Royal College of Surgeons
ADVANCING SURGICAL CARE

Smokers and overweight patients:

Soft targets for NHS savings?

Contents

Executive summary

During 2015 the Royal College of Surgeons (RCS) learned that some commissioners were beginning to delay or deny routine surgery – such as hip and knee replacements – for patients who smoke, or who are overweight or clinically obese. In a survey of CCG leaders in April 2015, 39% of respondents said their CCG was considering new limits on eligibility for services in 2015/16 for financial, value or efficiency reasons. Some reported that their CCG was considering introducing referral thresholds for joint surgery.[1] A survey of clinicians in December 2015 reported that three-quarters had witnessed rationed care in their area, and 89% of these respondents said that rationing was occurring owing to financial reasons.[2]

The NHS currently faces unprecedented financial pressures, with three-quarters of NHS providers reporting a year-to-date deficit in December 2015 totalling £2.26 billion for the provider sector,[3] and around 18% of clinical commissioning groups (CCGs) predicting a deficit by the end of 2015/16.[4] Although difficult to prove, we are concerned that this may lead to even more commissioners restricting access to planned surgery and other treatments to save money.

This report explores how widespread the practice of restricting surgery on the basis of weight or smoking status has become by examining the commissioning policies of CCGs in England and Health Boards in Wales. To determine whether there is clinical justification for these policies, we have compared them with guidance from the National Institute for Health and Care Excellence (NICE), the Royal College of Surgeons (RCS) and relevant surgical specialty associations (SSAs), and other clinical research or views. We have also examined whether local councils are increasing their public health programmes on smoking cessation or weight loss to support such patients.

We have found that a significant number of CCGs are restricting access to routine surgery for patients who smoke or have a high BMI (Body Mass Index), in contravention of national clinical guidance. Therefore we recommend that the government reiterates that access to NHS surgical treatment should be based solely on clinical guidance, and blanket bans do not best serve patient care.

Box 1 (p.3) shows the proportion of adults in England who are overweight or obese. These figures show that CCG policies restricting access to surgery based on a patient's BMI potentially affects a significant proportion of the population. For people who smoke, blanket restrictions on access to surgery are likely to cause distress, as stopping smoking is difficult and patients require robust support. It is therefore important that public health support programmes are in place to support weight management and smoking cessation. However, referral to these support programmes should be offered alongside referral to any clinically necessary surgical treatment, rather than acting as a barrier to it.

1 Welikala J, West D. *Survey: Third of CCGs consider limiting access amid cash squeeze*. 21 April 2015.

2 Campbell D. *NHS rationing 'is denying patients care' as cash crisis deepens*. December 2015.

3 Monitor and Trust Development Authority. *NHS Providers: Quarterly Performance Report (Quarter 3, 2015/16)*. London: Monitor; 2016.

4 The King's Fund. *Quarterly Monitoring Report 18, February 2016*. London: The King's Fund; 2016.

Box 1: Obesity levels in England and NHS classification of obesity by BMI level

The Health Survey for England 2014 found that 41% of men and 31% of women were overweight, and 24% of men and 27% of women were obese.[5] The average BMI for adults was 27. Therefore the commissioning policies of 31% of CCGs with mandatory BMI and weight loss thresholds have the potential to impact a significant proportion of the population.

The NHS classifies weight by BMI as the following:

- BMI above 25 'overweight'
- BMI between 30 and 39 'obese'
- BMI above 40 'severely obese'[6]

Box 2: Explanation of 'mandatory' and 'voluntary' CCG referral policies

Our findings in the report from 200 (out of a total of 209) CCGs in England demonstrate a distinction between what we characterise as 'voluntary' and 'mandatory' policies on patients' BMI level and/or smoking status before surgery.

- Voluntary policies instruct clinicians to encourage patients to voluntarily stop smoking or lose weight before and/or after surgery, for general health reasons and better surgical outcomes. They may also offer to refer patients to public health support services. However, they do not delay access to surgery. The RCS supports these voluntary policies as they encourage general health improvement and the provision of support and advice, alongside referral to clinically-necessary surgery.
- Mandatory policies direct clinicians to deny referral to surgery for patients who do not meet the criteria on smoking status or BMI level, or delay referral until patients can demonstrate smoking cessation or weight loss/management, sometimes over a specified time period. Mandatory policies may also require referral to a structured public health support programme with a smoking cessation or weight management service. Delay to surgery and reliance on another service is a cause for concern as a blanket approach is not supported by the clinical evidence, distresses patients, and prolongs pain or immobility that surgery would alleviate.

Main findings

Data in this report are based on a 96% response rate from CCGs (200 of the 209 CCGs in England); responses from all seven Health Boards in Wales; and a 93% response rate from local authorities (140 of the 150 local councils in England that are responsible for public health).

