NHS
Herts Valleys
Clinical Commissioning Group

BMI Threshold and Smokefree Policy: To be implemented for all elective procedures when patient requires GA or Epidural/Spinal

Version Number	1.0
Ratified By	HVCCG Commissioning Executive
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Responsible Director	Dr David Buckle
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DOCUMENT CONTROL

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1.0		Policy ratified by HVCCG commissioning Executive	June 2016	Miranda Sutters

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1. INTRODUCTION

Tackling the rise in obesity and reducing the number of people who smoke are key priorities for Herts Valleys CCG. The CCG is also committed to helping overweight patients and smokers to get better results from routine surgery.

2. CRITERIA ADOPTED BY HVCCG

HVCCG patients should be assessed for smoking status and Body Mass Index (BMI) on referral to surgical specialties

Criteria 1: BMI	**1.** Patients with a BMI >40, or those with metabolic syndrome* and a BMI >30, will be offered surgery if they lose at least 10% of their weight over 6-9 months or loses sufficient weight to meet criteria 2. **2.** Patients with a BMI between 35-40, without metabolic syndrome, should be offered advice to lose weight before surgery, and a brief intervention to promote long term behavioural change. In exceptional circumstances the above criteria will b waivered, for example, if delaying surgery is: • Detrimental to the outcome, or, • the BMI is artificially affected by large muscle bulk *IDF defines metabolic syndrome: central obesity/BMI>30 AND any two of the following: • Raised triglyceride ≥ 150 mg/dl (1.7 mmol/L), or specifi treatment for this lipid abnormality • Reduced HDL-C <40mg/dl (1.03 mmol/L) in men and <5 1.29 mmol/L)in women or specific treatment for this • High blood pressure (BP): >130/85 mmHg or treatment previously diagnosed hypertension • High fasting glucose: >110 mg/dl, or previously diagnos type 2 diabetes

Criteria 2: Smoking Status	1. All patients' smoking status should be recorded. 2. Smokers should be advised to quit, even if on a temporary basis prior to surgery. 3. Patients who smoke should be referred to Hertfordshire Stop Smoking Service or GP in-house service. 4. Hertfordshire Stop Smoking Service will provide evidence that a patient has been referred to a Stop Smoking Service and has one of the following outcomes: I. Attends a stop smoking service but declines to set a quit date. II. Attends a stop smoking service, sets a quit date but does not successfully quit smoking. III. Attends a stop smoking service, sets a quit date and successfully quits smoking (for maximum benefit, there should be at least 8 weeks between quitting smoking and elective surgery). IV. Has refused to attend but has had Stop Before the Op and support materials sent to them. V. Swaps smoking tobacco completely for electronic cigarette use.

3. PURPOSE

1. Improve the identification of patients who are obese and/or smoke
2. Provide a 'health trigger' for obese patients/smokers to promote long term behavioural change
3. To contribute to the wider local health improvement work to reduce levels of obesity and the impact of/ health consequences of obesity
4. To reduce the impact of obesity on osteoarthritis
5. To reduce the risks of routine surgery, in particular the risks of major complications.
6. To avoid or delay major surgery where conservative measures could provide similar symptom relief (specifically for osteoarthritis and joint replacement surgery).

4. DEFINITIONS

BMI: Body Mass Index is a person's weight in kilograms (kg) divided by his or her height in meters squared. The National Institutes of Health (NIH) now defines normal weight, overweight, and obesity according to BMI rather than the traditional height/weight charts.

Metabolic syndrome: A cluster of the heart attack risk factors: diabetes ar prediabetes, abdominal obesity, high cholesterol and high blood pressure.

