LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Acute CURE Tobacco Dependency Evaluation
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EXECUTIVE SUMMARY:

The purpose of this report is to update key boards on the delivery and progress of the Acute CURE Tobacco Dependency Service delivered across the University Hospitals of Leicester as part of the NHS Long Term Plan Prevention agenda for Tobacco Dependency. This programme requires joint efforts across the system to effectively address high smoking rates in Leicester.

Leicester City Council Public Health hold the NHS Prevention funding and employ the delivery team for this programme. In order to deliver on the national programme requirements the ICB, UHL and Local Authority Public Health teams are working together across the system to develop streamlined pathways from hospital to community.

The NHS Long Term Plan outlines a clear requirement to provide all people admitted to hospital who smoke with an NHS-funded in-house tobacco treatment service by 2023/24. Guidance and delivery models have been issued by NHS England and Improvement (NHSEI) to improve care for patients who smoke across various settings; these are acute inpatients, mental health inpatients and pregnant women. The Acute inpatient project (otherwise known as The CURE Project) was the first model to start implementation in March 2020 and has now reached full implementation, operating at Glenfield Hospital, Leicester Royal Infirmary and The General Hospital as of April 2023.

An evaluation has recently been conducted using RE-AIM methodology to gain a better understanding of service delivery and outcomes through quantitative and qualitative data collections. Two papers have been produced 1) An Acute CURE internal Evaluation report for service level use 2) An Acute CURE Evaluation research paper, submitted to Journal of Public Health to contribute to academic research in the field and share with national networks, if accepted. The lead author of these reports is Dr Shilpa Sisodia in collaboration with the CURE project team.

In summary, the evaluation of the service demonstrates that an in-reach tobacco dependency treatment service model which systematically identifies and treats inpatients on an ‘opt-out’ basis can be implemented successfully and effectively in a large tertiary hospital.

Key facilitators to implementation have been noted as strong leadership, joint working, a national mandate for delivery, and seed funding from East Midland Cancer Alliance (EMCA) to mobilise the service quicker. Key challenges are noted as lack of integrated systems for transfer of care and national data collection requirements, as well as, difficulty navigating Trust governance to request or approve actions, and accessing operational facilities such as office space and IT equipment on sites. Funding to sustain and meet the national expectations for the service has also been highlighted as a risk due to increasing referrals, pharmacotherapy costs, as well as increased pressure on our community stop smoking services, which are all key parts of the patient's pathway.

Next steps and considerations have been made to share the successful delivery and outcomes of the acute tobacco dependency pathway and respond to evaluation recommendations, as well as continue to monitor and evaluated the service as it improves and expands.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- To acknowledge the successful implementation of the NHS Long Term Plan Tobacco Dependency Programme; specifically, the Acute CURE service launched across UHL in partnership with local government public health and the ICB.
- To acknowledge and support the challenges and facilitators noted in implementing a programme across the ICS.
- Acknowledge the risk noted regarding the Long Term Plan funding and the resource required across the system to uphold and improve programme delivery.

1. Background and options with supporting evidence

1.1. Context

The NHS Long Term Plan (LTP) outlines a clear 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 was published in 2019:

"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)

Gradual funding, guidance and delivery models have been issued by NHSEI across various settings; these are, acute inpatients, mental health inpatients and pregnant women. LLR have initiated delivery for all three models of care, along with a bespoke staff tobacco dependency offer via a digital smokefree app service.

The CURE model was named as an example of an inpatient smoking cessation model by the NHS and Trusts around the UK have begun to implement various models against national requirements within their Integrated Care System (ICS).

Manchester was the first area of the UK to adapt and implement to the Ottawa Model for Smoking Cessation (OMSC). They developed the CURE programme, based on the OMSC but adapted and branded it for the UK.

