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Optimising Outcomes Policy Supporting Procedures

Introduction and Aim

This document outlines the supporting procedures for the optimising outcomes policy in order to achieve consistent implementation across the Cardiff and Vale University Health Board (UHB)

Objectives

- Outline the background, evidence and rationale for the policy
- Provide details of the policy statements, aims, objectives, scope and exclusions
- Provide guidance on the implementation of the policy in practice
- Provide details of the resources available to support implementation
- Summarise the finding of the EqIA
- Outline plans for monitoring and audit
- Identify recommended review period

Scope

These procedures apply to all staff in all locations, including those with honorary contracts, who manage patients that may need to access elective surgical pathways.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed and this found there to be a positive impact. Key actions have been identified and these can be found in the EqIA/HIA document
Health Impact Assessment	A Health Impact Assessment (HIA) has been completed and this found there to be a positive impact. Key actions have been identified and these can be found in the EqIA/HIA document.
Documents and online resources to read alongside this Procedure	• Keeping Me Well patient information resources for preparing for surgery, stopping smoking, eating well and weight management • Clinician information sheet – smoking cessation • Clinician information sheet – weight management • Frequently Asked Questions for Clinicians • No Smoking and Smoke Free Environment Policy • Compassionate Conversations (UHB Sharepoint link only) • Making Every Contact Count (UHB Sharepoint link only)
Approved by	Quality, Safety and Experience Committee

Accountable Executive or Clinical Board Director	Executive Director of Public Health
Author(s)	Consultant in Public Health Medicine
Disclaimer **If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**	

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	28/07/2016	18/08/2016	• Contents previously contained in policy. Transferred to separate document in line with revised UHB style. • Operational details of services update • Literature review updated
2	18/02/2020	03/03/2020	• To reflect expected changes in legislation effecting smoking on hospital sites • Update to service referral details and current versions of information resources • Additional evidence added to evidence in appendix 1
3	26/03/2024	12/04/2024	Reviewed to take account of the development of prehabilitation within the UHB since 2020: • Policy updated to ensure all links and reference to services and supporting materials are up to date • Additional referral details added for weight management support • Service contact details updated • Additional detail added to recommend earliest possible referral

			• Update governance and reporting arrangements

CONTENTS

1. INTRODUCTION

In July 2013, the UHB Board approved the Optimising Outcomes Policy statements relating to Smoking Cessation and Weight Management. The Policy was approved by the People, Performance and Delivery Committee (PPDC) on 29th October 2013 and the Policy became operational from 1st December 2013. Amendments to the Policy were made in the light of feedback received during early implementation and accepted by the PPDC on 13th May 2014. Policy reviews were conducted in 2016 and 2019, in accordance with UHB governance arrangements, when minor amendments were made to supporting information. A further update was carried out in 2023/24 to take account of the new services and structures put in place during and after the COVID-19 pandemic. These procedures support the amended version of the Policy and now links with Optimisation, Prehabilitation and Rehabilitation Services, details of which can be found at Keeping Me Well.

2. GUIDANCE AND EVIDENCE

This information is attached as Appendix 1.

3. AIM

The aim of this policy is to:

- Support best optimisation and prehabilitation practice by ensuring the lifestyle risk factors of smoking and living with obesity are appropriately managed in surgical care pathways.
- Introduce a systematic approach to supporting patients to access smoking cessation and weight management support, with the aim of reducing the risk of post-operative complications for the patient.
- Actively promote and support health and wellbeing via the Keeping Me Well Website.
- Ensure patient centred care and a compassionate approach to lifestyle change remain at the heart of this policy.

4. OBJECTIVES

The objective of the Policy and the supporting procedures is to improve health by promoting action to limit risks associated with smoking and living with obesity prior to, during and after surgery to protect and promote the health of the patient.

In order to achieve this, the following will be implemented:

- Provide effective communication processes to ensure compliance and adherence to the policy in Primary and Secondary Care.
- Provide effective communication processes to ensure the public are aware of the policy and understand the policy aim.
- Ensure Primary Care practitioners offer timely referral to smoking cessation and/or weight management support for those patients who smoke and/or live with a BMI of 40 or above that may require a surgical intervention.
- Ensure smoking cessation and weight management services are able to provide timely support for identified patients.
- Ensure that appropriate arrangements are in place for monitoring of the policy
- Ensure a 'second offer' of support is made at the first secondary care outpatient attendance if not already offered or undertaken.
- Ensure full UHB commitment and reinforcement of support from all independent members, executive directors, senior clinicians and managers.
- Ensure appropriate information (including patient information leaflets, digital resource and accessible formats) are available for staff and patients.