IDF defines metabolic syndrome: central obesity/BMI>30 AND any two of following:

- Raised triglyceride ≥ 150 mg/dl (1.7 mmol/L), or specific treatment for this lipid abnormality
- Reduced HDL-C <40mg/dl (1.03 mmol/L) in men and <50 mg/dl 1.29 mmol/L)in women or specific treatment for this
- High blood pressure (BP): >130/85 mmHg or treatment of previously diagnosed hypertension
- High fasting glucose: >110 mg/dl, or previously diagnosis type 2 diabetes

5. ROLES AND RESPONSABILITIES

5.1 Roles and responsibilities of clinicians managing the care of HVCCG patients

All clinicians with the responsibility for the care of HVCCG patients need to ensure that they are aware of the contents of this policy. This includes a requirement to review the contents and assess the relevance in managing the care of their patients. They should also familiarise themselves with the **HVCCG Elective Surgery Referral Cover Sheet for procedures requiring GA or Epidural / Spinal** which will need to be completed along with any referral elective covered by this policy.

5.2 Roles and responsibilities of CCG staff

All CCG staff need to ensure that they review the contents of this policy and assess the relevance to their role.

5.3 Consultation and Communication with Stakeholders

This policy replaces a HVCCG BMI and smoking guidance document developed in conjunction with Hertfordshire PCT in 2011 and reflects changes to the BMI as

previously agreed by the commissioning executive. This policy builds on evidence reviewed by the Beds and Herts priorities forum and ENHCCG.

A communications plan has been developed to disseminate the new policy with HVCGG primary care clinicians and with WHHT. This policy and the associated referral forms have been uploaded to the primary care DXS IT system.

6. CONTENT

6.1 National Policy Drivers

The *NHS Five Year Forward View (2014)* makes the case for action on prevention, and describes the impact from the rise in obesity. The Forward View states the NHS will back hard-hitting national action on obesity, smoking, alcohol and other major health risks.

Tackling obesity is also one of the priority areas for Public Health England. Their strategy *From Evidence into Action: Opportunities to Protect and Improve the Nation's Health (2014)* noted that if we could reduce obesity back to 1993 levels, five million cases of disease could be avoided.

NICE guidance (PH48) recommends that smokers using secondary care services are identified and offered support to quit. Although smoking cessation is the preferred option, where an individual unable or unwilling to stop smoking, a program of harm reduction (NICE guidance PH45) should be followed to support temporary abstinence or smoking reduction. This should include provision of behavioural support and nicotine replacement therapy and/or electronic cigarettes.

6.2 Local Policy Drivers

Tackling obesity is also a primary work stream within the *Health and Wellbeing Strategy for Hertfordshire (2013-15)*. In Hertfordshire, nearly 200,000 people (21% of all adults) are obese. These people are at increased risk of heart disease, diabetes and cancer.

The *Public Health Strategy for Hertfordshire (2013-17)* also highlights the rise in obesity as a key area for action. Falling under the 'Longer Healthier Lives' programme, the commitment is to develop obesity and health behaviour pathway with partners, with tiered weight management services within it.

The HVCCG Quality Strategy 2014-2016 notes that quality spans patient safety, clinical effectiveness and patient experience. One of the major challenges identified in the strategy is the need to improve quality through better outcomes and patient experience.

6.3 Demographics

Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health. Obesity can cause a number of health problems, such as type 2 diabetes, coronary heart disease, high blood pressure, stroke, gallbladder disease, reproductive problems, mechanical disorders such as osteoarthritis and low back pain, obstructive sleep apnoea, breathlessness and reduced mental well-being.

The WHO (World Health Organisation) categorises adults into the following BMI groups.

Table 1. BMI groups

BMI (kg/m2)	**Description**
Less than 18.5	Underweight
18.5 to less than 25	Normal
25 to less than 30	Overweight
30 or more	Obese
40 or more	Morbidly obese

In England and Wales obesity prevalence increased steeply between 1993 and 2000, and there has been a slower rate of increase after that. Levels of obesity in Hertfordshire are lower than the England average, but there is variation between localities, as shown in table 2 below.

Table 2. Percentage of Obese adults by Hertfordshire Locality.

Area	% Obese Adults

Dacorum	25.2
Hertsmere	20.2
St Albans and Harpenden	15.5
Three Rivers	24.0
Watford	20.9
Hertfordshire	21.5
England	23

(Source: Herts JSNA, Herts District Health Profile 2015)

While the overall trend in overweight and obesity prevalence appears to have stabilised, more people are falling into the higher categories of obesity. The table below shows the increase in the proportion of the adult population in England with a BMI>40 between 1993 and 2013. This is not available at locality level for HVCCG, but is likely to be similar for our population.

