

Greater Manchester **Cancer**

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| **DRAFT FOR COMMENT & DEVELOPMENT****­Business Case Details** |
| **Business Case Title** | Sustaining the CURE project at xxxxxxxxx Hospital – treating tobacco addiction  |
|  | **Name** | **Date** |
| **Executive Sponsor / Senior Responsible Officer** | Locality to specify |  |
| **Commissioning Lead** | Tobacco Commissioner |  |
| **Finance Lead** | Locality to specify |  |
| **Clinical Lead** | CURE Clinical Lead |  |
| **Value: £** | **Contract Length: Substantive posts** | **Recurrent** |

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| **Case version control log** |
| **Version no.** | **Author** | **Amendment** | **Date** |
| 1.0 | Freya Howle | First draft | 2/8/19 |
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| **Recommendation and Decision Record** |
| **Recommendation to reviewing panel:** |
| **Panel decision record:**

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| **Decision** |  | **Review date**  |  |
| **Comments / Conditions** |  |

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| 1. **Executive Summary**
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| The devastating effect tobacco addiction has on the population of Greater Manchester is unquestionable. For too long this disease has been neglected and the NHS has failed to provide fair and equal access to the highly effective treatments for tobacco addiction to the sufferers of this disease. The CURE project will address these deficiencies and provide a comprehensive and structured service for inpatients admitted to acute trusts across Greater Manchester. The CURE project is estimated to **deliver savings of £9,937,184** per year, **saving 30,880 bed days**, equivalent to 84 additional beds per day across Greater Manchester. It will **save 3,141 lives per year** and **result in 18,473 successful quitters per year**. These estimations are conservative and based on a 20% prevalence of active smokers in acute admissions to hospital and calculating the lowest likely number of overall admissions. |

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| 1. **Conflicts of Interest**
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| What actual or potential conflicts of interest have been identified and managed in line with statutory guidance? |
| Provider to complete based on internal knowledge |

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| 1. **Strategic Case**
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| Describe what is being proposed in this business case and the rationale (the proposal / case for change / problem to be addressed, scope, population / cohort / solution / evidence base(s)). |
| **Tobacco Addiction: The scale of the issue nationally** Smoking is the single biggest cause of preventable death, illness, disability and social inequality. In Greater Manchester approximately 400,000 people smoke and 13 people die every day as a result of their smoking. Smoking represents an unparalleled financial burden on Greater Manchester society, described in the boxes below. Smoking represents an unparalleled financial burden on Greater Manchester society, described in the boxes below.**Tobacco Addiction: The scale of the issue in ‘xx locality’**Locality specific data and statements to be included here – CURE team will provide some data which can be supplemented by locality data and narrative**Case for change & evidence base**Treating tobacco addiction is a highly cost effective intervention for the NHS. * **The cost per life year gained of treating tobacco addiction is 1/25th the cost of statin therapy in patients** with coronary artery disease (statin therapy is held up as the gold standard cost effective health intervention).
* Nicotine Replacement Therapy (NRT) is cost-effective even when modelling at the lowest quit rate (9%) and most expensive NRT (£763 per person). Cost per QALY £634.

Secondary care represents a key sector for the delivery of tobacco addiction treatment. ***On any given day there are 20,000 smokers in an acute hospital bed across the UK and more than one million smokers are admitted to hospital at least once every year***. Hospitals, therefore, have a concentrated population of sick smokers. Being admitted to hospital is a unique moment of motivation to stop smoking and a highly teachable moment. **A Cochrane review confirmed that providing NRT and specialist support to hospitalised smokers increases abstinence by approximately 60%.** **Current state**Despite this convincing and unquestionable need for comprehensive tobacco addiction treatment services in secondary care, the current service provision across the UK is wholly inadequate with only 6% of smokers admitted to hospital referred to a stop smoking service and only 4% are prescribed NRT. Locality to provide current smoking prevalence/recorded data – BTS audit**Proposed solution**The Royal College of Physicians have summarised this crisis in a call to arms document ‘Treating Tobacco Dependency in the NHS – Hiding in Plain Site’. The introductory comments are presented below:* **Smoking is the largest avoidable cause of death and of social inequalities in life expectancy in the UK**
* **Management of smoking in secondary care is woefully lacking**
* **By failing the address smoking, the NHS is failing to realise substantial gains in both health and sustainability**
* **The NHS needs system change to prioritise smoking cessation**

The CURE programme addresses these failings of the past and has several core components; 1. To provide immediate access to NRT for all hospitalised current smokers
2. To enable referral and consultation with a specialist stop smoking service on an opt-out basis
3. To provide a comprehensive service to all patients admitted with an addiction to tobacco,
4. To maximise the teachable moment of each admission
5. To maximise in-patient health, preventing health care associated complications (poor wound healing, sepsis, cardiovascular morbidity, thromboembolism) & reduce length of stay
6. To provide an effective, well supported workforce with a clinical Consultant level lead.