If a patient does not accept the offer of referral, or complete the support programme, the surgical clinician responsible for the patient's care should determine whether surgery will go ahead based on an assessment of all relevant operative risk factors.

5. DEFINITIONS

A full list of definitions used in this policy are listed in Appendix 2.

6.ROLES AND RESPONSIBILITIES

6.1 The UHB Board

The UHB Board has agreed the policy statements, and the Quality, Safety and Experience Committee will be responsible for monitoring the policy on behalf of the UHB Board.

6.2 Chief Executive

As Accountable Officer the Chief Executive is ultimately accountable for the effective management of the UHB's business and in particular for ensuring that policies are adhered to.

6.3 Executive **Director of Public Health**

The Executive Director of Public Health is responsible for ensuring the appropriate policy with regard to optimising outcomes is in place on behalf of the Chief Executive of the UHB. The Executive Director of Public Health advises and supports the commitment to this policy.

6.4 Directors and Clinical Board Directors

Directors and Clinical Board Directors have responsibility for compliance with the Optimising Outcomes Policy at Primary and Secondary Care level.

They should ensure that everyone in their Clinical Board/Directorates understands their responsibilities in ensuring compliance and this is reviewed and promoted at regular intervals.

6.5 Clinical Governance Leads

Leads on Clinical Governance in each Directorate will ensure that presentations on the policy (including smoking cessation and weight management) feature at least annually in their audit sessions with reference to the Optimising Outcomes Policy.

6.6 Clinical Service Managers

Clinical Service Managers in relevant Clinical Boards have a responsibility to ensure that their staff are aware of the policy and patients are referred in compliance with the policy.

6.7 All Employees

All UHB employees and independent contractors commissioned by the UHB for its population have a responsibility to inform patients about the policy and to offer referral to relevant services prior to their surgery. They also have a responsibility to promote the health and wellbeing of our population.

7. APPLICATION OF THIS POLICY

7.1 Patient information

Patients will be informed about the policy by their GP in a Primary Care setting and also by a member of staff at their first outpatient appointment at hospital and provided with a patient information and signposted to Keeping Me Well website

7.2 Non-compliance

The commitment to enforcing this policy should not just be a formal statement but be evident in the day to day activities of the UHB, so that it is readily known and understood by all staff. Where managers become aware of deficiencies in adherence to the policy they are required to take action to address this through promotion of the policy and relevant training.

See Compassionate Conversations and MECC.

Managers and staff are jointly responsible for ensuring that:

- Patients are aware of and understand this policy
- The policy is monitored in their own areas and contraventions are identified and managed.

7.3 Referral to relevant services for patients

Smoking Cessation

NHS Smoking Cessation services are available to support patients to stop smoking. People who smoke tobacco are four times more likely to successfully quit smoking with NHS stop smoking support, than going it alone. For all groups, quitting smoking will increase life expectancy, reduce the risks of ill health and optimise surgical outcomes. Pregnant smokers are more likely to have a healthier pregnancy and a healthier baby.

Help Me Quit community based smoking cessation services.

Help Me Quit (HMQ) is the NHS stop smoking service in Wales and offers people who smoke the greatest chances of success by providing structured, tailored and expert support, carbon monoxide monitoring and access to free licensed stop smoking medication .

Patients can choose one-to-one or group weekly sessions. These sessions are available across Cardiff and Vale of Glamorgan in community venues, and at different times of day (morning, afternoon or evening). Telephone support is also available for patients if they prefer this option. All patients will receive expert behavioural support and free no-smoking medication.

People who smoke can self refer by calling 0800 085 2219, Texting HMQ to 80818 (to get a call-back) or by visiting: www.helpmequit.wales/quit-now to request a call-back

Professionals can refer people who smoke by: Telephone (with client permission) on 0800 085 2219 or by using the professional referral short-form: www.helpmequit.wales/professional-referrer/

Hospital in-house smoking cessation services

Contact details: Helen Poole, Smoking Cessation Counsellor
02921 843582 (University Hospital Wales, Cardiff)
helen.poole@wales.nhs.uk

A hospital in-house smoking cessation service exists for all staff and patients (and their families) accessing Cardiff and Vale UHB. The service can be accessed either by self-referral or referral ‘in house’ (such as from a Clinician/GP) within the UHB. The programme incorporates elements from various behavioural therapies to allow flexibility, tailoring support to each individual. The first month consists of an intensive phase of weekly advice and support sessions, which includes a discussion of the various kinds of treatment available, such as Nicotine Replacement Therapy (NRT) and the newer stop-smoking aids that do not contain nicotine such as Buproprion (Zyban). The in-house service is also able to prescribe NRT patches/lozenges (signed by an

appropriate consultant). Follow up sessions take place at 3, 6 and 12 months, with telephone support at 2, 5 and 9 months.