Table 3. Proportion of Adults aged over 16yrs with a BMI >40.

Year	Men	Women
1993	0.2%	1.4%
2013	1.6%	3.9%

(Source: Health Survey for England 2013.
http://www.hscic.gov.uk/catalogue/PUB16076/HSE2013-Ch10-Adult-anth-meas.pdf)

6.4 Health Risks for adults with a BMI in the obese range

The tables below outlines the risk of obesity-related co-morbidities and the health benefits that an adult with a BMI in the obese range might see if they reduced their weight by 10%.

Table 4: Classification of adult underweight, overweight and obesity according to BMI and risk of obesity-related co-morbidities

BMI (kg/m2)	**Description**	**Risk of obesity-related co-morbidities**
Less than 18.5	Underweight	Low risk (but risk of other clinical problems increased)
18.5 to less than 25	Normal	Average risk
25 to less than 30	Overweight	Increased risk
30 or more	Obese	Medium to high risk
40 or more	Morbidly obese	Very high risk

Source: Public Health England
http://www.noo.org.uk/NOO_about_obesity/severe_obesity

Table 5: The Effects of a 10% reduction in weight by obese patients.

Mortality	20-25% fall in total mortality 30-40% fall in diabetes related deaths 40-50% all in obesity related cancer deaths
Blood Pressure	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	Lipids Fall of 10% in total cholesterol Fall of 15% in LDL Fall of 30% in triglycerides Increase of 8% in HDL

Source: CLEAR http://www.gain-ni.org/images/Uploads/Guidelines/obesity-guidelines-report.pdf

6.5 Impact of high BMI on Surgical Outcomes

A literature review presented to ENHCCG board in 2014 found that, in terms of surgical outcomes a BMI of over 40, or a BMI of over 30 associated with metabolic syndrome, appear to be significantly associated with worse outcomes from surgery and higher complication rates and death. (The report is available on request)

The evidence review also noted that a BMI of lower than 23 is also a risk factor for poorer surgical outcomes and those particularly at risk during admission are likely to be the elderly.

6.6 Body Mass Index as a risk factor during anaesthesia and in elective surgery

Obesity has an effect on the safety of anaesthesia. A recently published major UK study on complications of anesthesia has shown that obese patients are twice likely to develop serious airway problems during general anaesthetic than non-obese patients; also severely obese patients were four times more likely to develop such problems (RCA, 2011).

According to the American Society of Anaesthesiologists (ASA) Physical Status "Mild" obesity is classified as ASA PS2, or in the category of "patients with mild systemic disease", while patients with morbid obesity are classified as ASA PS3, in the classification of *patients with severe systemic disease* (ASA).

6.7 Smoking and Surgery

There is strong evidence that smokers who undergo surgery:

- have a higher risk of lung and heart complications (Moller, 2003) (Walker, 2009) (Petrar, 2012)
- have higher risk of post-operative infection (Jorgensen, 1998) (Jones, 1985) (Sorensen, 2002)
- have impaired wound healing (Jones *et. al.,* 1992) (Silverstein, 1992)
- are more likely to be admitted to an intensive care unit (Moller, 2001)
- have an increased risk of dying in hospital (LRO, 2006)
- are at higher risk of readmission (Myers, 2011)

- remain in hospital longer (LRO, 2006)

4.7.1 Benefits of quitting before surgery

There is evidence to suggest that quitting smoking before having surgery:

- reduces the risk of post-operative complications (Moore, 2005)
- reduces lung, heart and wound-related complications (Moller, 2003) (Nakagawa, 2001)
- decreases wound healing time (Sorensen, 2003)
- reduces bone fusion time after fracture repair (Ishikawa, 2002)
- reduces length of stay in hospital (LRO, 2006)

This is in addition to the long-term benefits of quitting smoking such as reduced risk of lung cancer and heart disease.

6.8 Hertfordshire Weight Management Services

This section briefly summarises the weight management services currently available in the HVCCG area.