- More than one in three CCGs (34%) have at least one **mandatory** threshold based on **either BMI level or smoking status**.
- Almost a third of CCGs (31%) have one or more **mandatory** policies on **BMI level,** stopping overweight or obese patients being referred for routine surgery. Twelve per cent of CCGs also require patients to stop smoking before they can access one or more routine surgical procedures.
- A majority of these mandatory thresholds are for hip and knee replacements. More than one fifth of CCGs (22%) are placing **mandatory** weight thresholds on referral to **hip and knee replacement** surgery. This is an increase from data we acquired in 2014 that showed 13% of CCGs surveyed employed such policies for hip and knee replacement surgery.[7]

5 Health and Social Care Information Centre. Health Survey for England 2014. London: HSCIC; 2014.

6 NHS Choices. www.nhs.uk/conditions/obesity. 2014.

7 Royal College of Surgeons. *Is Access to Surgery a Postcode Lottery?* London: RCS; 2014.

- Twenty-three per cent of CCGs have at least one **voluntary** policy on **BMI level** – ie patients are encouraged but not required to lose weight before surgery. Fifteen per cent of CCGs have a **voluntary** policy in place for **smoking** cessation.
- In total, 51% of CCGs have at least one mandatory or voluntary policy relating to BMI level, and 24% of CCGs have at least one policy relating to smoking status.
- Just over half of **local authorities** expect their total 2015/16 spend on **smoking cessation services** to be increased from their 2014/15 actual spend, 40% expect a decrease, and 6% expect spending to remain the same. The remaining councils (3%) did not provide any figures.
- Forty-two per cent of local councils expect their total 2015/16 spend on **weight management services** to be increased from their 2014/15 actual spend, 34% expect a decrease, and 18% expect spending to remain the same.
- In **Wales**, one of the seven Health Boards (Powys) reported having a **mandatory** policy of referring patients with a BMI above 35 to a **weight management programme,** along with a **voluntary smoking cessation** policy before planned surgery.
- A number of CCGs impose **mandatory** thresholds on access to some **cosmetic procedures** that are sought for medical reasons. Examples of such procedures include body contouring surgery to remove excess skin that is causing discomfort and may risk infection following bariatric surgery, or breast reduction surgery for back problems. We have dealt with these types of cosmetic procedures separately from routine surgical procedures, as the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) believes that all referrals for such procedures should undergo individual case assessment, and not be subject to pre-referral blanket thresholds such as BMI level and smoking status.

Recommendations

- Ministers, Health and Wellbeing Boards and Overview and Scrutiny Committees should echo clinical guidance and make clear it is unacceptable for the NHS to ban or delay treatment on the basis of a patient's weight or smoking status.
- CCGs' surgical commissioning policies should be based on clinical guidance from the RCS, surgical specialty associations, and NICE. CCGs should clearly publish the evidence base for their commissioning policies and this evidence should be made available in accessible formats to local communities, eg on CCG websites and in annual reports.
- Surgeons and GPs should also continue to encourage their patients to lose excessive weight or stop smoking before surgical treatment. CCGs should encourage access to weight management and smoking cessation services, alongside surgical treatment.
- Patients should not be afraid to challenge their CCG, via their local Healthwatch if necessary, if they feel that they are being denied access to necessary surgical treatment.
- CCG commissioning policies placing blanket thresholds on access to cosmetic procedures for medical reasons are not appropriate. These cases should instead be treated on an individual assessment basis, with referral decisions involving a plastic surgeon as well as a primary care clinician. BAPRAS therefore believes that these cases should be distinguished from purely cosmetic cases that are not funded on the NHS.

Background

This report follows the RCS report *Is Access to Surgery a Postcode Lottery?*[7] from July 2014, which examined whether the NHS was restricting access to certain types of surgical procedures. The report found that 73% of CCGs reviewed were not following NICE and clinical guidance on referral for hip replacements, or had no commissioning policy in this area, and 44% required patients to meet various thresholds before they were referred for a hip replacement. At this time 13% required patients to lose weight before hip replacement surgery.

Since the report was published we have seen further evidence of rationing of surgery, particularly on the basis of weight and smoking status.[8] Owing to these reports, we wanted to explore how widespread this practice is, particularly during a period of unprecedented financial pressure on the NHS. We became concerned that such patients were becoming soft targets for NHS savings; perhaps because of the public discourse around 'self-inflicted' illness, or owing to misinterpreted clinical guidance about encouraging weight loss or smoking cessation before surgery.

Surgeons and other clinical experts have long been clear that stopping smoking or losing weight (if a patient is overweight) before surgery can potentially improve outcomes and recovery following many types of surgery. However, the RCS and surgical specialty associations, or indeed NICE, have never proposed a blanket ban on surgery for all such patients. Decisions about whether to proceed with surgery should always take place between the clinician and patient, informed by the available clinical evidence. Delaying or denying surgery can prolong painful symptoms for patients, and cause additional stress for patients being required to make difficult lifestyle changes.

In this report we have distinguished between CCGs adopting mandatory and voluntary policies for referral to planned surgery (see Box 2 [p.3]).

Public health support programmes

Given these CCGs' policies either explicitly require or will probably necessitate referral to smoking cessation and weight management support programmes, which are the responsibility of local authorities, we have also considered whether local authorities are increasing their spend on such programmes. Local authority budgets are constrained, and the Chancellor's Comprehensive Spending Review in November 2015 outlined year-on-year reductions in spending on public health, which was confirmed in the Department of Health public health grant in the local government finance settlement for 2016/17.[9] Public health funding will decrease by 2.2% from £3.46 billion in 2015/16 to £3.38 billion in 2016/17, and by a further 2.5% to £3.3 billion in 2017/18.

