

HELPING SMOKERS QUIT

Tobacco dependency is a long term and relapsing condition that usually starts in childhood; treating it is the highest value intervention for today's NHS and Public Health system, saving and increasing healthy lives at an affordable cost.

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1. Executive Summary

Tobacco dependency is a long term and relapsing condition that usually starts in childhood; treating it is the highest value intervention for today's NHS and Public Health system, saving and increasing healthy lives at an affordable cost.

The benefits of supporting the tobacco dependent population will be felt not only by the individuals but also clinical and public health commissioners and providers of health and social care services. Therefore all must play their part in ensuring the right services are available in the right locations.

In London today there are an estimated 1,125,000 smokers. Across London's boroughs smoking causes around 8,175 deaths each year, and costs £2 billion, including direct costs to the NHS of £250 million¹. Yet there are extremely cost-effective interventions available that we are not routinely offering to people who are tobacco dependent. There were over 51,500 smoking attributable hospital admissions across London in 2014/15, with significant variation in the quality and value of care offered by trust and by borough.

As a result of smoking 3,827 more people in London are receiving care provided by a local authority or private provider.² A further 90,840 are receiving care from a relative or friend. Smokers are likely to need care on average nine years earlier than non-smokers, and being a smoker doubles the chances of receiving care of any sort and increases the risk for ex-smokers of needing care by 25%. Additional care costs due to smoking-related illnesses are £110 million annually, with local authorities responsible for £63.6 million.

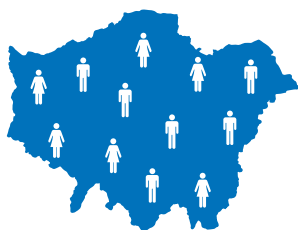
In August 2014 the London Clinical Senate launched a programme, Helping Smokers Quit, to support behaviour change within clinical teams and across care settings, specialities and organisations with the goal **that every London clinician knows the smoking status of each patient they care for and has the competence and the commitment to encourage and support that patient to stop smoking through direct action or referral**. The principles underpinning this work are to reduce the harm caused by tobacco, to reduce health inequalities and to champion value-based care.

This report draws out learning from the programme, the examples we have seen and discussions we have had with people and organisations that are helping to address this challenge. As a "how to guide" the recommendations it makes will assist clinicians, commissioners and providers to sustain and build on this programme through individual clinical action as well as new opportunities in particular the implementation of Sustainability and Transformation Plans (STPs) across London.

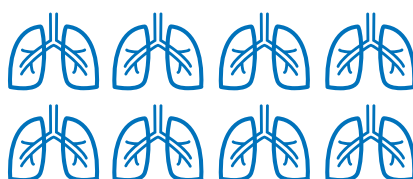
In addition to our **CO4** campaign (see 3.a.) to improve care and treatment, we recommend three key messages for leaders in the five STP footprints in London.

This programme, and its recommendations to address tobacco dependency, have been endorsed by the Minister for Public Health and the Mayor of London.³

In London today there are 1,125,000 smokers,



causes 8,175 deaths each year,



and directly costing the NHS £250 million.



¹ using the ASH "ready reckoner", see page 6. ² www.ash.org.uk/SocialCareCosts ³ www.londonclsenate.nhs.uk/helping-smokers-quit

2. Sustainability and Transformation Plans

Three key messages for stakeholders developing STPs

- 1. Tobacco dependence is a major problem for the NHS:** it is the main cause of most cancers, causes 10-20 years premature death for people with mental illness, is the main cause of the three top reasons for hospital admission of people under 75 years of age (cancer, COPD, CVD) and is the most modifiable factor in reducing stillbirth
- 2. Helping people stop smoking is the single highest value contribution to health that any clinician can make** and yet cost effective and clinically effective diagnostic tools and treatments are substantially underused by NHS clinicians across specialties, professions and settings: improvement in use offers the greatest opportunity to add value in the NHS today
- 3. Effective diagnosis and treatment of tobacco dependence requires an urgent improvement in clinical training, use of carbon monoxide monitoring as an essential near-patient test, and medicines optimisation**

The Programme: a call to action to clinicians in London

The Helping Smokers Quit programme has focused on clinical action, and what health system support is necessary to enable an improved interaction between a clinician and a tobacco-dependent patient. In the course of the programme we have deliberately moved to a different language which explicitly recognises that smoking is not a “lifestyle choice” but a sign of tobacco dependency, a long term relapsing condition that usually starts in childhood. Unlike some long term conditions, tobacco dependency has extremely clinically effective and cost-effective treatments available. People who are tobacco dependent deserve to have the same access to high quality, integrated, person-centred, and evidence-based services as people with other long term conditions.