- Hertfordshire County Council provide a variety of information and support on their Herts Direct pages.
  http://www.hertsdirect.org/services/healthsoc/healthherts/healthyweight/

- Slimming World or Weight Watchers on referral is available across Hertfordshire. Those who meet the referral criteria can access a free 12 week subscription, where individuals can get group support at weekly meetings across the county, to help them lose weight.

- Watford Football Club Community Sport & Education Trust are also running free 12 week weight management courses aimed at men aged between 18-50. The courses will run at a variety of locations across the County during 2015/16.

- HVCCG are also part of a pan-Hertfordshire Physical Activity and Exercise Referral programme, led by Public Health in Hertfordshire County Council.

7. MONITORING AND COMPLIANCE

GPs must complete a coversheet for all patients, and discuss the need for weight loss and/or stop smoking if necessary. The policy and coversheet are included in Appendix 1. Referral forms for Hertfordshire stop smoking service is included in Appendix 2.

Completed forms should be sent with the relevant referral forms/letter to the provider to be stored with the patient notes for auditing purposes.

Providers will be audited on a 6 monthly basis for compliance to the policy.
The policy will be reviewed every two years or earlier in response to new evidence, supported by Hertfordshire County Council Public Health Team.

8. EDUCATION AND TRAINING

Clinicians managing the care of HVCCG patients and HVCCG need to be aware of this policy and its implications.

9. REFERENCES

NHS Five Year Forward View (2014):
www.england.nhs.uk/ourwork/futurenhs/5yfv-exec-sum/

From Evidence into Action: Opportunities to Protect and Improve the Nation's Health (2014)
www.gov.uk/government/uploads/system/uploads/attachment_data/file/366852/PHE_Priorities.pdf

Health and Wellbeing Strategy for Hertfordshire (2013-15).
www.hertsdirect.org/docs/pdf/h/hwbstrategy

Public Health Strategy for Hertfordshire (2013-17)
www.hertsdirect.org/docs/pdf/p/phstrat.pdf

HVCCG Quality Strategy 2014-2016
http://hertsvalleysccg.nhs.uk/about-us/documents-and-publications/cat_view/4-corporate-documents/6-strategies

NICE Guidelines (PH48) Smoking: acute, maternity and mentak gealt services. 2013

https://www.nice.org.uk/guidance/ph48

NICE Guidelines (PH45) Smoking: harm reduction. 2013
https://www.nice.org.uk/guidance/ph45

ASH: Joint briefing: Smoking and surgery. 2016
http://ash.org.uk/files/documents/ASH_1023.pdf

ASA. *Patients with severe systemic disease.* American Society of Anaesthesiologists .

Ishikawa, et al. (2002). The effect of cigarette smoking on hindfoot fusions. *Foot Ankle Int*, 23(11):996-8.

Jones. (1985). Smoking before surgery: the case for stopping. *BMJ* , 290:1763-1764.

Jones, et al. (1992). The relationship of cigarette smoking to impaired intraoral wound healing: a review of evidence and implications for patient care. *J Oral Maxillofac Surg*, 50:237-9.

Jorgensen, et al. (1998). Less collagen production in smokers. *Surgery*, 123:450-5.

LRO. (2006). *Stop Before the Op.* London Health Observatory.

Moller, et al. (2003). Effect of Smoking on Early Complications after Elective Orthopaedic Surgery. *Journal of Bone and Joint Surgery*, (85B)178-81.

Moller, et al. (2001). Post-operative intensive care admittance: the role of tobacco smoking. *Acta Anaesthesiol Scand* , 45:345-8.

Moore, et al. (2005). Perisurgical smoking cessation and reduction of postoperative complications. *American Journal of Obstetric Gynaecology*, 192:1718-21.

Myers, et al. (2011). Stopping smoking shortly before surgery and post-operative complications. *Archive of Internal Medicine*, 171.11:983-98.

Nakagawa, et al. (2001). Relationship between the duration of preoperative smoke-free period and the incidence of postoperative complications after pulmonary surgery. *Chest Journal*, 120.3:705-710.

