Tobacco dependence treatment services: Lessons learnt from Early Implementer Sites

v1.0

December 2021

NHS England and NHS Improvement

Contents

Introduction and headlines (1)

The purpose of this document is to highlight the **range of lessons learnt** from across the tobacco dependence treatment service early implementer sites (EIS) that have run through 2020/21 and 2021/22. These lessons are derived from a range of services and settings and are designed to **give insight for sites that are starting to establish tobacco dependence treatment services**. The key headlines include:

- Ensure that there is **buy-in from senior staff** at the trust prior to rollout of services, identify all key stakeholders and ensure that there are structures in place to keep them engaged.
- Having a dedicated **project manager** has been key. They will need support from a wider and more senior stakeholder group but can drive delivery locally.
- Ensure that there is a strong **Clinical Lead** in place with dedicated time for the role and clear responsibilities. It is important that they know the system and are able to influence workforce practice.
- Stakeholder groups need to include a wide **multidisciplinary team** from both internal and external teams. For example, members could include representation from Respiratory teams, Pharmacy, Local Authority, Public Health, CCG, Comms, Finance, Information Technology (IT), Business Intelligence (BI) Community Stop Smoking Services (SSS), Training and Development.
- Effective **workforce training** is key, so it is important to get agreement to promote training with the trust, particularly for delivering very brief advice, as this can be done by all staff groups regardless of grade.

Introduction and headlines (2)

- Early **engagement with IT and BI teams** is vital to ensure that it gets priority and that there is a fit for purpose IT system in place. They will need to provide support with establishing data collection templates and facilitate the national reporting requirements. An ideal scenario is inclusion of specific tobacco templates in the electronic patient record (EPR) which can be linked to admission and ongoing care.
- A good relationship with trusts' **communications teams** is also important, and there is a variety of existing materials that can be supplied to be adapted based on local requirements.
- Resources from EISs and other organisations can be accessed via NHS England's Prevention Programme FutureNHS page.

Project management (1)

Getting the overarching governance right has been key to delivery of successful projects. This will vary locally but key learning includes:

- Having a dedicated project manager (PM) helped to drive the project forward. They can be split across multiple sites or even trusts, although this can make it a lot more difficult to drive change at pace. Being based in trusts (rather than a CCG etc) also supports buy-in and credibility from frontline services.
- It is vitally important to have an executive sponsor who is engaged and will drive the local Steering Group, alongside a strong and engaged Clinical Lead to support the PM role (experience from EISs indicates that these roles are needed to influence senior trust staff not relying only on PMs).
- It is important to establish where the programme sits in the governance structure. Projects should be led by a Steering Group, and gaining Medical Director and senior Operational Management leads' support has facilitated delivery of successful projects.
- Agreeing the scope and deliverables of the project upfront is key. This includes the role and responsibilities of the PM. These should be formalised in a project plan and key milestones agreed to help maintain momentum. A number of example documents are available on the FutureNHS website including example project plans, job descriptions, Standard Operating Procedures, etc.
- Initial stakeholder mapping is important as continued engagement of multiple stakeholders (internal and external) is vital to affect whole pathway change.

Project management (2)

- Internal teams such as clinical leaders (Matrons etc), Respiratory clinical teams, transformation teams, pharmacy, communications, IT, BI will all play a role in establishing the project and driving pathway / cultural change. As this involves additional investment, engagement of finance teams is also key.
- External engagement is also key; early engagement with commissioners (CCGs and/or ICSs) and local authority commissioned SSS is key to getting financial and governance oversight and joined up working across the health economy. Other key parties to engage with include Local Maternity Systems (if appropriate), Regional Public Health representatives, community pharmacy, local council, GP representatives and third sector partners.
- Stakeholder groups can help to identify key internal meetings that need to be informed / updated about the project to support rollout as well as wider external opportunities to link with other services, funding or support networks e.g. Patient Safety Collaboratives.
- It has been helpful for a number of EISs to join wider smokefree and smoking / tobacco strategy groups, where these exist. ICS oversight with appropriate governance can also help drive delivery.
- It is vital to establish key working groups, workstreams, task and finish groups, and to ensure that the PM is part of regular meetings. Use these groups to help develop a clear project plan and have leadership by an Executive via the overarching Steering Group.
- Consistent attendance and clear agenda / priorities for key meetings can be key to ensure tobacco dependence treatment remains high profile when there are other priorities, e.g. as there may be decreased access to SRO and other clinical leads when there are Covid-19 related pressures.