That tobacco dependency is the root cause of many other long term conditions, of many cancers, of poorer maternal outcomes (all STP priorities), and poorer

surgical outcomes should motivate everyone to discuss how to enable the clinical action we have encouraged in our **CO4** campaign (**CO**nversation, **CO** monitor⁴, **CO**de, **CO**mmission). Whilst the Five Year Forward View states “the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health” it does not mean that tackling smoking is or can be the sole preserve of Public Health. The 1,125,000 current smokers in London would benefit from NHS interventions to help them stop smoking as treatment as well as prevention and the NHS would benefit from fewer people with long term conditions needing treatment and care.

Where to focus?

We know where the majority of smokers are: they are in our hospitals, they are consulting our GPs, they are living in our most deprived areas, they are working in routine and manual jobs, they are using our mental health services, they are in our prisons, they are giving birth to low birthweight babies, and they are in our care homes.

Barts Health NHS Trust has recognised the scale of the problem: there are about one million patient contacts a year; of which 400,000 are contacts with smokers, and yet only 3,000 people are referred to specialist stop smoking services.

The treatment needs of a smoker will differ according to their smoking history and behaviour, age, gender, socioeconomic status, co morbid physical and/or mental health needs, if they are an inpatient or outpatient and their personal choice about receiving support. A place based approach recommended in Sustainability and Transformation Plans is perfect for tackling tobacco dependence. The provision of treatment for people who smoke would ideally be provided by an integrated tobacco dependence treatment service delivery model. This service will need stratifying according to intensity and cost.

⁴CO monitor = carbon monoxide monitor

We know the scale of the challenge and the opportunity for improvement. We also know the cost of tobacco dependency to smokers and how much smokers are costing the NHS:

Data is available that shows the scale of the challenge, and the opportunity for improvement at borough and CCG level. Action on Smoking and Health (ASH) has updated its Ready Reckoner⁵ toolkit for 2016 which provides a breakdown of the costs of smoking at a borough/CCG level.

There is an important recognised link between poverty and health. ASH has calculated the impact of smoking (expenditure on tobacco) on poverty which estimates how many people would move above the poverty line if the cost of smoking was returned to households with smokers at a borough/CCG level.

There are about 26,857 households in Brent with at least one smoker

When net income and smoking expenditure is taken into account, 4,815 or 18% of households with a smoker fall below the poverty line*

If these smokers were to quit, 1,760 households in Brent would be elevated out of poverty.

The residents of these households include:

- around 3,404 adults below pension age
- around 421 pension age adults
- and around 2,786 dependent children

This means that roughly 6,611 people would not be below the poverty line if the cost of smoking were returned to the household.

Where to start?

There is a long history of, and continuing, outstanding work that is taking place to the benefit of many Londoners. STPs are most likely to make progress by building on the isolated but excellent examples in London, and in particular where:

Behaviour change principles are already embraced.

At the Royal Free London NHS Foundation Trust tobacco dependency is championed by its Public Health Team, with two smoking cessation lead psychologists providing in-house stop smoking services at the Trust's acute hospital sites. The Trust also has a Smokefree MDT steering group, which meets quarterly with key stakeholders to develop and promote services, review efficacy of smoking cessation activities, develop policies and provide leadership on smoke free issues. It is now extending this approach to the other hospitals in its chain.

There is a clinical leader or leaders.

There are many different examples of where this is happening across London, such as a British Thoracic Society (BTS) Stop Smoking Champion or a specialty lead.

Clinical Leads for each of the four clinical divisions within the **Royal Free London NHS Foundation Trust** have taken responsibility for ensuring that treating tobacco dependent patients is at the heart of the Trust's clinical strategy and ensured the Trust smoking cessation service was funded. Clinical leadership is also in place within the respiratory, infection and HIV teams.

Source: www.ash.org.uk/current-policy-issues/health-inequalities/health-inequalities-resource-pack ⁵ www.ash.org.uk/localtoolkit/docs/Reckoner.xls

The BTS Stop Smoking Champion at **King's College Hospital NHS Foundation Trust** has ensured that CO levels are a standard part of respiratory assessment in the lung function lab and in all oxygen assessment patients. The respiratory physiologists are also being trained in giving very brief smoking cessation advice

The smoking cessation specialist workforce works very closely with or is embedded within clinical teams that are already treating the sick, tobacco dependent, smokers.

At Whittington Health NHS Trust the respiratory team includes two stop smoking specialists who join the daily ward multidisciplinary board round and are involved in training all staff who work with sick smokers. Through a COPD local enhanced service scheme they have also been up skilling primary care practices (GPs and practice nurses) in identification and treatment of tobacco dependence and strategy.

