	Senate Council member
Sally Pearson	Director of Clinical Strategy	Gloucestershire Hospitals NHS Foundation Trust	Senate Council member
Jayne Pye	Citizens' Asembly Member	South West Citizens' Assembly	Invited
Sarah Redka	Senate Project Manager	South West Clinical Senate	Senate Management Team
Becky Reynolds	Lead Consultant for Healthcare	Public Health	Invited
Philip Rolland	Consultant Gynaecological Oncologist	Gloucestershire Hospitals NHS Foundation Trust	Senate Council member
Peter Rowe	Consultant Nephrologist	Plymouth Hospitals Trust	Senate Council member
Debbie Stark	Public Health Healthcare Consultant	Public Health England	Senate Council member
Mark Stone	Pharmacist Consultant/Devon LPC Project Lead	Devon Local Pharmaceutical Committee and Tamar Valley Health Practices	Senate Council member
Andrew Tometzki	Consultant Paediatric Cardiologist	University Hospital Bristol NHS Trust	Senate Council member
Tariq White	Assistant Director of Transformation and Outcomes	NHS England South Region, South West	Senate Management Team
Rob White	Governing Body GP member	Kernow CCG	Invited
Justine Womack	South West Health and Wellbeing Programme Lead	Public Health England	Presenter
Phil Yates	Chair	South West Clinical Senate	Senate Management Team

Apologies:

Mary Backhouse	Senate Council member
Iain Chorlton	CCG, Invited
Katie Cross	Senate Council member

File path:

Malcolm Dalrymple-Haye	Senate Council member
Sara Evans	Senate Council member
Paul Eyers	Senate Council member
Melanie Feldman	Senate Council member
David Halpin	Senate Council member
Clare Higdon	Senate Council member
Clare Hines	Senate Council member
Ceri Hughes	Senate Council member
Paul Johnson	CCG, Invited
Martin Jones	CCG, Invited
Bruce Laurence	Senate Council member
Vaughan Lewis	Senate Council member
Shelagh McCormick	Invited
Julia Rees	BNSSG CCGs, Invited
Ann Remmers	Senate Council member
Nick Roberts	CCG, Invited
Emma Stapley	Senate Council member
Miles Wagstaff	Senate Council member
Margaret Wilcox	Senate Council member
Jenny Winslade	Senate Council member
Paul Winterbottom	Senate Council member