Tobacco dependence treatment services: delivery model

v2.0

July 2021

NHS England and NHS Improvement

Contents

Purpose of the delivery model

NHS

- This delivery model has been co-developed with a range of national, regional and system partners with an aim to support delivery of **NHS-funded tobacco dependence treatment services** in line with the NHS Long Term Plan commitments (LTP, 2019).

- It is designed to be a practical framework which lays out the **background, context and practical criteria** for delivering services alongside links to other available resources .

- It sets out our expectations for tobacco dependence treatment services, which include:

  - **smoking status is recorded** for every patient admitted to hospital (acute and mental health sites) and pregnant women;

  - they are immediately **opt-out** referred for an in-house discussion with an appropriately trained tobacco dependence adviser;

  - they have early access to appropriate **pharmacotherapy,** and;

  - are able to agree a **personalised plan** to support them to quit smoking tobacco both whilst in contact with NHS services and beyond.

- The delivery model is being tested in **Early Implementer Sites** who are stress-testing the acute, mental health and maternity model pathways so they can be refined prior to national rollout.

- This will be especially important in mental health services where we anticipate the most adaptations to the recommended model and where there is larger scope to **tackle current health inequalities**. Separately, work is being done in FY 21/22 through a Task and Finish group to define the target population and the recommended model for outpatients.

- This delivery model will be developed over the course of 2021/22 and informed by the early implementer sites' work, but we **welcome any additional feedback** on how it can be developed or any case studies that might be useful to share. Please send to the following address: england.prevention-pmo@nhs.net

Introduction

NHS

- The LTP set out clear commitments for NHS action to improve prevention by **tackling avoidable illness**, as the demand for NHS services continues to grow.

- Supporting patients, service users and staff to overcome their tobacco dependence will not only provide improvements in their health, but **reduce health inequalities** and also **decrease demand on services** by reducing the number of smoking related admissions and readmissions.

- The NHS is investing in frontline services to tackle tobacco dependence for all **inpatients**, **pregnant women** and those in long term **mental health** and **learning disability** services by 2023/24. This is being facilitated with support from national and local teams, as well as other key stakeholders.

- These services will be in addition to, and delivered in conjunction with, where relevant, **local authority (LA) Stop Smoking Services** (SSS). They will support delivery of the government's Tobacco Control Plan and the ambition to go smoke-free in England by 2030 (AOH, 2019).

- The recommended models will see **in-house opt-out services** rolled out across the NHS. Patients and service users will be given the opportunity and support to beat their tobacco dependence and quit smoking at a time when they are likely to be motivated to quit.

- Funding will be devolved to systems through Integrated Care Systems (ICSs) – to allow all providers to offer these services either individually or across local systems in conjunction with NHS and LA partners.

- This slide deck sets out the case for change, outlining both the clinical and business arguments. It includes expectations in terms of timelines and recommended evidence-based models of delivery, also offering ideas on how to improve local delivery and case studies from existing practice.

Why tackle smoking – clinical case (1)

NHS

*"Smoking cessation is not just about prevention. For many diseases, **smoking cessation represents effective treatment**"* ([Royal College of Physicians, 2018](#)).

- The Global Burden of Disease ranks **tobacco as the top modifiable risk factor** that drives deaths and disability, with 96,058 avoidable deaths associated with its use in England in 2019 ([GBD, 2019](#)).

- Tobacco dependency affects almost all patient pathways – both surgical and medical – from pregnancy and neonates through to children and adults. 13.9% of adults, 9% of 11-15 year olds and 9.6% of pregnant women at the point of delivery in England still smoke tobacco ([ONS, 2020](#); [NHSD, 2020](#); [NHSD, 2021](#)). During the pandemic, reported data ([UCL, 2021](#)) suggests more people are attempting and quitting smoking, but there is an increasing rate of uptake, especially in the young.

- Smoking tobacco is **linked to just over 500,000 hospital admissions** each year, with smokers being 36% more likely to be admitted to hospital than non-smokers. Smoking tobacco is linked to over 100 different conditions, including at least 15 different types of cancer, 9 mental health conditions and numerous respiratory, cardiovascular and other disorders ([RCP, 2018](#)).

- Stopping smoking results in an improved response to cancer treatments, faster recovery after surgery, fewer exacerbations of cardiovascular disease, slower decline in lung function, lower pharmacotherapy costs (for mental health patients) ([RCP, 2018](#)) and a beneficial impact on long-term levels of depression and anxiety ([Taylor, 2014](#)).

- Tackling tobacco dependence can also have a positive impact on health inequalities. Reported life expectancy for smokers is at least ten years shorter than for non-smokers with a disproportionate impact on those from poorer backgrounds – where smoking prevalence is higher – as well as people suffering from mental health conditions ([RCP, 2013](#)).

- A detailed analysis of mortality in England and Wales concluded that **85% of the observed inequalities between socioeconomic groups could be attributed to smoking** ([Gruer, 2009](#)).

Why tackle smoking – clinical case (2)

NHS

- Smoking in pregnancy is the **main modifiable risk factor for a range of poor pregnancy outcomes**, including include low birth weight (250g lighter), miscarriage (up to 3 times as likely), preterm birth (up to 27% more likely) and stillbirth (twice the likelihood) (ASH, 2018). Smoking in pregnancy also triples the risk of sudden infant death (ASH, 2018).

- Smoking in pregnancy increases the risk of sudden infant death three times (ASH, 2018).

- Maintaining smokefree status postpartum has a beneficial impact on subsequent pregnancies and the harmful impacts of exposure to second-hand smoke in infancy and childhood , which carries similar risks to smoking (ASH, 2018).

- Exposure to second-hand smoke carries similar risks to smoking, meaning it is important to address smoking in other family or household members too (ASH, 2018).

- People with mental health conditions smoke at higher rates and are more heavily addicted. Around one-third of adult tobacco consumption is by people with a mental health condition. As such, they experience much greater smoking related harm, relative to the general population (RCP, 2018).

- Those with mental health conditions die, on average, 10-20 years earlier than the general population. **Smoking is the single largest cause of this gap in life expectancy**.

- The decline in smoking prevalence rates among those with mental health conditions has been lower than that in the general population. Over a quarter (26.8%) of adults with long-term mental health conditions smoke, with rates being significantly higher in those with more severe mental illness. Prevalence rates in mental health units have been reported as high as 70% (MHSP, 2017).

- People with a mental health problem are more dependent on cigarettes but are more motivated to quit, engage in harm reduction and make a quit attempt than those without a mental illness (Brose, 2020). Smoking cessation interventions are both tolerable (Roberts, 2016) and effective (Banham & Gilbody, 2010) for those with mental health conditions.

Tobacco dependence treatment services: delivery model

Why tackle smoking – business case

NHS

- The estimated annual cost to the NHS in England of treating smoking-related illness is £2.6bn (GOV, 2015), and secondary care avoidable costs are estimated at £890m per year (RCP 2018).

- Supporting NHS staff to beat their tobacco dependence could save circa £206m per year by reducing absenteeism, ill health treatment and loss of productivity (RCP 2018).

- The RCP have estimated that adopting the Ottawa model for smoking cessation in the NHS would result in a net return of £60m in the first year. The estimated reductions in demand in Manchester (where a similar model has been implemented (CURE)) suggest savings of nearly £2m to their health economy (RCP, 2018; Evison, 2018).

- Other results from the Ottawa model suggest a 30-day reduction in readmissions by 6%,12 and 24 month reductions at 12%, a reduction in smoking-related physician visits (specialist 5% and GP 2%) and reductions in mortality of between 6-7% based on one and two year outcomes (Mullen, 2017).