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

1.1.2. Need

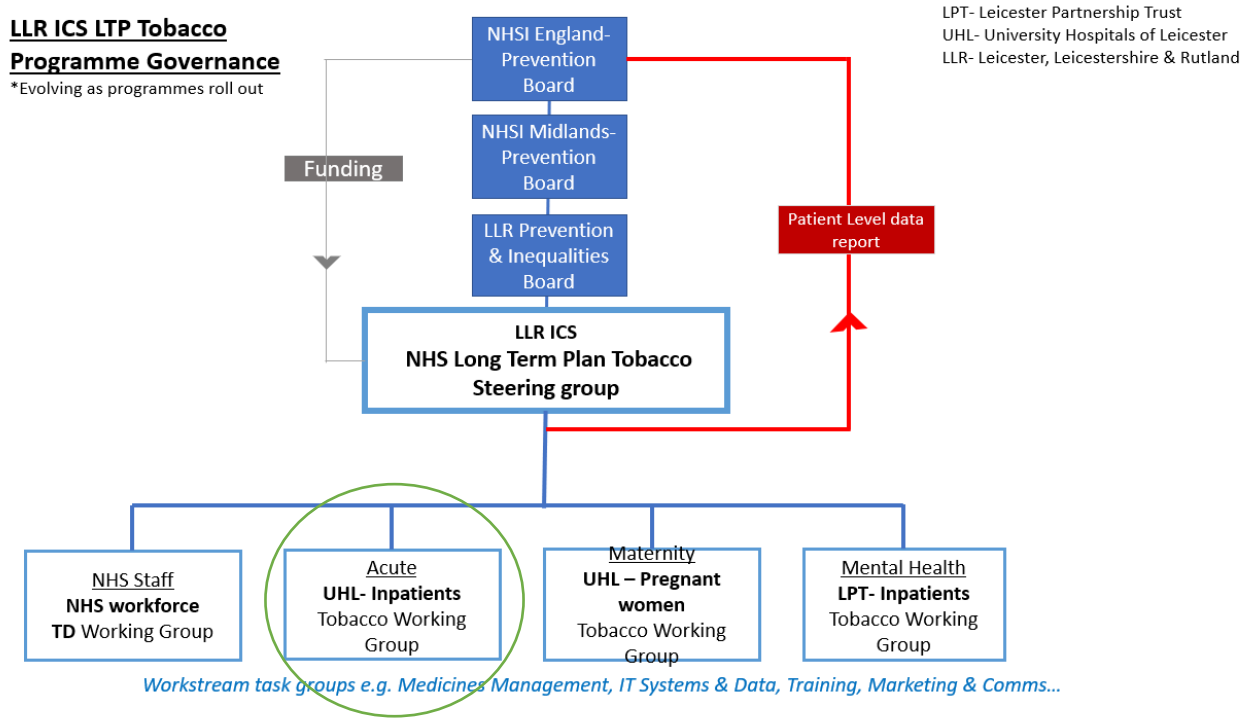
Smoking tobacco and the use of other tobacco products is intrinsically linked with health inequalities. Smoking is widely accepted as having significant disparity across socio-economic and geographical communities with those in the more deprived areas having higher smoking rates and poorer health outcomes.

The national average for smoking prevalence in adults in 2021 was reported 13% in 2021 with Leicester at 12.8% and Leicestershire at 11.2%. Leicester has around 346 deaths annually attributed to smoking. The majority of deaths attributable to smoking are due to lung cancer, chronic airway obstruction and ischaemic (coronary) heart disease. In addition, the rate of smoking attributable hospital admissions in Leicester is significantly higher than the national rate and is equivalent to over 2,800 admissions per year.

Addressing Tobacco addiction in our population is inarguable, recognising its health and economic benefits. Therefore, LLR took the initiative in 2019 to start the implementation of an Acute inpatient

Tobacco Dependency service through East Midlands Cancer Alliance funding. This enabled a faster and more co-ordinated approach to delivering the Tobacco Dependency programme models which were issued with mandatory reporting requirements in 2021.

Figure 2: Tobacco Programme Governance



1.2. LLR Acute CURE Service Model

Following disruption from Covid 19, the Acute CURE service has now reached full implementation, operating at Glenfield Hospital, Leicester Royal Infirmary and The General Hospital as of April 2023.

LLR's CURE model of delivery is defined as an in-reach model where a transfer of care takes place from one organisation to another. TDA's are employed by Leicester City Council and inpatients are referred to the community stop smoking services; Livewell (for City patients), Quit Ready (for County patients) and recently local pharmacies, post discharge for 12 weeks support to quit.