Community Pharmacy Smoking Cessation Service

An Enhanced Level 3 Smoking Cessation Service for Community Pharmacists operates in specific locations across Cardiff and Vale UHB.

Smokers wishing to quit can access the participating Pharmacy directly and are offered one-to-one weekly support in the Community Pharmacy and free NRT.

Alternatively, some GP Practices offer smoking cessation support either as a routine appointment or in a dedicated smoking cessation group or one to one meeting.

See Smoking Cessation Health Pathway for more information.
https://cardiffandvale.communityhealthpathways.org/

Weight Management

Weight management services are available to support patients to lose weight; following an initial assessment with a dietitian patients may choose either group or one-to-one support. One-to-one support is available over four to six sessions, held two weeks apart, depending on patient preference. All options are listed below

- Eating for Life – group intervention
- One to one dietetic support –
- Diabetes programmes (if relevant)
- Foodwise for life – self referral available through Keeping Me Well website
- Level 3 weight management service referral
- Sign posting

See Primary Care weight management Health Pathway for further information
https://cardiffandvale.communityhealthpathways.org/

Contact details: GP e-referral to Community Dietetic Service.
https://cardiffandvale.communityhealthpathways.org/
Tel: 02920907681 Email: Dietitian.Reception.UHW@wales.nhs.uk

Patients can also self-refer by e-mailing dietitians.cav@wales.nhs.uk or via Tel: 02920668089

Peer support sessions are being piloted by the weight management service and if successful will be rolled out as a permanent feature of the weight management service. One-to-one appointments are offered to people where a group education programme is not suitable.

Details of weight management service referral pathways can be found on the UHB Sharepoint site
Weight Management Services sheet (1).pptx (sharepoint.com)

- National Exercise Referral Scheme (NERS)

NERS is an evidence-based health intervention incorporating physical activity and behavioural change techniques, to support referred clients to make lifestyle changes to improve their health and wellbeing.

Once referred, patients that meet the criteria are invited to their local leisure centre for an initial assessment with a qualified exercise referral professional. They will be offered a tailored, supervised exercise programme for 16 weeks and their progress will be reviewed at key points.

Health care professional can refer patients via the NERS New Patient Management System - Public Health Wales (nhs.wales)

Once patients have completed the programme they can access a discounted NHS leisure centre membership.

Alternatively, patients can refer themselves to commercial weight management programmes, however this option will not be funded by the NHS.

8. TRAINING and resources for staff

Issues related to smoking cessation, weight management and public health will be included in the following:

- Cardiff and Vale UHB Induction
- Making Every Contact Count training (MECC) Level 1 and Level 2 (raising the issue of lifestyle behaviour change, including smoking and weight management, with a patient)
- Compassionate Conversation Cards
- Keeping Me Well Website
- Bespoke training available on request from Community Dietetics dietitians.cav@wales.nhs.uk

9. COMMUNICATION

9.1 Communication to staff

This policy will be communicated to staff via the internet, Sharepoint, clinical portal and bulletins.

Leads on Clinical Governance in each relevant Directorate will ensure that presentations feature at least annually in their audit sessions with reference to the Optimising Outcomes Policy.

All induction for relevant staff must refer to this policy.

9.2 Communication to Patients

Patients will be informed about the policy at the point of GP engagement and encouraged to access smoking cessation and/or weight management services prior to engagement with Secondary Care services. Patients will also be reminded about the policy at the first point of engagement with Secondary Care.

Patients ideally need to be referred from all initial assessment opportunities.

Patient information leaflets and resources will be available containing advice as to how to access smoking cessation and/or weight management services via the Keeping Me Well website.

Patients and visitors can access the full policy on the UHB Internet site.

9.3 Consultation

The 3 Ps Group maintains oversight of implementation of the policy.