Considering the rising levels of obesity in England (see Box 1 [p3]), and that 31% of CCGs have mandatory thresholds based on BMI and weight management, this has the potential to put pressure on a number of local authority weight management services. Structured public health programmes are of course only one way of helping a patient to lose weight or stop smoking. This report does not discuss the merits of such programmes or more suitable alternatives, only whether local authorities are increasing spending on these initiatives and whether there is a correlation with commissioners who are restricting access to surgery.

8 For example see https://www.rcseng.ac.uk/news/rcs-comment-on-north-tyneside-ccg-referral-guidance#.Vvu0fk0UUiQ

9 Department of Health correspondence with Council leaders. February 2016.

What does the clinical guidance say?

Clinical guidance produced by the National Institute for Health and Care Excellence (NICE), as well as the Royal College of Surgeons (RCS) and relevant surgical specialty associations (SSAs), sets out the circumstances under which surgical treatment should be commissioned on the NHS. The guidance states that treatment decisions should be based on clinical evidence, with no reference to financial considerations. Although CCGs are not required by law to follow such guidance (apart from NICE 'technology appraisals'), failure to provide a clear rationale for deviating from NICE guidance could potentially leave CCGs open to legal challenge. This follows from a 2014 legal case that ruled that CCGs are under an obligation in public law to have regard for NICE guidance and to provide clear reasons for any general policy that does not follow NICE guidance.[10,11]

Guidance for a number of more specific procedures is also clear that smoking status and obesity should not be barriers to referral for surgery.

Hip and knee replacement

Guidance from the RCS and the British Orthopaedic Association (BOA) states that 'patient-specific factors such as age, gender, smoking, obesity and co-morbidity should not be barriers to referral' to hip[12] and knee[13] surgery for osteoarthritis'. Equally, NICE guidance on joint surgery states that 'patient-specific factors (including age, sex, smoking, obesity, and co-morbidities) should not be barriers to referral for joint surgery'.[14] The BOA's view is that there is no consistent evidence that patients with a high BMI or those who smoke have better or worse outcomes for hip or knee replacements than other patient groups.[15] Moreover, the BOA states that hip and knee replacements are highly cost-effective, typically delivering sustained pain relief for a cost that equates to just £7.50 a week.[16]

In addition, there is evidence that prolonging the wait for total hip replacement in patients with severe pain and reduced mobility results in poorer outcomes from surgery, and this is outlined in NICE guidance for osteoarthritis.[14]

Varicose veins treatment

RCS/Vascular Society commissioning guidance, which follows a NICE-accredited process, does not recognise weight or smoking status as a factor in referral policy; however, it does say that lifestyle advice should be offered to patients 'that encourages people to maintain a healthy weight, undertake moderate physical exercise and avoid prolonged standing'.[17]

10 R (on the application of Rose) v Thanet CCG, Court of Appeal, Administrative Court, April 2014.

11 Price C. CCG warned in court for disregarding NICE guidance. *Pulse.* May 7, 2014.

12 The Royal College of Surgeons of England. British Orthopaedic Association. British Hip Society. Chartered Society of Physiotherapy. *Commissioning Guide: Pain Arising from the Hip in Adults.* London: RCS; 2013.

13 The Royal College of Surgeons of England. British Orthopaedic Association. British Association for Surgery of the Knee. Chartered Society of Physiotherapy. *Commissioning Guide: Painful Osteoarthritis of the Knee.* London: RCS; 2013.

14 National Institute for Health and Care Excellence. *Osteoarthritis.* London: NICE; 2014.

15 Private correspondence with The Royal College of Surgeons of England; 2014.

16 Briggs. *A National Review of Adult Elective Orthopaedic Services in England : Getting It Right First Time*, page 13. 2015.

17 The Royal College of Surgeons of England. Vascular Society of Great Britain and Northern Ireland. *Commissioning Guide: Varicose Veins.* London: RCS; 2013.

Tonsillectomy

RCS/ENT UK commissioning guidance, which follows a NICE-accredited process, does not recognise weight or smoking status as a factor in referral policy, and criteria refer to recurrence and significance of tonsillitis or other clinical conditions.

Methodology

CCGs

Freedom of information (FOI) requests were sent to all CCGs in England in November 2015 asking for details of commissioning policies for surgical procedures with referral thresholds or specific requirements for patients who smoke, and patients who have a BMI over a specified level. Similar requests were also sent to all seven local Health Boards in Wales.

Responses were collected between December and February 2016. These policies were then considered against RCS/SSA procedure-specific commissioning guidance as well as NICE guidance where relevant.

We also examined whether these thresholds for referral to surgery based on weight or smoking status were considered 'voluntary' or 'mandatory' (as described in Box 2 [p.3]).

Local authorities

The public health support programmes for smoking cessation and weight loss, provided by local government, form an integral part of the policies on thresholds for referral to surgery. FOI requests were therefore sent to local councils to consider any implications of CCGs increasing the demand on smoking cessation and weight loss support programmes, and funding trends for these programmes. FOIs requested that councils provide copies of actual spend in 2014/15, year-to-date spend, and full-year forecast for 2015/16 on smoking cessation programmes, and weight loss programmes.

In areas requiring referral to smoking cessation and weight management services for common procedures, the CCG's corresponding local authority spending on these services was taken into account, including whether spending has increased or decreased.

