

Acute CURE service report

Health and Wellbeing Board

Date of meeting: 05/03/2026

Lead director/officer: Rob Howard

Useful information

- Ward(s) affected: all
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- Report version number: 1

1. Summary

In hospital smoking cessation programmes are supported by both the NHS Long Term Plan and the 10 year “Fit for the Future” plan.

The CURE programme is the in-hospital smoking cessation programme for Leicester. Tobacco Dependency Advisors (TDAs) work with patients to advise and support them in their smoking cessation journey.

This programme is a unique opportunity to interact with people who may previously not have considered smoking cessation, but because of their admission to hospital, they are more likely to give up if they receive timely support.

In-hospital smoking cessation narrows health inequalities: the team see more patients, and generate more successful “quits” in those from lower IMD quintiles than higher.

In-hospital smoking cessation has been shown in studies from two other areas to have significant return on investment, not just for the NHS, but also for wider communities. (In Manchester, for every £1 invested in in-hospital smoking cessation, there was a return on investment of £30.49 for the wider public health of the local community).

The current programme works across all three hospital sites in Leicester and generated 245 new quits October 2024 – October 2025.

Work is ongoing to make the programme as efficient and effective as possible. This includes a new text-based programme, more streamlined transfer of care to community smoking cessation services, increased pharmacological support and workforce training and education.

2. Recommendation(s) to Health and Wellbeing Board:

Health and Wellbeing Board are invited to:

- Note the work of the CURE service and the on-going improvements
- Recognise the potential cost-effectiveness and reductions in inequalities the service provides

3. Detailed report

1.1. Background

There is a national push for in-hospital smoking cessation services. In 2019, the NHS Long Term Plan (LTP) outlined a requirement to provide all people admitted to hospital who smoke with an NHS-funded in-house tobacco treatment service by 2023/24.

The NHS Long Term Plan:

“2.9. First, the NHS will therefore make a significant new contribution to making England a smoke-free society, by supporting people in contact with NHS services to quit based on a proven model implemented in Canada and Manchester [26]. By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.” (NHS Long Term Plan, 2019)

This was further supported by the publication of the “Fit for the future 10-year health plan” which stated:

“We will deliver our manifesto commitment to integrate opt-out smoking cessation interventions in all routine care within hospitals” (Fit for the future 10-year health plan, 2025)

The programme was started after funding, guidance and delivery models were issued by NHSEI in 2019, services were to be implemented across three key settings: acute inpatients, mental health inpatients and pregnant women. This report focuses on the acute inpatients service (all three services are currently running across UHL and Leicestershire Partnership NHS Trust).

The work currently undertaken follows the “CURE model”. Manchester developed the CURE programme by adapting the Ottawa Model for Smoking Cessation (OMSC) to a UK context. CURE stands for Conversation, Understand, Replace, Experts and Evidence-based treatments (CURE). This model aims “to change healthcare practices so that smoking cessation treatment is provided as part of routine care to all patients who are tobacco users”. This model is evidence based, validated, and has shown favourable outcomes.



Figure 1: CURE acronym

The service is currently funded by the ICB, UHL and Leicester City Council. The ICB provide 4 Tobacco Dependency Advisors (TDAs), a co-ordinator, pharmacotherapy, communications team input, and QuitManager software. UHL contribute the majority of pharmacotherapy and Leicester City Council provide an additional TDA.

The TDAs work in all three of Leicester’s hospitals. They are given a list of patients each day who have been identified at initial triage as current smokers. They will visit these patients and conduct motivational interviews; they also provide NRT. If anyone would like to quit smoking then they will discuss the most suitable options for each person (which can include NRT or other pharmaco-therapy including varenicline and cytisine), they will then refer the patients to their local stop smoking service. Most referrals are made to either LiveWell for city residents or QuitReady for county and Rutland residents, but they can be further afield.

We have a bold vision within Leicester City Council “to make Leicester smoke-free by 2030”. To achieve this aim we need to have a high-performing service meeting the needs of our population. CURE is one part of the wider current smoking cessation programme operating in the city.

1.2 Why in-hospital support for smoking cessation is important for individuals

Smoking is the leading cause of all premature and preventable deaths. Tobacco kills up to half of its users ¹. After the age of 35, for every year of continued smoking, a person loses about 3 months of life expectancy ².

Furthermore, smoking has a direct effect on people's wealth. At today's prices smoking 20 cigarettes per day will cost an individual £67,267 over 20 years if they buy cigarettes in packets, and £31,450 over 20 years if they use hand rolled tobacco ².

In-hospital smoking support is able to reach people from all backgrounds, at a time where they are more likely to consider quitting.

1.3 Why in-hospital support for smoking cessation is important for our communities

In Leicester, we as a city are worse off when it comes to smoking. The Leicester Health and Wellbeing Survey in 2024, which conducted a total of 2100 interviews across the city, found that Leicester's current smoking prevalence is approximately 16%. This means that almost 50,000 individuals are smokers. 50% of those would like to quit. This 16% prevalence figure is higher when compared to the England average of 13.6%.

According to the Health and Wellbeing Survey smoking rates vary within different communities in the city. However, there is no area where smoking rates are zero. Prevalence in West locality 24%, and Northwest locality 23% are significantly higher than Leicester overall. North and Central localities are significantly lower than Leicester, 9% and 12% respectively.