- Applying the Ottawa assumptions to national modelling indicates that, nationally, the NHS could save nearly **100,000 admissions by the end of 2023/24**.

- Initial results from the CURE pilot show that over **1 in 5 of all smokers** admitted reported abstinence from smoking 12 weeks after discharge at a cost of £183 per quit (Evison, 2020).

- Maternal smoking during pregnancy costs the NHS in England approximately £21 million each year in secondary care costs, arising from low birthweight, premature rupture of membranes, ectopic pregnancy, miscarriage and placenta previa (RCP, 2018).

- Exposure of children to passive smoking costs the NHS in England at least £5 million, possibly as much as £12 million in hospital costs (RCP, 2018).

- The RCP (RCP, 2013) also estimated that smoking-related diseases among those with a mental health condition cost the NHS an approximate £719 million.

Why tackle smoking - Health inequalities   NHS

- Smoking tobacco and the use of other tobacco products is intrinsically linked with increased health inequalities. Smoking is widely accepted as having significant disparity across socio-economic and geographical communities with those in the more deprived areas having higher smoking rates and poorer health outcomes.

Drivers

- Smoking is the single biggest cause of preventable deaths in England.
- People from the **most deprived communities** are much more likely to smoke and less likely to quit, compared with more affluent groups. In addition, smokers from lower socioeconomic groups are more likely to be admitted and treated in hospital compared to smokers from higher socioeconomic groups.
- ONS (2020) data shows that 23.4% of those working in routine and manual occupations said they currently smoked in 2019; significantly higher than those reported among managerial and professional occupations at 9.3%.
- Rates of **smoking in pregnancy** have a strong social and age gradient with poorer and younger women much more likely to smoke in pregnancy. PHE has reported that 10 times as many pregnant women who smoke from the most deprive decile (based on maternal address) compared to the top decile (PHE, 2019).
- Smoking is the biggest driver of the life expectancy gap for **people with severe mental illness (SMI),** who on average die 15-20 years earlier than the general population.
- **Ethnic minority groups** in general have slightly lower rates of smoking, however some communities are at higher risk of harm, for example from shisha use.

- When rolling out tobacco dependence treatment services, engagement and outcomes should be analysed locally by subgroups such as age, ethnicity and deprivation. Services need to ensure **equity of access**, particularly by ethnicity and deprivation quintile, with an aim to achieve high rates of uptake, especially in smokers from the more deprived communities.

Recommended model: inpatients (acute)

NHS

The recommended model is based on delivering systematic in-house treatment of tobacco dependence in secondary care. Patients are provided with behavioural support, nicotine replacement therapy (NRT) or other pharmacotherapy (e.g. Varenicline) during their hospitalisation, with follow up post-discharge.
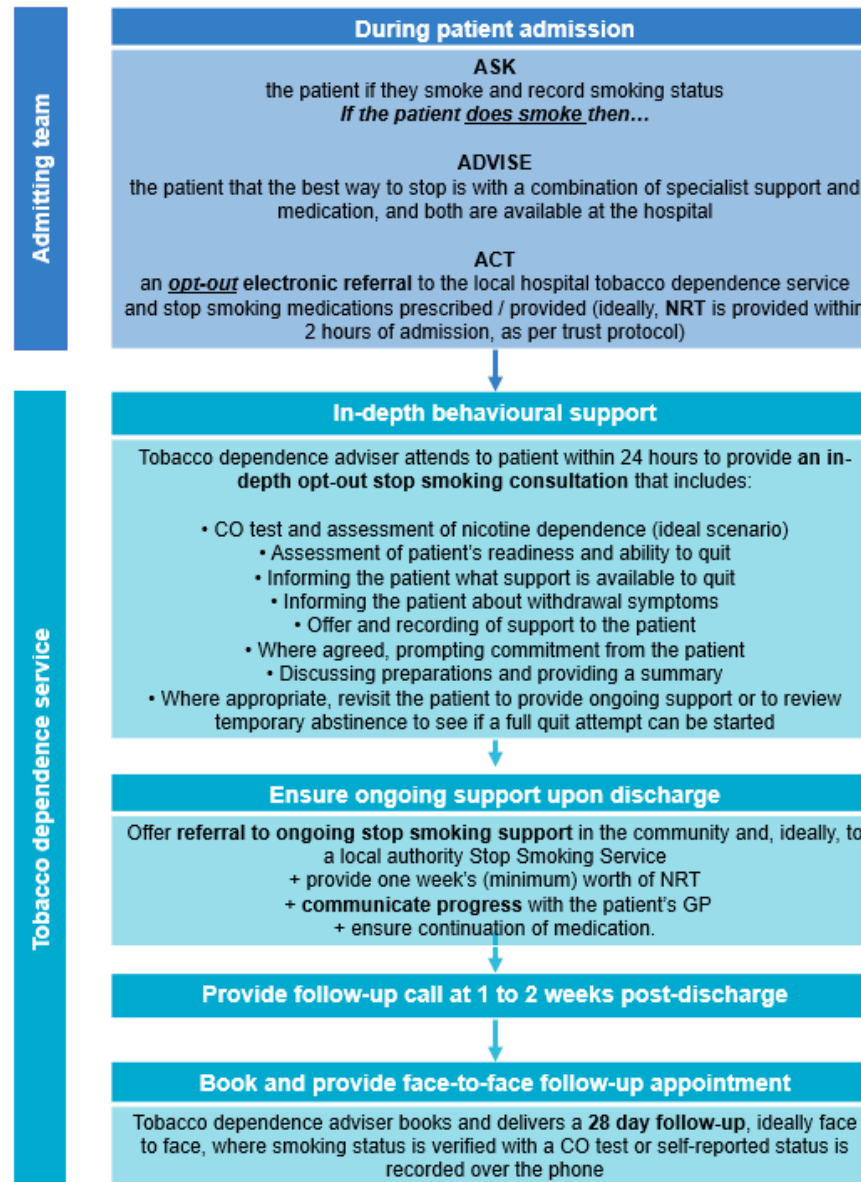
The recommended **acute inpatient pathway** is underpinned by published evidence on the Ottawa Model for Smoking Cessation and based on work undertaken in Greater Manchester as part of the CURE model. The recommended pathway should ensure that:

- The patient's smoking status is recorded during the admission process.

- Initial stop smoking medication is prescribed[1] (or given as part of local policies) to all admitted smokers (ideally within 2 hours of admission) to help with nicotine withdrawal while in a smokefree hospital, with delivery of very brief advice (VBA)[2] on tobacco dependence and stopping smoking.

- On an **opt-out** basis, a 1:1 meeting with a tobacco dependence adviser (approx. 40 min) is provided within 24 hours of admission to agree a personalised plan to support either a quit attempt or temporary abstinence. This will include a treatment plan, review/provision of pharmacotherapy (if applicable) and a discharge plan.

- A minimum of one week of NRT/other pharmacotherapy is provided upon discharge alongside a referral to a service which will continue to supply the 12 week course e.g. community pharmacy services or LA SSS. Irrespective of the provider of NRT/pharmacotherapy, a referral to available LA SSS for behavioural support will give patients the best opportunity to maintain the quit.

- A follow-up phone call at 1-2 weeks post-discharge is arranged by the hospital team (unless agreed otherwise as part of local step-down pathway), and a further follow-up arranged at 28-days post discharge (ideally face-to-face to undertake a carbon monoxide (CO) test, or via telephone to ascertain the self-reported quit status). Any appointment should be delivered as close to the patient's home as possible to encourage engagement. Where possible, it is recommended to also verify smoking status at 12 weeks to track long-term quits.