Project management (3)

There are also other key operational project management considerations:

- Identifying a “host” department and liaising with the local leadership team can help solve early challenges such as finding office space (which can take time), as well as identifying key contacts across different teams, e.g. for prescribing and IT, etc.
- Capacity modelling is vital; the existing GM CURE template was helpful in identifying the required number of staff and how much staff time will be needed. It is also important to get agreement on NRT and understand levels of pharmacotherapy activity early on.
- It can be better to advertise substantive positions in the tobacco dependence treatment teams, as where staff are seconded, many often return to previous roles. Having permanent posts will help progress the agenda without delays as there won’t be a need to restart recruitment. Similar issues can apply to part-time posts.
- It can be useful to have a signed letter from senior executives, or an MoU signed by stakeholders so that everyone is clear about funding and expectations of services.
- Consider other ways of securing additional funding to support the rollout, e.g. via trust, cancer alliance, PH grants, relevant charities, ICS transformations funds etc.

Service and team (1)

Good working relationships and regular engagement across multiple teams has been key for rapid rollout of services. Some of the key lessons include:

- It is important to understand what service delivery is already in place (e.g. in-reach LA SSS). It can be helpful to include specialists from these teams as they have an in-depth understanding of local prevalence, priority groups etc. and what has worked before / what doesn't work – it is important to collaborate with public health.
- It is helpful if the posts are directly employed by NHS trusts as this ensures the Trust is bought into delivery and they are part of the clinical MDT. However, good relationships with SSS will support sharing of skills and knowledge transfer.
- In terms of recruitment, it has been helpful to use job descriptions developed by other sites that can be adapted locally.
- In terms of leadership, it is important to have an experienced stop smoking lead supervise the TDAs.
- With SSS in-reach services, it can take slightly longer to understand who to engage within trusts. Also where advisers are employed through LA honorary contracts, this can be challenging in terms of training. If different sites and LA services operate across different IT systems, this can also present issues.
- It has helped to utilise the junior doctors to support use of NRT prior to TDA intervention. Ensure close working relationships with ward staff, ward sisters as well as many other staff including consultants, ward pharmacists, doctors, nurses, healthcare assistants, etc, as well as staff in the community, e.g. community mental health.

Service and team (2)

- It is important to hold regular team meetings and carry out evaluation of protocols in order to monitor patient outcomes. Data and KPIs are useful tools for monitoring to ensure continued improvement.
- It has been noted that once recruitment is completed and Tobacco Dependence Advisers (TDAs) are in place, on the ground clinical interest starts to build.
- In cases where it has been more challenging to engage the patient, particularly in mental health, it can help to take time to establish a relationship and gradually move the conversation from abstinence to a full quit.
- It has proved helpful for Tobacco Dependence Advisers (TDAs) do a phone call follow up of patients within a few days of discharge.

Clinical leadership (1)

Strong clinical engagement has proven to be vital for implementation. Key recommendations included:

- Outlining expectations for staff and clarifying the role of clinical leads is paramount, including how much time should be dedicated for the role. Dedicated paid time attached to the role, e.g. 1 PA has proven successful.
- Clinical Leads have been especially helpful with senior engagement and buy in – ability to step in and make things happen, perception from partners that this was a priority area with senior staff.
- Linking clinical leads into the wider clinical leadership teams early on is key i.e. respiratory clinical leadership, Chief Nurse, Head of Midwifery, risk teams and Matrons. Clinical leads will also be key at raising the profile of the project at key clinical meeting, both internally and across the ICS.
- Make use of the Clinical Lead networks as it can help in sharing experiences, knowledge and skills. It can also help to establish a peer-to-peer network across the ICS patch.
- A dedicated clinical lead has shown to be valuable engaging both staff and patients
- The clinical lead can work to standardise and drive training across different clinical teams and settings.
- Close relationships with the PM free up the clinical lead from more administrative tasks to lead working with staff and changing culture.
- Clinical leads can also assist with identifying and supporting ‘champions’ across the hospital which can help with engagement and the shift in culture towards medicalising the treatment of tobacco dependence.

