

**KING'S HEALTH PARTNERS
PUBLIC HEALTH PROGRAMME DELIVERY**

**DRAFT
TOBACCO STRATEGY**

**Helping our patients, staff and students live healthy and
longer lives**

1. Foreword

The purpose of creating our AHSC was to increase the contribution we can make to improving the health and wellbeing of people and patients locally and globally. Local and global health is massively damaged by tobacco. The strategy of King's Health Partners 2014-2019 includes three themes for which smoking reduction is a core goal: Mind and Body, Value Based Health care and Public Health.

Improving the health of the public, so long a neglected part of health policy, is now centre stage and reducing smoking is a priority.

It is now abundantly clear that the NHS is under intolerable strain, in large measure because of the massive demand for care from an unhealthy population. In his recent report Simon Stevens the CEO of NHS England recognises the reality that ongoing failure to address the health of the public places the future of the NHS in jeopardy.

“The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded – and the NHS is on the hook for the consequences. The NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks. We will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment.”
(NHS Five Year Forward View, October 2014)

As ever, good leadership is needed. Driven by the Mayor, smoking has fallen dramatically in the New York city (from 22% in 2002, to 15% in 2012)

“Nothing any of us will ever do will save as many lives as limiting the use of tobacco products”.
(Michael Bloomberg, Mayor of New York, Time magazine October 21st 2013)

Inspired by the example of NY, the recent London Health Commission, led by Lord Darzi, gives great emphasis to public health and smoking reduction.

“One of London's big killers . . . is smoking. There are still 1.2 million smokers (18%) and 8,400 deaths a year. . . . Smoking directly impacts on four of the top five biggest killers across London. Over 51,000 hospital admissions per year are attributable to the habit. London boroughs with high smoking prevalence are also some of the poorest boroughs. . . stark health inequalities are caused by smoking rates being much higher amongst people who work in manual or routine occupations. For the NHS and wider public services, the lifetime value of a person stopping smoking is huge – that's why stop smoking services must be supported and maintained as great public investment. “
(Better Health for London, London Health Commission, 2014)

King's Health Partners can make a big contribution to smoking reduction, in patients, staff and students. We can and should be leaders in this endeavour given our size and our ability to integrate research, education and clinical service for the benefit of thousands of smokers who want to quit and the children and young people who need our support to never start.



A handwritten signature in blue ink that reads "John Moxham".

Professor John Moxham
Director of Clinical Strategy
King's Health Partners

2. Recommendations

Integrating and strengthening our treatment pathways for smokers, particularly those who are highly dependent on nicotine

- Effective smoking cessation services are available for all patients treated in our hospitals and clinics.
- Specialist smoking cessation services are available for those patients who are highly dependent particularly those with long term conditions who access the Partner hospitals.
- Specialist smoking cessation advisors are available for those patients who have repeated failed attempts to quit, including mental health patients, pregnant women and mothers with babies and young children.
- All front line staff will receive training to ensure that they ask all service users whether they smoke and offer a referral to specialist support (a key component of making every contact count)
- New mothers who have quit smoking during pregnancy are followed up with continued support to achieve a year's quit target.
- Ensure smokers receive continuous, effective cessation treatment, including at transition points across the pathway
- All partner organisations to implement the NICE Guidelines for smoking cessation in mental health, acute and maternity settings.

Improving our intelligence and informatics about the people we see who smoke

- All Partners electronically record the number of smokers that access care.
- All Partners identify those smokers who wish to receive help either with temporary abstinence, stopping smoking or reducing their smoking and informatics systems are linked to appropriate smoking cessation services
- All Partners to record the numbers of people who have been offered support.
- All Partners record the numbers of patients who have successfully stopped smoking or reduced smoking.

Improving the health of our staff and students

- All staff and health school's students joining the Partners are assessed for smoking and advised of the best way to stop.
- Staff and students wanting to quit smoking have access to stop smoking services and are allowed time to attend these services during work hours.
- Staff and students who do not want to quit smoking are advised on appropriate nicotine replacement products to enable them abstain from smoking during working hours.
- King's Health Partners hospitals and grounds are completely smoke-free in accordance with

NICE guidance.

- Consider the introduction of a smoke-free university at KCL

Educating our staff and students

- All clinical staff are trained to assess patients smoking status, offer brief advice and refer appropriate patients to smoking cessation services.
- Selected staff are trained to level 2, to administer and prescribe smoking cessation interventions
- Teaching on smoking cessation interventions is a significant part of the health schools undergraduate curriculum and graduates are equipped to offer brief advice.