[1] Some Trusts stipulate prescribing, but NRT does not have to be prescribed or delivered via a Patient Group Directive as it is a General Sales List medicine.
[2] Very Brief Advice (VBA) is designed to be used by healthcare professionals to trigger a quit attempt among smokers. It is defined by a 3-step process: a) establishing and recording smoking status (ask); b) advising on the most effective way to stop (advise); and c) referring to specialist stop smoking support or prescribing stop smoking medicines (act).

Model pathway – inpatients

Admitting team

During patient admission

ASK
the patient if they smoke and record smoking status
If the patient does smoke then…

ADVISE
the patient that the best way to stop is with a combination of specialist support and medication, and both are available at the hospital

ACT
an *opt-out* electronic referral to the local hospital tobacco dependence service and stop smoking medications prescribed / provided (ideally, **NRT** is provided within 2 hours of admission, as per trust protocol)

Tobacco dependence service

In-depth behavioural support

Tobacco dependence adviser attends to patient within 24 hours to provide **an in-depth opt-out stop smoking consultation** that includes:

- CO test and assessment of nicotine dependence (ideal scenario)
- Assessment of patient's readiness and ability to quit
- Informing the patient what support is available to quit
- Informing the patient about withdrawal symptoms
- Offer and recording of support to the patient
- Where agreed, prompting commitment from the patient
- Discussing preparations and providing a summary
- Where appropriate, revisit the patient to provide ongoing support or to review temporary abstinence to see if a full quit attempt can be started

Ensure ongoing support upon discharge

Offer **referral to ongoing stop smoking support** in the community and, ideally, to a local authority Stop Smoking Service
+ provide one week's (minimum) worth of NRT
+ **communicate progress** with the patient's GP
+ ensure continuation of medication.

Provide follow-up call at 1 to 2 weeks post-discharge

Book and provide face-to-face follow-up appointment

Tobacco dependence adviser books and delivers a **28 day follow-up**, ideally face to face, where smoking status is verified with a CO test or self-reported status is recorded over the phone

A separate version of this graphic is available on the Community of Practice

Recommended model: maternity (1)

NHS

The model for **pregnant women** is more intensive and should be delivered **within maternity services – in house**. This expands on recommendations in NICE guidance NG92 to drive increased engagement – despite good referral rates to SSS and outcomes when engaged, many women do not convert their referral to an appointment/quit and this is often not picked up until later in the pregnancy.

We anticipate Local Maternity (and Neonatal) Systems (LMS) to play a key role in overseeing the delivery of these services across ICS footprints.

The recommended model builds on the Saving Babies' Lives Care Bundle version 2 (SBLCB), where all pregnant women are assessed for carbon monoxide (CO) exposure at booking, the 36 week antenatal appointment and other appointments as appropriate. Where elevated CO levels are identified, women should be immediately referred to a specialist stop smoking service team that will support them to beat their tobacco dependence through weekly face-to-face behavioural support and licensed pharmacotherapy – specifically combination NRT.

- At booking, all women should be offered a CO test, and maternity staff need to record the outcome (as per SBLCB). If the reading is ≥4ppm or if the woman has stopped smoking since conception, staff should provide VBA, offer initial NRT and refer to specialist stop smoking support on an **'opt-out'** basis, as per the local protocol.

- Ideally a 1:1 meeting with a Tobacco Dependence Adviser is arranged at the first antenatal booking appointment. If not possible, women should be contacted within 1 working day to arrange this. The first 1:1 should last approximately 40 minutes, taking place within 5 days of booking. If not already done so, NRT should be offered at the appointment, with easy access if not supplied at the time.

- Weekly face-to-face appointments with the Tobacco Dependence Adviser take place for at least four weeks (appointments can be in clinic, community or home visit, depending on local protocol), with NRT supplied for up to 12 weeks beyond the quit date. A further six face-to-face appointments should take place throughout pregnancy to support the woman to remain smokefree. The schedule is to be agreed between the pregnant woman and the specialist. Telephone and other forms of support can be delivered in addition to face-to-face support.
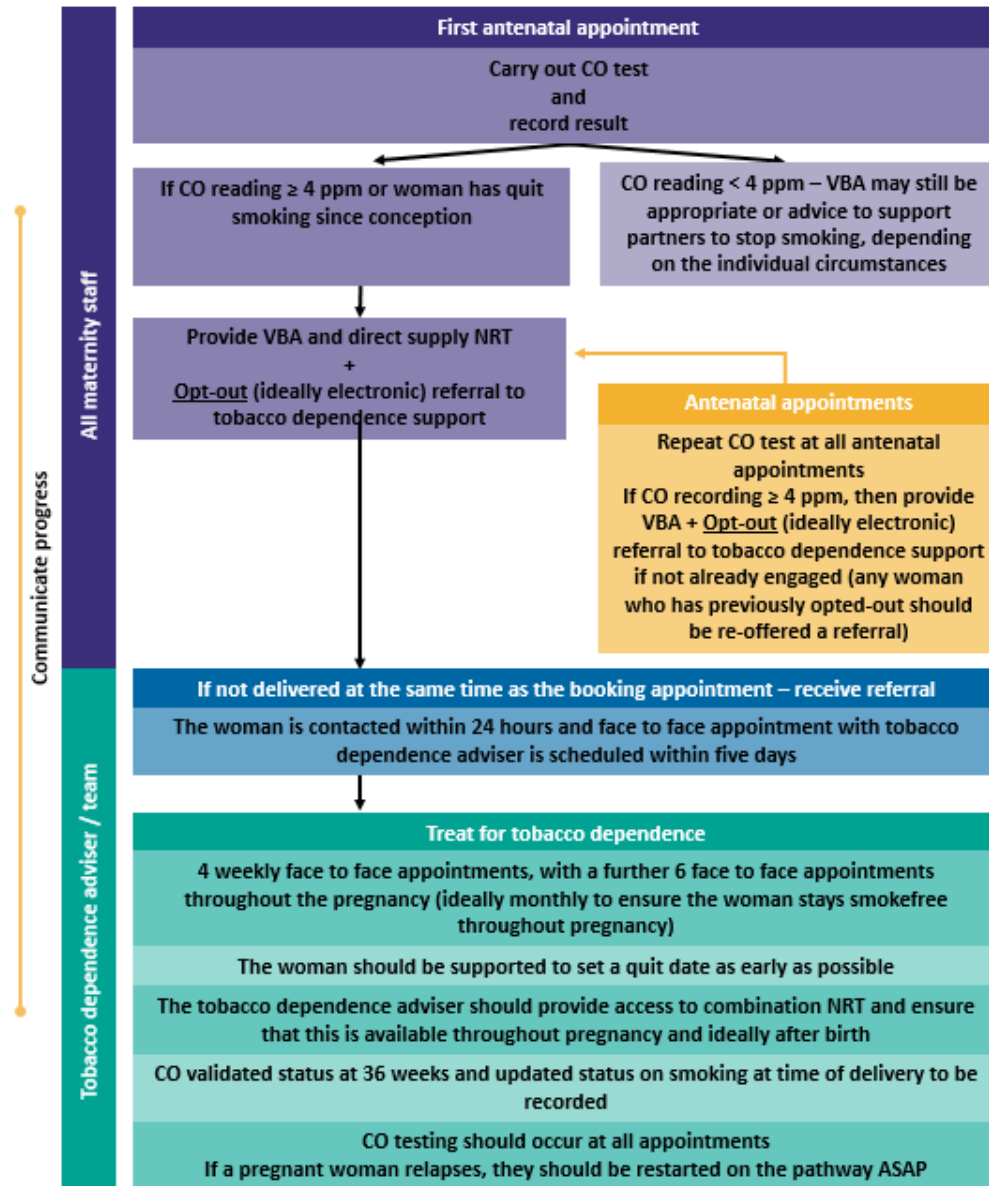
Recommended model: maternity (2)

NHS

- Pregnant women should have their 28-day quit status recorded by the TDA (ideally face-to-face to undertake a carbon monoxide (CO) test).