Clinical leadership (2)

- Ward manager and Service Manager are helpful to engage for ensuring staff are on the same message about the programme more broadly, as well as to e.g., influence culture change. These individuals are key to cnsitent delivery and changing the culture in patient facing environments
- Keeping the ask “simple but effective” is important, as clinical and medical teams are under a lot of pressure so it will help to recognise the increased workload.
- Dedicated time with the National Specialty Adviser has proven to be useful for clinical leads.

Communications and engagement (1)

Engagement with communications teams will be vital in promoting the profile of the new services. Lessons learnt included the following:

- Trusts should have a communications strategy linked to the programme where training and culture change are linked. It is useful to develop a comms plan at the start to identify key routes of access and dates.
- It is useful to have a dedicated communications lead to liaise with.
- As trusts' communication teams have a large portfolio of work, it can help to supply them with materials and templates that can be easily adapted.
- Patient success stories and champions explaining the importance of the programme can help drive engagement.
- Short videos from executive sponsors on Trust websites can be useful.
- Ensure all communication channels are utilised as not everyone will access the same materials. To spread the message about the programme it can help to use a variety of communication channels e.g. team briefings, staff bulletins and newsletters, events, desktop displays, reception/ward TVs, ground posters, stands, leaflets, social media and staff including Champions can help to spread the message.
- These materials need to be focussed at staff and patients, and ensure equity of access including for those that may not have access to IT equipment etc.

Communications and engagement (2)

- The COVID-19 pandemic in particular has created barriers due to less face-to-face contact. It is important to learn from others about how they have adapted to this new way of working. Using digital comms was important during this time; however, this can further exclude others through digital inequalities, so also consider using other methods, such as phones, e.g. via text messages.
- Ensure all stakeholders are engaged with communications so that all aspects of the service are covered, including LA, commissioners, System/Local Maternity System contacts, etc. It can help to engage through steering groups at both Trust and ICS level.
- If there is a good relationship, the LA can help to provide support with communications and training.
- Having something that identifies staff on wards can be helpful, e.g. badges, “Ask me about …” tags or having branding / a logo displayed somewhere on/around staff or champions.
- It can help to develop materials that will give information to patients on top of leaflets, e.g. a patient support plan, education patient leaflets and information for those with special needs, e.g. dementia or learning disabilities, etc.
- When engaging with patients, it is important that communication does not come across as shaming them about smoking tobacco.
- It can be useful to have some form of communication highlighting a patient is a smoker on patients note (e.g. a ‘sticker’ or ‘alert’, such as is done for high falls risk patients, dementia etc.) This helps to ensure support and pharmacotherapy is provided on ongoing basis.

Training (1)

Training is key to facilitate an effective rollout of services and will need to be tailored and easily accessible. The key messages were:

- Offer different training depending on the staff group e.g. for junior doctors and pharmacists.
- The training outcomes need to be tested: it is vital to ensure staff are confident in delivering interventions following the training, for example, are junior doctors confident in prescribing NRT.
- It is important to allocate an appropriate amount of time for staff to take part in the training.
- It can be difficult to find time to carry out staff training during busy times, particularly for nurses during the pandemic, so it can help to train multiple staff members at a time or deliver training on the shop floor at a time when it is less busy e.g. when coming off SCBU as sometimes ad-hoc training works better than scheduled time.
- Be creative with approaches to promoting training and resources e.g. visit wards, join in huddles/handovers, shadowing and proactively approaching staff to offer support. Don't wait for them to come to you. Getting on ward training can be challenging but is very useful.
- As a standard, some VBA training could be included into mandatory trust training for all clinical staff and be focussed for the different clinical specialties e.g. acute, maternity and mental health. However, it is important to be mindful to push training all year around.
- It is helpful to include key messages at trust induction days – raise the awareness of smokefree sites, smokefree support, training available for staff.