The London Borough of Barking and Dagenham funds the maternity service to deliver the Babyclear project which is fully compliant with NICE Public Health Guidance on smoking cessation in secondary care. Community midwives have been provided with CO monitors and trained in how to carry out CO readings. All antenatal clinics have and use CO monitors and stop smoking specialists carry out home visits. CO recordings are taken at all bookings and repeated at 36 weeks. Data is collected from the electronic system which enables lead midwives to routinely monitor, identify where CO readings are not being performed and take action on high CO readings including referral to Stop Smoking Service specialists, and potentially gas safety services.

Where the greatest opportunities exist. "Smoking cessation is THE value proposition for the NHS today⁶", so take opportunities to embed treating tobacco dependence within other value-based initiatives e.g. local roll out of the NHS Right Care approach.



⁶ Prof John Moxham, Director of Clinical Strategy, King's Health Partners

3. Treating tobacco dependence

1. Tobacco dependence is a major problem for the

NHS: It is the main cause of most cancers, causes 10-20 years premature death for people with mental illness, is the main cause of the three top reasons of hospital admission of people under 75 years of age (cancer, COPD, CVD) and is the most modifiable factor in reducing stillbirth.

- There were 51,546 smoking attributable admissions in Londoners aged 35 and over in 2014/15.
- 8,175 Londoners aged over 35 die each year due to smoking.
- 6,700 Londoners die prematurely (under 75) from cancer every year, of which 4,000 deaths are preventable.
- On average 6% of pregnant Londoners smoke but 36% of pregnant teenagers smoke. Significant risks include reduced birth weight, infection and sudden infant death. There were 614 stillbirths in London in 2014, that's nearly 12 a week.
- People with a mental health problem consume 42% of smoked tobacco in the UK. Patients with schizophrenia will die on average 14.6 years earlier than the general population, and 75% of deaths are cardio-respiratory, mainly due to smoking.

In addition, smoking has an impact on other areas of NHS care:

- Worse outcomes are associated with smoking before orthopaedic, cardiovascular, cancer, gastrointestinal, hernia, plastic and day surgery. Non-smoking patients need lower anaesthetic dosages and have fewer experiences of postoperative pain.
- Up to 18% of people with diagnosed dementia are current smokers with evidence suggesting a higher prevalence of vascular and Alzheimer dementia types in smokers.

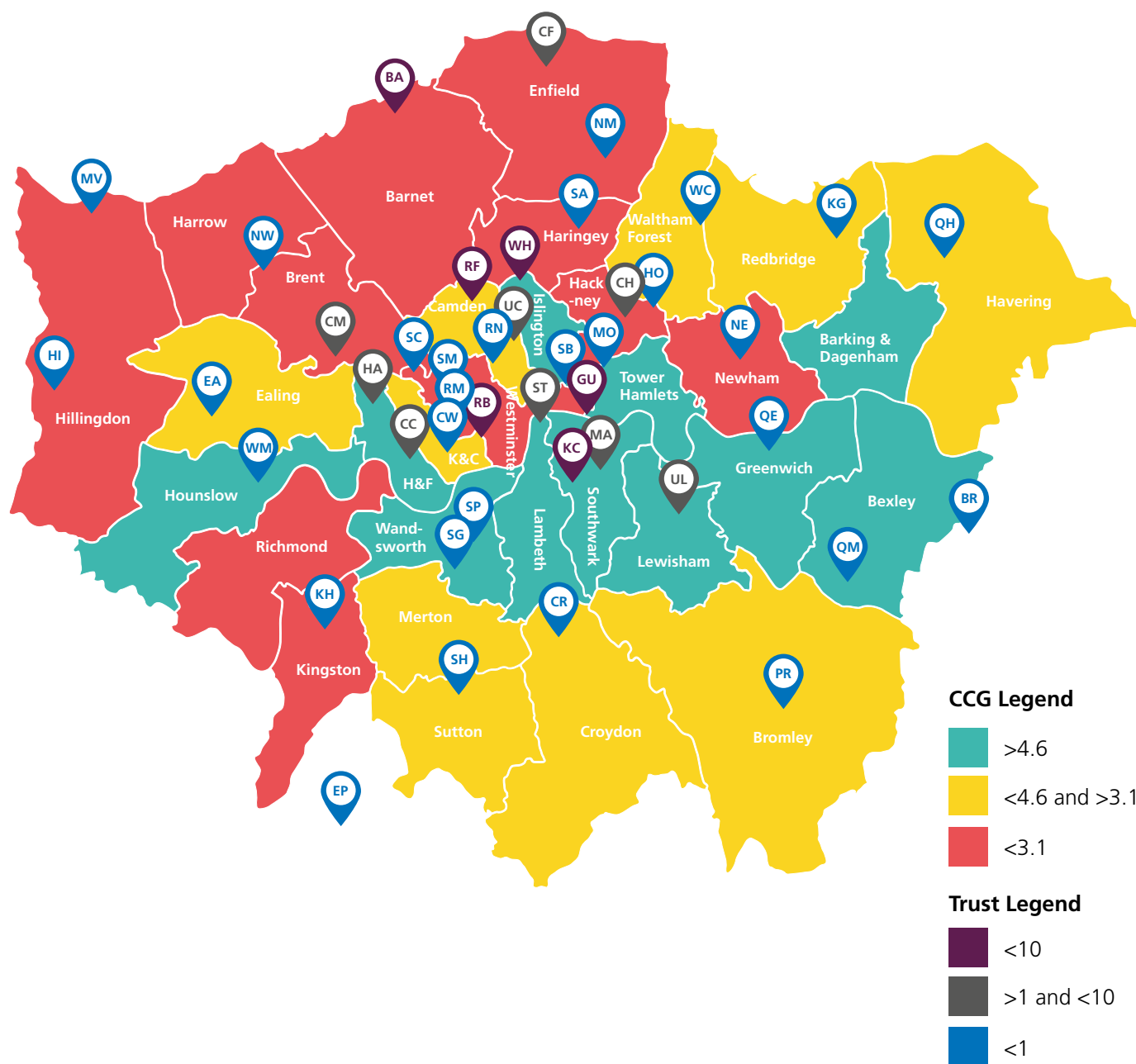
- North West London has the lowest rates Tobacco consumption is the modifiable risk factor contributing most to the development of non-AIDS-defining events among persons living with HIV/AIDS. In a Danish study HIV-positive smokers lost more years of life from smoking (7 years) than from HIV (5 years). (See Chapter 4 for guidance on death certification).