The in-reach service has advantages and disadvantages. Advantages include the ability to spread the workload and resource of implementation across specialist organisations, capitalising on existing infrastructure, experience, and expertise of community services, as well as establishing strong partnerships within the ICS.

Disadvantages include the need for exceptional team working, difficulties with co-ordinating data and integration of systems across organisations as well as increased challenges to influencing change in Hospitals and ensuring ownership from all organisations involved with care.

The Acute CURE inpatient pathway is shown in figure 3. Each stage of the patient's journey is pivotal in treating tobacco addiction; from identification on hospital admission to quitting within community care. This model is dependent on the community stop smoking services being able to provide ongoing care within the community setting and providing patient outcomes for national reporting.

This service operates 5 days Mon-Fri, with 4 full time TDA's. The LTP advises a 7-day service however further funding and capacity would be required to implement weekend working.

The Acute CURE Tobacco Dependency team sits in Public Health and consist of:

Figure 3: Acute CURE inpatient pathway

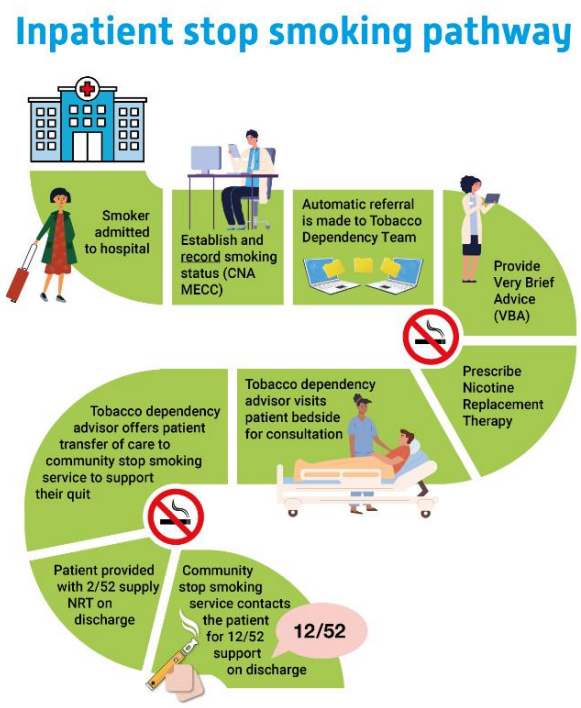


Table 1: Acute CURE Team:

1 x Project Manager	Fixed Term, Full Time
1 x CURE Co-ordinator	Permanent, Full Time
4 x FTE Tobacco Dependency Advisors (TDA's)	Permanent, Full Time
1 x CURE Admin & Business Support	Fixed Term, Full time

1.3 Acute CURE Tobacco Dependency Evaluation

A REAIM mixed methods evaluation of the Acute CURE service has recently been conducted by a Public Health Speciality Registrar to evaluate the implementation of Acute CURE and its early outcomes, using qualitative and quantitative analysis. A summary of finding using REAIM framework is presented below, and the full internal report including methods used is available on request.

1.3.1. Brief findings:

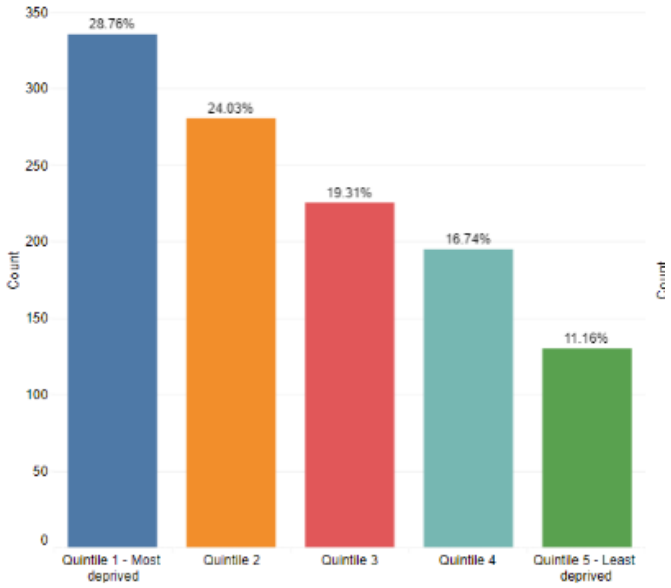
Reach: Between April 2021 and August 2022 (using initial pilot data collection metrics), 4965 smokers were referred to CURE, 3621 (73%) were contacted by the CURE team, of whom 1992 (55%) accepted NRT and 1986 (55%) accepted transfer of care to community services.