Findings

Overview of CCG responses

Of the 209 CCGs in England, 200 (96%) responded to FOI requests.

- 51% of CCGs who responded reported having voluntary or mandatory policies in place on patients' BMI level on referral to surgery[18].
- 24% of CCGs reported having policies on patients' smoking status on referral to surgery.
- There is no clear trend in the CCGs across regions or rural/urban split.

	CCGs with at least one mandatory policy	CCGs with at least one voluntary policy	CCGs with at least one mandatory cosmetic policy	CCGs with no policy
Weight management	31%	23%	43%	20%
Smoking cessation	12%	15%	18%	65%

	Councils with increased spending 2015/16	Councils with decreased spending 2015/16	Councils with unchanged spending 2015/16	No figures provided 2015/16
Weight management	42%	34%	18%	6%
Smoking cessation	51%	40%	6%	3%

BMI level and weight management

Almost a third of CCGs (31%) reported having at least one mandatory policy, and 22% reported having at least one voluntary policy on BMI level and weight management on referral to routine surgery. Appendix 1 lists these CCGs.

In addition, 86 CCGs (43%) reported having at least one mandatory threshold for BMI level on cosmetic procedures. Thirty-nine CCGs (20% of respondents) told us they do not have a policy on a BMI threshold to surgery.

Any planned surgical procedure

Three CCGs (1.5%) have a **mandatory policy** on BMI level before referral to any surgical procedure except urgent treatments such as cancer.

- Luton CCG requires a patient's BMI to be under 30 (the cut off for 'obesity') with referral to weight management services before surgery if necessary.
  - Luton Council reported an unchanged budget on weight management services from 2014/15 to 2015/16.
- East and North Hertfordshire CCG requires a patient's BMI to be under 30 before surgery, or weight loss of 10% if a BMI under 30 cannot be reached. Herts Valley CCG requires maintained weight loss for nine months before surgery if a patient's original BMI is over 35.
  - Hertfordshire Council expects increased spending on weight management services in 2015/16.

18 Despite being sent an older policy by North Tyneside CCG, the RCS became aware of a new policy, implemented by the CCG in August 2015, which stated that any patient listed for surgery who has a BMI above 40, or above 35 with another serious health condition that could be improved with weight loss, or any patient who smokes, must be offered, accept and complete weight management or smoking cessation support before being referred, 'where clinically relevant'.

Five CCGs (2.5%) in Surrey, Herefordshire and Cheshire have **voluntary policies** on BMI status for any planned surgical procedure. Some policies state that referral to a weight management service will be offered on referral to surgery, and others simply that healthy BMI level and weight management will be advised on by the clinician.

Hip and knee surgery

Seventy-seven CCGs (39%) have a policy on BMI for hip and knee replacement.

- Forty-four CCGs (22%) have **mandatory policies** on BMI levels for hip and knee replacement surgery. Six South West London CCGs and Swindon, Gloucestershire and North Lincolnshire CCGs require a patient's BMI to be below 30, and for commitment to lowering BMI to this level before surgery. Twenty-one CCGs require a BMI below 35, and 15 require a BMI below 40.
- Thirty-three CCG (17%) policies for hip and knee replacement are **voluntary**, encouraging weight loss if the patient has a BMI above 30 or 35, but not acting as a barrier to referral.

Based on data from the National Joint Registry for 2014, the average primary hip replacement patient is overweight (BMI 28.7) and the average primary knee replacement patient is obese (BMI 30.85). As stated in Box 1 (p.3), the Health Survey for England 2014 found that 65% of men and 58% of women were either overweight or obese; therefore these commissioning policies may affect a significant proportion of the population.

The National Joint Registry data are based on only 75% of hip and knee replacement patients, whose BMI was recorded in referral records. The BOA therefore warns that the figures could overestimate the average BMI of patients undergoing operations as surgeons may be more likely to record a patient's BMI if it is in the overweight or obese category.[19]

Hernia surgery

Five CCGs (2.5%) have a policy on BMI for hernia surgery. Three CCGs (1.5%) have **mandatory policies**, stating that weight loss should be attempted before surgery.

- NEW Devon, Cambridgeshire and Peterborough CCGs restrict access for a BMI above 30. Devon Council reported increased spending on weight management services and Peterborough Council reported an unchanged budget.
- Kernow CCG states that weight reduction must be tried before referral to surgery.

South Devon and Torbay CCG has a **voluntary policy** stating that weight will be considered on referral as BMI over 30 is a risk factor, and Shropshire CCG has a voluntary policy on patients with a BMI over 35.

Tonsillectomy and surgery for snoring

Two CCGs (1%) have **mandatory policies** on BMI levels for tonsillectomy for sleep apnoea.

- Dorset CCG requires a patient's BMI to be below 30, and Bath and North East Somerset CCG requires a patient's BMI to be below 30, or implementation of a weight management programme before referral to surgery.

19 Private correspondence with The Royal College of Surgeons of England; 2016.

Seven CCGs (3.5%) have a policy on BMI for surgery for snoring. This procedure is stated as not normally being commissioned on the NHS, and therefore all patients would have to go through an exceptional case process in addition to meeting the below criteria. Six policies (3%) are **mandatory**.