- Smoking status should be CO verified by the Tobacco Dependence Adviser at each appointment and at the appropriate midwife antenatal appointments (as per SBLCB). Women who have not previously quit or have relapsed should be offered another referral.

- CO validated smoking status at 36 weeks and updated status on smoking at time of delivery should be recorded.

- Tobacco Dependence Advisers are well placed to identify MH needs early and, where appropriate, escalate any concerns or suggest referral to IAPT/specialist perinatal MH teams as per local pathways.

- To improve a woman's chances of quitting, advisers can support partners who smoke, e.g. through referral to community stop smoking services, in line with local protocols or by delivering messages/resources to support smoke free homes.

- Good practice would be for services to think about how women can be supported postnatally – a time when relapse rates are traditionally high.

This model recommends face-to-face contact as the evidence available to date indicates that it is the most effective.

We will continue to monitor emerging evidence about the effectiveness of virtual and telephone appointments.

Model pathway – maternity

Communicate progress

All maternity staff

First antenatal appointment

Carry out CO test
and
record result

If CO reading ≥ 4 ppm or woman has quit smoking since conception

CO reading < 4 ppm – VBA may still be appropriate or advice to support partners to stop smoking, depending on the individual circumstances

Provide VBA and direct supply NRT
+
Opt-out (ideally electronic) referral to tobacco dependence support

Antenatal appointments

Repeat CO test at all antenatal appointments
If CO recording ≥ 4 ppm, then provide VBA + Opt-out (ideally electronic) referral to tobacco dependence support if not already engaged (any woman who has previously opted-out should be re-offered a referral)

Tobacco dependence adviser / team

If not delivered at the same time as the booking appointment – receive referral

The woman is contacted within 24 hours and face to face appointment with tobacco dependence adviser is scheduled within five days

Treat for tobacco dependence

4 weekly face to face appointments, with a further 6 face to face appointments throughout the pregnancy (ideally monthly to ensure the woman stays smokefree throughout pregnancy)

The woman should be supported to set a quit date as early as possible

The tobacco dependence adviser should provide access to combination NRT and ensure that this is available throughout pregnancy and ideally after birth

CO validated status at 36 weeks and updated status on smoking at time of delivery to be recorded

CO testing should occur at all appointments
If a pregnant woman relapses, they should be restarted on the pathway ASAP

A separate PDF version of this graphic is available on the Community of Practice

Recommended model: mental health

NHS

The recommended **mental health inpatient pathway** is currently based on the evidence generated by the acute inpatient model of care. However, adaptations will need to be made to ensure that this care model is best suited for mental health services and their users.

It is anticipated that this model will see the most development from learning from the EISs, with a **new bespoke model of care developed during 2021/22**.

Areas where variation is anticipated include:

- **Admission**: in many cases there may be a pre-agreed plan for smokers who are admitted to mental health settings that can be activated. If not, NRT needs to be started upon admission to tackle nicotine withdrawal, but other elements, including a visit by a tobacco dependence adviser within 24 hours, may need to vary – for example, if a patient is in crisis and isn't able to make an informed decision about starting a quit attempt or if multiple visits are required to build trust.

- **Revisit and recheck**: mental health admissions tend to have a longer length of stay. We expect up to four additional face-to-face appointments during the admission to ensure that all patients are seen at least weekly for the first month and that time and resource is available to build trust, which will help when having conversations about agreeing to quit or converting temporary abstinence into a full quit.

- **Step-down care**: a significant level of mental health service is delivered in community settings, and, following discharge, prolonged (in comparison to non-mental health pathways) treatment with pharmacotherapy and behavioural support as per the SCIMITAR+ study (Gilbody, 2019) may be more appropriate to support some mental health patients (recognising that full outpatient/community care will follow in 2022/23 and 2023/24).

- The Prevention Programme platform contains models that are in development by other areas and will continue to be updated.

Essential measures for success (1)

NHS

It is essential to ensure that there is dedicated support and capacity within NHS trusts to help embed tobacco dependence treatment interventions. This will require a combination of strategic measures and operational processes. A list of the **strategic measures essential for successful implementation** is set out below. These are overarching principles that should be adopted irrespective of the care setting.

- **Executive leadership** – visible, vocal commitment from ICS, commissioners and the Trust Board to deliver tobacco dependence treatment, reflected in system- and trust-wide smokefree policies.

- **Clinical leadership** – visible and vocal commitment from the Medical Director and other senior clinicians, with a dedicated clinical lead identified to implement the service in each Trust.

- **Local authority engagement and cross-organisational pathways** – pathways need to be agreed that ensure care for patients is seamless when they change organisations, e.g. transfer between acute and mental health trusts or into community/social care services.

- **Multidisciplinary Project Steering Group** – senior representation and early engagement to help implement the model with all stakeholders, including senior leaders, pharmacy, communications, LAs, primary care, information governance, IT, patient facing staff, shop floor team.

- **Established protocols** to formalise and enforce policies, including a trust Smokefree policy (in line with recommendations in NICE PH48) and prescribing protocols.

- **Governance processes** that incorporate **patient experience** – ideally in conjunction with LAs.

- **Data systems** that capture and report on patient smoking and delivery of stop smoking interventions – to enable the capture of inpatient and maternity smoking data, the requirement to record the 28-day smoking status post-discharge and, where possible, capturing smoking status at 12 weeks to verify long-term quits. IT departments should be consulted as early as possible.

- Appropriate **data sharing agreements** and processes between NHS external providers, e.g. LAs.

- **New funding** – directed to frontline services to underpin activity rather than developing additional system infrastructure.

Essential measures for success (2)

NHS

The minimum national requirements also include a number of essential **operational processes**:

- **Mandatory training programme for tobacco dependence advisers** – combination of online and face-to-face training for **all** staff who deliver in-depth advice. Staff need to be competent in having meaningful conversations and be familiar with the options for additional support outside the hospital.

- **Generic training programme for all frontline staff** – focussing on their role within tobacco dependence treatment, including online Very Brief Advice (VBA) training for all clinical staff (depending on local decision, this could be made mandatory).

- **Capacity of specialists to spend an appropriate amount of time with each patient**, including regular follow-up (preferably at least weekly) for long-stay patients. **Check-backs** should happen with people who are temporarily abstinent in case they wish to subsequently initiate a quit attempt and those who have not engaged or relapsed.

- Ensure the **availability of NRT** and other **pharmacotherapy** on hospital formulary for all patients, including inpatients and pregnant women.

- Capacity of and encouragement to all staff to provide **VBA and support** as part of everyday care to patients who are trying to quit or remain abstinent.

- **Support is offered to everyone**, even where it might be felt it may not make a difference (e.g. last years of life) or is too difficult. For example, research demonstrates that cancer survivors who quit smoking can live longer on average (NIHR, 2017) and women with perinatal mental health conditions can benefit due to links to anxiety, depression and impacts on child health (RCP, 2013; JBS, 2010).

- **Discharge package,** including the provision of a minimum of one week's supply of take home medications, an identified provider for ongoing pharmacotherapy for the remainder of the treatment course (up to 12 weeks) and advice on the local provision of ongoing behavioural support (ideally with a referral). Tested **discharge communication** between secondary and primary care.