During initial development (2012/13), the policy statements were raised at the following meetings:

- Public Health Steering Group
- Community Health Council
- Cardiff 3rd Sector Council Network
- Practising Public Health Organisation
- Tobacco Free Cardiff and Vale Group
- Vale 50+ Forum
- Directors of Public Health meetings
- Local Medical Committee

Support to the policy was also gained from:

- Tobacco Control Leads, Public Health Wales
- Obesity Leads, Public Health Wales
- Directors of Public Health

10. RESOURCES

10.1 Patient information leaflets

Patient information leaflets on smoking cessation and weight management are required to ensure patients can access information on the policy and what is required of them. These are available in English (Home - Keeping Me Well) and Welsh (Adref - Cadw Fi'n Iach (keepingmewell.com))

Clinician information sheets are available for Primary Care and Secondary Care, along with a frequently asked questions sheet was written to address commonly raised operational issues.

10.2 Relevant support services

Smoking cessation and weight management services are outlined in section 7.3 above.

11. REFERENCES

Details of the documents referred to in the development of this Policy are shown in Appendix 3.

12. MONITORING AND AUDIT

12.1 The 3Ps Delivery Group will monitor the progress of the policy via regular meetings, and report to the Planned Care Strategic Programme Board

12.2 The UHB's Quality, Safety and Experience Committee will receive updates as required.

12.3 The following indicators will be used to monitor the effectiveness of the policy:

- The number of patients accessing smoking cessation support and weight management support will be monitored.
- Revised monitoring data to be developed

Appendix 1

Optimising Outcomes Policy Guidance and Evidence

SITUATION

The NHS Wales Act 2006 places a target duty on the Welsh Health Minister, passed down to Health Boards by the Statutory Instruments that establish them, to promote the health of the people within the population it serves.

Healthcare professionals routinely manage clinical risks such as hypertension in people undergoing surgery. Lifestyle factors can increase clinical risk, with evidence suggesting that smoking cessation and weight loss (if required) improve post-operative outcomes.

The Optimising Outcomes Policy introduced a systematic approach to supporting patients to access smoking cessation and weight management, with the aim of reducing the risk of post-operative complications for the patient. The literature reviews conducted over time to support policy development are summarised in the background section below.

BACKGROUND

2012/13 - POLICY DEVELOPMENT
Pre-operative Smoking Cessation

In the policy published in 2013, the following guidance and evidence existed to support the policy:

- People who smoke are more likely to have lung, heart and infectious complications; have reduced bone fusion after fracture and impaired wound healing; be admitted to an intensive care unit; have an increased risk of in-hospital mortality; and remain in hospital longer[2, 3].

- Patients can reduce their risk of a wide range of complications if they stop smoking eight weeks before elective surgery, with improved recovery and outcomes[2, 3], including reduced wound related, lung and heart complications; decreased wound healing time; reduced bone fusion time after fracture repair; reduced length of hospital stay; in the long term reduced risk of heart disease, cancer and premature death[2, 3].

- Specifically for Cardiff and Vale, modelling suggests the following potential savings per year[4]: Based on 9,371 elective admissions being current smokers, approximately 10-30% of people who smoke are likely to give up through a Pre-operative Smoking Cessation programme (as calculated by London Health Observatory[4]), this would result in

approximately 754 – 1,574 quitters, resulting in 124 – 1,299 bed days saved and an estimated £41,941 - £437,650 saved per year.

A literature search was conducted to update the evidence base for the OOPs policy review in 2016. Emerging evidence since adoption of the original policy included the following:

Smoking

- People who currently smoke are at an increased risk of a range of postoperative complications following a range of surgical procedures compared to non smokers (including abdominal, head/neck, breast, orthopaedic, plastic, thorax, transplantation and general surgeries)9. The systematic review and meta-analysis concluded that smokers have a:
    - 1.52 fold higher risk of general morbidity post operatively
    - 2.15 fold higher risk of wound complications
    - a 1.54 fold higher risk of general infections
    - a 1.73 fold higher risk of pulmonary complications
    - a 1.38 fold higher risk of neurological complications
    - and a 1.60 fold higher risk of admission to intensive care unit
- People who smoke receiving general anaesthesia for major elective surgery have a 4.40 fold increased risk of peri-operative respiratory complications and a 1.86 fold increased risk of post-operative morbidity compared to non smokers[10]
- People who smoke are 1.45 times more likely to experience respiratory events (pneumonia, unplanned intubation, or ventilator requirement) following major surgery and 1.65 times more likely to experience an arterial event (myocardial infarction or cerebrovascular accident)[11]
- People who currently smoke are 2.21 times more likely to experience organ/space surgical site infections (SSI) and surgical wound complications in orthopaedic surgery with implants[12]
- People who currently smoke are 1.47 times more likely to have wound complications following primary total hip or knee athroplasty compared to non smokers[13]
- People who currently smoke are 2.37 times more likely to experience deep infection and 1.78 times more likely to need an implant revision after primary total hip athroplasty or total knee athroplasty compared to non smokers[14]
- People who currently smoke have an increased risk of post-operative morbidity by 1.3 fold and mortality by 1.5 fold for all types of major colorectal surgery (elective major colorectal resection for colorectal cancer, diverticular disease, or inflammatory bowel disease)[15]