Research

- Develop a systematic approach to identifying opportunities for research and evaluation related to tobacco across KHP to build upon our growing portfolio of research in this area
- Develop a data base for KHP research activities related to tobacco
- On an annual basis, collect naturalistic data using the enhanced informatics systems. Analyse data by patient diagnosis, CAG and partner organisation for:

Smoking demographics and characteristics

Prevalence of smoking of patients, staff and students

Severity of nicotine dependence of patients, staff and students

Prevalence of patients who want to temporarily abstain, with and without support during an inpatient admission, and those who want to make a quit attempt.

Number of referrals made to specialist stop smoking clinics

Efficacy and effectiveness of interventions

Uptake of:

support offered for temporary abstinence during an inpatient stay

support offered for smoking cessation during an inpatient/clinic episode

referrals to specialist stop smoking clinics

support for staff and student smokers

Outcome of above support on:

Four week, six and 12 month quit rates

Smoking reduction rates

Satisfaction with treatment

Cost of treatment

Effect of above support on Health Outcomes

Assess the impact of smoking and stopping smoking on each's CAG's minimum set of health outcomes they routinely measure.

Staff training

Evaluate the uptake of training by CAG and the effect of training on knowledge, skills and attitudes, patient metrics (e.g. referral for specialist support, uptake of support, quit rates)

3. Introduction and background – The health of the public and the impact of smoking

The purpose of King's Health Partners Academic Health Sciences Centre is to improve the health and wellbeing of our patients and population.

Those who smoke die 10 years sooner than non-smokers. As a consequence of the chronic diseases caused by smoking many smokers endure premature poor health and disability for years prior to their premature death. **Smoking is the single greatest cause of premature, preventable death in England and in our local boroughs.**

Life expectancy is much shorter in those who are poor and disadvantaged compared to those who are affluent. Rates of smoking are also very much higher in deprived and poor communities. Lambeth and Southwark have large deprived populations and are the 9th and the 12th most deprived boroughs in London. A stated commitment of the NHS and all levels of government is to reduce health inequalities. **Smoking is the cause of more than 50% of the difference in life expectancy between those who are poor and deprived and those who are affluent** (Figure 1). Although relatively few of the affluent in our society smoke, some do, and like all smokers, they would, as a group, live ten years longer if they did not.