¹ [Facts at a Glance - ASH](#)

² [Stopping Smoking - ASH](#)

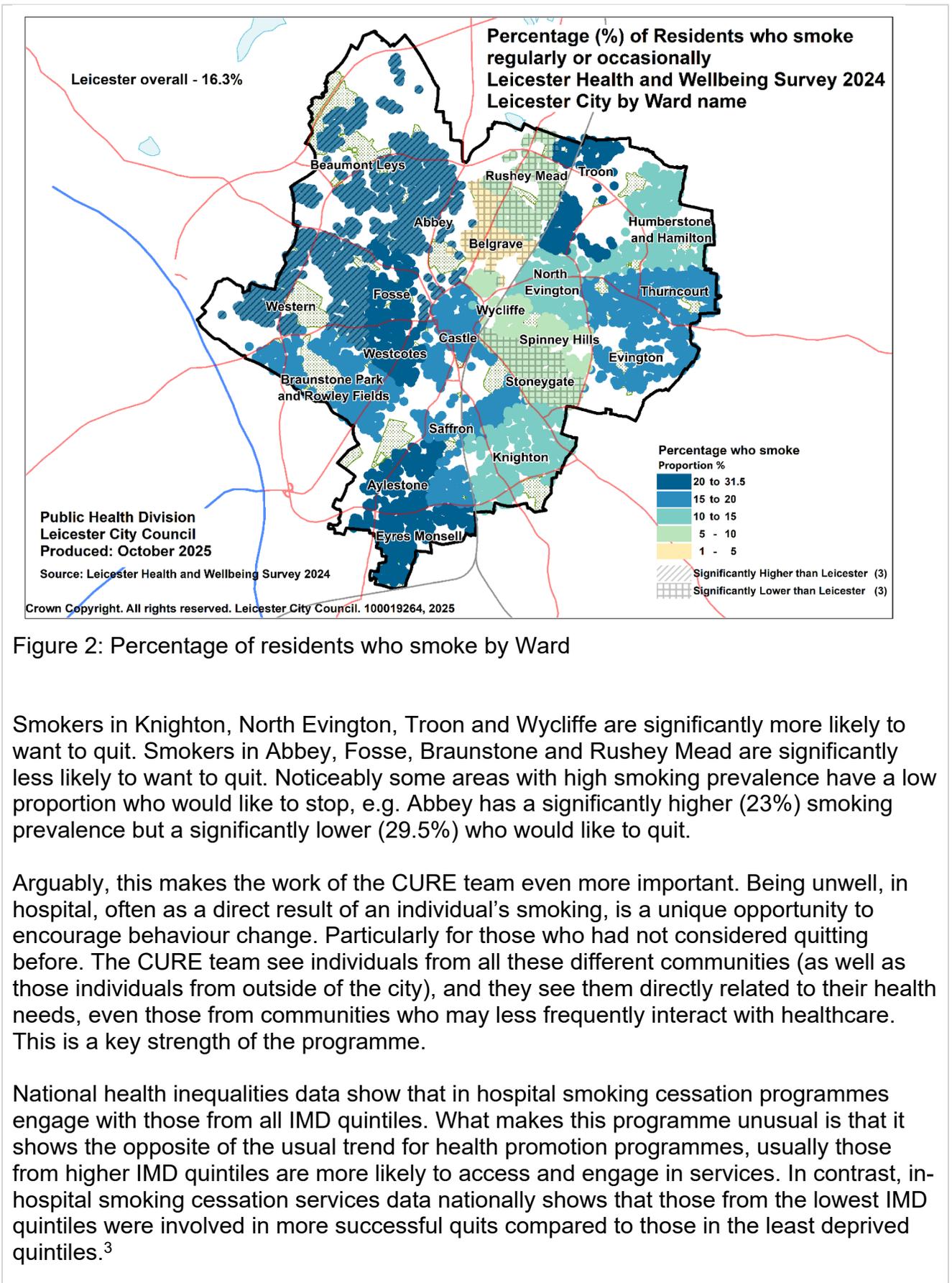


Figure 2: Percentage of residents who smoke by Ward

Smokers in Knighton, North Evington, Troon and Wycliffe are significantly more likely to want to quit. Smokers in Abbey, Fosse, Braunstone and Rushey Mead are significantly less likely to want to quit. Noticeably some areas with high smoking prevalence have a low proportion who would like to stop, e.g. Abbey has a significantly higher (23%) smoking prevalence but a significantly lower (29.5%) who would like to quit.

Arguably, this makes the work of the CURE team even more important. Being unwell, in hospital, often as a direct result of an individual’s smoking, is a unique opportunity to encourage behaviour change. Particularly for those who had not considered quitting before. The CURE team see individuals from all these different communities (as well as those individuals from outside of the city), and they see them directly related to their health needs, even those from communities who may less frequently interact with healthcare. This is a key strength of the programme.

National health inequalities data show that in hospital smoking cessation programmes engage with those from all IMD quintiles. What makes this programme unusual is that it shows the opposite of the usual trend for health promotion programmes, usually those from higher IMD quintiles are more likely to access and engage in services. In contrast, in-hospital smoking cessation services data nationally shows that those from the lowest IMD quintiles were involved in more successful quits compared to those in the least deprived quintiles.³

³ [Is the provision of a national opt-out tobacco dependence treatment service in acute hospitals in England equitable? A national cohort study | Thorax](#)

This national picture is also seen in UHL where those in the most deprived quintile commenced over triple the quit attempts than those in quintile 5. This is likely to be at least partly explained because those in quintile 1 are more likely to be in hospital, and that those in quintile 1 are more likely to smoke compared to quintile 5. The service success rate in persuading those people they see to commence a quit attempt is similar across the quintiles.