- NHS commissioners and LAs working together with provider organisations to ensure a smooth **referral pathway** on discharge and/or quick access to LA SSS for partners and family members.

- **Communications** plan to inform staff of the new tobacco treatment programme prior to launch.

Staff training

- Patient-facing staff will need to be given **training that is appropriate to their role** in the tobacco dependence treatment pathway. NCSCT provides guidance on training standards. Different modes of training should be made available, e.g. face-to-face, online, observed practice and mentoring. It should remind staff that **tobacco dependence is a medical condition**, not a lifestyle choice[1].

- This requirement applies not only to medical and nursing staff, but rather **all frontline healthcare professionals**, as the intervention can be delivered irrespective of grade, role or clinical registration.

- For the EIS work, below is a broad summary of the required competencies across the different models and staff groups. A new competency framework and eLearning packages are currently in development and will be made available through the Community of Practice.

	Staff group	Training need	Extrenal training resources
Maternity	All	VBA, including use of CO monitors Reintroduction of CO testing	NCSCT VBA (pregnancy) E-learning for healthcare (eLFH) E:FH
	Tobacco dependence advisers	VBA; use of CO monitors; evidence-based behavioural support; regulated and consumer nicotine products; local pathways and protocols; leadership	NCSCT (practitioner + specialty pregnancy programme), eLFH
Mental health	All	VBA	NCSCT VBA, eLFH
	Tobacco dependence advisers	VBA; where used, training for the use of CO monitors; evidence-based behavioural support; regulated & consumer nicotine products; drug interactions; local pathways and protocols; leadership	NCSCT (practitioner + speciality mental health programme)
Acute	All	VBA	NCSCT VBA NCSCT other resources, eLFH, CURE
	Tobacco dependence advisers	VBA; where used, training for the use of CO monitors; evidence-based behavioural support; regulated & consumer nicotine products; local pathways and protocols; leadership	NCSCT (practitioner), CURE

[1] Current NCSCT guidance focuses on community settings and not the opt-out model of treatment. However, the fundamental skills and knowledge that the training sets out are transferable.

Tailoring your service for success (1)

NHS

To optimise pathways and achieve success, there are a number of additional actions that systems and providers may wish to consider:

- Undertaking a CLeaR deep dive self-assessment on smoking in acute, mental health or maternity settings to help benchmark current activity. For areas where use of smokeless tobacco is more prevalent (e.g. higher numbers of South Asian populations (ASH, 2019)), the CLeaR Niche tobacco deep dive self-assessment will support the establishment of appropriate local pathways.

- Providing programme management – dedicated resource to plan and lead implementation.

- Reviewing how services could work with SSS to support / improve delivery and better support system integration.

- Delivery of CO testing of inpatients at admission (with appropriate training) is good practice and can help to drive honest and open conversations between patients and staff.

- Providing interventions for staff as part of a comprehensive Occupational Health offer, ideally supporting staff to access support within working hours, to help abstain when on-site and quit.

- Making information readily available to support visitors and contractors to stop smoking including links to local SSS (where applicable).

- Engaging with the LA and third sector to access wider community support, including support from social prescribers, promoting participation in peer support groups (Ford, 2013) and using volunteers and community support to help patients after they leave hospital.

- Ensuring there is clear signposting for longer-term support in the community, e.g. as about 50% of women who quit in pregnancy relapse within six months.

- To reduce prescribing burden, consider use of direct supply or adoption of home remedy policies.

Tailoring your service for success (2)

NHS

- Driving joined up and effective communication between teams caring for the individual across the pathway of care e.g. tobacco dependence advisers, the antenatal team and mental health practitioners for women with perinatal mental health conditions.

- Consider engagement with wider programmes, for example:

    - [Maternal and neonatal health safety collaborative](#) drivers, e.g. increasing the proportion of smokefree pregnancies.

    - [Mouthcare matters](#) – establish links into dentistry and promote good oral hygiene.

- Utilisation of patient experience surveys to understand how pathways can be improved – e.g. include young people's perspective or those affected by mental health conditions, to see if their needs are being met and that services are easily accessible, also focusing on health inequalities.

- Amendments to patient referral letters, informing of the new tobacco treatment policy prior to admission.

- Use positive messaging and communications to encourage quitting and adherence to a smokefree environment (e.g. "This is a smokefree hospital" not "smoking prohibited").

- Use quality improvement methodology to drive service improvement (e.g. the British Thoracic Society's [Quality Improvement Tool](#) for smoking cessation). The national [Maternity and Neonatal Safety Improvement Programme](#) will shortly publish a QI tool (driver diagram) on their website.

- Use unwarranted variation to identify areas for improvement (smoking data on this can be found in the GIRFT national specialty report on respiratory medicine, due to be published in early 2021).

Suggested delivery infrastructure

NHS

	NHS Prevention Programme	Regional Board (with responsibility for tobacco)	System Steering Group	Provider MDT Delivery Group
Core roles & responsibilities	National leadership National stakeholder management Provision of support package e.g. delivery model Identify national data collection processes & metrics Maintain Community of Practice Driving changes to culture at a national level	Oversight and assurance of delivery Reporting regional position to national team (incl. exception reporting) Engagement of regional partners e.g. clinical networks Driving changes to culture at a regional level	Ensuring cross-organisation engagement and planning Reviewing and agreeing whole system pathways Systems funding oversight Driving changes in culture at a system level Resilience planning Reporting at a systems level and provision of oversight, support and assurance to providers	Agreement on systems and processes to deliver the intervention with associated communications Ensuring recruitment and training of frontline staff Driving culture change Communications Collecting and reporting data Patient engagement in development & evaluation Quality improvement strategy
Suggested key membership	Central NHS Prevention Team Senior cross system membership of Prevention Board e.g. PHE, DHSC Tobacco dependence stakeholder group	RDsPH (SRO) RMD Prevention Programme Manager PHE Tobacco Control Programme Managers – LTP Delivery PHE Centre representation	ICS lead LMS SRO (for Maternity Models) Local Authority NHS Commissioner NHS Provider(s): primary & secondary care Clinical Lead Project Manager PHE Region representation	Trust SRO (Executive) Clinical Lead Nursing/Midwifery Lead Project Manager Lead tobacco dependence adviser User with lived experience Pharmacy Communications lead Analytics
Potential Delivery partners	PHE National / DHSC	PHE Regional Hubs Clinical Networks AHSNs	Local Authorities NHS RightCare / GIRFT AHSNs Clinical Networks 3rd Sector	

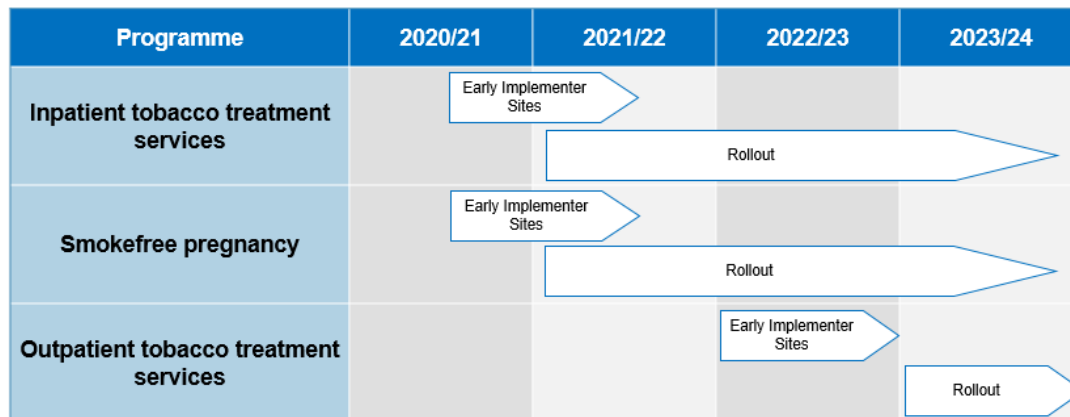# Planned implementation timeline

The impact to date and continuing uncertainty on how COVID-19 will affect delivery of NHS services means that there is a need for continuing flexibility in how tobacco treatment services are rolled out.