2. Helping people stop smoking is the single highest value contribution to health that any clinician can make

- and yet cost effective and clinically effective diagnostic tools and treatments are substantially underused by NHS clinicians across specialties, professions and settings: improvement in use offers the greatest opportunity to add value in the NHS today.
- There is substantial variation in the availability of carbon monoxide (CO) testing that is a low cost objective measure for smoking status that can motivate quit attempts.
- There is substantial unwarranted variation in the use of varenicline, a treatment that is particularly effective in helping dependent smokers stop smoking safely, and this is not compensated for by higher use of nicotine replacement therapy (see graphic from the NHS London Procurement Partnership below). A very recent study⁷ requested by the U.S. Food and Drug Administration (FDA) has shown that it is safe for people with mental illness, and therefore there is no reason not to prescribe it for people with mental health problems who are tobacco dependent. In the very rare circumstances where there are any risks to worsening mental health, the study showed it would be likely to be down to nicotine withdrawal and not the prescribed medication. As a measure of its safety varenicline is not a 'black triangle' medication.
- The variation is not explained by compensation between hospital and community use.
- North West London has the lowest rates of prescribing that cannot be explained by smoking prevalence.

⁷ [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)30272-0/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30272-0/fulltext)

Varenicline prescribing secondary care (Items) compared with CCG⁸ (Items per 100 Astro PU) October 2015 - December 2015



⁸ Does not include all data in CCGs whereby a supply is made using a pharmacy Patient Group Direction (PGD)