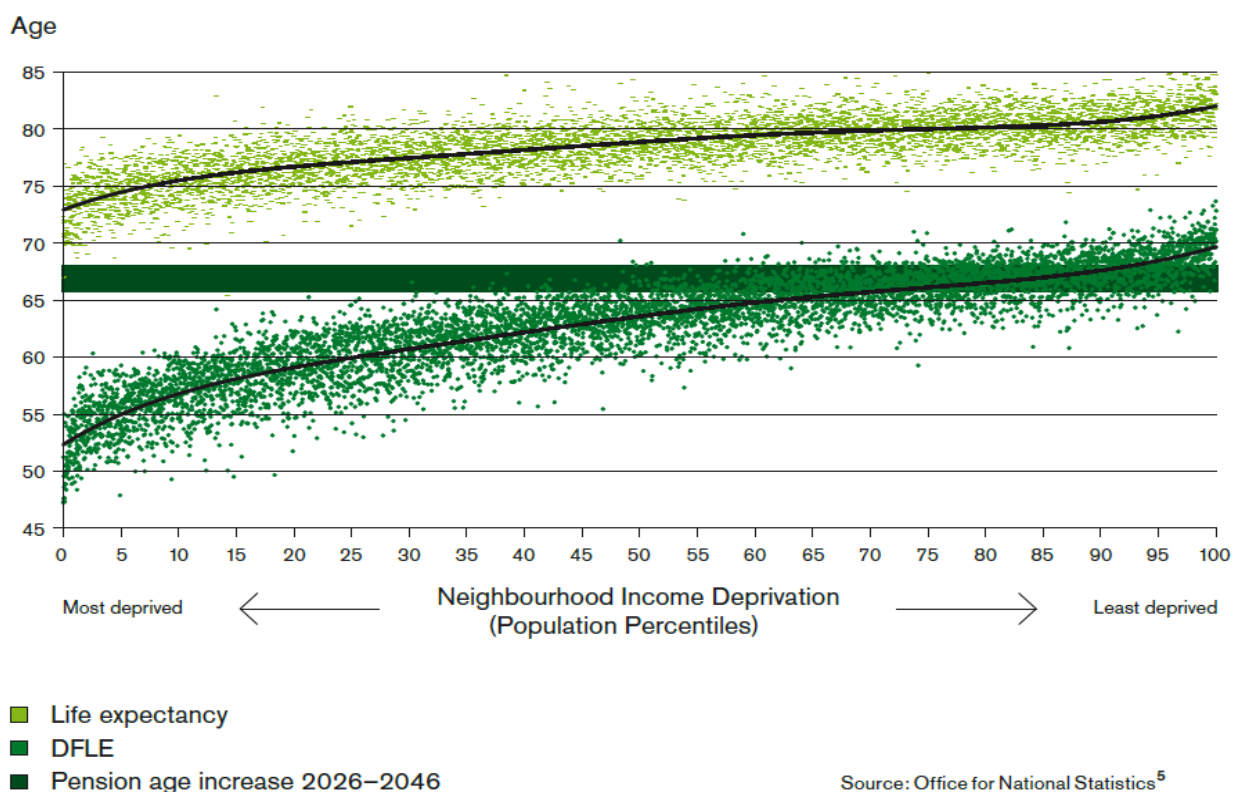


Figure 1: Note the life expectancy of the least deprived (average 82 years) and that of the most deprived (73 years), a difference of 9 years. Living a life free of significant disease and disability is important. The Disease Free Life Expectancy (DFLE) is close to 70 years for the least deprived and is 52 years for the most deprived, a difference of 18 years. More than 50% of these huge differences in life expectancy and disease free life expectancy are due to smoking.

The inevitable and important conclusions from these data is that **reducing smoking presents our health and social care system with a huge opportunity to improve the health and wellbeing of our people, reduce health inequalities, reduce healthcare costs and increase value.** KHP should therefore be striving to minimise smoking across its staff, service users and catchment area.












Tobacco control and smoking cessation is everyone's business, responsibility and

opportunity. King’s Health Partners will work closely with colleagues in our local boroughs, primary and community care to reduce smoking. Our Tobacco Strategy will align closely with that of the Lambeth and Southwark Health and Wellbeing Boards, and will be strongly informed by local public health leaders. By achieving smoke-free hospitals and reducing smoking by our patients, staff and students our contribution will be substantial.

Health care treatment systems can have only a limited effect on the health of the public (Figure 2). Hence the importance of Public Health improvements and the need to all work together, all ‘do our bit’, contributing to the success of an overarching Tobacco Strategy.

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

											
	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,669	\$3,925	\$5,643	\$3,405	\$8,508

Notes: * Includes ties. ** Expenditures shown in \$US PPP (purchasing power parity); Australian \$ data are from 2010.

Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011*; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

Figure 2: The analysis of eleven advanced healthcare systems ranks the UK NHS very highly. By contrast, the health of the UK population (‘Healthy Lives’) is very poor. These important data highlight, firstly that despite having a good treatment delivery system we have poor health and, further improvements to the delivery system can have only a relatively modest impact (even if we are able to afford the improvements). Secondly, it is our poor health that is putting the NHS under huge pressure, and **it is likely that only improvements in health, through public health and prevention actions, will ensure a future high-quality NHS service to patients that is affordable and sustainable.**

Smoking causes a range of diseases including cancer, cardiovascular and respiratory disease. **These diseases are the greatest cause of death in our local boroughs.** Tobacco smoking is by far the most important risk factor for cancer in the UK. Smoking also contributes to a myriad of health related problems and costs. Smokers undergoing surgery are more likely to have a longer hospital stay and are more likely to need intensive care. Smokers have an increased risk of re-admissions. Smoking is responsible for poor oral and dental health. Smoking causes complications during pregnancy, including an increased risk of miscarriage, premature birth, low birth weight and perinatal death. Second hand smoke exacerbates respiratory symptoms and can trigger asthma attacks. Children are particularly vulnerable to second hand smoke which can cause sudden infant deaths, wheezing, and ear infections. Currently, most people who smoke have grown up in smoking households. If a mother smokes, her

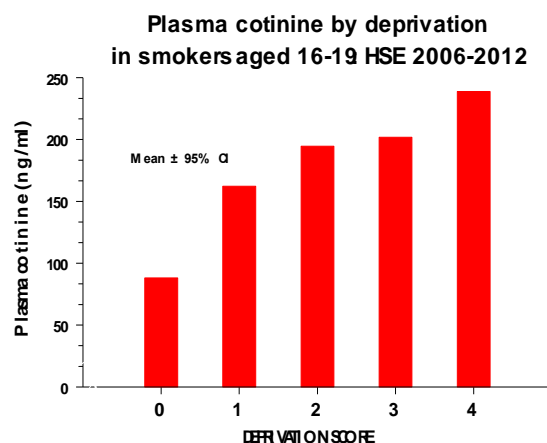
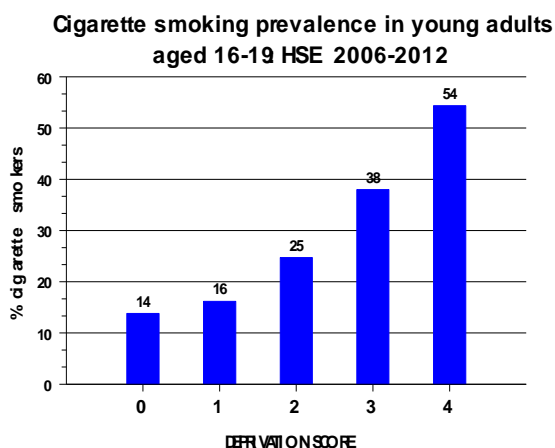
child is twice as likely to become a smoker than if she were a non-smoker. If both parents smoke there is a 3-fold increased likelihood. When young women, who then go on to have children, stop smoking the outcome is healthier women, mothers, babies, children (who are themselves much less likely to smoke) and grandparents who live to a greater age with less disease. **One of the greatest gifts a pregnant smoking mother can give to her baby (and to herself) is to stop smoking.**

