Quality Improvement in Tobacco Treatment

Learning Set 3

18 September 2023, 10:00 – 15:00

Quality Improvement in Tobacco Treatment

NHS England

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Welcome and introductions

Emily Cannon

Head of Quality Improvement

NCCMH

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Quality Improvement in Tobacco Treatment

Housekeeping

- Toilets are located to the right of the lifts on level 1 (men's and women's toilets) and the ground floor (gender neutral toilets and disabled toilets).
- Lunch will be from 12.20pm – 1.00pm and will be served on this floor.
- Room 1.1 is available if anyone who needs to take a break at any point or needs some quiet space (just outside the main auditorium).
- Please use the mezzanine area if you need to step outside for anything else.
- There will be a fire alarm test between 11:00 – 11:30.

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NCCMH shared principles (1)

Listen with respect and openness

We seek to value learning from different people and stay open to new ways of doing things.

Confidentiality

People may share something they wish to be kept confidential. We require everyone's agreement not to share anyone's information without their permission.

Please only take and share photos of people with their permission.

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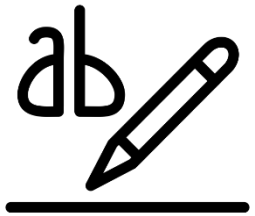
NCCMH shared principles (2)

Contribute

We seek to share ideas, ask questions and contribute to discussions. We can also choose not participate at any stage.

Please wait for the microphone before you contribute in this room



Use plain language

We seek first to understand, then to be understood. If possible, avoid using jargon and explain acronyms if they must be used.

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Time	Item	Speaker
10:00 - 10:30	**Registration**	
10:30 - 10:35	**Welcome and introduction**	Emily Cannon, Head of Quality Improvement, NCCMH
10:35 - 11:55	**Change ideas: What has been tried and tested?** QuITT teams share their progress, successes, and challenges so far.	Team 1 – Oxford Health NHS Foundation Trust Team 2 – Sussex Partnership NHS Foundation Trust Team 3 – East London Foundation Trust
11:55 – 12.40	**Learning from tobacco dependency work in other settings** • Quality improvement for tobacco dependency in the acute health setting • Supporting cessation and preventing relapse after a smokefree mental health inpatient stay	Robyn Fletcher, Public Health, Leicester City Council Dr Emily Shoesmith & Jodi Pervin, SCEPTRE programme, University of York
12:40 – 13:20	**Lunch**	
13:20 – 14:20	**Data for improvement** Round 1 teams: What do your numbers mean? Round 2 teams: Getting ready for your QuITT project	QI Team, NCCMH
14.20 - 14.55	**Translating national policy to local action**	Dr Peter Byrne, Consultant Liaison Psychiatrist at the Royal London Hospital
14:55 - 15:00	**Feedback and close**	Matt Milarski, Senior Quality Improvement Advisor, NCCMH

X/Twitter

- We will be live tweeting this event so you may see the QI coaches on their phones during some sessions. Please also find and follow us **@NCCMentalHealth** or search for **#QuITTCollaborative**
- We encourage use of X/Twitter and social media to share the work that you are doing throughout the collaborative.
- However, we kindly ask you not to tweet people's names, photographs of people's faces or their talks without their permission.
- Thank you!

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Change ideas

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Data

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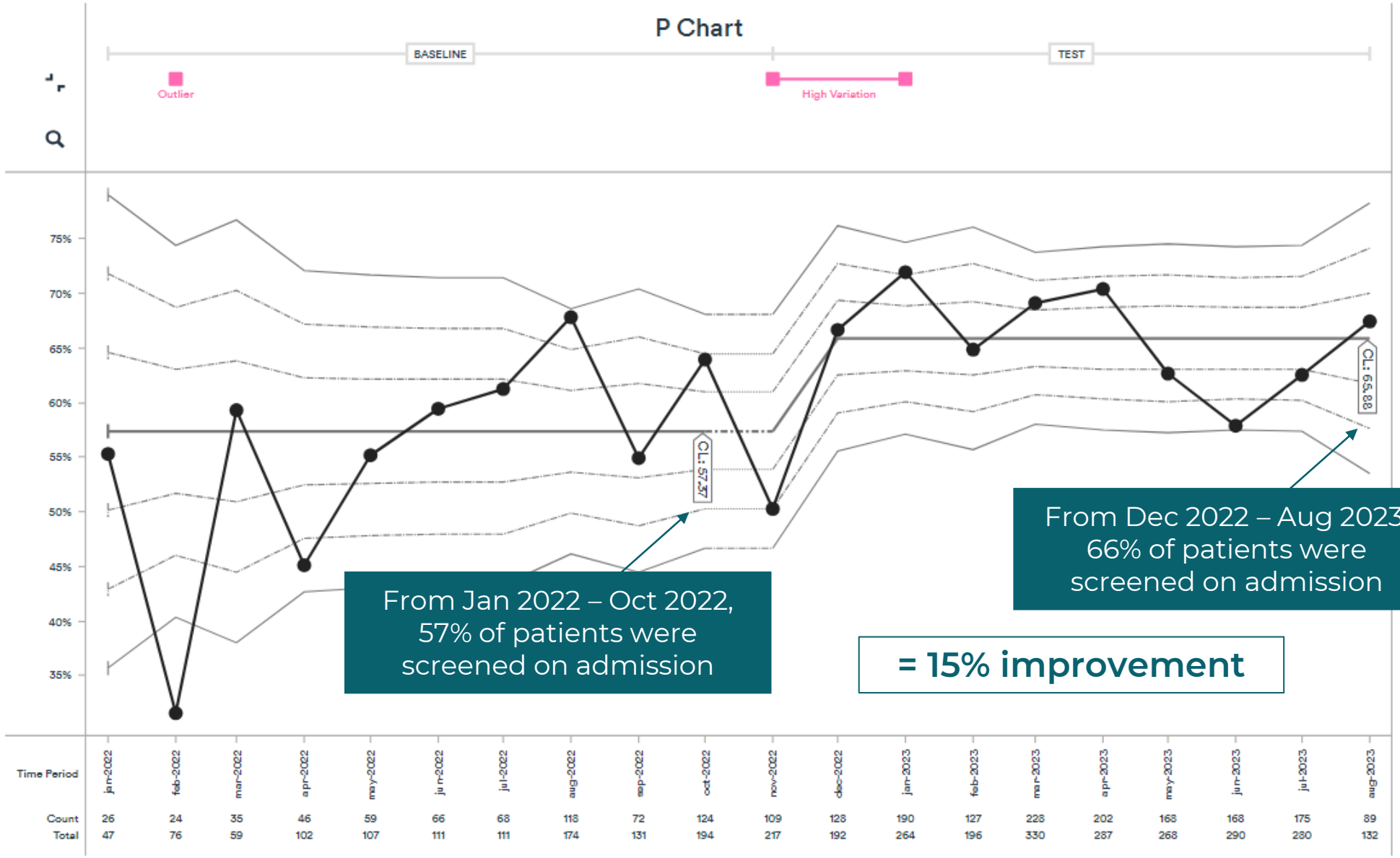
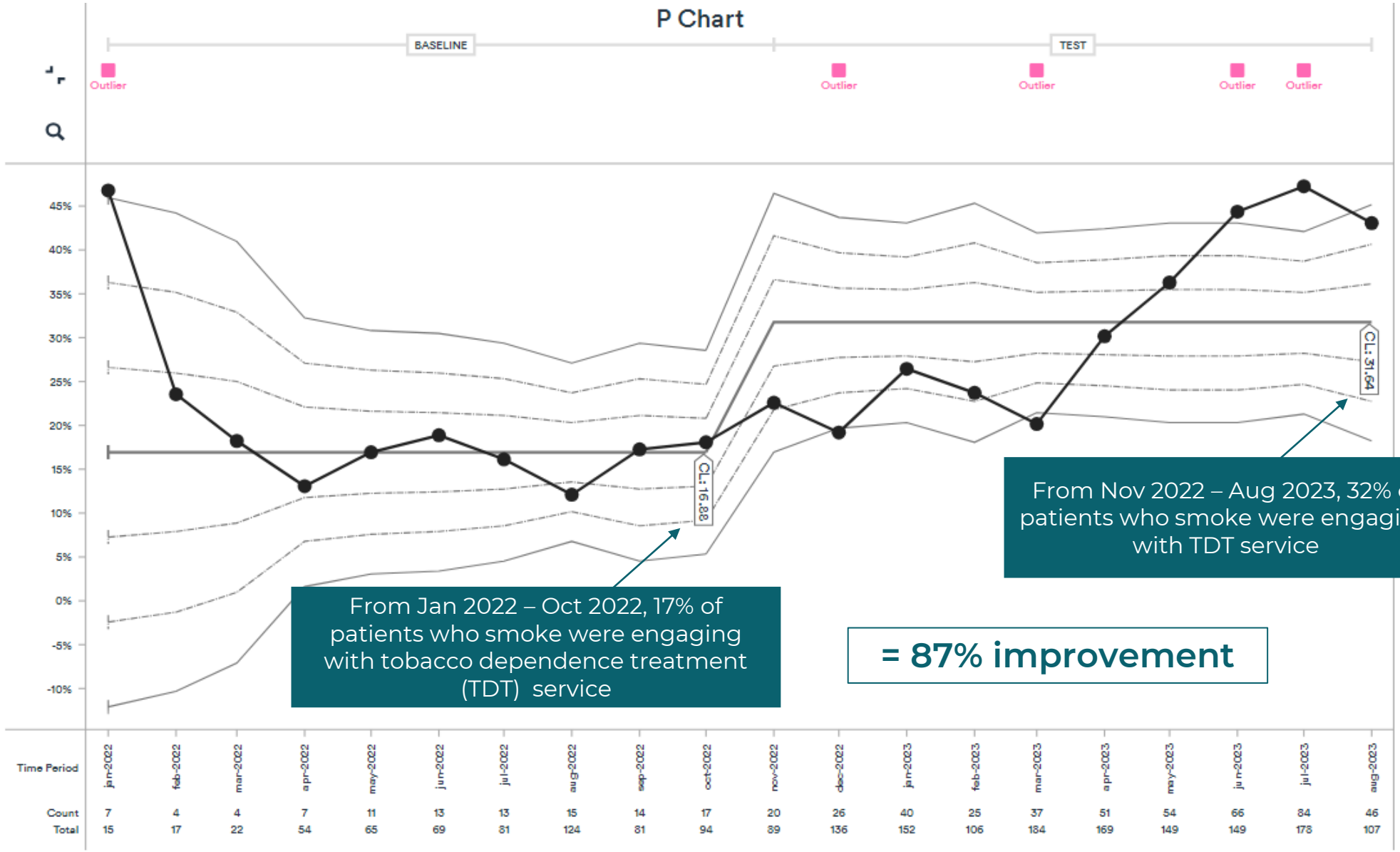
Measure 1: The percentage of patients screened for a recorded smoking status on admission (aggregate)