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- This suggests that there are unhelpful clinical beliefs about the value of helping smokers stop smoking, their prescription of effective treatments and their use of behavioural counselling that need to be addressed. The programme developed resources to help explain the value of different interventions that has led to the addition of varenicline to Trust formularies. See Chapter 4 for a link to the programme's guidance on prescribing varenicline.
 - Towards the end of the project we discovered some useful analytical and costing tools available from Johnson & Johnson that draw on a range of relevant NHS and commercial datasets. The FOCUSED (Frontline Opportunities in Smoking Cessation: Utilising Services and Evaluating Data) tool for general practice and the Vision (the value of investing in Smoking cessation: impact, outcomes, numbers) tool for CCGs and local authorities have both been used successfully by colleagues in London. Improvement case studies are also available. If you wish to access these tools please contact: Pete Sagoo, Healthcare Development Manager, Johnson & Johnson Ltd, pete.sagoo@apodi.co.uk
 - Referrals to smoking cessation specialists are falling due to a number of reasons including changes in commissioning, lack of data on effectiveness as well as the rise in use of e-cigarettes, which may lead to fewer referrals, even though most e-cigarette users continue to smoke tobacco⁹. However, NHS clinicians who provide Very Brief Advice (VBA) also need specialists to receive referrals of their most tobacco dependent, relapsing patients. Therefore there needs to be a review and focussed work on how to increase the value of these specialist services, for example through better integration with hospital services.
 - Using VBA to work with patients promotes and encourages a less paternalistic and more collaborative approach to consultations with patients. This is aimed at recognising tobacco dependency as an addiction that requires clinical diagnosis and subsequently appropriate evidence based treatment and support with onward referral to stop smoking specialists. This type of engagement with patients will also improve outcomes related to public health messages, such as the Making Every Contact Count approach. There is also significant potential for overlap into the general consultation and the outcomes for those specific conditions too.
- 3. Effective diagnosis and treatment of tobacco dependence requires an urgent improvement in clinical training, use of carbon monoxide monitoring as an essential near-patient test, and medicines optimisation**
- At the London Clinical Senate Helping Smokers Quit event on 17 March 2016 there was strong clinical and public health consensus from the 100 participants that there is an urgent need to improve the quality of clinical training at undergraduate, trainee and senior clinical level. Treating tobacco dependence is currently and shockingly absent from most curricula and continuing professional development programmes in London.

Central and North West London NHS Foundation Trust (CNWL) has made Level 2 training 'Essential to Role' for all clinicians, and Level 1 / VBA for all other staff.

⁹ ASH Survey 2016, from www.ash.org.uk/files/documents/ASH_891.pdf

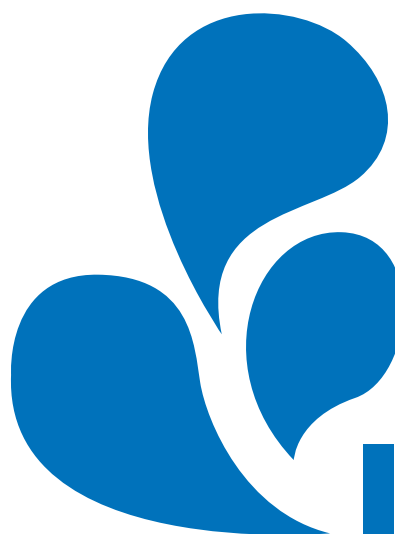
University College London Medical School

have agreed to include treating tobacco dependence in the first year of training of all medical students.

- Medical schools outside of London have taken a lead in having smoking cessation training already in the curriculum. However, things are beginning to change, and need senior commitment to support the spread of best practice. Undergraduates and clinicians at University College London are already making the case for identification and treatment of tobacco dependence to be prioritised in undergraduate training in the same way as alcohol dependence – it is unacceptable that it is not on every examined syllabus. Urgent change is needed to include this in every examined syllabus.
- Carbon monoxide monitors are not something individual clinicians should have to fight for – they are an essential tool for the job and should be as readily available as peak flow meters or blood pressure machines. They cost about £130, and should be available to every clinician who is trained not only in how to use one, but how to use evidence-based language to motivate change. The programme produced a guide¹⁰ to the use of CO monitoring to improve competence and confidence in its use. Feedback suggests increased use in a number of London trusts, including maternity services, but struggles to fund these continue.

- Every clinician includes surgeons. Smokers are not a “soft target” for NHS savings¹¹. They are people who need treatments in the right priority order: firstly, treatment for their tobacco dependence so that their surgical outcomes are optimal, and secondly, surgery.
- There is underuse of Nicotine Replacement Therapies (NRT) and varenicline. While this matters in itself, in addition dosages of inhaled medicines for chronic respiratory conditions, anaesthesia medication and psychotropic medication could be reduced if their users were helped to stop smoking.

Remember, tobacco dependence is a long-term relapsing condition that usually begins in childhood. Treating tobacco dependency is a priority for STP collaboration as they aim to improve population health, and requires all STP partners to take action. Fortunately there are cost-effective treatments available to help smokers stop, and new clinically-tested resources available in London to reduce the unwarranted variation in their use.



¹⁰ See Chapter 4 for a link to the programme's guidance on using CO monitors ¹¹ Royal College of Surgeons statement 22 April 2016

3a. CO4

The Helping Smokers Quit Programme developed its CO4 campaign as a practical and achievable way of identifying and treating tobacco dependence in London. It has been widely tested with trusts and CCGs, and has received overwhelming support from those who have heard the team deliver the messages. It has been promoted by ASH and Public Health England as a positive example of tackling the problem of harm from tobacco dependence.