**Transformation Funding** Provider name were provided with transformation funding as part of the initial rollout of the CURE Programme across Greater Manchester’s Acute Trusts which was used to fund the following:* Staff needed to deliver the service for one year,
* Pharmacotherapy costs for the estimated number of smokers that were to be admitted and treated for one year (2 weeks’ worth)
* Add detail if funding used for additional aspects e.g. IT

The GM Cancer CURE Project Team have supported with the mobilisation, planning and implementation of CURE. The transformation Funding was made available under the provision that is to support a 12 month project following which the results will be evaluated and consideration be given to future funding arrangements.A detailed GM CURE Service Specification is provided in the ‘Other Supporting Information’ section which describes the service and is what Providers should align their implementation and mobilisation of the CURE project to within its Trust. **Therefore this business case is to support the continuation and embed the CURE service as business as usual which would require the agreement of funding substantive posts (Provider to describe staffing needs) and agreement from Pharmacy Department to support and agreed uplift in the NRT budget assigned to directorates/departments to enable the treatment of smokers admitted to our hospital.** |
| Identify key relevant national priorities supported by this proposal |
| NHS Long Term PlanGreen Paper |
| Links to GM Health & Care Partnership Board priorities |
| The Greater Manchester Health and Social Care Partnership’s [**tobacco control plan Making Smoking History**](http://www.gmhsc.org.uk/wp-content/uploads/2018/04/Tobacco-Free-Greater-Manchester-Strategy.pdf), published in July 2017, set ambitious targets for the health economy to reduce smoking rates in our population by one third by 2020, resulting in 115,000 fewer smokers. Patients admitted to hospital are more likely to be smokers than the general population. This programme aims to use the unique teachable moment of a hospital admission to improve rates of smoking cessation during and immediately following hospital visits.The Greater Manchester vision is for a tobacco free future where together we make smoking history for all our children. Our transformation programme delivered in collaboration with all partners will include a range of innovative and evidence based interventions delivered at scale. A large gap currently which needs addressing to support the delivery of the plan is **advancing a fully Smokefree NHS including standardised primary and secondary care stop smoking journeys for all smokers.** |
| Identify how this proposal links to Greater Manchester Cancer priorities |
| The GM Cancer plan stipulates that:*‘Smoking is by far the biggest single cause of ill health and early death in Greater Manchester. The Greater Manchester Cancer Board has therefore made preventing tobacco related harm a key focus for this strategy and is sponsoring the work to develop a comprehensive tobacco control plan for Greater Manchester.’*There is recognition in the strategy that smoking is a chronic, relapsing addiction and that treating tobacco addiction is the single most cost effective health intervention the NHS can provide. The CURE Programme is a comprehensive secondary care treatment programme for tobacco addiction. The GMHSCP tobacco control plan Making Smoking History, has set ambitious targets for the health economy to reduce smoking rates amongst the sickest smokers. **This priority 1 project will enhance the pilot already in place** which will provide data on effectiveness in improving patient outcomes and mortality rates, and in reducing burden to the healthcare system. GM Cancer programme investment will support the delivery of the tobacco control plan to enable a GM roll out of CURE. |
| Comment on stakeholder engagement (e.g. patients, users, clinicians, reference groups, scrutiny / oversight groups). |
| Use governance structure and TOR membership |
| Identify the **key** measurable success criteria, KPIs and / or outcomes related that will be monitored to demonstrate that this proposal is successful. |
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| Outcome/metric/KPI | Target | Rational |
| Number and % of adult patients admitted as In Patients (IP) with LOS > 1 day that have smoking status recorded. | % to be set by the commissioner Indicative = 90% |  |
| Number and % of smokers offered brief advice | % to be set by the commissioner Indicative = 90% |  |
| Number and % of smokers that are given NRT within 24 hours of admittance | % to be set by the commissionerIndicative 30% |  |
| Number and % of smokers referred to the CURE team | % to be set by the commissionerIndicative = 90% |  |
| ​Number and % of smokers seen by the CURE team | ​% to be set by the commissioner​ Indicative = 50% |  |
| Total number and % of smokers prescribed NRT ​ | % to be set by the commissioner​Indicative = 50% |  |
| ​Total number and % of smokers prescribed varenicline | % to be set by the commissioner​Indicative = 20% |  |
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| Number and % of smokers referred to the community stop smoking service | % to be set by the commissionerIndicative 35% |  |
| Number of 4 week quits from referral to community stop smoking service | % to be set by the commissionerIndicative 35% |  |