Between October 2022 and February 2023 (using new national data collection metrics), 3615 smokers were referred to the CURE service, 1140 (31%) were seen by the CURE team (the CURE team were short staffed during period of analysis and seen rates are gradually increasing,

indicating 49% in June). Stakeholders stated that they could see more patients by increasing TDA capacity and increasing the completion of the screening assessment for smoking status, which is currently 75.91% on average across UHL. A breakdown of the smoking assessment across UHL for 30.05.23 can be found in appendix 1.

An acute hospital-based intervention provided a prime opportunity to capture smokers with greater need and who may not know how to refer themselves. Over half (53%) of patients 'seen' by the CURE team were from deprivation quintiles 1 and 2, quintile 1 being most deprived areas of LLR.

Graph 1: IMD score for count of patients by the Acute CURE team in UHL from Oct-Feb 23.



Effectiveness: There were early data issues in data extraction of 4 week quit data from community settings due to multiple reasons, but the latest figures of those that set a quit date with the community from October 2022- March 2023 indicated a 4-week quit rate of 65.6% with 57.9%% of these individuals going on to quit at 12 weeks. This is similar to or higher than community 4 week quit rates of 56% for City and 63% for County, with acute inpatients potentially being a harder to engage group due to referrals being opt out and not self-referred. TDAs suggested better access to Trust computer systems; the ability to prescribe and a more efficient and integrated IT system to process referrals and outcomes would allow them to see more patients and thus improve the effectiveness of the intervention.

Adoption: Adoption was both shown quantitatively and perceived qualitatively to be higher at Leicester Glenfield Hospital (GH) compared to Leicester Royal Infirmary (LRI). The reasons for this included GH being the original launch site for CURE, GH housing the cardiorespiratory unit, more clinical champions on site and GH being a smaller hospital, making visibility a quicker process. Adoption overall was viewed positively, with a main facilitator being leadership and training.

Implementation: IT was the main barrier to implementation alongside staff retention, recruitment processes and access to Nicotine Replacement Therapy. The main facilitator was the CURE team (including TDAs, clinical leads, project manager, project co-ordinator, administrator, and members of the steering group). Many clinical staff received tobacco dependency training and showed increases in confidence and knowledge related to treating tobacco dependency.

Maintenance: An increasing number of smokers were seen over time in hospital. To ensure CURE continues running in the long term, stakeholders felt sustainable funding was required.

1.3.2. CURE feedback quotes:

CURE Patient feedback:

"can I shake your hand/ I want to tell you that you have influenced me to make this change to my lifestyle and can't tell you how grateful I am"

"I had no idea there was support available for smokers to quit. I have been trying to quit on my own and really needed some help. Thank you so much for coming to see me. I really appreciate it"

"It's not usual that smokers get offered this support or understanding- usually taboo"

"I cannot believe that Nicotine patches are being offered in hospital -it is amazing"

UHL Staff feedback:

"I saw a man in PA today who you saw in July 40-60 cigarettes per day. Since you saw him he has not smoked one cigarette and has had no side effects other than feeling so much better in himself can taste things again. Thank you for all your support you are making a huge difference". – CRM Sister.

"It is an ESSENTIAL service, especially to the Glenfield Respiratory Team as we deal with a lot of smoking-related diseases. It sees patients in a timely manner and offers gives such a positive impact on their inpatient stay" – Respiratory SHO

"I think the CURE team is doing an excellent job of projecting their aims and message to the Respiratory team. Their teaching is clear and effective, and they are always available to speak to you when you need to clarify something". - Respiratory Dr GH

Patient case studies have also been produced and can be shared on request.

1.3.3. Evaluation recommendations:

Some key recommendations have been presented from the quantitative and qualitative findings of the evaluation. These will be reviewed and addressed, with some recommendations already completed or underway since research was conducted.