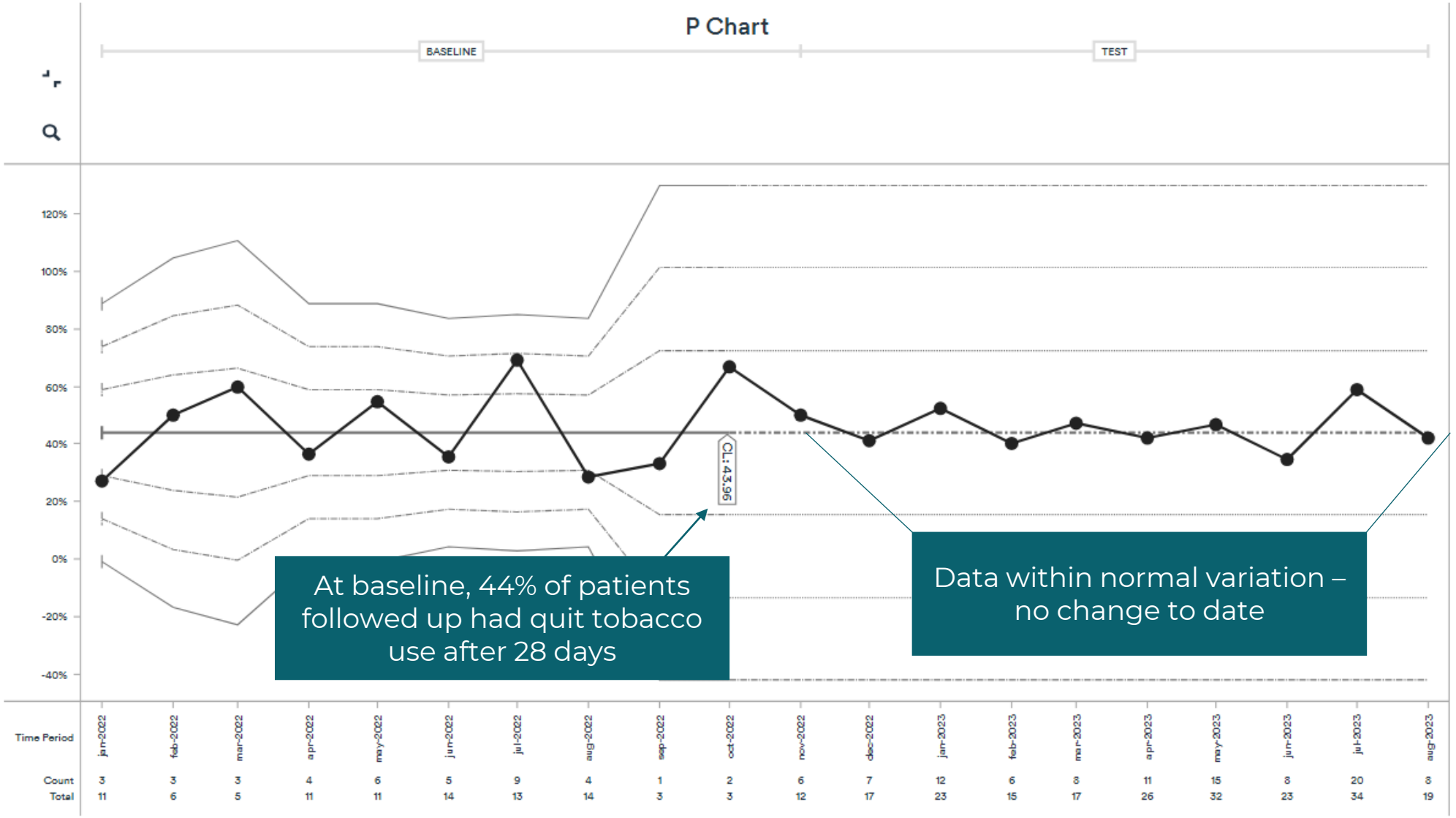


Direction of improvement

Measure 2: The percentage of patients, who smoke, engaged with a tobacco dependency treatment service (aggregate)



Measure 3: The percentage of patients engaged with a tobacco dependency treatment service who have quit tobacco use after 28 days (aggregate)



Direction of improvement

Measures 4-6: Patient survey return rates

- Measure 4: The percentage of patients that felt empowered to quit or continue to be smoke free
- Measure 5: The percentage of patients who rated their experience of the tobacco dependency treatment service as ‘quite good’ or ‘very good’
- Measure 6: The percentage of patients who felt that the support to quit smoking was tailored to their needs and preferences

Month/Year	Number of completed surveys
November 2022	1
December 2022	3
January 2023	7
February 2023	1
March 2023	6
April 2023	12
May 2023	13
June 2023	25
July 2023	43

Change ideas: What has been tried and tested?

- Oxford Health NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust
- East London Foundation Trust

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Change ideas: What has been tried and tested?

QuITT teams share their progress, successes, and challenges so far.

Quality Improvement in Tobacco Treatment

How this session will run…

We will divide attendees into three groups. All three groups will have the chance to hear from all three QuITT teams.

- **20 minutes (13.05-13.25):** 1st team presentation
- **5 minutes:** Move to next team / room
- **20 minutes (13:30-13:50):** 2nd team presentation
- **5 minutes:** Move to next team room
- **20 minutes (13.55 – 14.15):** 3rd team presentation

Team presenting	Room
Oxford Health NHS Foundation Trust	1.2
Sussex Partnership NHS Foundation Trust	1.3
East London Foundation Trust	1.4

Oxford Health NHS Foundation Trust
Our QuITT Journey

Tobacco Dependency Service
September 2023

How has it started?