Smoking rates are disproportionately high in every area of mental health care. Adults with common mental disorders such as depression and anxiety are twice as likely to smoke compared to adults who are mentally well. Those with schizophrenia or bipolar disorder are 3 times more likely to smoke. People with mental health disorders consume approximately 40% of the tobacco smoked in the UK. Compared to non-smokers with mental ill health, those who smoke have more severe mental health symptoms, require higher doses of psychotropic medication and spend more time in hospital. Mentally ill smokers use a high proportion of their income to pay for cigarettes and prioritise this expenditure over food and leisure activities. Smokers are more likely to report having suicidal thoughts and have higher suicide rates. People with mental ill health smoke more heavily, have higher blood nicotine levels and are more dependent on nicotine than those without mental illness.

Over the last 50 years smoking rates have gradually fallen across the general population and for England are now 18.4% and in London 18%. **Smoking rates in Lambeth and Southwark are 21.3% and 19.7%.** However, there are wide variations across populations depending on social, economic and health status. At one extreme smoking rates are less than 10% amongst the most affluent members of our community and at the other extreme smoking rates are 60% in those with serious mental illness and up to 90% in those with the combination of serious mental illness and substance abuse. Children and young people from deprived backgrounds are much more likely to take up smoking and are more heavily dependent (have higher blood nicotine levels) (Figure 3). In later life they are less able to quit. Smoking causes ill health and therefore it is not surprising that a high percentage of patients admitted to our acute hospitals are smokers. In a recent audit at King's College Hospital, of patients on acute medical and surgical wards, 42% were smokers.

When does the social gradient in smoking emerge?

The social gradient in cigarette smoking is clearly established by the late teens, as is also the gradient in nicotine intake in smokers



Prevalence of smoking and nicotine intake in 16-19 year olds by deprivation score HSE 2006-2012

Data courtesy of Professor Martin Jarvis, UCL.

The vast majority of people who smoke wish to quit. This applies equally, to those who do not have a health problem, those with physical diseases and those with mental ill health. The

underlying cause of chronic smoking is addiction to nicotine. **Those smokers who are deprived and/or mentally ill have greater addiction and therefore require more help to quit.** Evidence based and NICE recommended treatments for this addiction are well documented and recent NICE guidance has been published to increase smoking cessation in secondary care settings.

The NICE guidance on smoking cessation in secondary care emphasises the importance of achieving smoking cessation in those with mental ill health. For King's Health Partners this is particularly important in view of the high levels of mental ill health in our community and our deep commitment to improving the physical health of those with mental illness.

Patients, carers and mental health clinicians sometimes perceive smoking as beneficial and believe that high rates of smoking are due to patients using nicotine to improve mental health symptoms, particularly negative, cognitive and/or depressive symptoms. They attribute improved mood and reduced anxiety to the effects of smoking rather than the reality that smoking simply medicates the symptoms of nicotine withdrawal that occur many times throughout the day. The 'self-medication hypothesis' is popular among mental health clinicians but has little evidence to support it. Health professionals and patients often view tobacco addiction as less important to treat than alcohol or illicit drug addiction and believe that smoking cessation will impede successful outcomes for their primary drug use. **In addition to the immediate and long term physical health benefits that result from stopping smoking, particularly improvements in cardiovascular and respiratory health, recent evidence suggests people's mental health may also improve.** Depending on the type of psychotropic medication prescribed, some patients may be able to have the dosage of their medication reduced. Treating tobacco addiction at the same time as addiction to other substances is associated with a 25% greater likelihood of long-term abstinence from alcohol and illicit drugs, whereas continued smoking may increase the risk of alcohol relapse among alcohol-dependant smokers. A successful quit attempt can often be a catalyst for other positive behaviour change and the financial savings enable patients to participate more inclusively in society.