Training (2)

- Work with Learning & Development teams to ascertain what they believe to be the most effective ways to deliver training. Make use of the established learning platforms and upload training alongside existing clinical models so people can see it part of the hospital culture on clinical care.
- Online training developed by other sites can be adapted to suit local needs – resources are available on the Greater Manchester CURE and South Yorkshire and Bassetlaw QUIT websites.
- It can be helpful to get senior executive approval and communications teams support to promote training internally, e.g. through trust radio, etc.
- It is useful if a member of staff has a coordination role for training e.g. by including this in their job description. Training coordinators can be different staff groups – clinical leads, advisers, service managers – all can deliver training. Liaise with other teams (e.g. respiratory, Making Every Contact Count) to make sure every contact counts.
- Training should be delivered by a valued and experienced member of staff who has respect from other staff – sometimes training by those outside of the organisation isn't received well, even if the trainer is highly skilled and knowledgeable.
- Use peer to peer training and tailored messaging when engaging with nurses and doctors on wards.
- Champions are a very useful resource in early implementation as they can engage different staff groups e.g. junior doctors to do case studies and do knowledge sessions. Champions can also help to promote the training, as the message often spreads better through clinical staff.

Training (3)

- The core team of TDAs can have monthly clinical supervision (observed practice) to maintain competences. Ongoing clinical supervision is very important for the role of TDAs.
- If work closely with local authority services, they can help to deliver training, share knowledge and experience.
- Training should not just focus on clinical treatment. Training on the use of motivational/behavioural change is equally as useful to support patients whose mind is already geared towards quitting.

Pharmacy

Engagement with pharmacy teams will form a vital part of the running of the services. Key points were:

- Engaging with pharmacy teams early is key to ensure that policies and procedures needed for NRT are in place when the service is ready to be rolled out. It helped to use the Greater Manchester CURE Project self-assessment tool to understand the requirements and likely volumes for NRT.
- It is helpful to have a selection of NRT products available to patients – sometimes only one or two products are available, and it is better if patients have a choice and find what NRT products work best for them. The treatment might be less effective if patients are given a product as it's the only option available.
- Ensure a pharmacy representative is included in your Steering Group.
- Pharmacy teams can help to review medication and can pick up if someone has been missed off screening and ensure TTOs are issued.
- Consider having dedicated prescribers within the tobacco dependence treatment team. It's been helpful employing the homely remedies policy where a nurse hands out the medication and then a TDA makes any recommendations or amendments.
- Pharmacy can play a key roll in linking inpatient and community follow up; especially in terms of ensuring consistency in terms of NRT supply.
- Providing direct supply of NRT has been more challenging during the COVID-19 pandemic; ways to address this have included using collections or posting out.
- Non-registered health care workers not being allowed to prescribe off hospital grounds can create challenges that systems have to plan for i.e. maternity support workers working in community teams.

Information technology (1)

Setting up of IT systems is likely to require a lot of time and work so early mapping of priorities will be important. Some of the recommendations included the following:

- Early engagement with IT and BI teams is key.
- Ensure that the programme is added to the IT priority list, it helps to reinforce the messaging that this will be a mandatory collection from April 22. Ensure the process is linked to local governance processes and there is a clear line of escalation if required.
- Set clear scope and expectations for project (including funding) which should be communicated and approved through the formal routes at system and provider levels.
- Use the national data collection specification and local user requirements at the outset to agree a set of outputs that allow both national reporting and more detailed insight at a local level. The collection should be established so that it can be used as a quality improvement tool.
- It is important to create very specific product specifications and requirements, being clear on what information will need to be recorded, along with a product description on what is required on the extraction side. It is useful to separate as discrete pieces of work so collection can start as soon as possible.
- Consider investment in a single tobacco dependence data collection system or building a template on the existing one that can facilitate data entry, collection and reporting as well as electronic referring out to the patient's local step down services.