- QuITT Project was launched in **November 2022**
- Oxford Health is in Round 1
- 3 wards – **Vaughan Thomas, Wintle, Opal** – 2 Acute working age male/female wards and one rehab ward

Tobacco Dependency Service

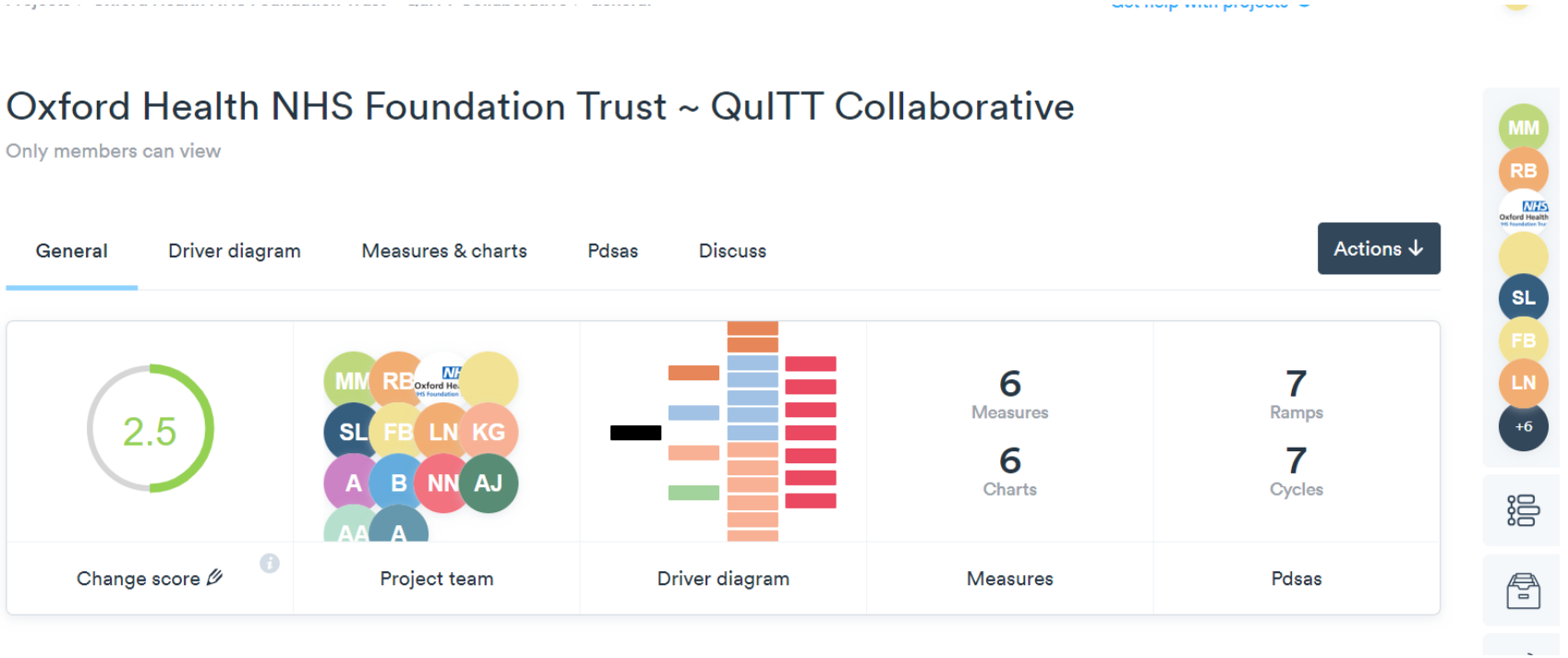
A new service.

- First Tobacco Decency Advisor (TDA) in post in July 2022, more recruitments February/March 2023 – As of September 2023, 4 TDAs are in post
- Started working on QuITT from February 2023

The Project Team

- Project Sponsor: Marie Croft, Chief Nurse – Karl Marlowe, Chief Medical Officer
- Senior Support : Rose Hombo, Deputy Director of Quality
- Project Lead : Filiz Bristow, TDA Lead
- Other Team Members: TDA Leads for respective wards, Ward mangers and Matrons, Physical Health Leads, Trust Safety and QI Lead, Ward Staff, RCP QI Coach, 2 Experts by Experience
- Team meets every 3 weeks
- Quarterly F2F Learning Set in London/RCP – supportive learning community and Online QuITT Workshops

Life QI


Oxford Health NHS Foundation Trust ~ QuITT Collaborative
Only members can view
General
Driver diagram
Measures & charts
Pdsas
Discuss
Actions ↓
2.5
MM
RB
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FB
LN
KG
A
B
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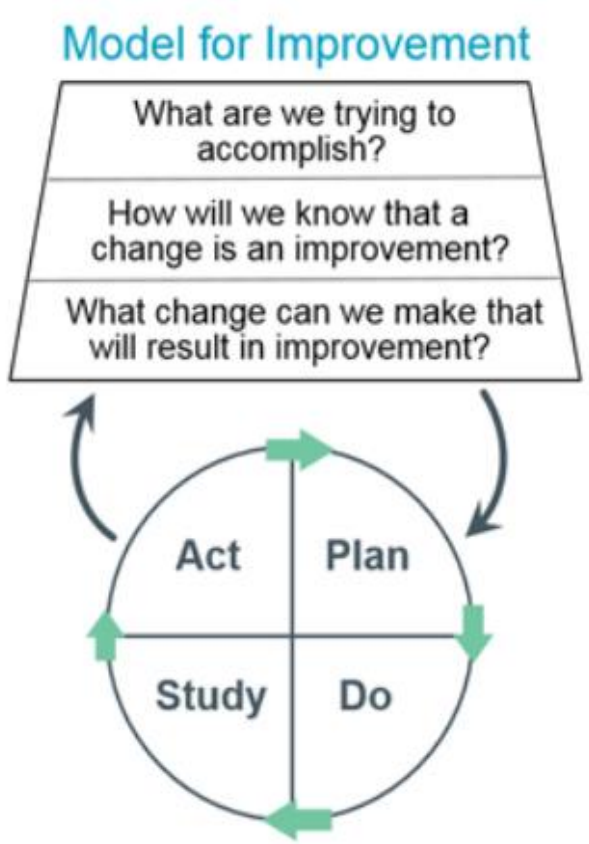
AA
A
6
Measures
6
Charts
7
Ramps
7
Cycles
Change score
Project team
Driver diagram
Measures
Pdsas
MM
RB
SL
FB
LN
+6

Initial Change Ideas

The Team met for the First Time F2F in **February 2023**. With Nominal Group Technique we produced over 30 change ideas.
The top five ideas were:

- Very Brief Advice (VBA) training for all staff on the three wards
- TDAs to be embedded and supported
- Fully embedding the smoke free policy
- Appreciating the system and culture including person-centred care and contextual understanding
- Creating literature (leaflets, posters etc) for patients