- Castle Point and Rochford, Southend, Thurrock, and Basildon and Brentwood CCGs require a patient's BMI to be below 35 or for the clinician to refer them to a weight management service.
- Dorset CCG requires a BMI below 30.
- Somerset CCG requires weight loss if a patient's BMI is above 27.
- Oldham CCG states that weight will be considered on referral.

The surgical specialty association, ENT UK (which represents ear, nose and throat specialists), is not aware of evidence that a patient's weight has an impact on the outcome of surgery for sleep apnoea.[20] ENT UK highlights, however, that tonsillectomy is dangerous in patients with a high BMI, above 20 and definitely above 30, and planning for safe airway management is essential before the surgical procedure is undertaken. This may entail a tracheostomy or intubation prior to the tonsillectomy in order to stabilise the airway.[21]

Varicose veins surgery

Twelve CCGs (6%) have a policy on BMI levels for varicose vein surgery. Six CCGs (3%) have a **mandatory policy**:

- Wiltshire CCG requires a BMI below 27 to be documented for 6 months before surgery. Wiltshire Council spending will have increased in 2015/16 on weight management services.
- Bromley and Southwark CCGs require a patient to have a 'normal BMI' or the clinician to provide evidence of the patient following NICE weight loss guidelines for at least a year. Southwark Council spending will have increased in 2015/16.
- Dorset CCG requires a patient's BMI to be below 30 for three months. Dorset Council expects decreased spending on weight management services.
- North East Essex, and Mid Essex CCGs require weight loss if a patient has a high BMI (the CCG did not define 'high'). Essex Council reported an unchanged budget.

Five CCGs (2.5%) have a **voluntary policy** on varicose veins. Policies state that patients with a raised BMI should be encouraged to follow weight loss advice.

20 Private correspondence with The Royal College of Surgeons of England; 2016.

21 Ibid.

Smoking status and cessation

Twelve per cent of CCGs reported having at least one mandatory policy and 15% of CCGs reported having at least one voluntary policy on smoking cessation on referral to routine surgery. Appendix 3 lists these CCGs.

In addition, 36 CCGs (18%) reported having at least one mandatory threshold on smoking cessation for cosmetic procedures. 129 CCGs (65%) told us they had no policy relating to smoking cessation and referral for surgery.

Any planned surgical procedure

Two CCGs (1%) have a **mandatory policy** on smoking status before referral to any type of surgery except urgent treatments such as cancer.

» Luton and North East Essex CCGs[23] require patients who smoke to stop and provide evidence of this through attending smoking cessation programmes before referral to surgery. Luton Council expects an increase in smoking cessation programme spending from 2014/15 to 2015/16, and Essex Council reported an unchanged budget.

Seventeen CCGs (8.5%) in Oxfordshire, Essex, Yorkshire, Cheshire, Hertfordshire, Shropshire, Suffolk and Surrey have a **voluntary policy** encouraging smoking cessation before referral to any surgical procedure.

Hip and knee surgery

Fourteen CCGs (7%) have a policy on smoking for hip and knee replacement surgery. Eight CCGs (4%) have **mandatory policies** requiring smoking cessation, with five requiring referral to smoking cessation services and proven cessation for eight weeks before surgery, and one CCG requiring smoking cessation for four weeks before surgery.

» These CCGs are: Hambleton, Richmond and Whitby, Norwich, North Norfolk, South Norfolk, Great Yarmouth and Waveney, Harrogate and Rural District, Scarborough and Ryedale, and Cambridgeshire and Peterborough. Norfolk and North Yorkshire Councils reported increased spending on smoking cessation services from 2014/15 to 2015/16; however, Cambridgeshire and Peterborough Councils reported decreased spending.

Six CCGs (3%) in Lincolnshire, Warwickshire and Somerset have **voluntary policies** for clinicians to encourage smoking cessation before surgery but to use their own discretion when referring.

22 Mid and South Essex Success Regime: A programme to sustain services and improve care: Operational briefing. 1 March 2016. http://www.hsj.co.uk/download?ac=3006315

23 Mid Essex CCG also responded to our FOI reporting a mandatory threshold, but has since changed its policy to a voluntary basis.

Case study: West Midlands

In the period after receiving FOI responses, six West Midlands CCGs consulted on a new joint policy outlining commissioning policies on procedures of lower clinical value. This policy includes hip and knee replacement surgery, and sets a mandatory threshold of a BMI equal to or below 35 before referral to surgery. Birmingham Cross City, Birmingham South Central, Sandwell and West Birmingham, Solihull, Walsall, and Wolverhampton CCGs are agreeing the new policy.

Of these CCGs, only Birmingham Cross City and Wolverhampton CCGs had responded to FOI requests. Wolverhampton reported having no policies with thresholds on referral to planned surgical procedures for patients who smoke or have a specified BMI level. Birmingham Cross City reported having a mandatory threshold on patients with a BMI above 40 for total hip and knee replacements, requiring patients to participate in a comprehensive weight management programme for 6 months before surgery.

Hernia surgery

Four CCGs (2%) have a policy on smoking for hernia surgery. Two CCGs (1%) have a **mandatory policy**.

- Cambridgeshire and Peterborough CCG require referral to smoking cessation services and proven smoking cessation for eight weeks before surgery. Councils covering this CCG reported decreased spending on smoking cessation services. Kernow CCG requires smoking cessation for incisional hernia.