King's Health Partners is committed to Value Based Health Care. Value is defined as outcomes that matter to patients and carers, over the full cycle of care, divided by the cost of achieving those outcomes. **Stopping smoking is arguably the greatest achievable value proposition within our gift.**

4. Integrating and strengthening our pathways for smokers, particularly those who are highly dependent on nicotine

Smoking is not a lifestyle choice; it is a chronic addiction, started in childhood or when a young adult. This addiction is treatable. Some individuals can overcome their addiction to nicotine without professional help, but for many the addiction is difficult to overcome. Smoking is best regarded as a long-term condition. Healthcare professionals should offer these patients the evidence-based treatments available, in the same way as they would see it as their role to treat raised blood pressure, diabetes or asthma.

King's Health Partners believes that smoking cessation interventions represent necessary correct treatment for all smokers, particularly those who continue to smoke beyond the age of 30 and younger women wishing to have children. For some people brief intervention and advice from concerned and knowledgeable healthcare professionals can be effective, but many individuals and patients who continue to smoke are heavily dependent on nicotine, live lives that make quitting difficult and require longer and more specialist support to successfully break their addiction.

Working with the Local Authority and in collaboration with Clinical Commissioning Groups we need to consider how smoking cessation services are most effectively commissioned and delivered.

NICE guidance demonstrates that evidence based interventions to help people reduce their tobacco use or stop smoking are clinically and cost effective. The most effective treatment

for smokers is a combination of medications (nicotine replacement therapies (NRT) plus varenicline or bupropion) combined with 6-12 sessions of intensive group or individual behavioural support. Intensive interventions are more effective and more costly than simple interventions, but highly cost-effective. **A tiered approach is appropriate, with the intensity of interventions depending on the severity of addiction and response to therapy. For heavily dependent smokers, including those with mental ill- health, intensive interventions should be offered first.** An analysis of 126,000 intervention episodes in English NHS Stop Smoking Services, showed that varenicline or combination NRT was more effective than single NRT, and specialist clinics achieved higher quit rates than primary care (e.g. practice nurses or pharmacists). **For patients who fail repeated quit attempts there is little point in repeating the intervention that has failed.** Progressively more support should be provided. Specialist cessation teams, working with groups of heavily dependent smokers using the full range of available drug therapies can achieve quit rates of 70% (e.g. Maudsley Smokers Clinic model). To achieve success with “difficult to reach” heavily dependent smokers cessation services need to be proactive, reaching out to patients and engaging with them. There is much good practice to be learned from the KHP 3 Dimensions for Diabetes (3DFD) programme. This innovative programme identified diabetic patients with dangerously high blood sugar levels, engaged with them, understood the multidimensional problems the patients faced and worked with them to reduce these problems, resulting in dramatic improvements in glycaemic control. In the context of an integrated health and social care system the 3DFD intervention is highly cost effective. For highly dependent smokers, including those with severe and enduring mental health problems a similar approach will be required. Commissioners will want to commission the most clinically effective and cost effective smoking cessation intervention for each patient who wishes to quit.

Smoking cessation services are funded by Local Authorities through Public Health England. **King’s Health Partners believes that smoking cessation interventions should be included as part of an individual’s treatment for their respiratory or cardiovascular condition or their mental health** and that local commissioning of these interventions in primary or secondary care, as part of treatment plans would strongly impact on disease progression, clinical outcomes and health care utilisation. We need to consider how smoking cessation interventions impact along whole pathways of care for all patients. This may require a different commissioning framework and tariff whereby smoking cessation interventions form part of an individual’s integrated treatment plan, rather than being seen as a separate intervention.

Finally, for smokers who may not be ready or able to stop smoking in one step or not want to, NICE recently introduced harm reduction guidance. Treatment pathways should also incorporate this guidance.

Much progress has been made recently with the introduction or planned introduction of smoke-free policies in SLAM (led by the Addictions CAG) and the acute trust Partners. It is important to sustain and build on this progress to ensure that we maximise the chances of all smokers entering our Trusts stopping smoking.

Recommendations

- Effective smoking cessation services are available for all patients treated in our hospitals and clinics.
- Specialist smoking cessation services are available for those patients who are highly dependent particularly those with long term conditions who access the partner hospitals.
- Specialist smoking cessation advisors are available for those patients who have repeated failed attempts to quit as identified by smoking cessation services, including mental health patients and pregnant women and mothers with babies and young children.
- All front line staff will receive training to ensure that they ask all service users about

smoking and offer a referral to specialist support (a key component of making every contact count).

- New mothers who have quit smoking during pregnancy are followed up for continued support to achieve a year's quit target.
- Ensure smokers receive continuous, effective nicotine dependence treatment, including at transition points across the pathway.
- All Partner organisations to implement the NICE Guidelines for smoking cessation in mental health, acute and maternity settings.