Long Term	
Evaluation: Evaluate the long term outcomes of CURE. Based on the logic model, long term outcomes are: (1) Reduced readmissions (2) Reduced smoking related morbidity and mortality (3) Reduced smoking rates in patients being admitted.	Ongoing – National Tobacco Dashboard is now able to present consistent data. The impact on re-admission and mortality will be more complicated and take time to demonstrate and will be sought from national evaluation work.
Culture change: Continue a culture change to embed "tobacco dependency as everyone's business" in the Trust. In the long term, this means ensuring all decision-makers see treating tobacco dependence as a key prevention activity.	Ongoing – Raise and share impact of the service through national and local boards to support priority status.
Medium Term	
IT and data: Prioritise improving LLR IT infrastructure to streamline patient	Underway – Partial data

care pathways and support efficient case management. Fulfil local and national data requirements for systematic reporting. Improve data submission to the NHS, particularly focusing on 28 day quit data.	submission are being made. A case management system is in development and community services are amending new/current systems to support full data submission requirements.
Treating all smokers: Improve screening and identification by making the Making Every Contact Count Core (MECC) Nursing Assessment a mandatory field on admission. Address the large number of patients lost between referral to community services and setting a quit dates with services through improving the transfer of care pathway.	Take forward – MECC assessment has not yet been made mandatory but has been raised. Further work is required to address community lost to follow up once IT systems are set up to extract accurate data.
Nicotine Replacement Therapy (NRT): Improve NRT accessibility and continuity of medication into community stop smoking services whilst considering sustainability and affordability of provision.	Completed/Underway- a significant improvement has been made to prescribing NRT and further work is underway to enable TDA's to prescribe inhouse. Continuity of medication is a risk with reduced budgets in community and pharmacy protocol. e.g. Quit ready have reduced NRT products and community pharmacy are unable to prescribe E-cigarettes.
Evaluation: Use the newly available tobacco dependency service dashboard to set and monitor service targets and report to key governance groups. Evaluate, audit and review delivery and outcomes on a regular basis to improve quality of service using NICE guidance and Patient and Public Involvement (PPI). Conduct an economic analysis of the service to assess sustainability of the full programme model and resource with a focus on NRT funding.	Underway- Further analysis work is being done to ascertain targets and are regularly monitored through the steering group. A Quality improvement task group is being set up to review and improve delivery and outcomes.
Short Term	
Translation: Ensure all TDAs are aware of translation services.	Underway – Working with comms to develop relevant resources.
Treating all smokers: Continue promotion of the CURE programme through training for clinical staff. Further encourage all staff to provide VBA and early NRT to patients who smoke.	Ongoing- CURE will continue to deliver training and seek all opportunities available to access different staff group to upskill them in VBA and prescribing.
Nicotine Replacement Therapy (NRT): Further work to ensure that patients receive NRT as quickly as possible. This could include messages through UHL staff training, continued clinical staff training sessions and ensuring NRT is accessible.	Underway – Quality Improvement projects have already focused on and improved NRT prescribing and accessibility and will be continued.
Wider support: Support TDAs to engage with conversations with patients about health improvement topics such as mental health and stress management, including signposting to support. This in turn may facilitate a patient's quit journey.	Underway/take forward- CURE TDA's all receive Healthy Conversation Skills and mental health first aid training. Further work can be taken forward to equip

	staff further for wider conversations.