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| 1. **Economic Case / Options appraisal**
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| Identify the key implementation options (i.e. how the proposal can be delivered) and evaluate how well each of these support achievement of the key success criteria / outcomes outlined in Section 3. |
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| Option | Description | Pros | Cons |
| 1 | Revert to previous limited and unsupported smoking cessation specialist serviceProvide no training to enable staff to deliver on CQUIN |  | Inconsistent tobacco addiction specialist service provided to patientsContinuation of increase in admissions of patients who smoke due to negative impact on health and co-morbiditiesIncrease pressure on Primary Care to provide treatment for tobacco addiction |
| 2 | Support delivery of CURE Programme through funding & supporting:* Specialist Nurses
* Admin support staff
* IT systems support (EPR) updates
* Training
* Comms & engagement
 | Specialist care plan for smokers discharged from secondary careReduction in re-admissions at 30 daysReduction in mortality rate at 1 yearIncrease quite rates at 6 monthsIncreased confidence and expertise of staff through effective trainingCompliance with smoking CQUINCompliance with PHE smoke free NHS instructionDelivery GM tobacco control planSupporting Primary Care with standardised approach to providing treatment for tobacco addictionIncome from new telephone clinic activity Maximising the teachable moment with equitable access to specialists & treatmentTelephone support without need to travel to the hospitalNumerous health benefits associated with quitting smoking  | Increased cost within service due to nursing and admin staff requirements and development of internal IT support systems.Increase in number of prescriptions for Nicotine Replacement Therapy for inpatients and 1 week standard TTOTime required for all staff to attend mandatory VBA trainingTime required for all prescribers to attend 30min training  |

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| Identify the preferred option / rationale. |
| **Staffing – CURE Service**The CURE pilot data from Wythenshawe Hospital suggests 60% of smokers admitted will accept a specialist consultation with a stop smoking practitioner.

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| CURE IP Service | Approximately xxx referrals / month (opt-out)xxxx patients per year (60% uptake)1x 40min initial assessment20min admin | xxx WTE |
|  | Administrative support1.5 WTE per 5000 smokers | Xxx WTE |

The service also requires:**Pharmacotherapy – CURE Service**The additional cost for this service, above the staffing requirements, is the provision of inpatient pharmacotherapy. The CURE pilot data suggests approximately 25% of smokers are classified as low level addiction, 50% as moderate level addiction and 25% as high level addiction.

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| Low level addiction | Short acting NRTe.g. Lozenges £9.58 (96), microtabs £15.99 (100), inhalator £17.17 (20)**Average = £14.20**  |
| Moderate level addiction | Long acting nicotine patch**Average 16hr and 24hr patch costs = £10.75** |
| High level addiction | Short acting NRT + long acting patch**Average = £14.20 + £10.75 = £24.95** |

Data from the CURE pilot suggests 50% of smokers will accept treatment with NRT and 10% will accept treatment with varenicline (varenicline cost £27.30 though a UK price of £2.53 is being provided Pfizer across the UK – it should also be noted that Varenicline comes off patent in July 2020). Total cost estimates for pharmacotherapy for average 2 weeks treatment for the CURE programme (per year):NRT * Estimated xxx low level addiction = …….. x (2x14.20) = £……………
* Estimated xxx moderate level addiction = …….. x (2x10.75) = £…………..
* Estimated xxx high level addiction = …… x (2x24.95) = £………….

Varenicline* Estimated xxxx patients treated with varenicline = 27.30 x = £………..

Total estimated CURE pharmacotherapy costs per annum: £……………… |
| Append the completed Equality Impact Assessment to the case and comment upon the proposed adjustments to the case (Ref - legal duties under the Equality Act 2010) |
| To include an EIA once completed |
| Document other impact considerations, as necessary, including reference to relevant consultation requirements surrounding the preferred option.  |
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| Summarise the expected measurable improvements (benefits) or consequences (e.g. dis-benefits) relating to the preferred option and the time period over which these will be realised. (This will inform future quality/ performance monitoring and evaluation if approved.) |
| The benefits of a comprehensive tobacco addiction treatment programme are far reaching and profound. The evidence is undisputable that this is a highly effective intervention that will save lives and is highly cost effective for the NHS. For every year of service at xxxxxxxxx Hospital the CURE programme alone is estimated to deliver the following benefits per year (based on the benefits seen in the Ottawa Model of Smoking Cessation) * **xxx admissions prevented**
* **xxx lives saved**
* **xxxx successful quitters**

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| **Outcome, metric, expected change** | **Baseline** | **Target** | **Rationale**  | **Timeline** | **Source / method of measurement and reporting** |
| Reduction in re-admissions (at 30 days) |  |  |  |  |  |
| Reduction in mortality (at 1 year) |  |  |  |  |  |
| Reduction in A&E admissions (commonly related to smoking) |  |  |  |  |  |
| Increase in quit rates (4 weeks) |  |  |  |  |  |
| Increase in quit rates (12 weeks) |  |  |  |  |  |
| Increase in number of staff trained in treating tobacco addiction |  |  |  |  |  |
| Increase in confidence of staff to treat tobacco addiction |  |  |  |  |  |