Current PDSA Cycles

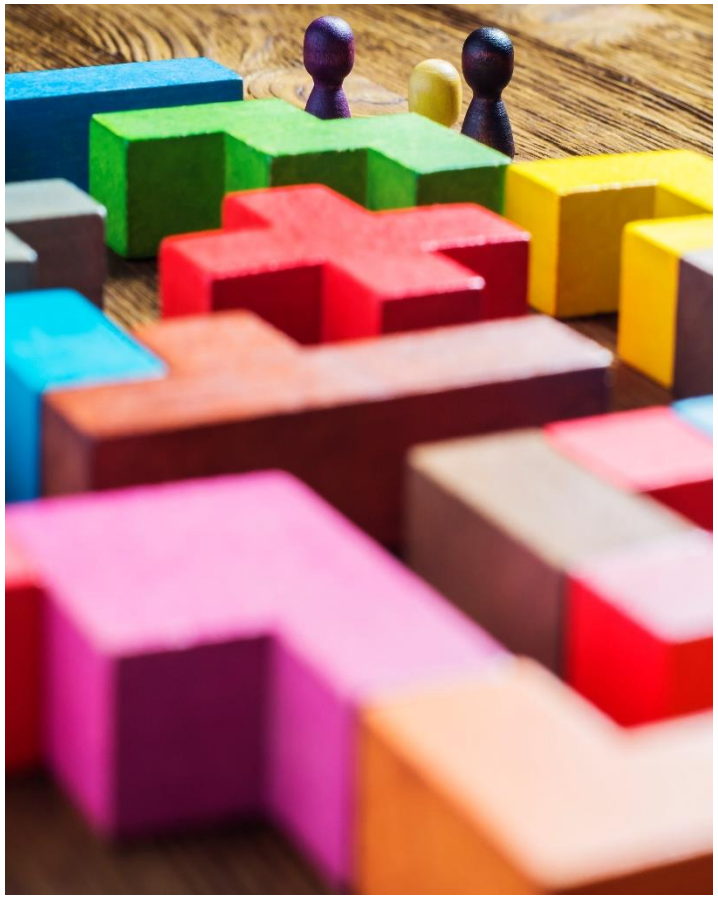


- TDAs attending regular ward meetings
- EbE Involvement
- Patient referrals to TDA
- VBA Training for the pilot wards
- Patient Survey completion on discharge
- Patient Tobacco Groups
- Smoke-free Policy – embedding non-return of tobacco

Challenges

1- Ward culture, routine and lack of engagement impacted:

- Referrals – ongoing
- Patient Surveys – got better

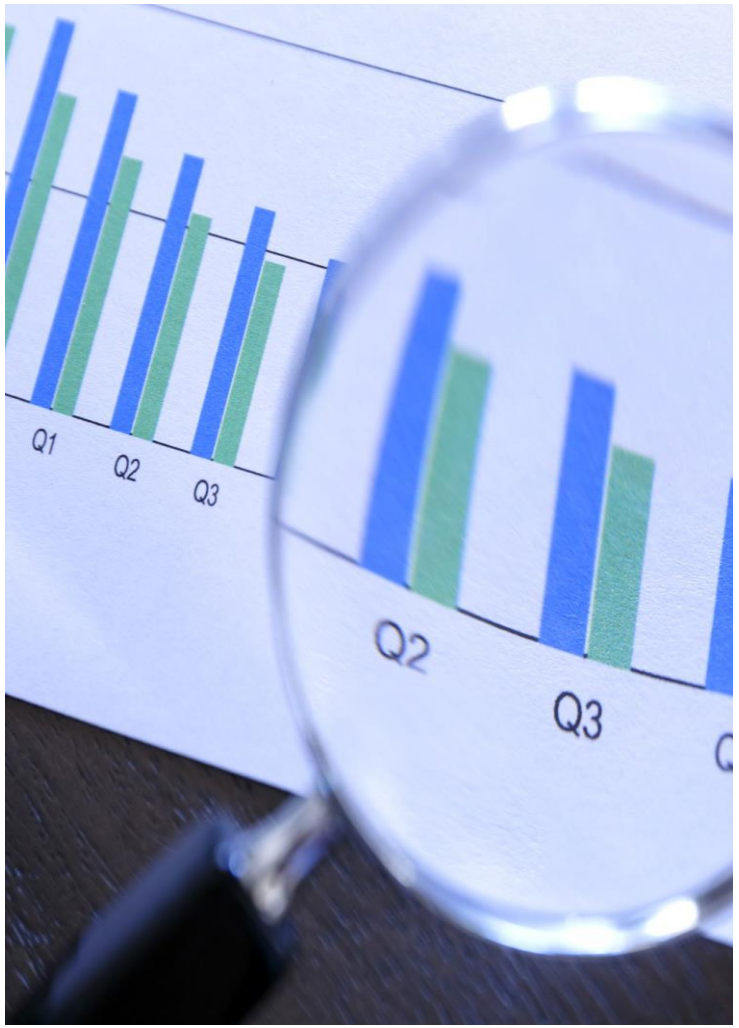


2- Staff understanding: No differentiation between Smoke-free Policy and QuITT Project.

3- Tobacco Dependency service wasn't fully established and changes to staffing.

4- Data collection impacted by above challenges.

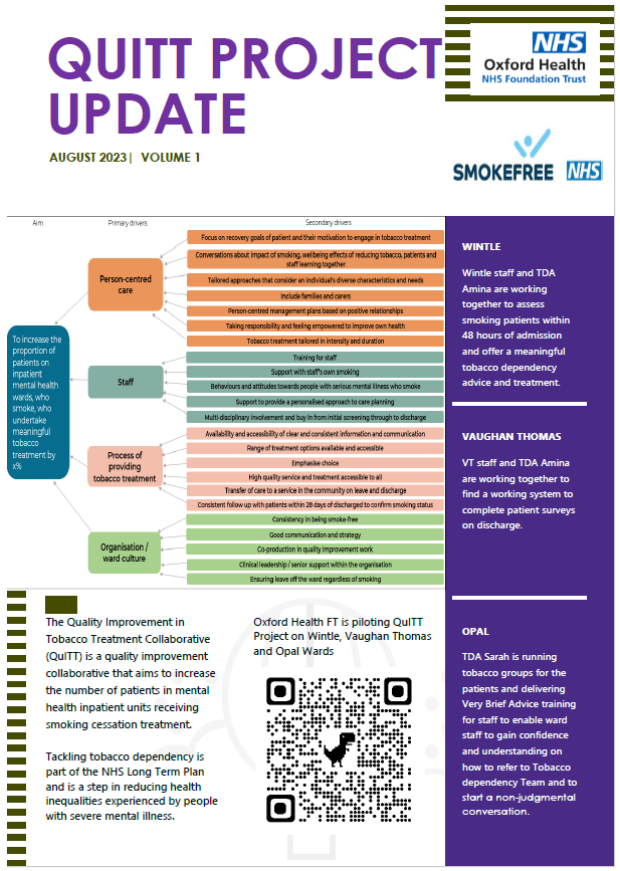
- Long term issues with referring patients to TDA and completing surveys on discharge.
- Lack of fully functioning patient admin system.



Successes/Positives

- Strong TDA collaboration
- Working change ideas
- EbE Involvement
- Supportive QI Coach from the RCP
- Quarterly Bulletin
- Despite the challenges we have the data

Quarterly Bulletin



QUITT PROJECT UPDATE

AUGUST 2023 | VOLUME 1

NHS Oxford Health NHS Foundation Trust

SMOKEFREE NHS

Aim: To increase the proportion of patients on inpatient mental health wards, who smoke, who undertake meaningful tobacco treatment by x%

Primary drivers: Person-centred care; Staff; Process of providing tobacco treatment; Organisation / ward culture

Secondary drivers:
- Focus on recovery goals of patient and their motivation to engage in tobacco treatment
- Conversations about impact of smoking, wellbeing effects of reducing tobacco, patients and staff learning together
- Tailored approaches that consider an individual's diverse characteristics and needs
- Include families and carers
- Person-centred management plans based on positive relationships
- Taking responsibility and feeling empowered to improve own health
- Tobacco treatment tailored in intensity and duration
- Training for staff
- Support with staff's own smoking
- Behaviours and attitudes towards people with serious mental illness who smoke
- Support to provide a personalised approach to care planning
- Multi-disciplinary involvement and buy in from initial screening through to discharge
- Availability and accessibility of clear and consistent information and communication
- Range of treatment options available and accessible
- Emphasise choice
- High quality service and treatment accessible to all
- Transfer of care to a service in the community on leave and discharge
- Consistent follow up with patients within 28 days of discharged to confirm smoking status
- Consistency in being smoke-free
- Good communication and strategy
- Co-production in quality improvement work
- Clinical leadership / senior support within the organisation
- Ensuring leave off the ward regardless of smoking

The Quality Improvement in Tobacco Treatment Collaborative (QuITT) is a quality improvement collaborative that aims to increase the number of patients in mental health inpatient units receiving smoking cessation treatment.

Tackling tobacco dependency is part of the NHS Long Term Plan and is a step in reducing health inequalities experienced by people with severe mental illness.