From October 2020, EIS started the development of services, and are starting to post learning and resources on the Community of Practice.

Assuming minimal impact of COVID-19, the **proposed delivery timeline** will see:

- EIS start service delivery in Q1/Q2 of 2021/22 with learning and resources being shared
- ICS Prevention plans prioritising rollout agreed in Q1/Q2
- Phased additional rollout starting during Q3/Q4 of 2021/22
- Long term mental health and learning disability treatment services **stress-tested** in new EIS during 2022/23 with further rollout in 2023/24.

Programme	2020/21	2021/22	2022/23	2023/24
Inpatient tobacco treatment services		Early Implementer Sites	Rollout	
Smokefree pregnancy		Early Implementer Sites	Rollout	
Outpatient tobacco treatment services			Early Implementer Sites	Rollout

The intention is still to deliver an offer of NHS-funded tobacco treatment to 100% of inpatients, pregnant women and higher risk outpatient service users by the end of 2023/24.

Metrics

Metrics are being tested with EISs and are likely to be refined depending on site feedback. Templates supporting semi-aggregate and patient-level data collection are accessible on the NHS Futures Prevention Programme page. Below is a list of the headline metrics summarising what they consider:

Metric	Description
Smoking cessation services provided (coverage)	% of acute, maternity & mental health services per system for which a tobacco dependence treatment service is provided
Identification of smoking in hospital/maternity services	% of all Admitted Patient Care Spells (APCS)/pregnant women that have a recorded smoking status at admission/booking (CO testing in maternity)
Smoking prevalence in hospital-admitted patients / pregnant women	Proportion of admitted patients identified as a current smoker, as % of total APCS or total number of pregnant women booked identified as current smokers
Number of current smokers referred to, and seen by, an in-house service	% of APCS or pregnant women where current smoker status is recorded that are referred to and seen by the in-house service
Tobacco dependence interventions provided for current smokers identified in hospital	% of all current smokers provided with an intervention (incl. the recommended intervention from this model). This includes support for temporary abstinence
Referral for follow-up of smokers identified in hospital post discharge (continuity of care)	% of smokers identified in hospital referred for additional ongoing support at or before discharge
Type of pharmacotherapy prescribed	% of different pharmacotherapies out of all current smokers in receipt of tobacco dependence pharmacotherapy
Smoking cessation 28-day quit rates – all smokers provided with support	% of all smokers (inpatient and maternal) who receive support/undertake an intervention (and the recommended intervention) with the Tobacco Dependence Adviser and report a 28-day quit. A sperate measure focuses on 28-day quits based on the recommended intervention from this model.
Change in smoking status – maternal booking against delivery and 36 weeks	Change in smoking status as a % of total number of women identified as smoking at antenatal booking compared to at delivery and at 36 week antenatal appointment

To note, these are the headline metrics, but more detail specific to each care setting as well as the accompanying guidance is available on the FutureNHS page.

PHE support for regional and local health systems

PHE has programme managers in each NHS region who are dedicated to supporting roll out of the NHS LTP tobacco dependence treatment programme. The programme managers are:

- Expert in evidence-based models and pathways to treat tobacco dependence and can provide advice to health systems about how models can be adapted to meet local contexts.

- Connected to implementation partners across the healthcare system and can convene discussions, support with formalising steering groups and support systems to establish meaningful governance structures.

- Familiar with tobacco control and health inequalities datasets and can assist with using these to support programme planning, implementation and monitoring.

- Knowledgeable of the resources that are available to support programme implementation and can ensure partners have access to these tools and understand how to use them.

- Part of national NHSEI and PHE teams, and can feedback regional and local learning to inform direction of the national programme and support peer-to-peer learning.

- CLeaR tobacco control assessment and deep-dive facilitators, and can support local systems to use these tools.

Contact england.prevention-pmo@nhs.net to connect with your regional PHE lead.

To find out more about what we've learned through providing support at regional and local footprints, please visit the Prevention Programme's NHSFutures platform.

Case study: Greater Manchester CURE Project (inpatients) (1)

NHS

C | **Conversation**
The right conversation every time

R | **Replace**
Replace nicotine to prevent withdrawal

U | **Understand**
Understand the level of addiction

E | **Experts and Evidence-base treatments**
Access to experts & the best evidenced-based treatments

Challenge

Tobacco is the greatest cause of preventable death, disability, illness and social inequality. Nicotine addiction is a disease – chronic and relapsing. GM was identified to have one of the highest smoking prevalence rates – 17.5% compared to a national average of 14.9%. Treating tobacco dependence is the most cost-effective health intervention the NHS can provide. There are many highly effective treatments, and the CURE team saw an opportunity to change the statistics by helping smokers quit when admitted to hospital.

Intervention

The CURE project is a comprehensive secondary care treatment pathway for treating tobacco dependence. It is focused on:

- systematically identifying all active smokers admitted to hospital;
- immediately offering nicotine replacement therapy and other medications; and
- specialist support for the duration of the admission and after discharge.

Approach

The project was launched at Wythenshawe hospital in October 2018. In order to implement the new model, the team sought to:

- develop a standardised assessment and treatment pathway for smokers admitted to secondary care;
- implement an updated supporting IT system – Electronic Patient Record (EPR);
- recruit additional Specialist Nurses, establishing an appropriately resourced team to assess all smokers admitted and design personalised treatment plans, including beyond discharge; and
- develop new e-Learning modules.

Visit the website to find out more about the CURE Project.

Outcomes and benefits

>2,300 smokers identified in pilot, 96% given VBA, 51% prescribed NRT by admitting nurse/doctor.
>300 had specialist assessment with CURE team.

- 1 in 5 of **all** smokers abstinent at 3 months post discharge
- Translated nationally-200,000 quitters p.a. with £183 per quit

Estimated savings from preventing readmissions across GM - £9,937,184 p/a.
This saves an estimated 30,880 bed days p/a or 84 beds p/d (GM).
Estimated for year 1:

- 6,176 readmissions prevented
- 3,141 lives saved
- 18,473 successful quitters

Greater Manchester CURE Project (2)

NHS

The culture change

- Nicotine addiction is a disease
- Every patient deserves access to the most effective treatment
- Every health care professional requires the confidence and the competence to treat tobacco dependence
- Nicotine addiction is no different to the treatment of alcohol addiction, MRSA screening & thromboprophylaxis
- Effective treatment of tobacco dependence brings immediate and substantial benefits to the NHS
- Hospitals must become institutes of health care promotion

Training

The CURE project addressed this with training in tobacco dependence treatment for all staff including pharmacotherapy for all prescribing practitioners.

E-learning modules were included as part of mandatory training, and further training is provided through a mixture of lecture-based sessions, hospital induction presentations, remote e-learning, ward visits and drop-in sessions.

There are two training modules….

Level 1

For all hospital staff, clinical and non-clinical
- Understanding tobacco dependence
- Providing brief advice to smokers
- Supporting a smokefree site

Overview:
- Baseline Questionnaire
- Understanding tobacco dependence
- What is the CURE project?
- 30 seconds to save a life – giving brief advice to smokers
- Supporting a Smokefree hospital site
- Talking to smokers on the hospital site
- The CURE team

Visit the website to find out more about the CURE Project.