Measuring our success

- Year on year quit rates for people with mental ill- health, long-term physical conditions, and pregnancy.
- Year on year quit rates for family members who have young children.
- Reduced repeat admissions and length of stay for those highly nicotine dependant patients who have long term conditions.
- Reduced numbers of admissions locally for attributable smoking related conditions in infants.

5. Informatics

Across KHP we are making progress on our informatics strategy. For our clinicians to be able to assess and plan the right care we need to be able to share our records, ensuring that across Kings Health Partners, primary and social care, we are able to collect and record the same metrics and track the journey of our patients' as they move across the health care providers. **We must be assured that smokers are receiving the most effective care, delivered in the best place at the best time.**

Our informatics systems need to be able to record and identify those patients that smoke, and those who have attempted to quit smoking. We will then be able to measure the number of smokers looked after by our services. Access to a single health record will ensure that patients will be offered the most appropriate treatments along the pathway and inform clinicians of interventions that have been successful and those that have not. Comprehensive data collections will inform our service provision and research strategies. **In the near future the health record will include data from primary care and it will be possible to document our progress in helping smokers to quit along complete care pathways.**

Recommendations

- All Partners electronically record the number of smokers that access care.
- All Partners identify those smokers who wish to receive help either with temporary abstinence, stopping smoking or reducing their smoking and informatics systems are linked to appropriate smoking cessation services
- All Partners to record the numbers of people who have been offered support.

- All Partners record the numbers of patients who have successfully stopped smoking or reduced smoking.

Measuring our success

- We will have accurate data on our local hospital and community prevalence of smoking.
- We will have accurate data on the severity of nicotine dependence of our local hospital and community populations
- We will be able to identify the numbers of patients who want to temporarily abstain or make a quit attempt and to whom a brief intervention and referral to specialist support was offered, by ward, service and hospital.
- We would be able to identify the number of people who quit smoking either during or following a hospital admission.

6. Promoting the Health of our Staff and Students

The health and wellbeing of staff and students must be a priority across King's Health Partners. It is important that we support and encourage our staff and students to lead healthy lives and avoid preventable illnesses. In 2012 KHP gained a competitive grant from NHS London to support the health and wellbeing of staff. As part of that programme a smoking cessation advisor was appointed to support staff to quit. The service reached 99 staff members, was well received, achieved a quit rate of 63% and was cost effective. It is important that across KHP we develop consistent, high quality, accessible, effective smoking cessation support for all staff and students who wish to quit. Staff who smoke lose more work days through illness (more than one working week annually). As NICE guidance demonstrates, staff who smoke are less committed in supporting both smoke-free hospitals and smoking cessation by patients. We should also consider the importance of our Partner institutions offering protection from exposure to second-hand smoke and consideration should therefore be given to all partners becoming completely smoke-free. SLaM and our acute trusts have already started this process. **All staff are carers and their health and attitudes are crucial to our mission.**

Recommendations

- All staff and health school's students joining the partners should be assessed for smoking and advised on the best way to stop.
- Staff and students wanting to quit smoking should have access to stop smoking services and given time to attend these services during work hours.
- Staff and students who do not want to quit smoking should be advised on appropriate nicotine replacement products to enable them abstain from smoking during working hours.
- King's Health Partners hospitals will become completely smoke-free in accordance with NICE guidance (SLaM October 2014; KCH January 2015; GSTT March 2015).

Measuring our success

- Reduction in the year on year prevalence of smoking amongst staff and students

- Across KHP all Partners will provide the same level of support to enable staff and students to quit smoking.
- Reductions in days off sick due to smoking related illnesses.

7. Education of our Students and Workforce

Improving the knowledge and skills of our workforce and students so that they understand and deliver successful smoking cessation interventions, through either brief intervention or more advanced personalised interventions, is essential if we are to reduce future smoking related disease amongst our patients and local population. **Supporting patients and staff across KHP to stop smoking requires a competent workforce.** The attitudes and confidence of health professionals affect their practice and willingness to adopt new ways of working, and are likely to be important determinants of their involvement in this key part of their role. Compared to non-smokers, staff who are current smokers have more permissive attitudes about patients smoking.

A local training programme will need to target knowledge, attitudes, confidence, and clinical skills. It will need to have a demonstrable impact on both clinical competency and patient outcomes (in addition to being cost effective). This will need to move at pace as all KHP organisations are becoming completely smoke-free.