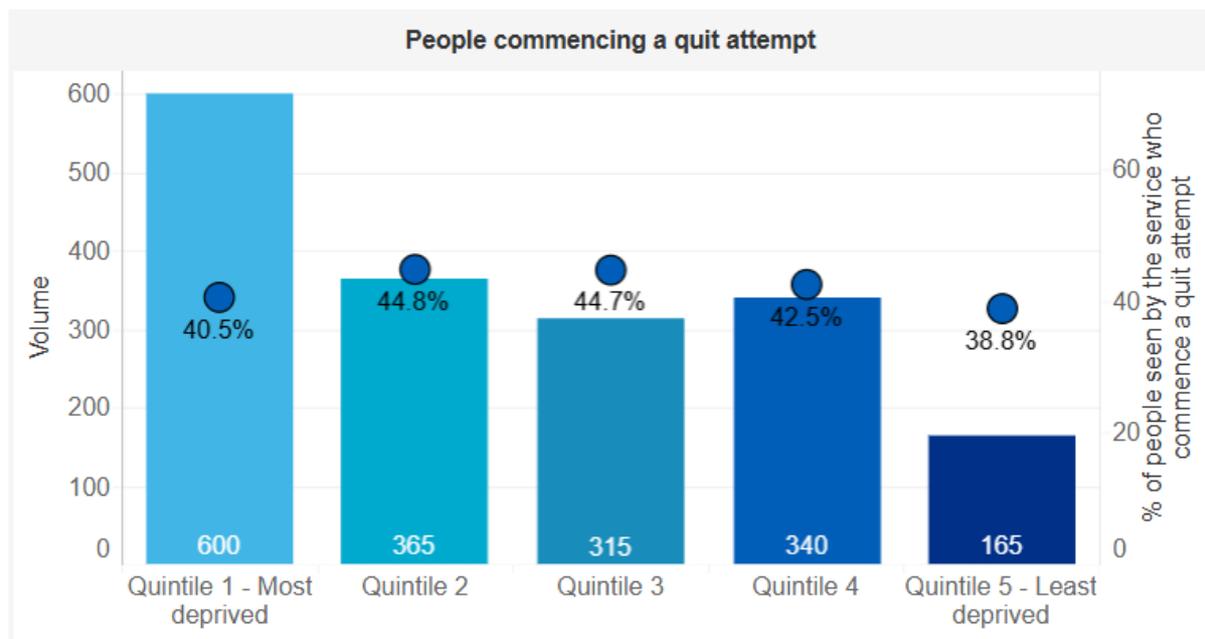


Figure 3: UHL quit attempts by IMD quintile (October 24 – September 25)

In Leicester, in the last 3 months of published data (September – December 2025), 33.73% of the patients the CURE team saw, were from the most deprived quintile of the population. Therefore, based on current data the CURE team provide a service which reduces rather than widens health inequalities in our communities.

In total, nationally in 2024, after the work of in hospital smoking cessation programmes, more people in lower IMD quintiles quit smoking compared to those in higher quintiles.

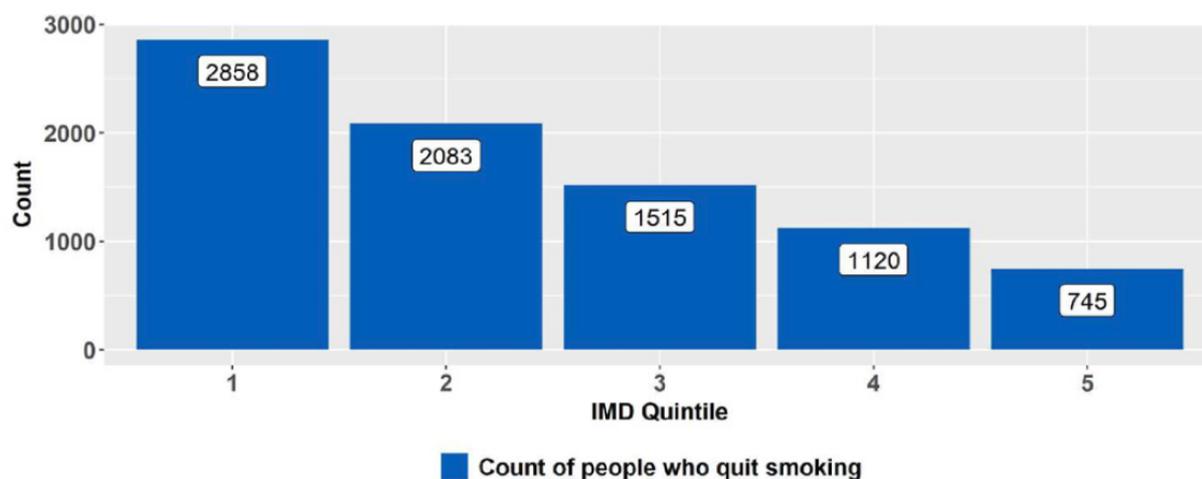


Figure 4: People successfully quitting after a supported quit attempt which started after an in-hospital smoking cessation intervention ³

This is likely due to the facts that those in quintile 1 are more likely to smoke and are also more likely to be in hospital. In UHL this trend was the same as the national picture.