Oxford Health FT is piloting QuITT Project on Wintle, Vaughan Thomas and Opal Wards

WINTLE

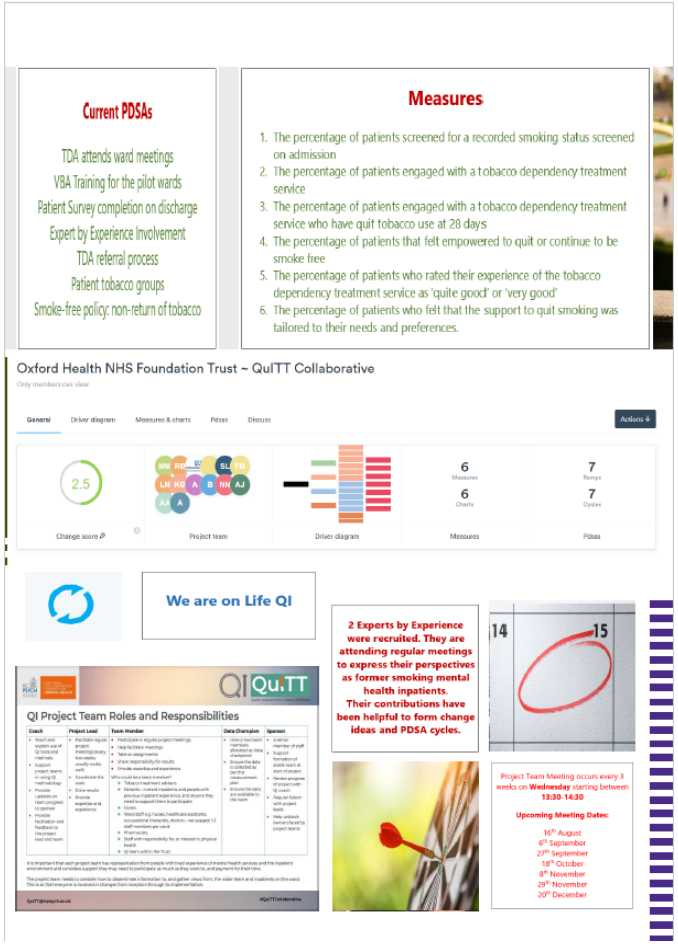
Wintle staff and TDA Amina are working together to assess smoking patients within 48 hours of admission and offer a meaningful tobacco dependency advice and treatment.

VAUGHAN THOMAS

VT staff and TDA Amina are working together to find a working system to complete patient surveys on discharge.

OPAL

TDA Sarah is running tobacco groups for the patients and delivering Very Brief Advice training for staff to enable ward staff to gain confidence and understanding on how to refer to Tobacco dependency Team and to start a non-judgmental conversation.



Current PDSAs

TDA attends ward meetings
VBA Training for the pilot wards
Patient Survey completion on discharge
Expert by Experience Involvement
TDA referral process
Patient tobacco groups
Smoke-free policy: non-return of tobacco

Measures

1. The percentage of patients screened for a recorded smoking status screened on admission
2. The percentage of patients engaged with a tobacco dependency treatment service
3. The percentage of patients engaged with a tobacco dependency treatment service who have quit tobacco use at 28 days
4. The percentage of patients that felt empowered to quit or continue to be smoke free
5. The percentage of patients who rated their experience of the tobacco dependency treatment service as 'quite good' or 'very good'
6. The percentage of patients who felt that the support to quit smoking was tailored to their needs and preferences.

Oxford Health NHS Foundation Trust ~ QuITT Collaborative

General | Driver diagram | Measures & charts | Pdsas | Discuss | Actions

2.5 Change score | Project team | Driver diagram | 6 Measures, 6 Charts | 7 Ramps, 7 Cycles | Pdsas

We are on Life QI

2 Experts by Experience were recruited. They are attending regular meetings to express their perspectives as former smoking mental health inpatients. Their contributions have been helpful to form change ideas and PDSA cycles.

QI QuITT

QI Project Team Roles and Responsibilities

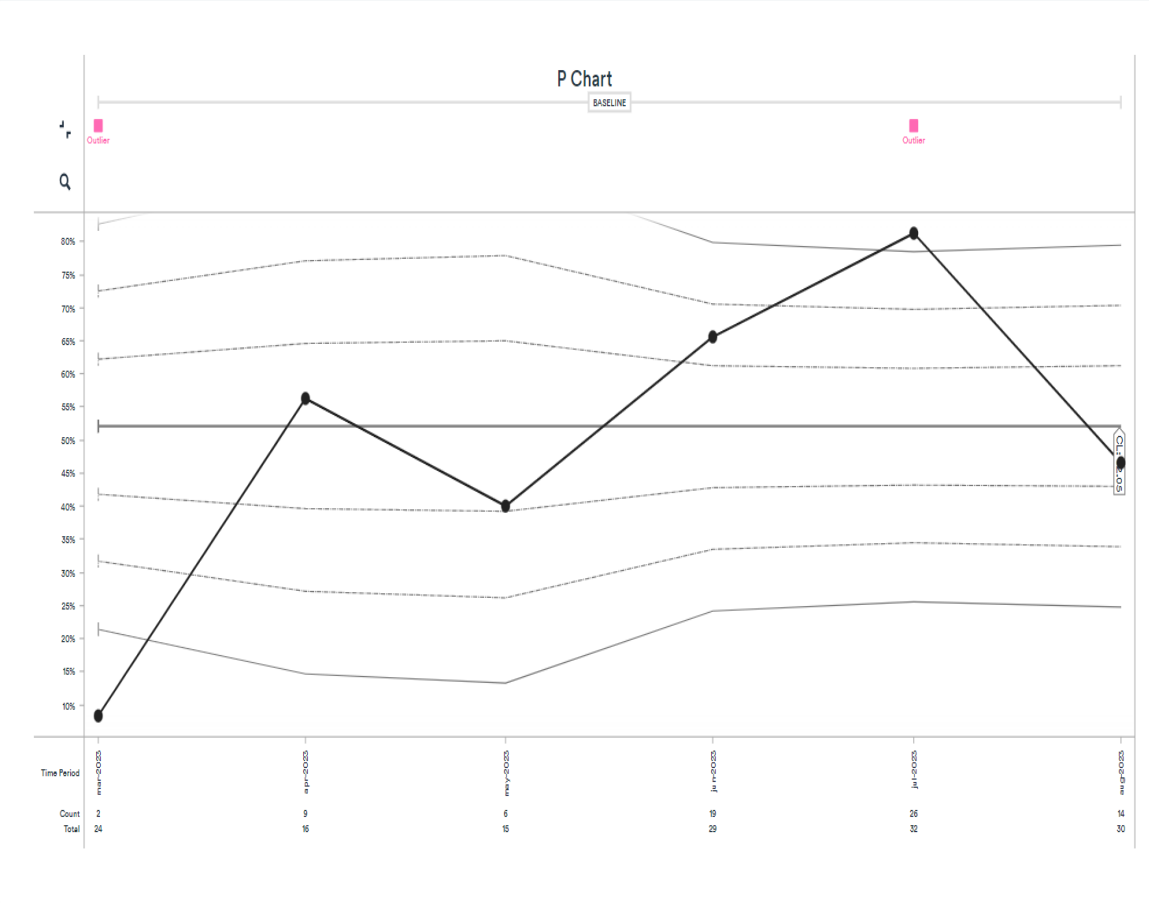
Project Team Meeting occurs every 3 weeks on Wednesday starting between 13:30-14:30

Upcoming Meeting Dates:

16th August
6th September
27th September
18th October
8th November
29th November
20th December