CO4 refers to four elements:

1. **The ‘right’ COnversation for every patient and staff member who smokes that gives him or her a chance to quit, referring if necessary.**
2. **Make routine near-patient (i.e. desktop, bedside and home) exhaled carbon monoxide (CO) monitoring by clinicians possible through the routine provision of CO monitors and training in how to use them with a patient as a motivational tool: “Would you like to know your level?”**
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.**

1. COnversation

The ‘right’ conversation requires a significantly improved approach to training. Making the National Centre for Smoking Cessation Training (NCSCT) module on very brief advice (VBA) elearning.ncsct.co.uk/vba-launch, or equivalent training, a part of all NHS employees’ statutory and mandatory training would encourage a culture of understanding and responsibility for addressing tobacco dependency. This will support the “smokefree” movement currently being adopted by many trusts and hospitals.

However, onward referral to, and intervention by, smoking cessation specialists will still be required for the most tobacco dependent patients. Clinicians and Stop Smoking Specialists can access further training on the NCSCT website at elearning.ncsct.co.uk/practitioner_training-registration, and additional modules specifically designed for practitioners working in maternity services⁸ and mental health¹².

South London and the Maudsley NHS Foundation Trust also offer an eLearning course that can be added to some Learning Management Systems www.slam.nhs.uk/about-us/education-and-training/e-learning

2. Carbon monoxide (CO) monitoring

Carbon monoxide is one of the toxic gases inhaled by smokers from cigarettes. It is a useful marker of regular smoking, as it is usually undetectable around 24 hours after the last cigarette. It is an easy way for clinicians to validate self-reported smoking status and supports them to start the conversation with their patients about accessing the right type of treatment and support for their tobacco dependency.

Organisations that have made CO monitors available to their clinical teams and embedded their use within everyday practice are already reporting the value both in improving clinicians’ consultation with the patient and as a motivational tool for patients themselves.

Further guidance for clinicians on using CO monitors, including a helpful chart produced by the programme is linked in Chapter 4. In this video, [youtube/HtW8YRqOXfg](https://www.youtube.com/watch?v=HtW8YRqOXfg). GP Noel Baxter demonstrates how to use a carbon monoxide (CO) monitor and chart during a consultation, in this case an asthma review, to validate smoking status.

¹² elearning.ncsct.co.uk/pregnancy_specialty_module-registration

3. COde

We need to ensure better recording – across the system – of smoking status, the interventions used and the outcomes of tobacco use and successful treatment of tobacco dependency. Improving coding of interventions will enable their impact on mortality, morbidity and health service utilisation to be properly evaluated. We need to communicate this back to our population, patients, and commissioners, health professionals who provide the care and our public health and epidemiological colleagues so that services can be improved and targeted. We focused in particular on the paucity of recording of death due to smoking¹³ and therefore a missed opportunity to reinforce to clinicians, family and friends and our national recording system the causal link between death and tobacco.

The Clinical Senate believes that full implementation of the Medical Examiner-enabling regulations will be a helpful way in which considered inclusion of tobacco dependence on death certificates can happen as part of wider improvements in death certification. The introduction of medical examiners and reforms to the process of Death Certification in England and Wales are expected to be introduced from April 2018. See Chapter 4 for guidance on completing death certificates.

We have tested this out with a team of clinicians at University Hospital Southampton NHS Foundation Trust who have worked together and become trained in order to provide a daily internal medical examiner (IME) team meeting that evaluates every hospital death and agrees with the presenting clinician the death certificate content. They have found that this process supports patient safety work, the training of junior doctors and the patient experience. In collaboration with the HSQ team they adopted an approach that built on this work to include tobacco as a cause.

Trusts that have invested in the National Centre for Smoking Cessation and Training (NCSCT) referral system or equivalent are able to produce timely and relevant information by scrutinising the referral data and using it to advise clinicians, teams and departments of their performance and impact.

4. COmission

To have a system that delivers best value tobacco dependency therapy will require clinical and local authority commissioners and providers to come together to agree a budget and population approach. As treating tobacco dependence requires action from all partners we suggest an investment split of a third, a third, a third.

Whittington Health NHS Trust, London Boroughs of Camden and Islington and Islington CCG agreed to jointly fund their specialist stop smoking service as this service provides a benefit to their population as a whole.

Guidance has been developed from experience at three acute trusts in London that considers an approach through CQUINS. Whilst an incentive scheme is one mechanism the guidance will support commissioners and providers with a process for coming to an agreement. A link to this guidance is in Chapter 4.