Therefore, the CURE service is an unusual service because it is more likely to engage, and be used by, those in lower IMD quintiles. It is more likely to narrow rather than widen health inequalities. This is down to the demographics of those admitted to hospital and those who smoke. Due to the hospital setting, it represents a unique opportunity to provide targeted health promotion interventions to individuals who may have less access to this material outside of acute healthcare.

1.4 Why in-hospital support for smoking cessation is important for the economy

Nationally, the NHS bears a heavy cost from smoking – £1.8 billion annually,⁴ with one person admitted to hospital nearly every minute due to smoking-related disease. Up to 75,000 GP appointments each month are linked to smoking - more than 100 every hour.⁵ Therefore, the more quits that can be generated the more capacity is created across the whole health system.

An economic evaluation was made for an in-hospital smoking cessation service in Southeast London in 2024⁶. They have a very similar service to Leicester where TDAs would perform motivational interviews to patients whilst they were in hospital and then refer those interested in stopping smoking to the local community smoking cessation services. They calculated that their “cost per quit” was £1712.55. The ICER (Incremental cost-effectiveness ratio) was £3325 per life year gained i.e. for every £3325 spent on this scheme 1 additional year of life in full health was gained. This would be significantly under the threshold of £25000-35000 that NICE currently uses, showing that this method is very cost-effective at improving health.

The Southeast London study then looked at all the patients that their TDAs had seen and calculated that re-admissions of these patients were significantly lower than those who were not seen (5% vs 11%). (This was all patients who were seen, not just those who agreed to a quit attempt). They calculated that there was a return on investment for the NHS of £1.37 for every £1 spent. It should be stressed that this was just the financial benefit to the NHS and that quitting smoking also leads to financial benefits to individuals, families and wider society (through increased productivity and reduced inequality).

Another health economic study was performed looking into the Manchester CURE project, published in 2021⁷. This calculated that their cost-per-quit was £475 and their ICER was £487. This, therefore, represents even better value. The return on investment was £2.12 for every £1 invested. They also calculated that the “public value”, which considered longer term cost savings related to improved health of those who quit, meant that the return on investment was £30.49 per £1 invested in this wider context.

⁴ ashresources.shinyapps.io/ready_reckoner/

⁵ [Ending smoking could free up 75,000 GP appointments each month](#)

⁶ [Economic evaluation of a hospital-initiated tobacco dependence treatment service | BMJ Open](#)

⁷ [Health economic analysis for the 'CURE Project' pilot: a hospital-based tobacco dependency treatment service in Greater Manchester | BMJ Open Respiratory Research](#)

We predict that our own health economic figures would be somewhere between these two studies, this is because of the relative sizes and ages of the services. Our approximate cost per quit is between £900 - £1,200 per quit. Furthermore, public health interventions typically generate greater cashable cost savings when implemented at scale and when implemented over longer time scales. The Manchester project is larger and has been going for slightly longer than the Leicester project. Therefore, we would expect its return on investment to be larger at this stage.

1.5 Our current service performance

The most recent performance data of the service over one year (October 2024 – October 2025) is below.

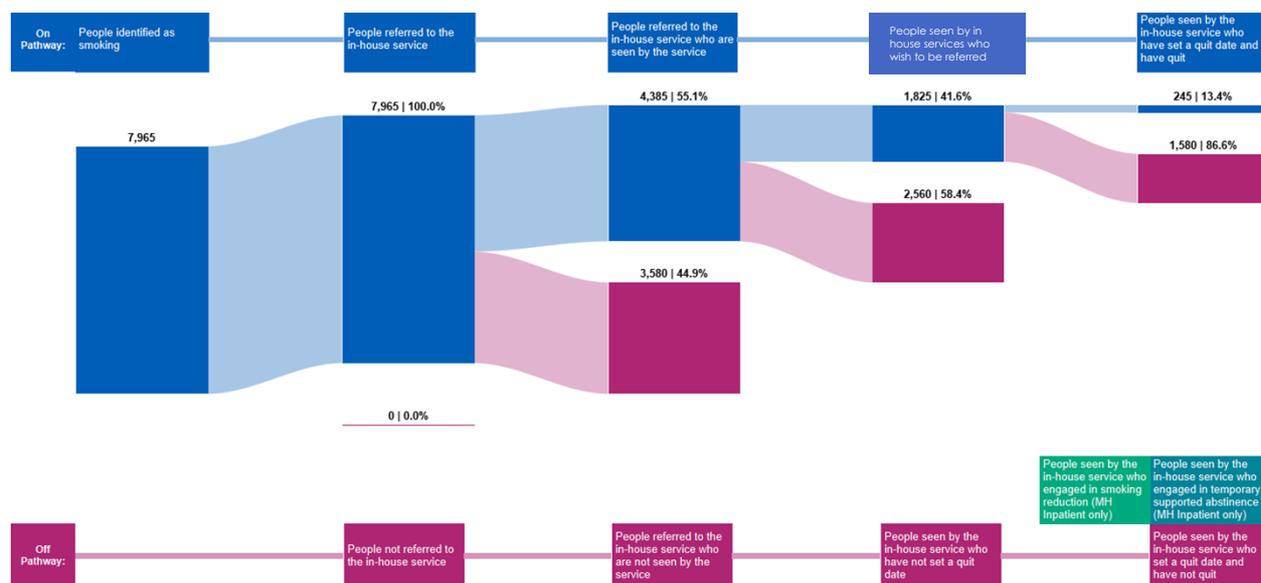


Figure 5: 1 year overview of the current service.