Level 2

For prescribing practitioners
- Treating tobacco dependence

Overview:
- Baseline questionnaire
- Introduction to treating tobacco dependence
- Prescribing nicotine replacement therapy – the CURE protocol
- Additional treatments for tobacco dependence
- Discharging patients on treatment for tobacco dependence

Greater Manchester CURE Project (3)

NHS

CURE Very Brief Advice

1. ASK: "Do you smoke currently?" (move to number 2 if the answer is 'yes')

2. ADVISE:
- The very best chance of stopping smoking is with the help of medications and specialist support, both are readily available at this hospital.
- We will support those trying not to smoke by maintaining smokefree hospital grounds.

3. ACT: Provide a smokefree flyer with contact information for the CURE team
- Refer all inpatients to the CURE team
- Make sure inpatients have medications prescribed to reduce cravings (nicotine replacement therapy)
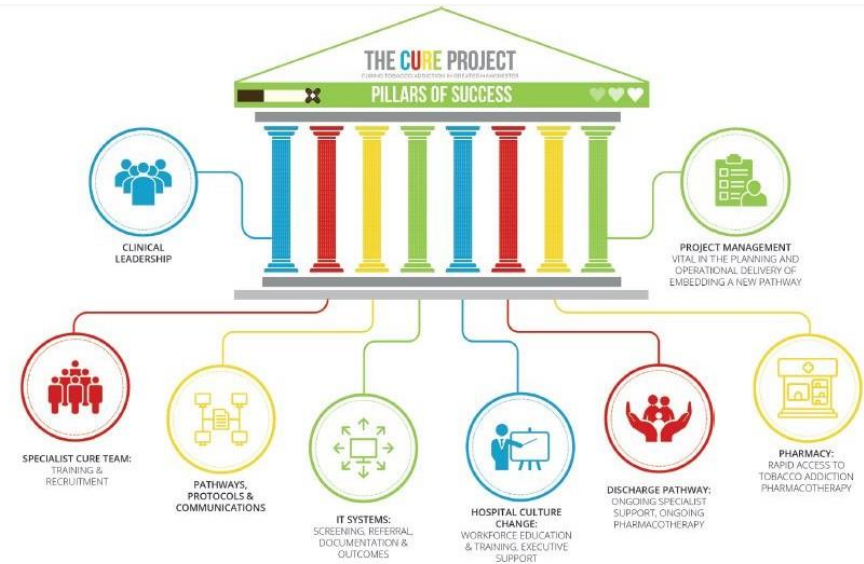
A personal touch…

- Within 24 hours of admission, a specialist talks to the patient on an opt-out basis, focusing on the individual and what is right for them. The Specialist Nurse discusses the patient's situation at home, to ensure that treatment is appropriate and to start planning how to support the patient after discharge. Other staff on wards have all had training and try to make a positive reinforcement whenever they talk to the patient, checking on their progress and encouraging their efforts.
- 'Yes' to question 1 should prompt provision of VBA and a smokefree patient leaflet. Questions 2 and 3 allow each smoker to be categorised into low, moderate and high-level addiction. These different categories map to specific NRT prescriptions in the treatment pathway.
- Each locality has a different discharge pathway depending on the community services. For rollout, detailed pathway mapping sessions were held with hospital staff and the commissioned service (if there is one).
- There has been engagement with the CCG, Public Health, current smoking cessation services, GPs and providers in each locality, with representatives as active members in each Task & Finish group.

Visit the **website** to find out more about the CURE Project.

Case study: Greater Manchester Smokefree Pregnancy Programme

NHS

The Programme

Challenge

The vision is to reduce smoking in pregnancy across Greater Manchester through a standardised smokefree pregnancy pathway to achieve no more than 6% pregnant people smoking at time of delivery in any locality by 2021 and ultimately for no person to smoke during their pregnancy.

Approach

System-wide support for smoking cessation in pregnancy delivered via the evidence-based babyClear model which includes a unique risk perception intervention for parents who continue to smoke at their booking scan.

A smokefree pregnancy incentive scheme targets a defined group of vulnerable pregnant people.

The Intervention

Our Smokefree Pregnancy Programme includes:

- Funding for band 3 maternity support workers (MSWs) to train as specialist stop smoking advisers across local maternity systems

- Pan-GM Smoking in Pregnancy Guidance including a Standardised Pathway

- Encouragement for maternity services to CO test at each antenatal appointment for those who have quit since conception or are smokers – optimising making every contact count

- Standardised training for midwives/MSWs/medical staff

- Introduction of CO testing at 36 weeks as well as at booking for all

- Stop smoking pathway – weekly support by advisers at the place defined by the pregnant smoker (home, hospital clinics, children's centre and stop smoking services)

- Weekly appointments for the first 4 weeks then monthly until birth – CO validating quits and provision of Love2shop vouchers

- The programme ensures those pregnant smokers who relapse are offered a second attempt at benefiting from the incentive scheme

Benefits and Outcomes

- 250 additional smokefree babies born in the first year of programme implementation

- Increased CO testing at booking from 20% to over 90%

- Increased referrals to SSS by 170% in some localities

- Increased number of CO validated 4-week quits from c.25% to 57%

- Increased numbers of pregnancy smokers achieving 4-week quits – with maximum quit rate of 84% in one geography with specialist midwife and MSW support

- Increased capacity to offer maternity-led support

- Increases in significant others making quit attempts >50%

- Increases in smokefree homes

- Over 1200 women signed up to the incentive scheme to date

Case study: South London and Maudsley SmokeFree Policy (mental health) (1)

NHS

Challenge

42% of all the tobacco consumed in England is by people with mental health problems. Approximately 50% of people with a severe mental illness who receive services from SLaM smoke and 88% of people who receive treatment for a substance use are current smokers. Staff smoking rate is 10%.

People with a mental illness who smoke are more likely to be heavier smokers and more tobacco dependent than smokers in the general population. People with mental health conditions die on average 15–20 years earlier than the wider population, with high smoking rates being one of the key reasons for this health inequality. Furthermore, emerging evidence suggests smoking is causal in the development of schizophrenia. However, smokers with a mental health condition report wanting to quit at a similar rate to the general population, and evidence-based tobacco dependence treatments are effective for this population. Research shows that smoking cessation is beneficial to mental health, with the impact of quitting larger than that of some antidepressants.

Approach

Tobacco dependence treatment was embedded across the whole care pathway, whereby, on admission, smoking status is recorded for everyone, with NRT provided within 30 minutes of arrival (if required, combination NRT provided using a 'homely remedy' policy).
The SLaM Smokefree policy accessible online.

Intervention

- 12 tobacco dependence advisers work across the care pathways to support smokers to quit or cut down (when granted leave outside hospital grounds)
- patients who decide to quit are offered ongoing NRT and other pharmacotherapy (if appropriate – varenicline or bupropion)

Case study: South London and Maudsley SmokeFree Policy (mental health) (2)

NHS

Intervention

- an integrated automated referral system allows clinical staff to easily refer smokers to specialist support
- smokers' CO levels are routinely tested, which helps to keep smoking on the agenda
- a live dashboard is used to show patients that have been admitted and screened, along with their smoking and vaping status
- for community patients who smoke, advance statements are developed to ensure that every smoker is prepared for the possibility of a smoke-free admission
- a bespoke smoking cessation level 1 course with a focus on mental health has been developed and is **mandatory** for **all clinical staff**
- level 2 classroom-based training is also provided for staff interested in enhancing their skills and knowledge
- since 2012, smokers have also been supported in their use of e-cigarettes to facilitate temporary abstinence, cutting down or quitting.