Information technology(2)

- Building pages into the electronic patient record, especially as part of the admission process will help to drive data completeness.
- It is helpful to ensure that an automatic opt-out electronic referral is built in. This reduces burden on nursing/medical staff and reduces the risk of patients being missed.
- Different IT systems across different trusts are likely to pose challenges, and manually entered data can create errors. Using standard electronic systems will reduce variation.
- Provision of a clinical system that can support advisers on questions about prescribing and NRT are helpful.
- If the patient is stepping down into community support with the SSS and/or community pharmacy, best practice is to link the IT systems; tracking the full patient journey and the outcome.
- You need to promote IT training for those who will be collecting and entering data so they can collect the data in the intended way. Training would address any concerns and anxieties staff may have in regards to the data collection and would enable better data submissions.
- A dashboard or app can help with reporting as it can flag up incorrect referrals and show an up-to-date picture of admission, screening, referrals and smokers discharged.
- If data is being shared between organisations, you will need to consider data sharing agreements.

Pathways – step down care

A clear discharge pathway forms an integral part of the services to ensure that patients continue to be supported after they leave the hospital. The main recommendations include:

- It is vital to have a clear discharge pathway, with details to be included in the discharge summary, agreed early in the project with all partners signed up to delivery.
- Local Authority (LA) and community involvement from the start is very important for the pathway, and they should be represented on the Steering Group.
- There need to be clear and recognised channels for routine communication and escalation.
- It is important to confirm details on treatment upon discharge to the GP as well as the ongoing provider of care.
- 2 weeks worth of TTOs worked better than 1 week.
- Formally signing agreements with community services to report back 28 day smoking status avoids confusion.
- Try to make the process of referral through discharge pathways as easy and straightforward as possible, e.g. using one-click electronic referral. One site established an online app that includes the health and prescribing information and then a route for community providers to submit data on 28 day quits.
- More information and strong relationships with step down are particularly important for mental health pathways, as there are often higher risk factors / triggers when patients return to their natural environment.
- Where possible, continue engagement with pregnant women after post-partum, also partners / household to avoid relapse.

Culture change (1)

Culture change can be the biggest barrier to successful rollout of services. All of the elements that have been covered previously in this pack will support changing culture. However, key learning related to this area includes:

- Do not to underestimate the amount of time that culture change can take.
- It is vital to try frame mindsets around tobacco dependence being an addiction – there is a medical justification for supporting people – it is not just a lifestyle choice.
- Staff attitude can be a blocker, so support from staff is needed to alleviate this. Supporting staff who smoke is crucial alongside linking this work to the smokefree estate policy.
- Getting engagement of senior clinical managers such as Director of Nursing or Medical Directors can help linking to wider agendas. If effectively engaged, these executive leads should also be willing to challenge cultural barriers and vocally support staff on the front line leading change.
- It can prove to be challenging to roll out the services if non-medical senior executives see it as a lifestyle choice, so it can help to highlight the "economic" case for change in terms of costs saved through reduced admissions, etc. as well as the health benefits.
- In-depth training for the different departments needs to be tailored to tackle culture change, showing the benefits for each setting. For example, not focussing in on financial savings, but outlining the time "costs" saved in terms of patient care e.g. reduced scans/contacts with pregnant smokers or the evidence that links quitting smoking and violence reduction in mental health settings.
- Patient stories can also be an incredibly powerful tool as opposed to only focusing on statistics.

Culture change (2)

- Engage clinical leads, they are big advocates of stopping smoking because they can articulate the consequences faced by patients. Some Trusts use Respiratory consultants or Public Health leads, although other options include cardiologists, midwives and obstetricians.
- Identify leaders and champions on every ward to help reinforce changes everyday, but ensure they are supported by senior colleagues and have a clear and easy route to escalate issues or request help.
- Peer support is especially important, with local networks and champions linked into each other as well as TDAs. Linking to wider advocates via Grand Rounds and governance / clinical leads meetings have also been adopted.
- Clear policies on smokefree estate, tobacco dependence treatment (and prescribing) pathways are important to set tone and support staff. These can also support changes to practice i.e. rolling out CO monitoring.
- Staff sometimes assume that patients are not interested in quitting, particularly in mental health settings, but experience from the EISs has shown that more patients want to engage than ward staff had anticipated.
- To facilitate messaging about the programme, it can be useful to measure other successes e.g. where people have tired to quit– many people need multiple attempts, alternatively reductions in the volume of cigarettes smoked.
- Investing time in staff over a long period through a range of media will help change culture, but never underestimate the importance of meeting with people face-to-face when explaining the importance of this work.