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| 1. **Commercial Case – feasibility**
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| Outline the key market and / or supplier considerations, including likely contestability, reliability, ability and capability to deliver requirements?  |
| n/a |
| How will we secure a value for money service / contract for this service (e.g. single tender action, tendering / procurement route) and how does this adhere to procurement guidance and / or standing financial instructions (reference advice required / received)? **Document advice received from procurement / contracting / finance teams.** |
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| 1. **Financial Case**
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| Identify the full cost of the development, one-off costs (e.g. implementation programme costs, legal, consultancy evaluation etc), recurrent costs and phasing |
| **Note that embedded template is optional. If an alternative working is used, please ensure that a return on investment and payback period is calculated and clearly shown.** |
| Comment on the value for money / savings assessment / cost benefit analysis, savings realisation period / phasing (activity and financial) / pay-back period / return on investment |
| The average admission costs and length of stay at xxxxxxxxx Hospital is £xxxxx and xxx days. The saved bed days would be **xxxxx bed days equivalent to xxx additional beds available every day.** This simply focuses on the savings from preventing readmissions let alone the wides reaching effects of disease prevention, lives saved and additional relief on NHS services such as outpatient clinics and primary care utilisation. An NHS England working group has committed to producing an NHS tariff for treating tobacco addiction in secondary care. This is work is in development and the information provided here is subject to change. The tariff documentation is planned for public consultation in December 2018 and implementation and testing April 2019 with formation of the mandatory tariff 2020-2021. Currently the estimated tariff will be (subject to change):* **£107.60 for inpatient treatment of tobacco addiction (1xspecialist assessment 40min and 2 weeks of pharmacotherapy – NRT and additional medications)**
* £42.88 – 40min specialist assessment
* £44.25 NRT
* £27.30 Varenicline

Therefore, the CURE programme alone may generate up to:* **£xxxxxxx (60% uptake on specialist assessments n=xxxxx)**
* **£xxxxxxx NRT (50% uptake of NRT n=xxxx)**
* **£xxxxxx (20% uptake varenicline n=xxxx)**

Total estimated CURE pharmacotherapy costs per annum: £xxxxxxxxx**The savings made from the CURE programme alone would cover the costs of the staff required & pharmacotherapy. This does not incorporate the value of the lives saved, the benefit for the economy and wider society as well as other aspects of the healthcare service like reduced OP visits, better chronic disease management and reduced primary care utilisation.** **Summary of the key benefits and costs**

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| **Costs** | **Benefits** |
| ***Pharmacotherapy:***CURE - £xxxxxx | **NHSE Inpatient tariff**Tariff income - xxxxxx |
| ***Staffing***xx permanent WTE stop smoking practitionersxx permanent band 3 admin staff | **Bed savings:****xxx additional bed days per year with positive impact on patient flow, A&E performance and capacity for elective surgery****Lives saved****Over xxxx lives saved per year** |

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| Outline the source and nature (recurrent / non-recurrent) of the intended funding identified for the business case, including any existing funding required and / or new grants / funds required |
| Recurrent |

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| 1. **Management Case**
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| Timescales, key milestones, phases, dependencies, project resources |
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| **Stage / Phase***(adjust as necessary)* | **Key Milestone** | **Date** |
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| Is the success of the preferred option dependent upon any other projects, pending decisions or internal or external services? |
| Provider to complete |
| Key risks (e.g. clinical, political, environmental, social, technological, financial, organisational – their impact, mitigation and risk owner) – ensure key risks are captured within the risk management system, as necessary. |
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| **Risk description and impact if not mitigated** | **Indicative risk rating** **(H / M / L)** | **Mitigating actions** |
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| Applicable governance, including any consultation to date / planned. |
| Provider to complete for internal consultation |
| Comment upon the intended methods / evaluation plans for the preferred option. |
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| What does the organisation need to consider if the preferred option proves unsuccessful (i.e. what are the triggers for initiating an exit strategy) and what other matters should be considered in terms of exit strategy? |
| It is unlikely there will be a requirement to exit given need to for Acute Trusts to provide Tobacco Addiction services as referenced in NHS Long Term Plan, the requirement to deliver a CQUIN, and the vision of The Greater Manchester Health and Social Care Partnership’s tobacco control plan Making Smoking History.The Transformation Funding provided by GM Cancer via a contract variation with our host CCG will no longer continue after March 2020, potentially before as this will be based on when staff are recruited into 12 months contracts. |

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| 1. **Other supporting information or references**
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| Please reference any other supporting information for this proposal (e.g. appendices, service specification, case material from proven pilots in other areas, patient stories). |
| GM Service SpecificationRCP reportGreen PaperNHS Long Term PlanPilot abstract |