In the year between October 2024 and October 2025 (the most recent available published data from NHSE) the service had individual motivational interviews with 4,385 individuals. This led to 1,825 people wanting to undertake a quit attempt, and of these 245 were successful (13.4%). The successful quit percentage has steadily increased over the last year. The last month's quit percentage was 19.2%. This compares to all-time the national average of 18.2%.

These quit percentages are much lower than the quit rates seen in community stop smoking services (LiveWell's current quit rate is over 55%). However, LiveWell's quit rate is based on people being motivated enough to refer themselves to LiveWell, and then, after they have a discussion with an advisor being motivated enough to set a quit date. LiveWell's quit rate is calculated as the number of people in this group who then successfully quit. Conversely the 19.2% figure for CURE is a percentage of those people who are seen by the CURE team whilst in hospital and wish to be referred to community

services to then have a further discussion to set a quit date. Furthermore, the CURE team are not seeing a predetermined group of people who already have some motivation to quit, they are seeing everyone in hospital whether they are part of the 50% of the population who are thinking about quitting or not. Therefore, there are often individuals who wish to be referred whilst in hospital and then change their minds or who are later uncontactable.

More recent data than October 2025 is presented below. This is taken directly from the TDA patient software “Quit Manager” from July 2025 and January 2026.

CURE is usually referred between 600-800 patients to see each month. The team typically sees between 55%-65% of these patients. It should be noted though that the TDAs do usually see all those referred patients who are still in the hospital. There are many patients who are admitted and discharged in the evening or weekend who are unable to see a TDA. The numbers of patients seen by each individual TDA compares favourably to other areas and has increased over the last year (see successes section).

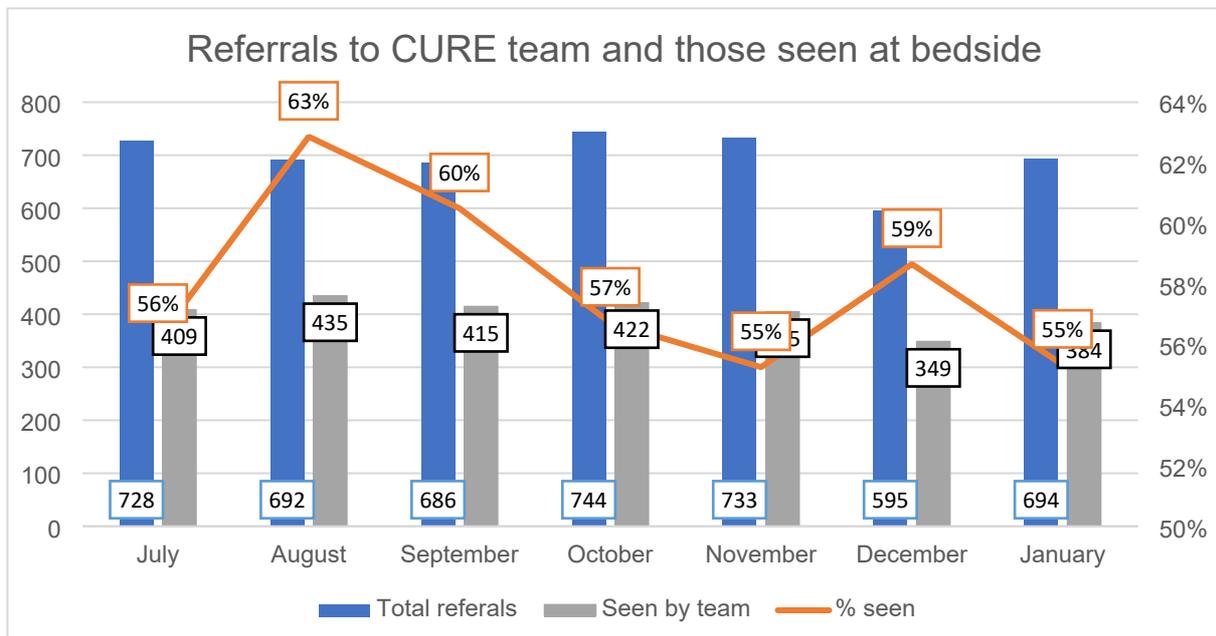


Figure 6: Referrals to CURE team and numbers seen by CURE team

Those who are referred to, but not ultimately seen by, the CURE team are part of a cohort of patients who we are actively exploring how we might contact more regularly. When TDA capacity allows they call some of these patients post-discharge. However, this is only a small percentage currently as it is dependent on workforce capacity.

After a patient is seen by a TDA many are then referred on to the relevant community smoking cessation services. This is usually between 100 and 160 patients each month. These patients are prioritised by LiveWell and phoned, normally, within a week of their discharge. This is to ensure that momentum is not lost in their quit journey.