Helping Smokers Quit Awards

The programme sought examples of best practice happening across London in delivering **CO4** for the Helping Smokers Quit awards in March 2016 and received 10 high quality applications, demonstrating that there is potential to make an impact if all organisations followed their lead. These are set out in Chapter 5.

¹³ www.ncbi.nlm.nih.gov/pubmed/22024242

3b. Helping Smokers Quit Programme Recommendations

Tobacco dependence needs to be tackled at a systems level with a commitment from all partners

- A. Every NHS organisation and local authority in London should have a clear pathway for people who are tobacco dependent, which ensures access to local specialised services that provide the evidence based care and support people require.
- B. Patients' who are tobacco dependent have a treatable long term condition and should have equivalent access to diagnosis, information and evidence-based care as for other long term conditions, such as diabetes.
- C. Sustainability and Transformation Plans in London offer a real opportunity for a step change in tackling tobacco dependence across the health and care system within each footprint. London's five STPs should clearly set out responsibilities and actions for addressing tobacco dependence agreed by all partners.
- D. Every NHS Trust should have a board level clinician responsible for addressing tobacco dependence within the Trust's patient population. Clinical leads should be identified in each area to support this action.
- E. Referral data should be used and scrutinised: trusts that have invested in the NCSCCT National Referral System or equivalent are able to produce timely and relevant information.

Improving value

- F. Improving the value of healthcare in London is a priority for all STP partners given the increasingly challenging financial environment in which they operate. Addressing tobacco dependency is the highest value proposition for the NHS and should be a priority for everyone. Debates about where responsibility lies can be overcome if all partners accept responsibility and agree on a fair distribution of resource: for example 1/3 funding from the CCG, 1/3 from the local authority and 1/3 from the hospital trust.

Access to specialist services

- G. The existing smoking cessation specialists within the NHS and Public Health workforce are a highly skilled and cost-effective resource that should be integrated within clinical teams to give tobacco dependent patients access to the specialist advice and support they need. This approach will also enhance clinical teams' skills and knowledge.
- H. NHS Trusts and Public Health teams should jointly review how to increase the value of these specialist services, for example through better integration with hospital services.

Treatment

- I. All London's health organisations should commit to **CO4**, a four pronged approach to identifying and treating tobacco dependence.
- J. All formularies should include a full range of Nicotine Replacement Therapy products as well as varenicline.
- K. All patients should be offered a combination of interventions, with combined behavioural support and pharmacotherapy being most effective.
- L. The smoking status of all NHS patients should be established, recorded and updated as necessary at every patient contact, with appropriate referral to stop smoking services as required. Both the smoking status and intervention should be coded so the effectiveness can be evaluated.

Health and care professionals training

- M. All initial educational programmes for health and care professionals should include skills for identifying and treating tobacco dependence, including behaviour change.
- N. All NHS organisations should make Very Brief Advice stop smoking training part of all health professionals' mandatory training requirements.
- O. All clinicians should be trained in recording smoking on death certificates when it is appropriate to record it as a cause of death.

4. Guidance to support clinicians and commissioners

The Helping Smokers Quit programme has developed several documents to support clinicians, commissioners and others to implement the CO4 message. These have been produced using the expertise of clinicians, commissioners and organisations across London who are leading a movement of change that will address tobacco dependence. The guidance is freely available for use via the links below and we encourage you to promote its adoption and share through your organisations and networks.

A. Commissioners enabling clinicians to help smokers quit (March 2016)

This document provides guidance for commissioners on how they can ensure the CO4 messages are being implemented as part of normal service delivery, including examples of how this has been introduced in London. www.londonsenate.nhs.uk/wp-content/uploads/2015/04/Commissioners-enabling-clinicians-to-help-smokers-quit.pdf

B. Helping Smokers Quit factsheet (July 2016)

This factsheet sets out the clinical evidence behind the CO4 messages including why smoking cessation and the treatment of tobacco dependence are key priorities for the NHS and the responsibility of all clinicians to take action. www.londonsenate.nhs.uk/wp-content/uploads/2015/04/Helping-Smokers-Quit-Factsheet-July-2016.pdf

C. Why and how to prescribe varenicline in hospital (March 2016)

Guidance for both acute and mental health trust clinicians on the evidence for and best way of prescribing the most cost-effective treatment to help patients who want to stop smoking. www.londonsenate.nhs.uk/wp-content/uploads/2015/04/Why-and-how-to-prescribe-varenicline-in-hospital.pdf



London Clinical Senate

Adding value to every clinical contact by treating tobacco dependence

CO4: Commissioners enabling clinicians to help smokers quit

- 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.