Two CCGs (both in Devon) have a **voluntary policy** stating that clinicians should encourage smoking cessation for abdominal and incisional hernia, as it is a risk factor for hernia development and risks surgical complications.

Tonsillectomy and surgery for snoring

Three CCGs (1.5%) have a policy on smoking for tonsillectomy.

- Two CCGs (Dorset, Bath and North East Somerset CCGs) specify **mandatory** smoking cessation for tonsillectomy for sleep apnoea. Dorset Council reported decreased spending, but Bath and North East Somerset Council reported increased spending on smoking cessation services.
- Cambridgeshire and Peterborough CCG requires mandatory smoking cessation for tonsillectomy, and the Councils covering it expect decreased spending on smoking cessation services.

Six CCGs (3%) state that they have policies on smoking for surgery to treat snoring, with five being **mandatory**. As above, this procedure is stated as not normally being commissioned on the NHS, and therefore all patients would have to go through an exceptional case process in addition to meeting the below criteria.

- Dorset, Castle Point and Rochford, Southend, Thurrock, and Basildon and Brentwood CCGs require patients to be non-smokers on referral. As noted above, Dorset Council expects decreased spending on smoking cessation services, and Essex reported an unchanged budget for 2015/16.

Only Somerset CCG has a **voluntary** policy for clinicians to offer referral to smoking cessation services before surgery.

In the view of ENT UK, there is no relationship between the outcome of surgery for sleep apnoea and smoking status, and they are therefore not aware of evidence that would support restrictions on surgery for sleep apnoea in smokers.[24]

Varicose veins surgery

Five CCGs (2.5%) have a policy on smoking for varicose veins surgery.

- All of these are **mandatory policies**, requiring smoking cessation for six weeks before surgery in Southern Derbyshire, North Derbyshire, Erewash, and Hardwick CCGs. Derbyshire Council, covering these four CCGs, reported decreased spending on smoking cessation services.
- Cambridgeshire and Peterborough CCG require eight weeks' smoking cessation.

According to the Vascular Society of Great Britain and Ireland, there is no relationship between smoking and risk for varicose veins, and there is therefore no logical clinical rationale for restricting access to surgical treatment for varicose veins.[25]

Box 3: CCGs' use of exceptional case panels where patients do not meet mandatory thresholds

Although a number of CCGs have mandatory restrictions in place on referral to planned surgery, some CCGs have stipulated that patients who do not meet the requirements of the policies may be referred to an exceptional case panel to assess whether they can be referred for surgery. This indicates that patients may be able to access surgery. However, this additional step would inevitably delay referral, and it is unclear how many patients would actually have access to surgery by these means.

24 Private correspondence with The Royal College of Surgeons of England; 2016.

25 Private correspondence with The Royal College of Surgeons of England; 2016.

Wales Health Board policies

FOI requests were sent to the seven Health Boards in Wales on whether they have policies for thresholds to planned surgery.

Powys Health Board has a mandatory policy on patients with a BMI above 35. If a patient has a BMI above 35, they will be placed on a District General Hospital waiting list and can be referred to a weight management programme funded by Public Health Wales. If a patient cannot reach a BMI below 35, they will be taken off the waiting list and will have to be re-referred by their GP for surgery. Powys reported having a voluntary policy on smoking cessation, where patients are offered referral to a smoking cessation service before surgery.

Abertawe Bro Morgannwg University (ABMU) Health Board reported having no general policies on thresholds to surgery for patients who smoke or have a high BMI; however, it was noted that different specialties will have their own criteria for patients to meet before surgery. Prior to referral to a consultant-led anaesthetic pre-assessment clinic, patients with endocrine disease with a BMI above 40 are to be referred to a dietician and to be advised on weight reduction on referral to the clinic.

Hywel Dda Health Board has policies on BMI levels for cosmetic procedures. Patients undergoing breast surgery or abdominoplasty must have a 'normal' BMI of between 18 and 25.

The other four Health Boards reported no specific policies on referral to surgery and smoking status and BMI level.

Local authority spending

Of the 150 tier 1 (county councils) and tier 3 (London/Metropolitan Borough Councils/unitary authorities) local authorities in England that have responsibility for public health, 140 responded (93%) to FOI requests on spending on smoking cessation and weight management services.

There was **no clear link between the number of councils increasing or decreasing spending on these public health services and their local CCGs' policies** on BMI level and smoking status before surgery. Thirty-one per cent of the councils with increased weight management service spending cover CCGs with at least one mandatory BMI level threshold on surgery, and 33% of those with decreased spending cover CCGs with at least one mandatory policy. Eleven per cent of councils with increased spending on smoking cessation services cover CCGs with at least one mandatory smoking status threshold on surgery, and 9% of councils with decreased spending on smoking cessation services cover CCGs with at least one mandatory smoking status thresholds on surgery.

However, as a third of local authorities with decreased spending on weight management services cover CCGs with at least one mandatory BMI level threshold, and 9% for smoking cessation, this risks leaving patients without the structural support that may be required for patients to lose weight or stop smoking.

Weight management services

Fifty-nine local authorities (42%) forecast an increase in spending on weight management services from 2014/15 to 2015/16, and 48 councils (34%) expect a reduction in spending in their 2015/16 full-year forecast. Twenty-five councils (18%) reported the same forecasted spend for

2015/16 as their actual spend in 2014/15 on weight management services. Nine councils could not provide distinct figures for these services. Eight local authorities (6%) could not provide distinct figures on spending on weight management services.