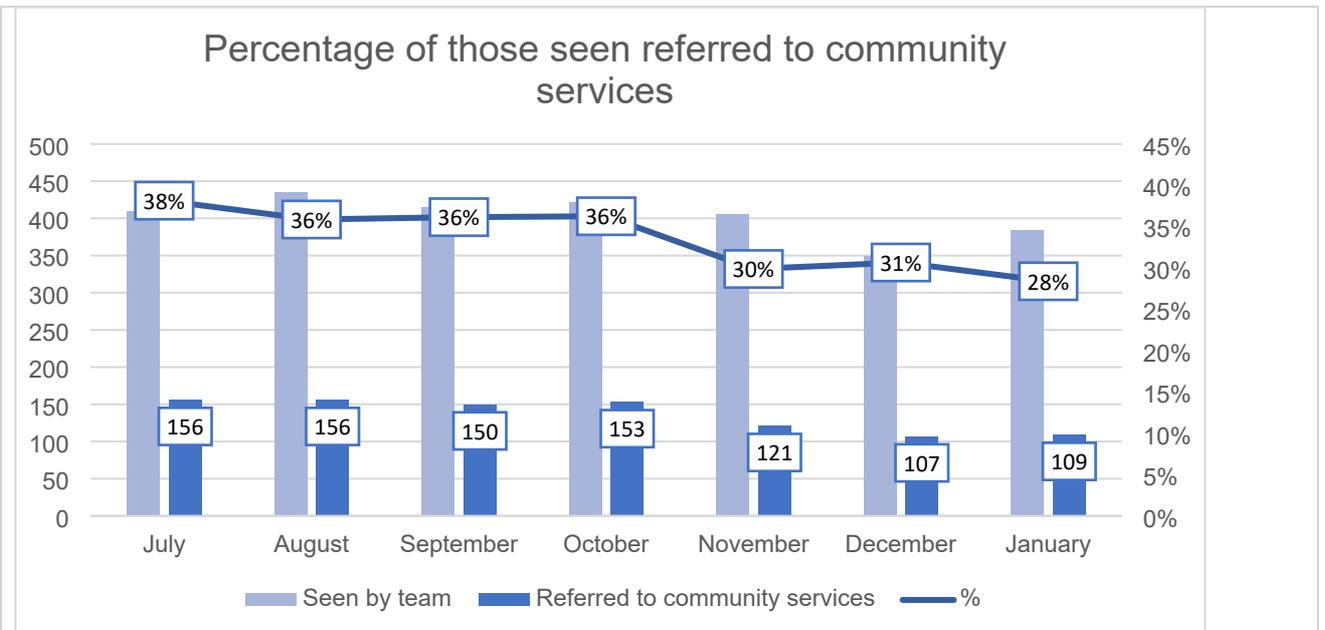


Figure 7: Percentage of those seen who are then referred to community services.

The total number of quits is shown in the next figure. Please note that the January quit data is not yet available as the measure is taken 28 days after they have set their quit date. We also expect the December number to increase as there is often a lag in reporting. (Usually, this increase is between 1 and 5 each month).

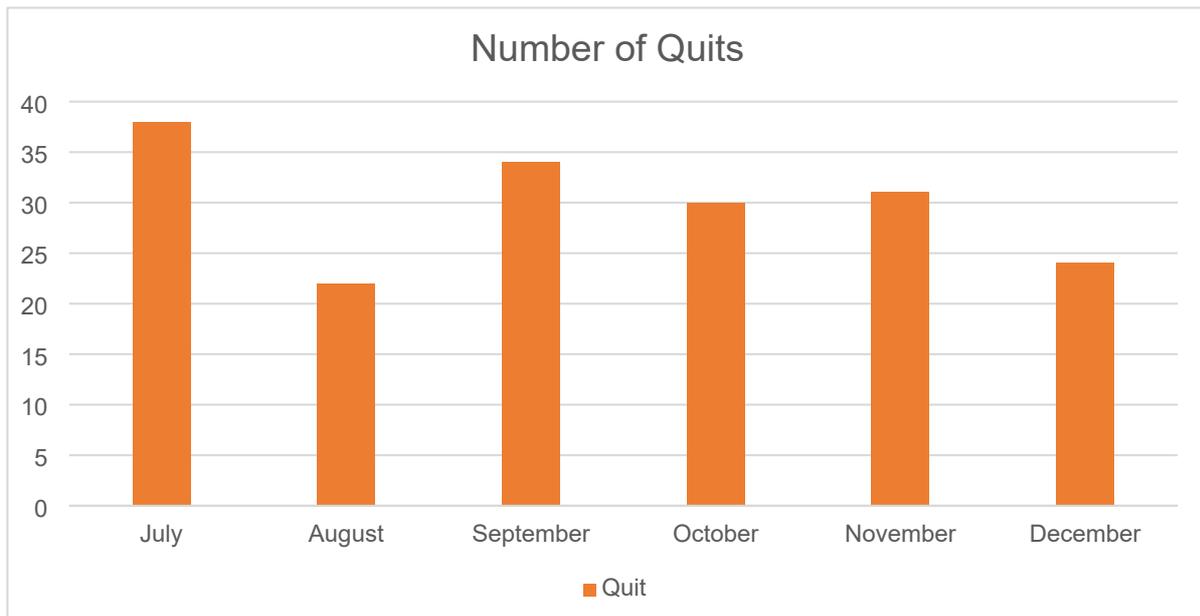


Figure 8: Total quit numbers per month, July – December 2025.

The service feeds into different reporting groups. There are regular (every 2 months) steering group meetings between CURE, in-patient mental health services, and maternity services, with representatives from the ICB and UHL present. There are also data working group meetings (every 2 months) where data issues are specifically covered with IT and informatics representatives also present. The group feeds into the UHL prevention board.