King's Health Partners requires:

- Undergraduate curricula for future healthcare practitioners to include details of best practice smoking cessation interventions
- Training programmes to support Stop Smoking Practitioners deliver evidence based interventions for smokers, to improve knowledge and skills, and to promote standardization of good practice
- The development and implementation of clinical care pathways for tobacco addiction underpinned by a sustainable training programme.
- As well as providing training for staff to deliver very brief advice, brief interventions, and intensive support, KHP should also identify appropriate opportunities to thread information about smoking and cessation into existing internal and externally commissioned training programmes.
- SLaM and Institute of Psychiatry, Psychology and Neuroscience (IoPPN) are currently developing a training pathway to support the implementation and sustainability of smoke free across their sites. This will take a stepped approach using blended learning. Each step of the pathway will have a built in competency assessment. Components of this are being evaluated through the CLAHRC South London project. The learning from this will be shared with Partners.

Mental Health Module

SLaM and the IoPPN have collaboratively developed an E-Learning module to equip mental health workers with the knowledge and skills to engage service users in conversations about smoking and provide brief interventions. Using text, animation, videos and service user narratives, the course content covers:

- Smoking prevalence in mental health settings.
- Why mental health service users smoke and find it hard to stop.
- The impact of smoking and stopping smoking on wellbeing.
- Evidence based interventions for smoking cessation in mental health settings (including how to use NRT).
- How to provide brief interventions and how to refer on for specialist support.

The online course takes 2-3 hours to complete and a randomly chosen 10 item multiple choice questionnaire is completed pre and post training. Results of a preliminary 6 month evaluation of the module showed that 791 mental health staff had completed the module and there was a 37% increase in knowledge scores pre and post training. Completion of the module enabled the Trust to exceed their CQUIN target for level 1 smoking cessation training.

Delivering the training via E Learning rather than face to face enabled wider dissemination and greater uptake. For example, previously 99 staff completed face to face level 1 training over a 5 year period, whereas over 1000 staff completed online training in 12 months.

Recommendations

- All clinical staff are trained to assess patients' smoking status, offer brief advice and refer appropriate patients to smoking cessation services.
- Selected staff are trained to level 2, to administer and prescribe smoking cessation interventions.
- Teaching on smoking cessation interventions is part of the health schools undergraduate curriculum and graduates are equipped to offer brief advice.

Measuring our success

Increase year on year on the numbers of staff trained to both Level 1 and 2 smoking cessation training across all CAGs and services.

Increase in positive staff views on the value of smoking cessation interventions.

8. Research

Our audits in the past have shown that not all our patients were being asked whether they smoke and nicotine dependent treatment not being routinely offered. This demonstrates the need for an improved informatics structure which will enable KHP to routinely collect data on smoking for all patients, new data on the tobacco dependence treatment needs of patients and enable us to evaluate the efficacy and effectiveness of our interventions.

We are also creating as many opportunities as possible to attract funding for service development novel research and policy development and evaluation. In the past our nicotine dependence treatment services have been at the forefront of practice, delivering among the highest success rates and researching novel treatments. This has been allowed to slip. There are many exciting cutting-edge projects in tobacco across King's, and improving our informatics structures and treatment pathways will facilitate our research in the future.

A unified co-ordinated research plan across KHP will enable the Partners to make the best use of our resources and expertise and put King's back at the forefront of nicotine dependence research.

Recommendations

- Develop a systematic approach to identifying opportunities for research and evaluation related to tobacco across KHP
- Develop a data base for KHP research activities related to tobacco
- On an annual basis, collect naturalistic data using the enhanced informatics systems. Analyse data by patient diagnosis, CAG and partner organisation for:

Smoking demographics and characteristics

Prevalence of smoking of patients, staff and students
Severity of nicotine dependence of patients, staff and students
Prevalence of patients who want to temporarily abstain, with and without support during an inpatient admission, and those who want to make a quit attempt.
Number of referrals made to specialist stop smoking clinics

Efficacy and effectiveness of interventions

Uptake of:
Support offered for temporary abstinence during an inpatient stay
Support offered for smoking cessation during an inpatient/clinic episode
Referrals to specialist stop smoking clinics
Support for staff and student smokers

Outcome of above support on:

Four week, six and 12 month quit rates
Smoking reduction rates
Satisfaction with treatment
Cost of treatment

Effect of above support on Health Outcomes

Assess the impact of smoking and stopping smoking on each's CAG's minimum set of health outcomes they routinely measure.

Staff training

Evaluate the uptake of training by CAG and the effect of training on knowledge, skills and attitudes, patient metrics (e.g. referral for specialist support, uptake of support, quit rates)

9. Communications

(To be completed)

10. Next Steps

King's Health Partners will consult widely to finalise the strategy and to agree a plan for implementation.

- *Operational Executive – Dec 16th*
- *Board – 17th*
- *CAG leaders in Jan 2015*
- *CCGs, Health and Wellbeing Board, charity*

11. References

Key references:

National Institute for Health and Care Excellence (NICE). Smoking cessation in secondary care: acute, maternity and mental health services. NICE public health guidance 48. November 2013. Available at: <https://www.nice.org.uk/guidance/ph48>.