The situation across the country for weight management service spending is again mixed. For instance, 14 (24%) of the local authorities with increased spending are in London, 4 of the councils with unchanged spending (16%) are in London, and 11 of the councils with decreased spending (23%) are in London. This spread within and across regions is similar for the rest of England.

Of the 59 local authorities reporting **increased spending** on weight management services between 2014/15 and 2015/16, 18 councils (31%) have 26 CCGs all with **mandatory BMI level thresholds**. Seven local authorities (12%) have 13 CCGs all with **voluntary policies** encouraging patients to manage their weight. Therefore, 31% of the councils with increased weight management service spending cover CCGs with at least one mandatory BMI level threshold on surgery, and 12% cover CCGs with at least one voluntary weight management policy.

Of the 48 councils expecting **decreased spending** on weight management services from 2014/15 to 2015/16, 16 (33%) have 20 CCGs all with **mandatory BMI level thresholds**. Eleven councils (23%) have 14 CCGs all with **voluntary policies** encouraging patients to manage their weight. Therefore, 33% of the councils with decreased weight management service spending cover CCGs with at least one mandatory BMI level threshold on surgery, and 23% cover CCGs with at least one voluntary weight management policy.

Smoking cessation services

Seventy-two councils (51%) reported an expected increase in spending on smoking cessation services from 2014/15 to 2015/16, and 56 councils (40%) reported decreased spending in their 2015/16 full-year forecast. Eight councils (6%) reported the same figures for their 2014/15 actual spend and their 2015/16 full-year forecast. Four local authorities (3%) could not provide distinct figures for these services.

Regionally, the picture is mixed across the country for changes in local authority spending on smoking cessation services. For example, 15 of the local authorities with increased spending (21%) are in London, half of the councils with unchanged budgets are in London, and 11 of the councils with decreased spending (20%) are in London. This spread within and across regions is similar for the rest of England.

Of the 72 councils expecting **increased spending** on smoking cessation services from 2014/15 to 2015/16, 8 (11%) have 10 CCGs all with **mandatory thresholds** on smoking cessation requiring smokers to quit before surgery. Eleven councils (15%) have 18 CCGs all with **voluntary policies** encouraging smoking cessation. Therefore, 11% of CCGs with increased spending on smoking cessation services cover CCGs with at least one mandatory smoking status threshold on surgery, and 15% cover CCGs with at least one voluntary policy on smoking cessation.

Of the 56 councils expecting **decreased spending** on smoking cessation services from 2014/15 to 2015/16, 5 (9%) have corresponding CCGs with **mandatory thresholds** on smoking cessation requiring smokers to quit before surgery. A further 4 councils (7%) have 5 CCGs all with **voluntary policies** encouraging smoking cessation. Therefore, 9% of councils with decreased spending on smoking cessation services cover CCGs with at least one mandatory smoking status thresholds on surgery, and 7% cover CCGs with at least one voluntary policy on smoking cessation.

Cosmetic surgery for medical reasons

Sometimes patients require 'cosmetic surgery' on the NHS for medical reasons, as opposed to purely aesthetic ones. An example of this is body contouring surgery after major weight loss. This is where a surgeon will remove excess sagging fat and skin while improving the shape of the underlying supporting tissue. Such excess skin can actually cause problems for a patient – it can become infected, or create difficulties in exercise or wearing clothes. It therefore sometimes needs to be removed by a surgeon.

Such cosmetic procedures with medical indications are not routinely commissioned. It is the view of the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS)[26], the surgical specialty association (SSA) for cosmetic and plastic surgery, that such procedures should not have the same referral process, in order to distinguish between cases of cosmetic surgery with medical indications that should be funded by the NHS and cases of pursuing purely aesthetic surgery, which is not funded on the NHS. We have therefore not included such procedures in the overall totals. Instead, each case should be assessed for medical need and benefit by a cosmetic procedure case panel made up of primary and secondary care clinicians and a doctor from the CCG, for example, a public health doctor. Cosmetic surgery requests from patients to GPs should be referred to the case panel organised by the CCG, and include a plastic surgeon. In cases of a patient referred for surgery after weight loss following morbid obesity, a bariatric surgeon could substitute for a plastic surgeon if the bariatric surgeon undertakes skin reduction surgery. The panel should assess each case on its individual circumstances, using photographic evidence, and a full medical history and referral notes from the patient's GP. Therefore CCGs issuing commissioning policy instructions placing blanket restrictions on access to these procedures is inappropriate.

For the procedures that warrant NHS treatment (including female breast reduction, female breast enlargement, female breast asymmetry surgery, male breast reduction, abdominoplasty [tummy tuck], and body contouring surgery), FOI responses showed that CCGs have implemented blanket thresholds on access.

Eighty-six CCGs (43%) reported having a **mandatory policy** only on BMI levels for cosmetic surgery (some of these have a voluntary policy on other procedures but all cosmetic procedure policies were mandatory). Sixty CCGs (30%) reported only having a policy on BMI for such cosmetic surgery. Policies were justified by the rationale that smoking and a high BMI incur increased risk from complications and worse postoperative outcomes. The BMI thresholds usually required patients to be within the 'normal' range (18–25), or under 30.