1.6 Service successes

As already stated above the percentage quits has increased over the last year. This is likely due to several factors. One of the most important is the introduction of a new texting service. We are now sending out texts, to those who consent to it, after they leave hospital. If they want to consider a quit attempt at this point we can then refer into community services. We have also found that we hear of more successful quits from those individuals who did not engage with local services but successfully quit by themselves. This further emphasises the importance of connecting with people whilst they are in hospital and are more focussed on their health.

| | |
|---|------------|
| Texts sent | 514 |
| Number replied -“quit” | 86 |
| Number replied – “not quit” | 61 |
| Percentage of people who replied to text | 29% |
| Percentage of people who replied to say they quit | 17% |

Table 1: Most recent texting results September – November 2025

Another factor is likely to be that the TDAs are seeing a higher number of patients in hospital. This is because an additional TDA was appointed one year ago and reflects a more mature service - our TDAs have recently been contacted by two other local trusts to discuss this increase in efficiency as other areas want to copy our model.

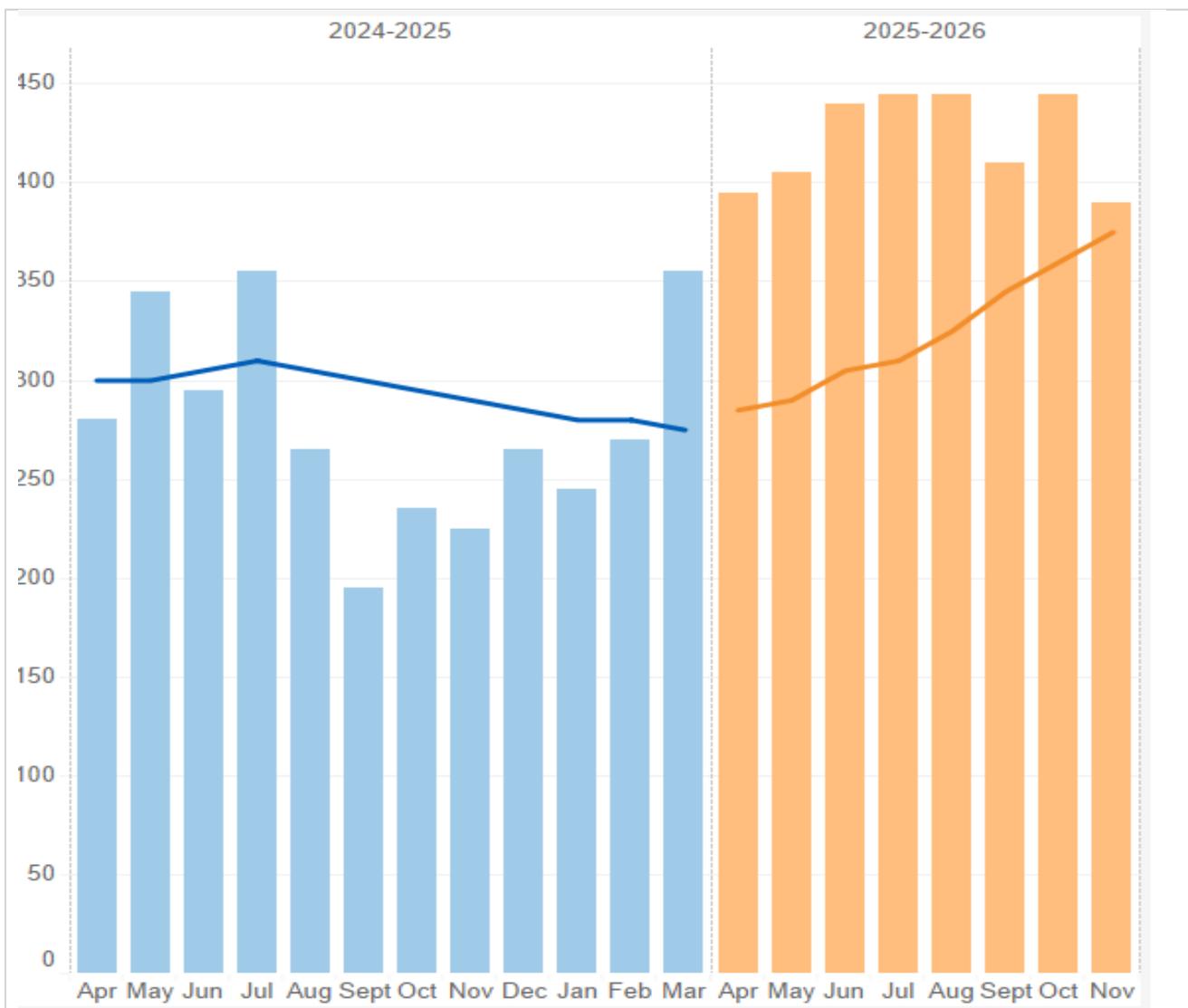


Figure 9: Number of patients seen by CURE team over time

Another on-going quality improvement project is trying to reduce the drop-off in people being referred to LiveWell and ultimately engaging in the service. Previously individuals were contacted by a hub advisor and then booked in with a smoking advisor. The hub advisor would complete a survey of general health questions to see if there were any other areas of the LiveWell service the patient might benefit from. Feedback suggested that this sometimes put individuals off as they wanted to focus on smoking cessation. QuitReady (the county community service) did not have this additional survey set of questions and had less drop off in engagement. Therefore, a new pathway is currently being reviewed where this survey is not completed at the point of booking. Initial reports suggest that this is leading to improved engagement.