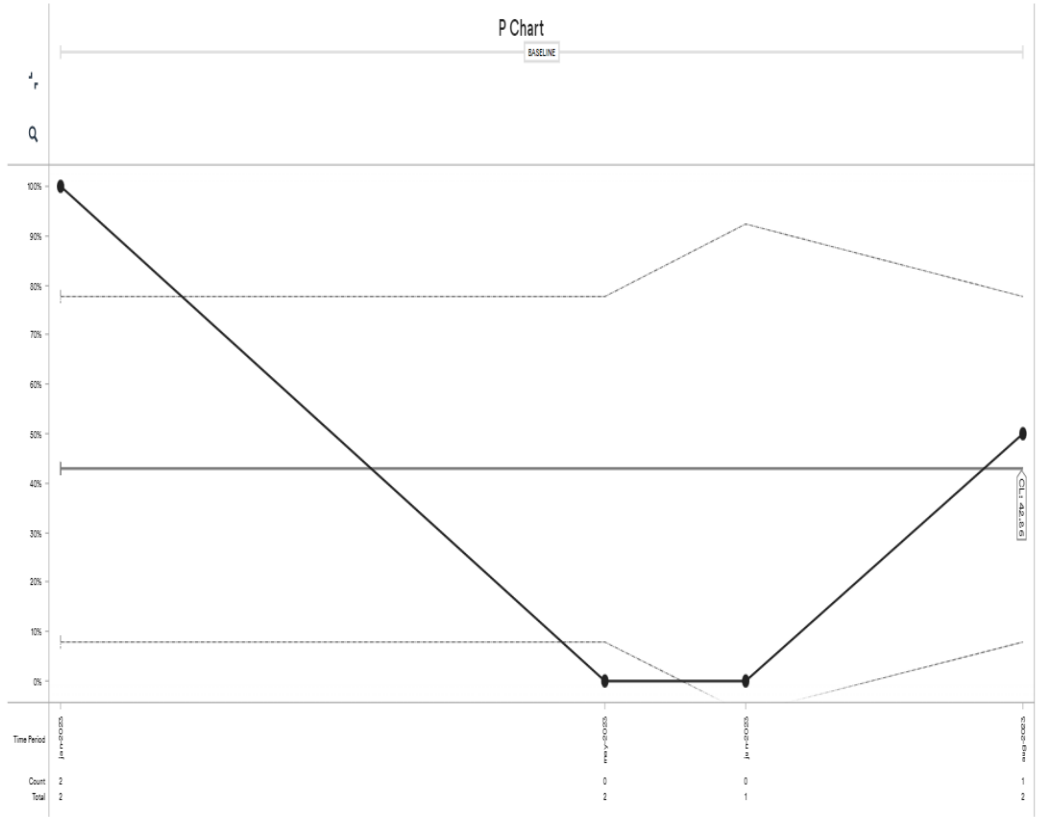
DATA (March–August 2023)

Measure 2: The percentage of patients engaged with a tobacco dependency treatment service. 52%



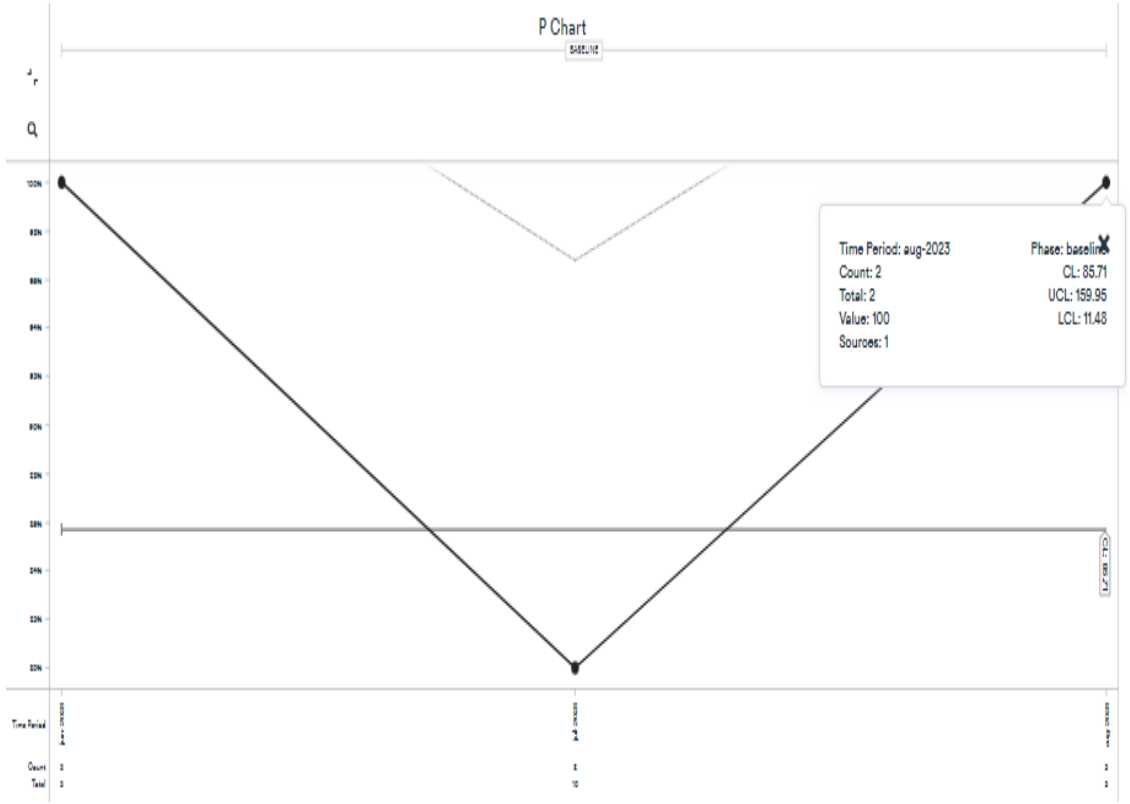
DATA (January – August 2023)

Measure 3: The percentage of patients engaged with a tobacco dependency treatment service who have quit tobacco use after 28 days. 42%



DATA (June-August 2023)

Measure 6: The percentage of patients who felt that the support to quit smoking was tailored to their needs and preferences. 85%



What have we learnt?

- Ward management and staff engagement is the key
- Tailored training for the pilot wards required
- EbE Involvement is essential to see from the service users' perspectives
- '**Data collection**' should have been made as the first PDSA to work through the challenges

What is next?

- PDSAs - ongoing
- The data collection – more focus
- Patient Groups – Patient perspective
- Continue with EbE Support
- Rollout

We would like to hear your success stories on the '**data collection and engaging with wards**'.


THANK
You!

Any questions?

Sussex Partnership NHS Foundation Trust

Tobacco Dependency Service

Heather Frazer, Andreea Mitoi and Anmol Kacker

Sussex Partnership NHS Foundation Trust

Our service

Aims to provide advice, support and treatment to help patients stop smoking, both in hospital and in the community.

We also aim to increase the number of patients engaging in treatment for smoking - and successfully quitting. As well as working across all inpatient units, we are one of seven National Early Implementer sites for community patients.

We provide strategies to aid in coping with nicotine cravings and withdrawal symptoms by providing behavioural support and nicotine replacement therapy (NRT).

We cover sites across East Sussex, West Sussex, and Brighton and Hove.

The QI project team

Clementine Fitch Bunce (Quality Improvement Coach)

Heather Frazer (Tobacco Dependency Service Lead)

Jaime Dawn Wain (Project Support Officer for Tobacco Dependency Service)

Georgia Moffatt (Matron Caburn Ward)

Jack Pumphrey (Ward Manager Caburn Ward)

Lisa Dyde (Matron Rowan Ward)

Jessica Archer (Ward Manager Rowan Ward)

Patrick Fenton (Matron and Smoke free Lead Meadowfield)

Andreea Mitoi (Tobacco Dependency Advisor Rowan Ward)

Anmol Kacker (Tobacco Dependency Advisor Caburn Ward)

Our QI journey so far…

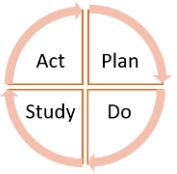
Change ideas:

CABURN WARD

1. Timing
2. Any nicotine cravings
3. Anxiety
4. Explain NRT
5. Offer NRT
6. Patient sees NRT working
7. If the patient is hesitant, don’t talk about quitting/abstaining from smoking

Change ideas for Rowan ward

- Training all staff
- Smoking cessation champions
- Professional Nurse Educator
- Participate in leadership meetings and ward meetings



Key learning from testing change ideas

1. Vaping is inhibiting NRT usage
2. Staff training
3. Patient Awareness
4. Patient Encouragement
5. Adopting the approach

Successes

1. Engagement
2. Willingness
3. Achievable Goals
4. Positive Attitude
5. Increased Communications

Challenges and ways to overcome them:

1. Patients still allowed to vape on the ward.
2. Ward staff sometimes are unable to have conversation with the patients about tobacco dependency. Talks mostly happen only when I am on the ward.
3. Members of staff hold mixed perceptions about smoking, therefore don't refer to us.
4. NRT mentioned as PRN on medication charts.