- Women who currently smoke are 1.16 times more likely to experience venous thromboembolism in the first 12 postoperative weeks than never-smokers[16]
- People who currently smoke are 2.41 times more likely than non-smokers to have post-operative pulmonary complications after coronary artery bypass grafting surgery[17]
- Smoking is associated with wound dehiscence after cesarean delivery (46.7% vs. 21.1%, smokers vs non-smokers)[18]
- Smoking is associated with increased wound complications and 30-day mortality after laparotomy (32% vs 23%, smokers vs non-smokers)[19]
- People who currently smoke are 1.28 times more likely to develop wound complications after an open cholecystectomy and 1.20 times more likely after a laparoscopic cholecystectomy compared to non smokers[20]

Pre-operative Weight Management

Living with Obesity is a recognised risk factor for a wide variety of peri-operative complications. Research highlights that patients living with obesity are likely to experience:

- A nearly 12-fold increased risk of a post-operative complication after elective breast procedures[21]
- A 5-fold increased risk of surgical site infection (SSI)[22]
- A two fold increased risk of SSI risk in orthopaedics[23]
- An increased risk of SSI as much as sixty percent (60%) when undergoing major abdominal surgery[24]
- A higher incidence of SSI (up to 45%) when undergoing elective colon and rectal surgery[24]
- An increased risk of bleeding and infections after abdominal hysterectomy[25]
- A 2.1 fold increased risk of any complication after elective spine surgery[27] [29] including:
    - a 1.2 - 3.11 fold higher risk of SSI [28, 29, 30, 31, 32, 37]
    - a 1.21 fold increase in risk of SSI for every 5-unit increase in BMI[36]
    - A 2 - 3.15 fold higher risk of venous thromboembolism [28,31,32,33]
    - a 1.43 fold higher risk of revision[28]
    - a 28.89 fold higher risk of blood loss during surgery [28,29,30]
    - a 14.55 fold higher risk of longer surgical time [28,30,37]
    - and 2.6 fold higher risk of mortality[28]
- A 1.67 fold increased risk of superficial wound infection and a 1.52 fold increased risk of deep wound infection following orthopaedic trauma surgery[35]

Research indicates that people living with obesity are likely to experience:

- A 1.6 – 1.84 fold increased risk of any complication following spinal surgery[37 38] including:
    - a 2.5 – 3.22 fold increased risk of SSI[32,37]
    - a 2.5 fold increased risk of venous thromboembolism[32]
    - a 1.7-2.43 fold increased risk of urinary complications[32,37]
    - a 15.3 fold increased risk of acute renal failure[32]
    - a 1.7 fold increased risk of sepsis[32 34]
    - a 2.18 fold higher risk of pulmonary complications[37]
    - a 2.3 fold higher risk of re-admission[38]
    - a 1.8 fold higher risk of return to the operating room[38]
- A 2.51 fold increased risk of deep wound infection and a 2.29 fold increased risk of wound dehiscence following orthopaedic trauma surgery[35]

- An increased risk of restrictive pulmonary syndrome, including decreased functional residual capacity (for people living with obesity)[26].

It is understood that around 50 percent of patients who live with obesity have a poor outcome following joint replacement surgery compared to less than ten percent of patients with a healthy Body Mass Index (BMI) for the following reasons:

- A significantly higher risk of a range of short-term complications[7]
- A less likely outcome of surgery improving symptoms[8]
- A higher risk of the implant failing, requiring further surgery[8]
- A higher incidence of weight gain following joint replacement surgery[7].

This weight management pre-operative intervention should be seen as a basic component of evidence based commissioning for elective surgery.

