London Clinical Senate

Adding value to every clinical contact by treating tobacco dependence

CO4: Commissioners enabling clinicians to help smokers quit

Who is this information for?

This guide is primarily to assist clinical commissioners directly support the population they are commissioning for, but will also be of interest to local authority and public health commissioners and healthcare providers.

Why has it been provided?

Tobacco dependence is a long term and relapsing condition that starts in childhood. Helping smokers quit is probably the highest value intervention for today's NHS that saves and increases healthy lives at an affordable cost.

Whilst local authorities and public health in London have a mandate to develop and action a tobacco control strategy, clinical commissioners also have a critical role in taking action on tobacco to fulfil their remit to address inequality, improve outcomes for their populations, ensure parity of esteem for people with mental health problems and, with an increasingly challenging financial environment across the health and care system, achieve better value for their citizens.

Key statistics on smoking and hospital admissions

- 28% of total hospital admissions are attributable to smoking, including **(Ref. 1):**
    - 43% of respiratory admissions;
    - 18% of circulatory admissions;
    - 48% of cancer admissions;
    - 28% of digestive disease admissions
- Locally reported London CCG data estimates up to 50% of people with COPD are current smokers
- People with HIV who smoke will currently lose 12 years of life from the impact on health of tobacco smoking compared to 5 years from the virus **(Ref. 2)**

These patients will not be directly affected by prevention policies. They need treatment for their tobacco dependence. Our vision is that every London clinician knows the smoking status of each patient they care for and has the competence and the commitment to encourage, enable and support that patient to quit or reduce their consumption through direct action or referral.

The Clinical Senate is asking all London's health organisations to commit to CO4, a four pronged approach to identifying and treating tobacco dependence. The fourth element is commissioning the system to enable three high value interventions that will, in the long term, reduce demand:

1. The 'right' COnversation for every patient and staff member who smokes that gives him or her a chance to quit, referring if necessary. **(Ref. 3)**
2. Make routine near-patient (i.e. desk-top, bed-side and home) exhaled carbon monoxide (CO) monitoring by clinicians possible: "Would you like to know your level?"**(Ref. 4)**
3. COde smoking status and the intervention so we can evaluate effectiveness – including death certification.
4. **COmmission the system to do this right: so the right behaviours are incentivised systematically**

What information is provided?

The following information has been provided to support commissioners to enable clinicians to help smokers quit:

- **Top tips** for commissioners based on experience of commissioning initiatives involving seven London CCGs and three providers
- **A step by step guide**
- **Examples of progress** so far across London
- **Resources** and further reading

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Tips for commissioners

These tips offer commissioners some practical ways forward to achieve the goal of incentivising the right clinical behaviours.

These tips are based on two recent examples, a Commissioning for Quality and Innovation (CQUIN) agreement in North London between Islington CCG (population 206,100 2011 census) and Whittington Health and a Local Incentive Scheme (LIS) in South London across the London boroughs of Lambeth, Southwark and Bromley (population 907,234 ONS 2012) with two acute foundation trusts. The LIS scheme had a broader remit to 'make every contact count' for staff and patients by supporting smoking and alcohol cessation, and increasing physical activity.

These tips focus on identifying and treating tobacco dependence. Elements of the incentive schemes referenced in this document could be used as a Helping Smokers Quit programme, or a wider Making Every Contact Count programme.

We recommend that London's commissioning support teams involved in reviewing contracts for 2016/17 and beyond consider whether treating tobacco dependence is adequately embedded as a core standard for any provider e.g.

- Any communication between providers about a patient should include:
    - a current and historic smoking status
    - a record of any stop smoking medicines used during the episode and plan to support a continued attempt
- A range of quit smoking therapies are available on formulary according to current NICE advice
- Clinicians, who are prescribers, are confident to prescribe a range of quit smoking therapies including varenciline. Guidance is available that may be helpful for clinicians who do not have prior experience of prescribing varenicline **(Ref. 5)**
- Training in helping smokers quit is included at induction and is reviewed annually within appraisal and revalidation processes.
- The provider adheres to or has a plan in place to achieve NICE Quality Standard 82 – Quality Statements 4-7 **(Ref. 6):**
    - **Statement 4.** Employers allow employees to access evidence-based 'stop smoking' support during working hours without loss of pay.
    - **Statement 5.** Healthcare services use contracts that do not allow employees to smoke during working hours or when recognisable as an employee.
    - **Statement 6.** Healthcare settings do not allow smoking anywhere in their grounds and remove any areas previously designated for smoking.
    - **Statement 7.** Secondary healthcare settings ensure that a range of licensed nicotine-containing products and stop smoking pharmacotherapies is available on site for patients, visitors and employees.

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Step by Step

1. Mapping your problem and making a case for change

a. **What is the prevalence of tobacco dependency** in your population and where is more resource required? **(Refs 7, 8)**

b. **Are you as a CCG,** and your partner local authority and providers you commission from, compliant with NICE guidance on smoking? **(Ref. 9)**

c. **How many, and what proportion,** of your healthcare delivery staff are trained to provide smoking cessation advice? **(Ref. 10)**

d. **How many, and what proportion,** of your healthcare delivery staff have had (some) training in behaviour change and/or motivational interviewing?

e. **Have you calculated the return** on investment in tobacco dependency treatment? **(Refs 11, 12)**

f. **How much health professional** and other staff time (WTEs) is lost each year due to sickness?

2. Establish your core project / leadership group:

a. **Find your local clinical champions who are best placed to help establish the local case for change.** In South London, for example, these were members of the Integrated Respiratory team and a Head and Neck Surgeon, in North London it was the Respiratory team who led and then recruited other clinical champions, including paediatric (medical and nursing) leads.

b. **Identify your decision makers with a stakeholder map** – are you speaking to the right people in the right organisations? Someone with the most enthusiasm might not be the person who can influence change and keep momentum. In South London the decision makers included the Assistant Director of Nursing and the Associate Director of Operations within the acute hospital trust.

c. **Identify your change agents** – who will keep things moving in between meetings and coordinate the process? In South London this was a contracts manager within the Commissioning Support Unit and in North London it was the respiratory physician, who was the hospital lead for smoking cessation, working with a project manager.

d. **Who else in the organisation is leading and enabling behaviour change skills in the healthcare delivery workforce?** For example, in North London staff have access to Co-Creating Health training - a behaviour change skills development programme for clinicians developed by the Health Foundation.

3. Get the right buy-in from the right stakeholders:

a. **Get Trust Executive sign off and involvement from the start** – if the Trust senior medical team is not signed up to the concept it won't happen. In one example the GP clinical lead engaged the Nursing and Medical Directors directly. If the local Health and Wellbeing Boards and trust board have not signed up to the NHS Statement of Support **(Ref. 13)** or Local Government Declaration on Tobacco Control **(Ref. 14)** get it added to a forthcoming agenda.

b. **Involve your patient groups and engagement teams** – speak to Healthwatch about what patients want and what they are saying. Tobacco dependence is a long-term condition that starts in childhood, so ensure the views of children and young people (CYP) are included - the North London paediatric team asked CYP their views on tobacco dependence, and found they had a lot to say, both about how smoking cessation is currently discussed and approached, and how they would like it to be addressed.

c. **Think about the wider impact of the work –** take inspiration from the Cleveland Clinic's approach to staff tobacco smoking in the US **(Ref. 15)** and from Simon Steven's statement on NHS staff health in September 2015 **(Ref. 16).** Consider the possibility of impacting positively on staff behaviour and recruitment. The South London team needed Occupational Health input from the beginning about what was possible. A NICE Quality Standard **(Ref. 6)** on tobacco also supports working with employees in health sectors.

d. **Get buy in from Training and Education leads** – this enables smoking cessation training to be included at induction and as part of training programmes e.g. trainee doctors, pharmacists, nurses and allied health professionals (AHPs). Include delivery and evaluation of this training, which needs to be tailored to clinician need, in contract performance indicators. Start to have conversations about where this fits and how it can be built into and assessed in undergraduate health professional training.

e. **Explicitly including smoking cessation** conversations in all generic behaviour change training.

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Examples of key stakeholders who should be involved

	NHS Trust	Clinical Commissioning Group (CCG)/ Commissioning Support Unit (CSU)	Local authority
Governance	Governance lead		
Contracts	Contracts manager	Commissioning manager, CSU contracts manager	Contracts manager
Planning data	Head of Planning and Performance, Data analyst		
Clinical leadership	Medical Director and Director of Nursing (or deputies), Clinical directors/consultants in key areas e.g. head and neck surgeon, respiratory physician, British Thoracic Society Stop Smoking Champion	Clinical quality lead	Public Health Consultant
Academics	Tobacco addiction researcher		
Quit smoking expertise	Stop smoking specialist	CCG smoking cessation lead	Stop smoking commissioner
Prescribing	Trust pharmacist	Medicines optimisation lead	Stop smoking specialist, Public health consultant

4. Run a kick-off meeting to get broad ownership from the start

Convene a workshop with all stakeholders so that by the end of the session you have agreement on what is possible and what your top objectives are. Everyone needs to agree the high level objectives for the work to ensure there is alignment and joint ownership across the system.

5. Pinch with pride

a. **Use learning from areas that have started this work** – the South London team took a smaller group of stakeholders on a site visit to Sandwell and West Birmingham NHS trust to hear more about their plan to be a health promoting hospital.

b. **One local mental health trust (Ref. 17) had gone first on being a smokefree site in London and second nationally** – the London Clinical Senate Helping Smokers Quit team sought their learning and practical tools

6. Treat it like a project

Follow usual project management processes, including costing and providing project manager resource, and agree touchpoints with all stakeholders to review progress. Project manager resource is particularly important to support and enable on-going effective clinical leadership and engagement. These examples from North London and South London both had dedicated project managers and quarterly review milestones, included as part of the contractual requirements.

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7. Be vocal and make every one of your contacts count

Use every opportunity to promote the work and embed the project in other local initiatives by raising awareness and making links. Take time to make direct and influential contacts, manager-to-manager and clinician to clinician and show how directorates could take the lead using the scheme e.g. with respiratory paediatricians who want to reduce respiratory infection and improve asthma outcomes, midwives and obstetricians with regard to the stillbirth bundle and preterm delivery, anaesthetic and surgical teams who want to further develop Enhanced Recovery pathways and Academic Health Science Network (AHSN) projects on improving discharge planning and reducing bed- days. Pharmacy took the lead in one of the South London trusts with an enhanced medication discharge innovation that included smoking status and quit smoking medicines use an integral part of the documentation.

8. Use your contractual levers

Is there anything in the acute or General Medical Services (GMS) contract that supports this work? Can the incentive scheme become embedded into the quality schedule and/or included in contract negotiations.

9. Be creative but realistic

This is about improvement and innovation but be aware of competing demands and financial constraints.

When setting your objectives consider:

a. **It is about clinicians helping patients, and health organisations helping staff.** Choose a catchy name as part of developing a brand that helps to make this part of everyone's business. In one example the work is called the Health Promoting Hospital – reflecting a World Health Organization scheme from the past that is relevant again with the NHS Five Year Forward View **(Ref. 18)** statement that we are now a prevention NHS. The Trust developed a communications strategy and created a logo for use on literature.

b. **Using what you know about motivation and behaviour change.** Start with people ready to make a change, for example, roll out carbon monoxide (CO) testing with midwives, the respiratory team, children and young people's teams and services seeing head and neck and lung cancer survivors. Use them as 'how to' examples in other areas.

c. **How you best enable clinicians with influence to role model and lead in taking on doing this work and make it as easy as possible to build this into routine clinical practice.**

d. **Can you measure it?** Make your objectives SMART and involve Public Health to help identify what is evidence-based improvement. **(Ref. 19)**

e. **What can realistically be achieved?** The South London example has commitment in the form of a three year programme and the North London example, although based on an annual contract, was a contract that was renewed and applied over several years with an annual 'stretch' – attitudinal change takes time and needs to be supported and recognised as a long term local priority.

f. **How flexible can you be –** allow directorates and trusts to develop their own outcome focused action plans to deliver the agreed overarching objectives. Challenge and 'stretch' providers but also recognise what it is realistic to deliver.

g. **How to use national drivers** – the main national driver is the NHS Five Year Forward View **(Ref. 18).** Ensure that all objectives set are aligned to policy and make it clear how they will contribute.

10. Sustainability: the triple bottom line (people (patients and staff), environment and finance)

What happens at the end of the work? Consider how it can continue within the contracts of new models of care, i.e. Primary and Acute Care Systems (PACS) and Multispecialty Community Providers (MCPs). Population based targets will require a scale up of your desired change. Make sure the right information is collected from the start to make the case to continue it. This should include contextual information that helps explains how and why it worked in that setting, and what might need adaptation in another setting; as well as data on cost, uptake of services, use of pharmacotherapy, changes in referrals to specialist smoking cessation services and ultimately sustained quits.

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Progress so far

Whittington Health and NHS Islington CCG

Incentivising and Embedding *Stop Smoking as Treatment* in an inner London general hospital

The Whittington Health Stop Smoking CQUIN

Dr Myra Stern, Integrated Respiratory Consultant Physician and Stop Smoking CQUIN Lead May 2014

Introduction

"Smoking kills, stopping works" was the theme of Sir Richard Peto's Harveian Oration in 2012. This simple statement captures the most important development that followed on from the link made between smoking and ill health: the knowledge that stopping smoking has profound effects on life span and morbidity and that evidence-based stop smoking interventions are the single most cost-effective life-saving intervention provided by the NHS. Thus, the role of smoking cessation as core treatment for sick smokers admitted to hospital has growing support and has been underpinned by the British Thoracic Society 'Case for Change' (2013) and the NICE Guidelines (Smoking cessation - acute, maternity and mental health services (PH48), November 2013) on smoking cessation in secondary care.

How do you normalise and embed - at scale and pace - the practice of supporting evidence-based smoking cessation in hospital, when historically, stop smoking has been the domain of public health, delivered in the community and seen to be marginal to the business of acute care of in patients? The CQUIN payment framework has provided important incentives for improving quality of practice in many areas of hospital practice and here we report on the Whittington Health (WH) CQUIN for Stop Smoking which was launched in April 2012, and is now entering its 4th successful year.

The CQUIN Indicators include documenting the smoking status of every adult inpatient, offering brief advice to sick smokers, offering and prescribing stop smoking pharmacotherapy to alleviate nicotine withdrawal, referring (on an opt-out basis) to Stop Smoking Services and training frontline medical and clinical staff to support and deliver stop smoking interventions. 90% of adult inpatients had to have these indicators documented in order to achieve the payment - worth ~£350K/year for the trust!.

OUTCOMES

Although seemingly impossible at the start, the indicator targets were achieved by December 2012, and have been maintained to the present. Referrals to Stop Smoking services quadrupled in the first six months of the CQUIN and have been maintained at a level 3-4 x higher than observed in the years prior to the CQUIN (graph 1). Prescribing of NRT and Varenicline doubled in the first year of the CQUIN and has continued to increase since then. Stop Smoking Training (brief advice or level 1) has been delivered to >300 frontline staff, including nurses, doctors, therapists and medical students.

ENABLERS

A number of enablers have contributed to the success of the CQUIN. These include ongoing clinical leadership by a respiratory consultant with sufficient professional credibility with management and consultant colleagues to champion the process, 'sign up' from the Hospital Executive Management and Trust Board, genuinely committed to the idea of the hospital as an institution of health care promotion, a committed multidisciplinary working committee that meets regularly (1 x week) and includes the consultant lead, a senior hospital manager, a CQUIN administration manager, a Clinical Lead (responsible for on-the- ground direction, an IT Data Analyst , the hospital Stop Smoking Specialist, the Community Stop Smoking manager and a pharmacist to support the pharmacotherapy on the wards (photo below).

Daily, monthly & quarterly audit through strong I.T. support has underpinned the management and delivery of the CQUIN

CHALLENGES

Sustaining the intensity of support to keep the process to target and to embed it sufficiently to eventually sustain itself remains our long term goal. In the shorter term, the most pressing challenges have included an ongoing campaign to incorporate stop smoking training into staff induction and mandatory training, and to 'find' the funding for more specialist stop smoking advisors to support the increase in referrals resulting from the CQUIN, and thus deliver the service to patients - preferably while in hospital

A FINAL OBSERVATION

Although less easily measurable, one of the most important outcomes of the CQUIN years has been a change in attitude amongst hospital staff about the role of stop smoking and the stop smoking advisor. Documentation of smoking status, giving brief advice and making a referral for stop smoking interventions (graph 2 & 3) - as often as possible to occur DURING admission - has become a routine component of basic clerking for the junior doctors and carefully checked at each morning 'board round'. Not getting an immediate response from the stop smoking specialist to come and see a sick smoker on the ward, can be a real source of frustration for a ward sister who previously might never have considered stop smoking as part of ward activity!

WHAT EVERY CLINICIAN SHOULD KNOW

* Half of all smokers die from smoking-related disease
* Supporting people to stop smoking is TREATMENT not prevention

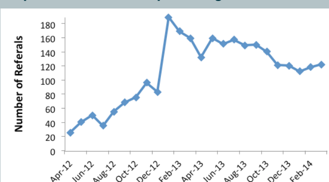
Supporting smokers to quit smoking is every clinician's business

Whittington Health Stop Smoking CQUIN Working Group

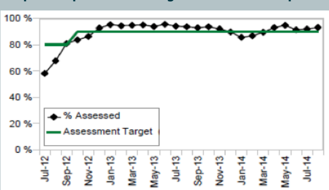
A.Project Manager, B. IT Analyst, C. Pharmacist, D. Respiratory Consultant, E. CQUIN Clinical Lead, F. Senior Hospital Manager, G. Community Stop Smoking Services Manager, H. Stop Smoking Specialist Advisor

A Junior Doctors Credit-card size 'prompt' for Brief Advice

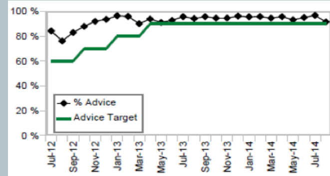
Graph 1 - Referrals to Stop Smoking Services



Graph 2 - Inpatient smoking assessments completed - by month



Graph 3 - Inpatient smokers given advice - by month



Would you like to share your experience as a stop smoking champion?
We would love to hear from you please contact stopsmokingchampions@brit-thoracic.org.uk

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Progress so far

NHS Bromley, Lambeth, Southwark CCGs, Kings College Hospital Foundation Trust and Guy's & St Thomas' Foundation Trust - Progress after 9 months of 2015/16.

- Data combined for both trusts as it is a system wide incentive shows that:

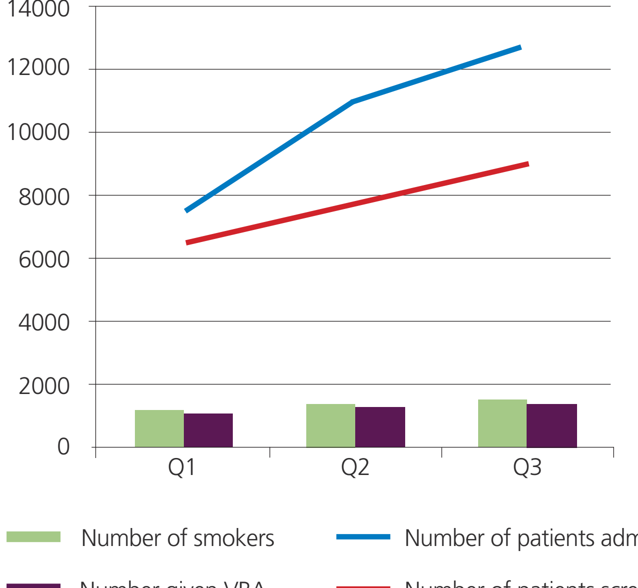
23,299 **Patients have been screened for smoking**

Nearly 4000 **smokers identified**

Over 90% **of identified smokers have received Very Brief Advice**

2393 **NRT prescriptions**

1500 **staff have been trained to deliver Very Brief Advice (Ref. 3) including the senior medical and nursing directors across the two hospital trusts**



- Over 2000 referrals to local smoking cessation services
- Over 350 patients seen on the ward by a stop smoking specialist
- Stop smoking clinics available to visitors and family members
- 17% of patients asked are current smokers suggesting smokers under-represented in hospital as the background smoking in the boroughs where most live is higher. We suggest that increased use of carbon monoxide (CO) monitors **(Ref. 4)** as early as possible in the admission and a review of how the question is asked may help improve the accuracy of these figures.
- "There is enthusiasm and progress is being made despite significant financial pressures and other challenges that trusts are facing" Dr. Jonty Heaversedge, Chair of Southwark CCG

Resources for commissioners

The Helping Smokers Quit pages of the Clinical Senate website **(Ref. 20)** includes templates from the examples below that the organisations involved are happy to share and for you to use. However, we recommend that you follow the processes outlined in this guidance to gain most from this learning and best tailor it to your local circumstances and systems.

1. Guy's and St Thomas' Hospital NHS Foundation Trust's 3 year 'Prevention' local incentive scheme (LIS) in conjunction with NHS Lambeth and NHS Southwark
2. King's College Hospital NHS Foundation Trust's 3 year 'Health promoting hospital' LIS in conjunction with NHS Bromley, Southwark and NHS Lambeth
3. Whittington Health stop smoking CQUIN in conjunction with Islington CCG

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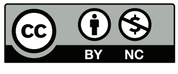

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