Some patient testimonials about the service from those patients who successfully quit are below:

"[I have] never felt so good. I feel great! Approaching 70 and feel 45. Those 10 days in hospital changed my life; it was for the best I fell down. Giving up smoking means I am saving £2,500 a year. I have booked two holidays, and it's not stopping there! The help I received was excellent".

“The thing I am most pleased with is not coughing in the morning. I used to cough a lot. I can also smell more and taste things better. Overall, I feel so much better, feel my lungs are healthier. I’ve also saved some money.”

“My bank balance is better. I used to buy x4 packs a week at £12 so saving £48 a week now and I feel a lot better. You’ve all been brilliant!”

1.7 Areas for improvement

There has recently been an expansion of smoking cessation work into the outpatient setting. Those who are identified in A&E, lung cancer clinics and TIA clinics as being current smokers enter an opt-out pathway where they are called and then referred into their local community smoking cessation service. This is an area which we are looking to expand.

The quit rates for those people who are referred into lung cancer clinic are particularly high. Over a 4-year period (August 2021 – August 2025) 1204 patients were referred via the opt-out pathway. The service successfully contacted 417 people who then went on to engage in a quit attempt. Of these 258 successfully quit. The overall quit rate among all current smokers who were successfully contacted was 31% (258/834).

It is likely that lung cancer clinic patients are the most highly motivated to quit smoking so their quit rates are significantly higher than those who are current inpatients. It is likely that those referred from other related outpatient settings would have lower quit rates. However, this represents another route where the smoking cessation advisors have an interaction with a person when they are much more likely to be focused on their health and are therefore, more likely to consider a quit attempt. Work is underway to try and automate and expand the current service.

We are currently working to ensure that varenicline and cytisine prescriptions are done in a timely and effective manner. In a pilot of targeted prescriptions, there was an almost 40% quit rate for local patients. Therefore, we are keen to ensure that, for those who would like to try these, they have the option. Currently there are three main barriers to prescribing these drugs. Firstly, there is a hesitancy from staff to prescribe as there are warnings in the (British National Formulary) BNF about prescribing due to the risk of mental health crisis. New studies have shown that it is actually the effect of stopping smoking which raises this risk. We are tackling this with an awareness raising campaign (through targeting prescriptions, pharmacy champions and education sessions). Secondly, there can be difficulties ensuring that these medications are added to the discharge letters. This is usually due to communication breakdown between the TDAs, the ward team, and those individuals who are preparing the paperwork. We are tackling this issue with a quality improvement project around new giant stickers for the notes to improve handover to new ward team members and teaching sessions to ward staff. The third barrier is ensuring that the full course is prescribed on discharge. This has improved after pharmacy support and is being further tackled through pharmacy champions to facilitate discharges. To note, there is also work on-going for local community smoking cessation services to also have the capability to provide these drugs. This will also help to improve access to these medications.

1.8 Final comments

The CURE team provides a service to people which benefits their health, their communities' health and the wider economy. Quitting smoking is usually the single best thing someone can do to improve their health ⁸.

This service drives down health inequalities.

This service is very likely to produce a positive return on investment, both to the NHS and to the wider public health system.

4. Financial, legal, equalities, climate emergency and other implications

4.1 Financial Implications

This service is jointly funded by the ICB, UHL and LCC however this report is not seeking any additional funding, therefore there are no direct financial implications arising. Successful delivery of this service will reduce public expenditure across local authorities and the NHS as outlined throughout the report.

Signed: Mohammed Irfan, Head of Finance

Dated: 17 February 2026

4.2 Legal Implications

There are no apparent adverse legal implications of the content of this report.

Signed: Emma Youn

Dated: 17 February 2026

4.3 Equalities Implications

Under the Equality Act 2010, public authorities have a Public Sector Equality Duty (PSED) which requires them, in carrying out their functions, to have due regard to the need to eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act; to advance equality of opportunity between people who share a protected characteristic and those who do not; and to foster good relations between different groups. Protected characteristics under the Act include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Tobacco use remains one of the leading causes of health inequalities across Leicester. People living in more deprived areas, those in routine and manual occupations, and individuals with mental health conditions are more likely to smoke and to experience smoking-related illness. The CURE service reaches people during hospital admission, including those who may not otherwise access community-based smoking cessation support. Local data shows that patients from the most deprived communities are more likely to engage with the service and successfully quit, helping to narrow health inequalities.

⁸ [Benefits of Quitting Smoking | Smoking and Tobacco Use | CDC](#)

The service supports equality of opportunity by providing inclusive, free, and evidence-based support to all patients who smoke, regardless of background or circumstance. This includes offering materials in accessible formats, interpreters where required, and ongoing workforce training to ensure that support is sensitive to diverse needs. By reducing smoking prevalence, the service will make a significant contribution to improving health outcomes across protected characteristic groups and to reducing health inequalities across the city.

Signed: Equalities officer, Surinder Singh, Ext 37 4148

Dated: Dated 18 February 2026

4.4 Climate Emergency Implications

There are no significant climate emergency implications arising from this report.

As service delivery generally contributes to the council's carbon emissions, any impacts of carrying out new projects can be managed through measures such as requesting partners use sustainable travel options or provide remote services where appropriate, using buildings and materials efficiently and following the council's sustainable procurement guidance, as applicable to the programme.

Signed: Phil Ball, Sustainability Officer, Ext 372246

Dated: 18th February 2026

4.5 Other Implications

Signed:

Dated:

5. Background information and other papers:

6. Summary of appendices: