

## Adding value to every clinical contact by treating tobacco dependence

The London Clinical Senate Helping Smokers Quit (HSQ) programme August 2014 – June 2016 has made a case for how and why health leaders and health professionals can support the historic and continued successes of Public Health and Local Authority smoke free initiatives that have had a measurable and clinically meaningful impact on the health of people in London. **The HSQ final report**<sup>1</sup> has excellent examples of how stop smoking specialists within clinical teams are delivering high value care for their NHS trusts.<sup>1</sup> In England in April 2016 the smoking prevalence was the lowest ever at 18.1%.<sup>2</sup> However, we cannot be complacent because:

- In 2016, the number of people who have quit has slowed compared to 2014 and 2015.<sup>2</sup>
- Since 2013, year on year fewer people are trying to quit.<sup>2</sup>
- In England in 2014/15 **475,000** admissions to hospital were **attributable** to smoking and represented **28%** of all hospital admissions.<sup>3</sup>
- In 2014/15 the number of prescription items dispensed in England to help people stop smoking was 1.3 million, compared to 2.0 million ten years ago.<sup>3</sup>

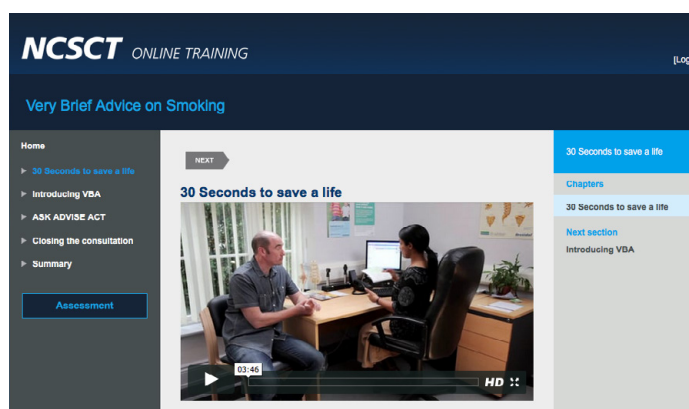
Almost two years ago the NHS Five Year Forward View stated that we now need a “radical upgrade in prevention and public health” following a failure to heed the learning from the Wanless report 12 years ago; smoking is still the “number one killer.”<sup>4,5</sup>

The HSQ team has recommended a four step approach for each London **Borough, Provider Trust** and **CCG** – The **CO4** approach, with each partner taking overall a **1/3** of the responsibility.

1. The ‘right’ **con**versation for every patient and staff member who smokes that gives him or her a chance to quit, referring if necessary.
2. Make routine desktop exhaled carbon monoxide (**CO**) monitoring by clinicians possible: “Would you like to know your level?”
3. **Code** 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.

1. The ‘right’ **CO**nversation for every patient and staff member who smokes that gives him or her a chance to quit, referring if necessary.

The very brief advice (VBA) training takes only 20 minutes and the intervention can take as little as 30 seconds to complete in a real consultation. Learn how to provide this high value intervention at [elearning.ncsct.co.uk/vba-stage\\_1](http://elearning.ncsct.co.uk/vba-stage_1). NICE guidance for in- and out-of hospital services recommends this intervention.<sup>6,7</sup>



2. Make routine desktop exhaled carbon monoxide monitoring by clinicians possible: “Would you like to know your level?”

The use of exhaled CO testing is recommended by NICE for monitoring a quit attempt and because of the huge impact on maternal and fetal health in maternity services it is recommended as a routine test as early as possible in order to reduce the toxic effect of tobacco smoke on the fetus. The Baby Clear project currently running in Barking and Dagenham following successes in the north east of England has ensured that the team around pregnant women who smoke can support them to quit including routine use of exhaled CO monitors.

The HSQ team has developed a **chart and quick guide**<sup>1</sup> to support any health professional who wants to use a CO monitor to motivate smokers in health settings to stop smoking.

### **'Tobacco dependency is a long term and relapsing condition that usually starts in childhood and is often familial' –**

Professor John Moxham, Director of Clinical Strategy, KHP

The WHO Framework Convention on Tobacco Control Article 14 considers the use of tobacco to be a condition that requires diagnosis and treatment stating: "...include diagnosis and treatment of tobacco dependence ... in national health and education programmes, plans and strategies ..."<sup>8</sup>

The utilisation of health services by people who smoke tobacco exceed that in the background population. The presence of tobacco smoking in these people can and should be considered a co-morbidity requiring an intervention and not a lifestyle choice. In the case of COPD where tobacco use is often assumed as a 'risk factor' either in the past or currently it is now being discussed in the NEJM as tobacco dependence and a co-morbidity to COPD that requires treatment.<sup>9</sup> Further, the American Thoracic Society has recommended that pulmonologists are now formally trained in the treatment of tobacco dependence.<sup>10</sup>

London reflects the national picture where people who smoke tobacco are no longer engaging as much with traditional stop smoking services. Despite the continued fall in prevalence, the health burden seen in GP surgeries, hospitals and mental health settings remains high. The morbidity and mortality attributable to tobacco smoking occurs across specialties and places where care is delivered and is an issue for adults, children and those not born yet. Every health professional practicing and in training needs to know what their responsibility is, how to do it according to NICE guidance, and when not delivering the intervention themselves, ensure they are aligned with colleagues who do and amplify their message. Stop smoking specialists tell us they are more effective when this happens.<sup>6,7,11-13</sup>

**Reduce childhood asthma and respiratory illness:** The 2014 national review into asthma deaths reported that 46% could have been prevented. 1/3 of cases had regular exposure to tobacco smoke and shockingly, deaths where smoking was a factor included child smokers with one as young as ten.<sup>14</sup> **67 children start smoking in London each day.**<sup>15</sup> Admissions and A&E attendances for both asthma and respiratory infection have declined due to the 2007 onwards smoking ban in public places. Child health leaders in London must start to work with children, young people and families to understand how to intervene as the outcomes of respiratory illness clearly improve when tobacco smoke harm is reduced or removed.<sup>16-19</sup>

**Get better surgical outcomes:** Improved outcomes are associated with smoking cessation before orthopaedic, cardiovascular, cancer, gastrointestinal, hernia, plastic and day surgery. Non-smoking patients need lower anaesthetic dosages and have fewer experiences of postoperative pain.<sup>10</sup> The UK's 7500 anaesthetists and 4000 trainees have ten million contacts per year giving an estimated two million opportunities to save a smoker's life. The hazard ratio for developing perioperative complications for a 20/day smoker is 2.62 for women and 3.04 for men.<sup>20</sup>

**Enhance cancer therapy:** Smoking cessation before the initiation of radiation therapy in lung cancer is associated with an increased rate of complete response to treatment compared to those who continue to smoke through treatment.<sup>21</sup>

**Increase the impact of therapy for people with HIV:** Tobacco consumption is the modifiable risk factor contributing most to the development of non-AIDS-defining events among persons living with HIV/AIDS.<sup>22</sup>

**Improve the health of future generations in London:** On average 6% of pregnant Londoners smoke but 36% of pregnant teenagers smoke. Significant risks include failure to achieve expected in-utero growth, infection, preterm delivery, stillbirth and sudden infant death. Reduced exposure to tobacco smoke in pregnancy reduces stillbirths.<sup>17,23,24</sup>

**Reduce acute and emergency activity:** The impact of alcohol misuse on health services, and in particular the ambulance service, is well documented but tobacco smoking has its impact too. A 2013 cross-sectional study demonstrated a higher odds ratio for ambulance call out in male current smokers - 1.63 (1.03-2.57) than male regular strong alcohol drinkers - 1.35 (0.79-2.31).<sup>25</sup>

**Make an impact on the extreme premature mortality of people with SMI:** in a double blind RCT for relapse-prevention in 247 smokers with schizophrenia or bipolar disease involving varenicline +/- CBT, the combined treatment arm showed no worsening of mental illness. At one year, abstinence rates were 60% in the varenicline group (24 of 40) vs. 19% (9 of 47) in the placebo group (odds ratio 6.2; 95% CI, 2.2-19.2; P<.001). Varenicline is a safe medication, including in those with SMI.

**Prevent dementia:** After accounting for non-independence between risk factors, around a third of Alzheimer's diseases cases worldwide might be attributable to potentially modifiable risk factors. Alzheimer's disease incidence might be reduced through improved access to education and use of effective methods targeted at reducing the prevalence of vascular risk factors including tobacco smoking.<sup>26,27</sup>

**Improve outcomes for people with tuberculosis:** Smoking substantially increases the risk of tuberculosis (TB) and death. More than 20% of global TB incidence may be attributable to smoking. Tobacco smoking is a risk factor for TB, independent of alcohol use and other socioeconomic risk factors increasing the risk of TB disease by more than two-and-a-half times.<sup>28</sup>

**Get better response to TNF inhibitor therapy in Psoriatic arthritis:** Current smokers had worse baseline patient-reported outcomes, shorter treatment adherence and poorer response to TNFi's compared to non-smokers. This was most pronounced in men and in patients treated with infliximab or etanercept.<sup>29</sup>

### 3. **CO**de the intervention so we can evaluate effectiveness - including death certification.

#### A case for **CO**ding tobacco causation on death certificates:

a retrospective analysis of 290 adult deaths at a London inner-city district teaching hospital between April 2013 - March 2014 revealed 72% attributable to tobacco smoking but only 9% of death certificates recorded the cause. Why should we do this better?

- Changes how clinical teams think about smoking and interventions
- Increases family awareness in families where smoking prevalence is high (as recipients of the death certificate)
- Enables more accurate documentation of impact of tobacco smoking in death statistics

The HSQ team has developed guidance for clinicians on **Writing a medical certificate of cause of death when the death is attributable to tobacco smoking.**<sup>1</sup>

### 4. **CO**mmission the system to do this right: so right behaviours incentivised systematically.

As London boroughs, commissioning groups and providers begin to work more closely together to ensure a sustainable and transformed health and social care service the HSQ team advocates the **1/3** approach in terms of responsibility for dealing with tobacco. What is in the contract that supports an NHS or social care provider to be a health promoting organisation? Is it possible to read measures of tobacco status and treatment across the system as our localities start to work out how to share patient records?

The HSQ team has developed a **step by step worksheet for a CQUIN**<sup>1</sup> with SMART metrics and processes.

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