Petrar, et al. (2012). Pulmonary complications after major head and neck surgery: a retrospective cohort study. *The Laryngoscope.* , 5:1057-1061.

RCA. Royal College of Anaesthetists (2011). *NA P4 Report and findings of the 4th National Audit Project of The Royal College of Anaesthetists: Major complication of airway management in the UK.*

Silverstein. (1992). Smoking and wound healing. *American Journal of Medicine* , 93(1A):22S-24S.

Sorensen, et al. (2003). Abstinence from smoking reduces incisional wound infection: a randomised controlled trial. *Annals of Surgery* , 238(1):1-5.

Walker, et al. (2009). The effect of pre-operative counselling on smoking patterns in patients undergoing forefoot surgery. *Foot and ankle surgery*, 15:86-89.

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Appendix 1:

HVCCG Elective Surgery Referral
Cover Sheet for procedures requiring GA or Epidural / Spinal Anaesthetic

Herts Valleys CCG does not routinely fund elective procedures likely to need a general anaesthetic, epidural or spinal anaesthetic for individuals with a BMI >40. For further information and rationale refer to HVCCG BMI and Smokefree Policy.

Patient Name:	DoB:	NHS Number:	GP:

PLANNED PROCEDURE:	

1. Is patient a current smoker? YES ☐ NO ☐

   If **YES**: Confirm patient has been referred to Hertfordshire Stop Smoking Service and given "stop before your op" information: YES ☐

2. Is the patient's BMI >40 or (>30<40 with metabolic syndrome*) YES ☐ NO ☐

   If **YES**:

   Is there evidence of recent weight loss of at least 10% over 6-9 months? YES ☐

   OR are there exceptional circumstances to waive the BMI rule? YES ☐

   (Record details below).

Exceptional circumstance to waive BMI rule (e.g. Detrimental to outcome if delay, BMI artificially affected due to muscle bulk etc.)

3. If the BMI >35 without metabolic syndrome has weight loss advice been given YES ☐

NB: The Surgeon and Anaesthetist retain ultimate responsibility for the decision to proceed v
Surgery. Any previous approval will be considered void if it is the clinical judgement of
the Surgeon and Anaesthetist that surgery will not be in the patient's best interest.

GP: …… **Practice:**……

Date:……

This form must be completed by the referring GP and sent to Secondary Care for all
referrals for Elective Procedures likely to need general, spinal or epidural anaesthesia

*Metabolic syndrome is a cluster or heart attack risk factors; diabetes and pre-diabetes, abdominal ob
high cholesterol and high blood pressure.
As an example the IDF defines metabolic syndrome as:
Central obesity/BMI>30 **AND** any two of the following:

- Raised triglyceride ≥ 150 mg/dl (1.7 mmol/L), or specific
  treatment for this lipid abnormality.
- Reduced HDL-C <40mg/dl (1.03 mmol/L) in men and <50 mg/dl
  1.29 mmol/L)in women or specific treatment for this.
- High blood pressure (BP): >130/85 mmHg or treatment of previously diagnosed hyperte
- High fasting glucose: >110 mg/dl, or previously diagnosed type 2 diabetes.

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Appendix 2

Hertfordshire Stop Smoking Service
Referral Form

CLIENT INFORMATION - Please write clearly

Name:…… **Phone number:** ……

Date of birth: …… **Can a voicemail message be left: Yes ☐ No ☐**

Address: ……

Town: …… **Postcode:** ……

E-mail: …… **GP name & address** ……

……

……

Is the Client:

FURTHER INFORMATION:

REFERRER INFORMATION – Please write clearly and avoid abbreviations

Date of referral: …… **Referrer's name :** ……

Appendix 3: HVCCG Equality & Quality Analysis Form

Step 1:

Name of 'Policy or function' – this may relate to: • Decisions made, Budget, Business Case, Care Pathways Commissioning or De-commissioning, Employees, Function, Practices, Procedure, Processes, Procurement, Projects, Programme, Protocols, Services, Service re-design, Strategy, Systems **Policy for BMI threshold and smokefree policy for elective surgery**	**Aim:** To provide criteria and guidance for clinicians managing patients with a high BMI/metabolic syndrome/smoke who require an elective procedure under GA/epidural **Objectives** 1. Improve the identification of patients who are obese and/or smoke 2. Provide a 'health trigger' for obese patients/smokers to promote long term behavioural change 3. To contribute to the wider local health improvement work to reduce levels of obesity and the impact of/ health consequences of obesity 4. To reduce the impact of obesity on osteoarthritis 5. To reduce the risks of routine surgery, in particular the risks of major complications. 6. To avoid or delay major surgery where conservative measures could provide similar symptom relief (specifically for osteoarthritis and joint replacement surgery). **Outcome** Better surgical outcomes for patients with a high BMI

	and/or smoke.

Step 2:

Test for relevance:

- **Will this help to deliver one or more of the aims of the Equality Act 2010? (**Eliminating unlawful discrimination, harassment and victimisation, Advancing equality of opportunity between people, Fostering good relation between people)
- **Will this have a potential impact on the nine protected groups and/or others ('seldom heard' groups) as described in the guidance?**

Does the above 'Policy' have any relevance to equality? **Yes X No** Please give your reasons for your selection.

The policy provides criteria for referral for elective procedures requiring GA/epidural based on an individual's BMI and/or smoking status.

If you have selected yes, please complete section 3-8 below.

Step 3:

Engagement, involvement and consultation undertaken	PSED Due regard to	1. Eliminating unlawful discrimination, harassment and victimisation			2. Advancing equality of opportunity between people			3. Fostering good relation between people			Please provide details of equality evidence considered, service, workforce, research (national or local), demographic etc.
Internal ☐x											
External ☐X											
Provide details	**Equality Characteristic Groups**	**-ve**	**N**	**+ve**	**-ve**	**N**	**+ve**	**-ve**	**N**	**+ve**	
	Age		**X**			**X**			**X**		The policy does not include a lower or upper age limit on the referral criteria.
	Disability		**X**			**X**			**X**		This policy does not discriminate against a person's disability.
	Gender		**X**			**X**			**X**		This policy does not discriminate against a person's gender.
	Gender Reassignment		**X**			**X**			**X**		This policy does not discriminate against a person's gender

											reassignment.
	Marriage & Civil Partnerships		**X**			**X**			**X**		This policy does not discriminate against a person's martial or civil partnership status.
	Pregnancy & Maternity		**x**			**X**			**X**		This policy would not be relevant for a pregnant women requiring an elective procedure, see local Trust's policy for the management of increased BMI in pregnancy, labour and post-delivery.
	Race or Ethnicity		**X**			**X**			**X**		This policy does not discriminate against a person's race or ethnicity.
	Religion or Belief		**X**			**X**			**X**		This policy does not discriminate against a person's religion or belief.
	Sexual Orientation		**X**			**X**			**X**		This policy does not discriminate against a person's sexual orientation
	Carers		**X**			**X**			**X**		This policy does not discriminate against

											a patient being a carer.
	Other groups (please list)										

Key: +ve = positive impact, -ve = negative impact, N = no impact

Step 4:

Quality			
Patient/Programmes	**-ve**	**Neutral**	**+ve**
Patient Experience – will it: Impact on the experience of patients and service users? Impact on patient choice?	Patients with a BMI>40 or with a BMI between 30-40 and metabolic syndrome will be required to lose 10% of their weight before they can be referred for an elective procedure. Patients will be required to attempt stop smoking before the procedure. Only in exceptional circumstances will the criteria be waivered,		

	which will mean a delay in referral until the criteria has been met. This policy does not apply to non-elective procedures.		
Patient Safety – will it: Impact on safety? Impact on preventable harm? Impact on the risk of healthcare acquired infection? Impact on clinical workforce capability, care and skills?			<u>Body Mass Index as a risk factor during anaesthesia and in elective surgery:</u> Obesity has an effect on the safety of anaesthesia. A recently published major UK study on complications of anesthesia has shown that obese patients are twice likely to develop serious airway problems during general anaesthetic than non-obese patients; also severely obese patients were four times more likely to develop such problems (RCA, 2011). According to the American Society of Anaesthesiologists (ASA) Physical Status "Mild" obesity is classified as ASA PS2,

			or in the category of "patients with mild systemic disease", while patients with morbid obesity are classified as ASA PS3, in the classification of *patients with severe systemic disease* (ASA). There is evidence to suggest that quitting smoking before having surgery: ▪ reduces the risk of post-operative complications ▪ reduces lung, heart and wound-related complications ▪ decreases wound healing time ▪ reduces bone fusion time after fracture repair ▪ reduces length of stay in hospital
Clinical effectiveness – will it: Meet evidence based practice/NICE guidance? Impact on clinical leadership?			The *NHS Five Year Forward View (2014)* makes the case for action on prevention, and describes the impact from the rise in obesity. The Forward View states the NHS will back hard-

Include systems for monitoring clinical quality supported by good information?			hitting national action on obesity, smoking, alcohol and other major health risks. Tackling obesity is also one of the priority areas for Public Health England. Their strategy *From Evidence into Action: Opportunities to Protect and Improve the Nation's Health (2014)* noted that if we could reduce obesity back to 1993 levels, five million cases of disease could be avoided. NICE guidance (PH48) recommends that smokers using secondary care services are identified and offered support to quit. Although smoking cessation is the preferred option, where an individual unable or unwilling to stop smoking, a program of harm reduction (NICE guidance PH45)

			should be followed to support temporary abstinence or smoking reduction. This should include provision of behavioural support and nicotine replacement therapy and/or electronic cigarettes. The *NHS Five Year Forward View (2014)* makes the case for action on prevention, and describes the impact from the rise in obesity. The Forward View states the NHS will back hard-hitting national action on obesity, smoking, alcohol and other major health risks. Tackling obesity is also one of the priority areas for Public Health England. Their strategy *From Evidence into Action: Opportunities to Protect and Improve the Nation's Health (2014)* noted that if we could reduce obesity back to 1993

			levels, five million cases of disease could be avoided. NICE guidance (PH48) recommends that smokers using secondary care services are identified and offered support to quit. Although smoking cessation is the preferred option, where an individual unable or unwilling to stop smoking, a program of harm reduction (NICE guidance PH45) should be followed to support temporary abstinence or smoking reduction. This should include provision of behavioural support and nicotine replacement therapy and/or electronic cigarettes. Completed referral forms should be stored in the patient notes. Compliance to the policy will be monitored with regular audits of patient notes in WHHT.

Step 5:

Have you identified any gaps or potential negative impact from the above? If yes, please state: Delay in referral until criteria is met; criteria can be waivered in exceptional circumstances, for example if there is going to be a detrimental to the outcome of the procedure.			
Do you plan any further engagements? **Yes x No** Engagement with planned with clinicians from each of the HVCCG localities and WHHT		**Do you require further information or data to complete the analysis/actions?** **Yes ☐ No X**	
Any actions to be undertaken (including mitigation) regarding the negative impact: An exceptionality clause has been included in the policy to mitigate any negative health impacts of this policy			
Action	**Outcome**	**Lead**	**Date for completion**
Any changes made as a result of this assessment?		YES ☐	NO X
Please provide brief description of changes			

Step 6:

Conclusion and/or recommendations:
The policy includes evidence based criteria to ensure the best surgical outcomes for patients with an increased BMI and/or smoke.

Following information (internal use only)

Step 7: Key individuals

Analysis conducted by:	**Lead Name:**	Job Title:	Contact Details:
	Miranda Sutters	**Public health consultant**	**Miranda.sutters@hertfordshire.gov.uk**
Other key contributors involved:			

Step 8:

Date form completed:	**Clinical/Managerial approval:**	**Job Title/Directorate:**	**Date:**	**Signature:**
Does a Board or Committee or Senior Leadership Team need to be informed about this EQA? **Yes ☐ No ☐**		**Do you need to undertake monitoring/review Yes ☐ No ☐ If yes, date of Review:**		**Date of publication:**
Completed copy to be forwarded to Quality Team (Diane Curbishley)				