1.4. Implementation Facilitators and Challenges

Facilitators	
Clinical leadership and project management:	The support of a clinical lead in UHL was raised from all stakeholder levels as a key facilitator to an in-reach integrated service to help navigate the Trust and escalate issues and change, this includes a consultant lead and also clinical leads in pharmacy and admitting teams etc. Project management was pivotal to co-ordinating the number of workstreams and aspects to launching a new integrated service across organisations.
Seed Funding:	Funding for this programme has been released gradually and the recurrent amount is unknown until year end for the following year. This makes forward planning challenging in securing staff and planning for increasing pharmacotherapy costs within Trust and community settings. Seed funding from EMCA allowed quicker roll out for LLR in comparison to other areas and enabled us to recruit permanent staff.
Leadership and Joint working	Strong leadership and an early active steering group with key leads from UHL, ICB and LA supported the project to launch and overcome many barriers and obstacles to delivery. Proactive support from pharmacy enabled significant improvement to prescribing protocols.
CURE Training and champions	A large number of clinical staff received Tobacco dependency training and showed increases in confidence and knowledge to deliver VBA and prescribe pharmacotherapy to the patient. Recruiting champions also improved delivery in clinical areas, particularly in admission departments to improve screening and prescribing. CURE training has made a huge impact on the delivery of the service.
National Mandates	Aspects of the tobacco dependency programme came in phases and big changes in engagement was notice post covid when Trusts were given responsibility to submit data returns. Progress in IT and data workstreams significantly improved by raising the profile and mandating delivery.
Challenges	
Governance	Navigating the Trust and finding the right person to initiate change to support aspects of work was a challenge with many high priority areas in the Trust to compete with, particularly in a time of a pandemic. It has been noted whether this was made more challenging as an in-reach model rather than an inhouse model which may improve ownership.
Recurrent Funding	Recurrent funding for the programme is unknown and there is a real concern that LLR's allocation will not cover the required resource for a sustainable and effective service for all acute inpatients.
IT Systems	IT systems requirements for LLR's pathway were seen as the main barrier from all stakeholders and has impacted systems across the ICS to meet national data returns. Request for change in IT systems are a lengthy process slowing down delivery or not meeting national requirement.
Data Collections	Data has been a challenge as definitions and data fields for this programme were not streamlined with existing smoking cessation data collections. Large changes and additional asks had to be

	considered and requested to multiple systems to deliver an in-reach model.
Pharmacotherapy provision	NRT provision is a key aspect of patient care though the pathway. Funding pharmacotherapy is being approached in different ways, with many Trusts and community services absorbing NRT costs. LLR are funding the programme's NRT cost through LTP which will not be sustainable long term with expansion and improved prescribing.
Operational facilities	Working across local authority and UHL created many operational challenges for staff such as gaining their honorary contracts and getting appropriate IT access to systems and application on all devices. Significant delays were also experienced in trying to obtain office space at each site.

1.5. Next steps & Considerations

- Address learning and remaining recommendations from the main internal acute CURE evaluation to improve service delivery for users including the CURE team, clinical staff and patients.

- Share the experience of implementing and delivering an integrated patient pathway across organisations with key local and national stakeholders and boards.

- Assess sustainability of the Acute CURE Service within the current ICS funding allocation for LTP Tobacco Dependency, noting increased numbers of patients, costs of pharmacotherapy and increased resource required by community services.

2. Detailed report

The detailed internal Acute CURE Evaluation Report is available on request.

3. Appendices

Appendix 1:

Current Inpatient MECC Assessment Stats as at 30/05/2023

Current Inpatients, aged 18 and over, exlcuding maternity

Hospital Code	N. of Current Inpatients	N With MECC Assessment Recorded	N With NO MECC Assessment Recorded	% MECC	Count of Smokers	% Smoke
GH	533	453	80	84.99%	61	11.44%
LGH	285	169	116	59.30%	14	4.91%
LRI	913	692	221	75.79%	88	9.64%
UHL Total	**1731**	**1314**	**417**	**75.91%**	**163**	**9.42%**

Clinical Management Group	N. of Current Inpatients	N With MECC Assessment Recorded	N With NO MECC Assessment Recorded	% MECC	Count of Smokers	% Smoke
CHUGGS	395	219	176	55.44%	34	8.61%
CSI	6		6			
Emergency and Specialist Medicine	660	567	93	85.91%	59	8.94%
ITAPS	10	4	6	40.00%	2	20.00%
Musculoskeletal and Specialist Surgery	171	100	71	58.48%	15	8.77%
Renal, Respiratory and Cardiovascular	464	417	47	89.87%	53	11.42%

GH = Glenfield Hospital
LGH = Leicester General Hospital
LRI = Leicester Royal Infirmary
CHUGGS = Cancer, Haematology, Urology, Gastroenterology, General Surgery
CSI = Clinical Support imaging
ITAPS = Intensive Care Theatres, anaesthesia, Pain, and Sleep