HELPING SMOKERS QUIT
Adding value to every clinical contact by treating tobacco dependence

London Clinical Senate

Interpreting expired air carbon monoxide (CO) readings

CO (ppm)	% CO Hb
20 and above	3.20+
20	3.20
19	3.04
18	2.88
17	2.72
16	2.56
15	2.40
14	2.24
13	2.08
12	1.92
11	1.76
10	1.60
9	1.44
8	1.28
7	1.12
6	0.96
5	0.80
4	0.64
3	0.48
2	0.32
1	0.16

The expired carbon monoxide (CO) test Guidance for health professionals – March 2016

8

D. The expired carbon monoxide (CO) test – guidance for health professionals (March 2016)

The guidance provides an overview of how to use carbon monoxide monitors to validate and motivate patients who want to make a quit attempt. This includes advice on effectively communicating with patients. www.londonsenate.nhs.uk/wp-content/uploads/2015/04/The-expired-carbon-monoxide-CO-test-guidance-for-health-professionals.pdf

E. Writing a medical certificate of cause of death when the death is attributable to tobacco smoking (March 2016)

Recording tobacco smoking accurately on death certificates will provide more accurate data about mortality and increase awareness of its impact on health in families that smoke. This document provides clear guidance to change how clinical teams think about the impact of tobacco dependence and the importance of smoking cessation treatment. www.londonsenate.nhs.uk/wp-content/uploads/2015/04/Writing-a-medical-certificate-of-cause-of-death-when-the-death-is-attributable-to-tobacco-smoking.pdf

These documents and other resources are shared on the London Tobacco Control Network Knowledge Hub¹⁴. The hub also offers access to a community of professionals who are addressing tobacco dependency across London.

¹⁴ khub.net/web/london-tobacco-control-network

5. Best Practice Examples

The London Clinical Senate hosted an Awards Event in March 2016 to recognise and share best practice examples from across London. This event highlighted much of the good work already happening in support of the **CO4** messages and that more generally addresses the needs of the tobacco dependent population of London. The **reasons for awards** outlined below will chime with organisations looking to introduce new elements of good practice, and offer learning and examples of how to do this that will be relevant to your organisation. Further information about the award winners can be found at: www.londonsenate.nhs.uk/wp-content/uploads/2015/04/Helping-Smokers-Quit-Award-Winners-Summary.pdf

These and several other examples are mentioned throughout the report and there is good practice happening across London and in other parts of the country that will provide ideas and insight that will be of interest to all.

Organisation(s)	Reasons for awards
Oxleas NHS Foundation Trust + Bexley & Greenwich Stop Smoking Service	<ul style="list-style-type: none"> • Use of CO4 as a CQUIN target for 2016/17 • Use of CO monitors on all wards
Barts Health NHS Trust	<ul style="list-style-type: none"> • Introduction and use of CO monitors in maternity services and pre-operative assessment clinics • Number of staff completing VBA training, and sharing resources on the e-learning hub
South London & Maudsley NHS Foundation Trust	<ul style="list-style-type: none"> • Development of a training pathway for mental health staff • Contribution to the work of other organisations to promote best practice • Outreach from acute settings into the community

Organisation(s)	Reasons for awards
Whittington Health NHS Trust	<ul style="list-style-type: none"> • Work with commissioners and public health to fund a stop smoking service • CQUIN for inpatient and outpatient services including paediatrics • Up-skilling primary care and community pharmacy in identifying and treating tobacco dependence
Guy's and St Thomas' NHS Foundation Trust	<ul style="list-style-type: none"> • Use of a local incentive scheme • Staff training including in maternity services, and support to staff to stop smoking
Barking, Havering & Redbridge University Hospitals NHS Trust, North East London Foundation Trust + London Borough of Barking & Dagenham	<ul style="list-style-type: none"> • Implementing the Baby Clear project in maternity services • All community midwives provided with CO monitors • London Borough of Barking & Dagenham provided financial support to enable a population based approach
King's College Hospital Foundation Trust	<ul style="list-style-type: none"> • Medical Director engaged in driving clinical leadership • Training of medical students • Comprehensive use of performance data
Barnet, Enfield, & Haringey Mental Health Trust + Public Health Enfield	<ul style="list-style-type: none"> • Patient and public participation and engagement • Comprehensive training of staff in the relevant skills
Royal Free London NHS Foundation Trust	<ul style="list-style-type: none"> • Clinical leadership from each division to place at heart of the trust's clinical strategy • Use of psychologists to promote behaviour change • Work done in HIV clinics
St George's University Hospitals NHS Foundation Trust	<ul style="list-style-type: none"> • Adding varenicline to the Trust formulary • The establishment of the Health and Wellbeing working group for Trust staff