Benefits and outcomes

- publications detailing how violent behaviour has changed since the introduction of the SmokeFree policy can be found here and here, highlighting that there was a 39% reduction in the number of physical assaults per month after the policy was introduced
- a survey on the e-cigarettes project conducted at Ladywell Unit showed that of those patients who took up an e-cigarette as their quit method (from a pool of patients who remained in hospital for >4 weeks), 31% achieved a verified quit status
- in the 6 month period before the project, there were 14 smoking-related incidents of physical assault, while in the 6 months after the project began this had reduced to 2 incidents.

Useful resources (1)

NHS

There are a number of external resources that can be used to support implementation and treatment of tobacco dependence:

- The NHS LTP website, providing background to our work on prevention (incl. tobacco dependence) https://www.longtermplan.nhs.uk/areas-of-work/prevention/treating-and-preventing-ill-health/
- Further resources from the National Centre for Smoking Cessation and Training https://www.ncsct.co.uk/
  This includes treatment programmes and a variety of resources specific to secondary care.
- Use of Local Tobacco Control Profiles can assist regional and ICS teams to have a clear map of local smoking behaviours and smoking related morbidity and mortality to inform implementation priorities.
- Resources developed by Action on Smoking and Health Smoking in Pregnancy Challenge Group http://smokefreeaction.org.uk/smokefree-nhs/smoking-in-pregnancy-challenge-group/
- PHE guidance on Screening and brief advice for alcohol and tobacco usehttps://www.gov.uk/government/publications/preventing-ill-health-commissioning-for-quality-and-innovation
- e-Learning for Healthcare, Alcohol and Tobacco Brief Interventions programme https://www.e-lfh.org.uk/programmes/alcohol-and-tobacco-brief-interventions/
- e-Learning for Healthcare, Supporting a SmokeFree Pregnancy https://portal.e-lfh.org.uk/Catalogue/Index?HierarchyId=0_41043&programmeId=41043
- E-Learning for Healthcare, Making Every Contact Count https://www.e-lfh.org.uk/programmes/making-every-contact-count/
- PHE, All our Health: https://portal.e-lfh.org.uk/Component/Details/596376
- Equally Well – resources on smoking and mental health https://equallywell.co.uk/resources/
- British Thoracic Society –Smoking Cessation Quality Improvement toolkit https://www.brit-thoracic.org.uk/quality-improvement/clinical-resources/smoking-cessation/smoking-cessation-qi-tool/
- South Yorkshire and Bassetlaw QUIT Programme: https://sybics-quit.co.uk/

Useful resources (2)

- The NHS Prevention Programme FutureNHS Collaboration Platform is also available for staff to access various resources for tobacco dependence treatment services.

- The platform has been created to be a hub of information for sites and to encourage communication and knowledge sharing between sites and the national team.

- As shown in the folder structure, the platform includes various materials that are useful for sites to initiate tobacco dependence services such as delivery models, cover template job descriptions, example governance documentation, data templates, communications materials and case studies.

- To join our Community of Practice, please access the NHS Prevention Programme FutureNHS Collaboration Platform, click "Request to Join" and send a brief message as to why you would like to join the platform. A platform manager will review your request and give you the appropriate access.

Tobacco Dependence Treatment - Early Implementer Site Information

01 Background

02 Delivery model

03 Early implementer sites

04 Data and metrics

05 Workforce and training

06 Governance and service guidelines

07 Communications

08 Case studies

09 COVID-19

10 FAQs

11 Pharmacotherapy

12 Discussion forum

13 The National Team

National Team Communications

Tobacco: Events & Meetings

NHS

AOH, 2019: Department of Health and Social Care, Cabinet Office, Prevention Green paper, 'Advancing our health: prevention in the 2020s', July 2019

ASH, 2018: Action on Smoking and Health. Smoking in pregnancy challenge group. Review of the Challenge, July 2018

ASH, 2019: Tobacco and Ethnic Minorities, August 2019

Banham & Gilbody, 2010: Smoking cessation in severe mental illness: what works? Addiction. 105(7): 1176-1189

Brose et. al, 2020: Mental health, smoking, harm reduction and quit attempts – a population survey in England, BMC Public Health, August 2020

Evison, 2018: Evison M, Agrawal S, 'Building the case for comprehensive hospital-based tobacco addiction services: Applying the Ottawa Model to the City of Manchester', July 2018 Lung Cancer

Evison, 2020: Evison M, Pearse C, Howle F *et al*. 'Feasibility, uptake & impact of a hospital-wide tobacco addiction treatment pathway: results from 'The CURE Project' pilot' Clinical Medicine

Ford, 2013: Ford P, Clifford A, et al., 'A systematic review of peer-support programs for smoking cessation in disadvantaged groups'. Int J Environ Res Public Health. 2013;10(11):5507-5522. Published 2013 Oct 28

GBD, 2019: Global Burden of Disease Study, 2019

Gilbody 2019: Gilbody S *et al*. Smoking cessation for people with severe mental illness (SCIMITAR+): a pragmatic randomised controlled trial. The Lancet Pyschiatry 6(5): 379-390

GOV, 2015: Cost of smoking to the NHS in England: 2015,

Gruer, 2009: Gruer L, Hart C L, Gordon D S, Watt G C M, 'Effect of tobacco smoking on survival of men and women by social position: a 28 year cohort study', British Medical Journal 2009

JBS, 2010: Blood-Siegfried J, Rende EK. 'The Long-Term Effects of Perinatal Nicotine Exposure on Neurologic Development', J Midwifery Womens Health. 2010;55(2):143–152

LTP, 2019: NHS England, 'NHS Long Term Plan', January 2019

References (2)

![NHS logo]

MHSP, 2017: Mental Health Smoking Partnership (2017) Shared Key Messages,

Mullen, 2017: Mullen K A, *et al*, 'Effectiveness of a hospital-initiated smoking cessation programme: 2-year health and healthcare Outcomes', May 2017 Tobacco Control

NHSD, 2019: Statistics on Smoking, England – 2019, NHS Digital,

NHSD, 2021: Statistics on Women's Smoking Status at Time of Delivery: England Quarter 3, 2020-21

NIHR, 2017: The National Institute for Health Research, Cancer survivors who quit smoking sooner can live longer, September 2017

ONS, 2020: Adult smoking habits in the UK: 2019

PHE, 2019: Public Health England, Health of women before and during pregnancy: health behaviours, risk factors and inequalities, November 2019

PHE, 2020: Public Health England, Health Matters: Smoking in mental health, February 2020

Roberts et al. 2016: Efficacy and tolerability of pharmacotherapy for smoking cessation in adults with serious mental illness: a systematic review and network meta-analysis. Addiction. 111(4): 599-612

RCP, 2013: Royal College of Physicians, Smoking and mental health, March 2013

RCP, 2018: Hiding in plain sight: Treating tobacco dependency in the NHS, Royal College of Physicians, 2018

Taylor, 2014: Taylor G, McNeill A, Girling A, Farley A, Lindson-Hawley N, Aveyard P. 'Change in mental health after smoking cessation: systematic review and meta-analysis.' 13 February 2014. British Medical Journal

UCL, 2021: The University College London Smoking Toolkit data, 2021

Contacts

NHS

To join our Community of Practice please sign up to the FutureNHS Collaboration Platform and search for the NHS Prevention Programme

For further queries, please contact the NHS England & NHS Improvement national prevention team at:

england.prevention-pmo@nhs.net