National Institute for Health and Care Excellence (NICE). Tobacco: harm reduction approaches to smoking. NICE public health guidance 45. Modified July 2013. Available at: <https://www.nice.org.uk/guidance/ph45>.

Royal College of Physicians/Royal College of Psychiatrists. Smoking and Mental Health. A report of the Tobacco Advisory Group of the Royal College of Physicians. London: Royal College of Physicians, 2013.

Additional references

1. Pasco JA WL, Jacka FN, et al. Tobacco smoking as a risk factor for a major depressive disorder: a population-based study. *The British Journal of Psychiatry* 2008;193:322-26.
2. Wu C, Chang C, Robson D, Jackson R, Chen S, Hayes R, et al. Evaluation of Smoking Status Identification Using Electronic Health Records and Open-Text Information in a Large Mental Health Case Register. *PLoS ONE* 2013;8 (9).
3. Cookson C, Strang J, Ratschen E, Sutherland G, Finch E, McNeill A. Smoking and its treatment in mental health services: Clients' and staff behaviour and attitudes. Final Report.
4. McManus S, H. M, Champion J. Cigarette smoking and mental health in England Data from the Adult Psychiatric Morbidity Survey 2007. London: National Centre for Social Research, 2010.
5. Aguilar MC. Nicotine dependence and symptoms in schizophrenia: Naturalistic study of complex interactions. *The British Journal of Psychiatry* 2005;186(3):215-21.
6. Champion J, Checinski K, Nurse J. Review of smoking cessation treatments for people with mental illness. *Advances in Psychiatric Treatment* 2008;14(3):208-16.
7. de Leon J, Diaz FJ, Aguilar MC, Jurado D, Gurpegui M. Does smoking reduce akathisia? Testing a narrow version of the self-medication hypothesis. *Schizophr Res* 2006;86(1-3):256-68.
8. Taylor G., McNeill A., Girling A., Farley A., Lindson-Hawley N. and Aveyard P. (2014) Change in mental health in mental health after smoking cessation: systematic review and meta-analysis *BMJ* 2014;348:g1151 doi: 10.1136/bmj.g1151.
9. Prochaska, J.J., Delucchi, K., & Hall, S.M. (2004). [A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery](#). *Journal of Consulting and Clinical Psychology*, 72, 1144-1156.
10. Taylor, B.J.; Graham, J.W.; Cumsille, P.; et al.(2000) Modeling prevention program effects on growth in substance use: Analysis of five years of data from the Adolescent Alcohol Prevention Trial. *Prevention Science* 1:183–19.
11. Royal College of Physicians, Royal College of Psychiatrists (2013). Smoking and mental health. London: RCP.

12. Parkin, DM, Boyd L & Walker LC (2011) The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010: Summary and conclusions. *British Journal of Cancer*, 105, S77 – S81.
13. McBride CM, Emmons KM, Lipkus IM. Understanding the potential of teachable moments: the case of smoking cessation. *Health Educ Res* 2003;18:156-170.
14. 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. *BMJ* 2014;348:g1151
15. Cookson C, Strang J, Ratschen E, Sutherland G, Finch E, McNeill A. Smoking and its treatment in addiction services: Clients' and staff behaviour and attitudes. *BMC Health Services Research*. 2014, 14:304. Available at: <http://www.biomedcentral.com/1472-6963/14/304>
16. Wu C, Chang C, Robson D, Jackson R, Chen S, Hayes R, et al. Evaluation of Smoking Status Identification Using Electronic Health Records and Open-Text Information in a Large Mental Health Case Register. *PLoS ONE* 2013;8 (9).
17. Brose LS, West R, McDermott MS, Fidler JA, Croghan E, McEwen A. What makes for an effective stop-smoking service? *Thorax* 2011;66:924-6.
18. Szatkowski L, McNeill A. Diverging trends in smoking behaviours according to mental health status. *Nicotine & Tobacco Research*, 2014 Sep 1. pii: ntu173. [Epub ahead of print].
19. Szatkowski L, McNeill A. The delivery of smoking cessation interventions to primary care patients with mental health problems. *Addiction*. 2013 Aug;108(8):1487-94. doi: 10.1111/add.12163. Epub 2013 Mar 27.
20. Brose LS, West R, Michie S, Kenyon JA, McEwen A. Effectiveness of an online knowledge training and assessment program for stop smoking practitioners. *Nicotine & Tobacco Research* 2012;14:794-800.
21. Robson D, Haddad M. Mental health nurses' attitudes towards the physical health care of people with severe and enduring mental illness: the development of a measurement tool. *Int J Nurs Studies* 2012 49:72-83. doi: 10.1016/j.ijnurstu.2011.07.011. Epub 2011 Sep