Thirty-five CCGs (18%) reported having a **mandatory** smoking cessation policy only for cosmetic procedures (some of these have a voluntary policy on other procedures but all cosmetic procedure policies were mandatory). Twenty-seven CCGs (14%) reported only having a commissioning policy on smoking cessation for cosmetic procedures.

Plastic surgeons would prefer patients not to smoke before surgery, because smoking increases the risk of complications. However, the RCS and BAPRAS would not support a blanket ban on referral to surgery for patients who smoke. Clinicians should advise patients on smoking and weight issues; however, these should not act as barriers to clinically necessary procedures.

26 Private correspondence with The Royal College of Surgeons of England; 2016.

Individual circumstances around cosmetic procedures vary, and it is important that cases are treated on an individual assessment basis. Referral decisions should involve a plastic surgeon as well as a primary care clinician. BAPRAS therefore believes that commissioning policies placing blanket thresholds on NHS access to these cosmetic procedures for medical reasons are not appropriate. Individual case panels should be used to help CCGs to distinguish genuine medical cases that should be funded on the NHS from purely cosmetic cases that are not funded on the NHS.

Appendix 1: CCG responses

200 of 209 CCGs (96%) responded to freedom of information requests.

The nine CCGs who did not respond were:

- East Surrey
- Guildford and Waverley
- Isle of Wight
- Islington
- West Essex
- Leicester City
- Walsall
- West Norfolk
- West Lancashire.

Appendix 2: BMI level and weight management

The table below shows the CCGs reporting at least one mandatory and at least one voluntary policy on BMI level and weight management before planned surgery.

CCGs with at least one mandatory policy on weight management (62)	CCGs with at least one voluntary policy on weight management (45)
Basildon and Brentwood	Ashford
Bath and North East Somerset	Brent
Birmingham Cross City	Cambridgeshire and Peterborough
Birmingham South Central	Canterbury and Coastal
Bromley	Central London
Cambridgeshire and Peterborough	Coventry and Rugby
Cannock Chase	Dartford, Gravesham and Swanley
Castle Point and Rochford	Ealing
Coastal West Sussex	Eastern Cheshire
Croydon	Erewash
Dorset	Hammersmith and Fulham
Dudley	Hardwick
East and North Hertfordshire	Harrow
East Staffordshire	Herefordshire
Fareham and Gosport	Hillingdon
Gloucestershire	Hounslow
Great Yarmouth and Waveney	Kernow
Harrogate and Rural District	Lincolnshire East
Halton	Lincolnshire West
Herefordshire	Medway
Herts Valley	Milton Keynes
Ipswich and East Suffolk	Newbury and District
Kernow	North and West Reading
Kingston	North Derbyshire
Knowsley	North, East and West (NEW) Devon
Liverpool	North Norfolk
Luton	North West Surrey
Merton	Norwich
Mid Essex	Oldham
North East Essex	Oxfordshire
North East Hampshire and Farnham	Southern Derbyshire
North, East and West (NEW) Devon	South Devon and Torbay
North Hampshire	South Kent Coast
North Lincolnshire	South Lincolnshire
North Tyneside	South Norfolk
Oldham	South Reading
Oxfordshire	South Warwickshire

Portsmouth	South West Lincolnshire
Richmond	Surrey Downs
Sandwell and West Birmingham	Surrey Heath
Scarborough and Ryedale	Swale
Shropshire	Warwickshire North
Solihull	West Kent
Somerset	West London
South East Staffordshire and Seisdon Peninsula	Wokingham
South Eastern Hampshire	
South Sefton	
Southend	
Southampton City	
Southport and Formby	
Southwark	
Stafford and Surrounds	
Sutton	
St Helens	
Swindon	
Telford and Wrekin	
Thurrock	
Wandsworth	
West Cheshire	
West Hampshire	
West Suffolk	
Wiltshire	

Appendix 3: Smoking status and cessation

The table below shows the CCGs reporting at least one mandatory and at least one voluntary policy on smoking status and cessation before planned surgery.

CCGs with at least one mandatory policy on smoking cessation (23)	CCGs with at least one voluntary policy on smoking cessation (29)
Basildon and Brentwood	Bath and North East Somerset
Bath and North East Somerset	Basildon and Brentwood
Cambridge and Peterborough	Castle Point and Rochford
Castle Point and Rochford	Coventry and Rugby
Dorset	Eastern Cheshire
Erewash	East and North Hertfordshire
Great Yarmouth and Waveney	Harrogate and Rural District
Hardwick	Herefordshire
Hambleton, Richmond and Whitby	Herts Valley
Harrogate and Rural District	Ipswich and East Suffolk
Kernow	Lincolnshire East
Luton	Lincolnshire West
Mid Essex	Mid Essex
North Derbyshire	North, East and West (NEW) Devon
North East Essex	North West Surrey
North Norfolk	Oldham
Norwich	Oxfordshire
Scarborough and Ryedale	Shropshire
Southend	Somerset
Southern Derbyshire	South Devon and Torbay
South Norfolk	South Lincolnshie
Thurrock	South Warwickshire
West Suffolk	South West Lincolnshire
	Southend
	Surrey Downs
	Surrey Heath
	Thurrock
	Vale of York
	Warwickshire North

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