2017 – EVIDENCE REVIEW

In 2017, two rapid evidence reviews were conducted by Cedar to explore the effects of smoking[39] and obesity[40] on primary hip or knee replacement. The conclusions were as follows:

Smoking

Although some studies did not show an association between smoking and poorer outcomes, there seems to be some evidence that smoking is an independent risk factor for poorer outcomes in patients undergoing total hip or knee arthroplasty. Based on current evidence, patients who smoke appear to be at increased risk of both local and systemic complications and have an increased risk of implant failure and revision compared with patients who do not smoke.

Obesity

Hip Arthroplasty

There is evidence that patients who live with obesity have an increased risk of complications following primary hip replacement surgery including major complications such as deep infection, dislocation, osteolysis and/or aseptic loosening and minor complications such as superficial infection, wound healing and/or haematoma.

The evidence indicates that people living with obesity have a higher risk of dislocations.

The evidence suggests that although people living with obesity have significantly lower pre-operative and post-operative patient reported outcome scores compared with people who do not live with obesity, the difference in the change of scores from pre to post-op follow-up is not significant at 2 year follow-up suggesting that the magnitude of benefit or obese and morbidly obese patients is similar to that of non-obese patients. One study however did report a significantly lower patient reported outcome score in obese and morbidly obese patients at 5 year follow-up compared with non-obese patients suggesting that it is possible that although obese and morbidly obese patients benefit from surgery initially, this benefit is not maintained in the longer term. It is not possible to say whether the lower score at 5 years is the result of increased BMI and primary hip surgery however; there are other factors which impact on a patient's score.

Knee Arthroplasty
There is evidence to suggest that patients living with obesity have an increased risk of both superficial infection and deep wound infection following primary knee replacement, however there is some uncertainty around the robustness of the results relating to deep infection and it is possible that the risk of deep infection does not differ between obese and non obese patients.
Patients living with obesity appear to have a greater risk of undergoing a revision procedure for any reason when compared with non-obese patients.

Patients living with obesity do not appear to have a greater risk of intra-operative complications such as intra-operative fracture, tendon/ligament rupture or nerve damage compared with non-obese patients and there also appears to be no difference in the risk of post-operative deep vein thrombosis.

Patients living with obesity record lower patient reported outcome scores preoperatively compared with patients who are not obese and the evidence suggests that patient reported outcome scores in obese and morbidly obese patients are lower at 6 and 12 months post-operatively. However information was not provided on the change in patient reported outcomes from pre-operative scores to post-operative scores, so it cannot be assumed that the obese/morbidly obese patient group did not achieve an improvement in functional outcomes compared with their pre-operative scores of a magnitude similar to non-obese patients.

2019 – POLICY UPDATE

No additional literature searches were completed as part of the 2019 policy review. However, it was noted that both smoking cessation and weight management featured in national guidance for effective pre-operative care published by the Royal College of Anaesthetists[41].

ASSESSMENT

2023 – POLICY UPDATE

This most recent update has seen the Policy align to the development of prehabilitation services within the UHB and the Keeping Me Well resource, all of which are informed by the evolving evidence base. No additional literature reviews were conducted as part of the review, but the following were noted:

- Further development of 'Fitter, Better, Sooner', including patient information resources on 'preparing your body' which reference smoking, exercise and diet/weight
- A rapid review by Public Health Wales, on behalf of the Wales COVID-19 Evidence Centre (WCEC) whose findings showed 'the benefits of exercise, education, smoking cessation, and psychological interventions for patients awaiting elective surgery'[42]

RECOMMENDATION

The continuation of the Optimising Outcomes Policy to offer smoking cessation and weight management advice in pre-operative patients enables a systematic approach to addressing lifestyle risk factors with the aim of supporting action to ensure optimal post-operative outcomes for patients.

Appendix 2

LIST OF DEFINITIONS

BMI	Body Mass Index
CHC	Community Health Council
Completed programme	A completed programme is defined as a patient having attended the following number of sessions for each programme: 4 out of 6 smoking cessation sessions 5 out of 8 Eating for Life sessions (or equivalent individual sessions) 10 out of 16 Exercise Referral sessions
EqIA	Equality Impact Assessment
Listed	For the purposes of the Optimising Outcomes Policy, listing is defined as 'given a date to come in for surgery'. This means the patient can be added to the waiting list for an elective procedure in the normal way and the waiting time clock will continue.
LMC	Local Medical Committee
Smoking Cessation Services	Includes NHS community and hospital based Smoking Cessation Service
UHB	University Health Board
UHW	University Hospital of Wales, Cardiff
Weight Management Services	Includes Dietetic Services and National Exercise Referral Scheme

Appendix 3

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