How I would overcome the above challenges:

1. Vaping protocol to be introduced
2. Encouraging and training staff to have these conversations with the patients when the Advisor is not around. Asking them to complete MAUPs and undergo Tobacco Dependency Training.
3. Promoting conversations around smoking and referrals to the Tobacco Dependency Service during ward reviews and referring the patient to us post review. This prepares the patient and gives them the opportunity to come to a decision about what they would like to do.
4. Asking staff to encourage patients to use NRT during the period when they struggle the most.

Next steps

- Consultants will be adding a referral to the Tobacco Dependency Service as part of the ward review for new patients. This will increase patient referrals and open up the opportunity to have more conversations with more patients. Hopefully, this might even create a ripple effect where one smoker might encourage another smoker on the ward to speak to us and try NRT.

- We have been invited to attend an upcoming Leadership Meeting at Mill View. This will be a good platform for us to talk about the change idea to more staff members, discuss challenges and ways to overcome them, ask for any other change ideas that the staff think might be worth trying, asking Ward Managers and Matrons to encourage staff to attend the Tobacco Dependency Training and working together towards making Mill View a smoke free site by assisting both patients and staff.

Questions for participants…

- *Encourage training attendance*
- *Patient involvement*
- *Boredom*

Ogechi Anokwuru, Trust and Forensic Lead for Tobacco Dependency

Chris Oleru-Uda, RGN, Newham Tobacco Dependency Advisor

Dr Marios Krespis, Consultant Psychiatrist, Newham

Our service

ELFT TDS journey began in 2019, and expanded in summer 2022. 3 advisors covering the Trust to 10 advisors. These areas are: Bedford and Luton, City and Hackney, Newham, Tower Hamlets, Forensics and community services. We have assessed over 1200 patients, with 828 quit or cut down to quit!

The QI project team

Clem Bunce- QI coach

Ogechi Anokwuru, ELFT Trust and Forensic Tobacco Dependency Lead

Chris Oleru-Uda, RGN Tobacco Dependency Advisor, Newham

Dr Marios Krespis –Consultant Psychiatrist

Gifty Obeng-Nsiah - Clinical Practice Lead

Rosemary - RMN

Tim Opoku- Ward Manager

2 Service user (anonymised)

Ahmed Abdi – Social therapist

Data! Topaz ward

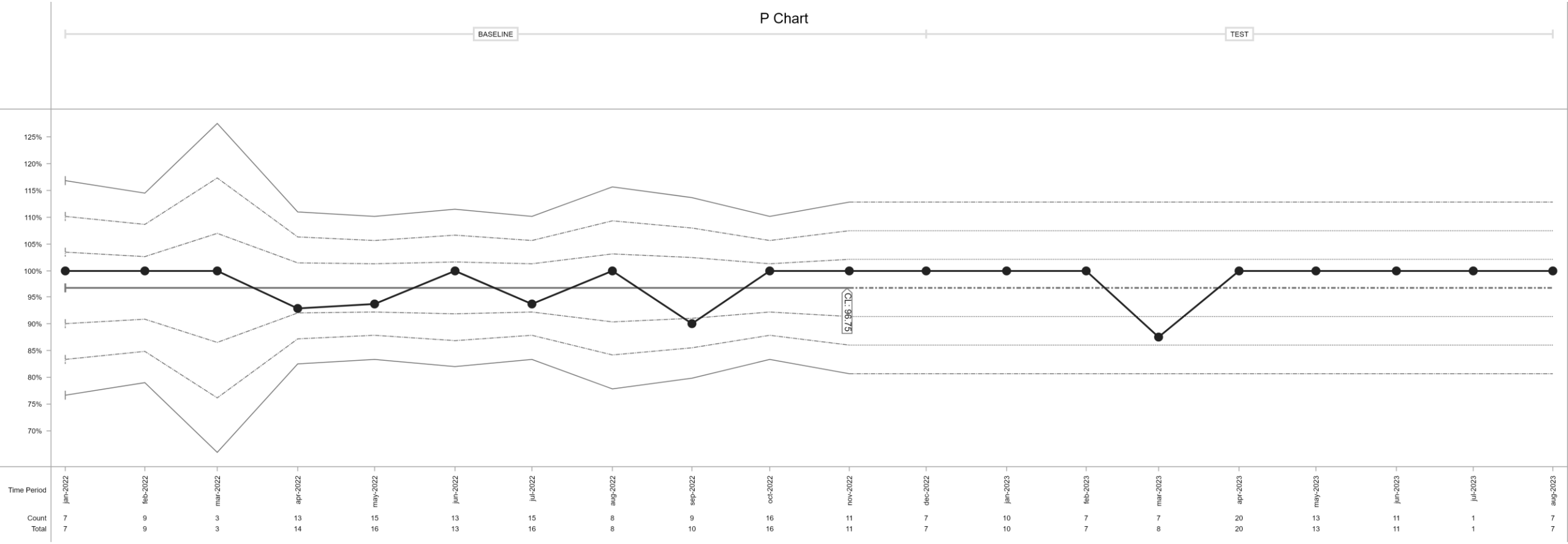
- Quit data Q1 (Sep 2022 to Aug 2023)
- Across Newham: 101 in-patient contact
- 29% on quit pathway
- 39% smoking reduction pathway
- 55% only vapes
- 22% accepted licensed and unlicensed NRTs
- 23% were on combination of NRTs.

Topaz ward:

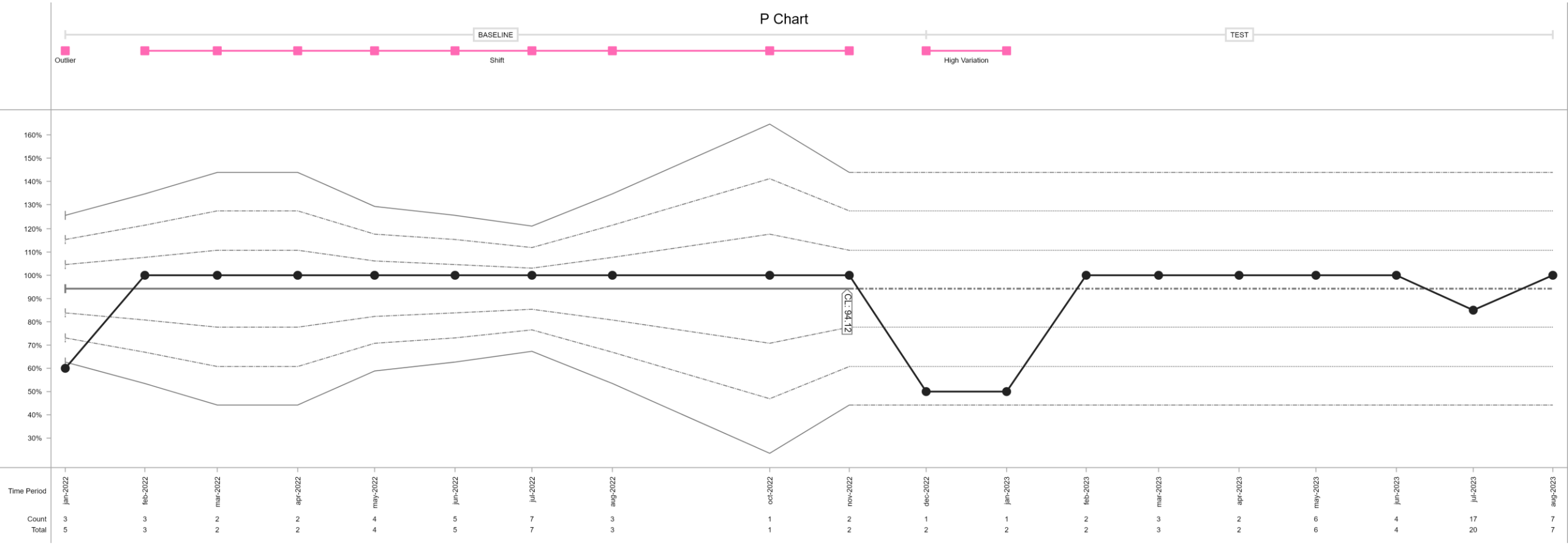
Quit : 42

Opt out: 11

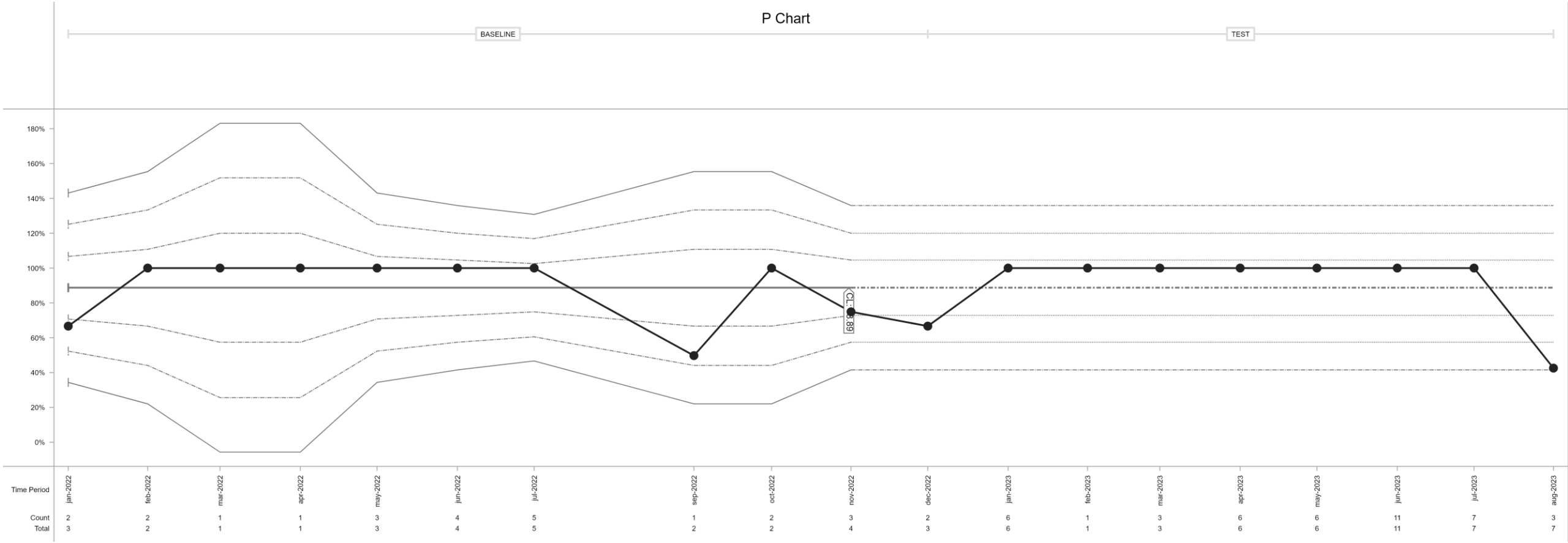
The percentage of patients screened for a recorded smoking status on admission



The percentage of patients engaged with a tobacco dependency treatment service who have quit tobacco use after 28 days



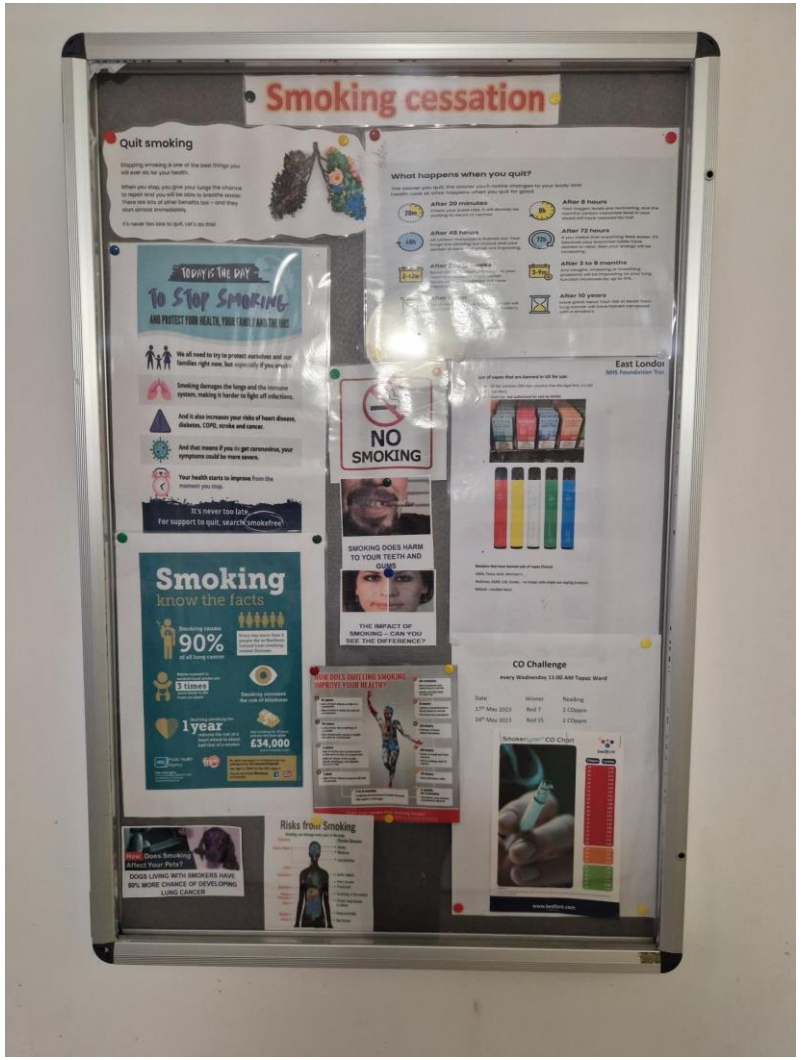
The percentage of patients engaged with the tobacco dependency treatment service



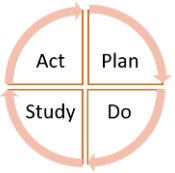
Our QI journey so far…

Change ideas:

- Know your CO reading, every Wednesday morning, service user with the lowest CO reading is given a free disposable vape, we had meetings every 2 weeks or ad hoc that was convenient for all staff to attend due to time and ward constraints
- Health promotion on safer vaping and illicit vape use for service users that are displayed on the wards
- Staff and service users attending community meetings to debunk myths
- Staff training on CO monitoring
- Prescribing NRT by doctors has become routine and increased uptake
- Vaping- interest from staff and patients as quit tools – incentive for formulating change idea



Key learning from testing change ideas



What have you observed and learnt so far?

- Staff engagement and service user involvement is crucial to ensuring that the weekly CO reading takes place
- Service users want to feel empowered and having a reward helps them feel valued for their effort to give up smoking

Have you involved patients/carers when testing your change ideas?

- Yes. 2 service users who have quit via our service have taken part with our change ideas

How have your team found the PSDA process?

- Initially challenging, as staff availability would overlap and clash with set meetings
- Great way of brainstorming ideas and setting a plan in place to ensure tasks were achievabl and list any challenges that may occur
- Able to set deadlines and document and review task as we go along

Successes and challenges
ELFT QuITT data

- Weekly readings of patients taken on an inpatient ward between two advisors alternating
- Regular feedback from staff and service users who want to know their improvement week in and out
- Challenges: service users may not always be available for a CO reading due to being on leave, unwell or asleep
- Staff shortage to facilitate CO monitoring

Next steps

- To obtain feed back from service users for evaluation
- Ward staff to conduct CO readings as part of regular physical health checks

Learning from Tobacco Dependence work in other settings:

- **Quality improvement for tobacco dependence in the acute health setting -** Robyn Fletcher, Public Health, Leicester City Council

- **Supporting cessation and preventing relapse after a smokefree mental health inpatient stay -** Dr Emily Shoesmith, SCEPTRE programme, University of York

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British Thoracic Society

Quality Improvement (QI) programme for tobacco dependency treatment

Dr Robyn Fletcher

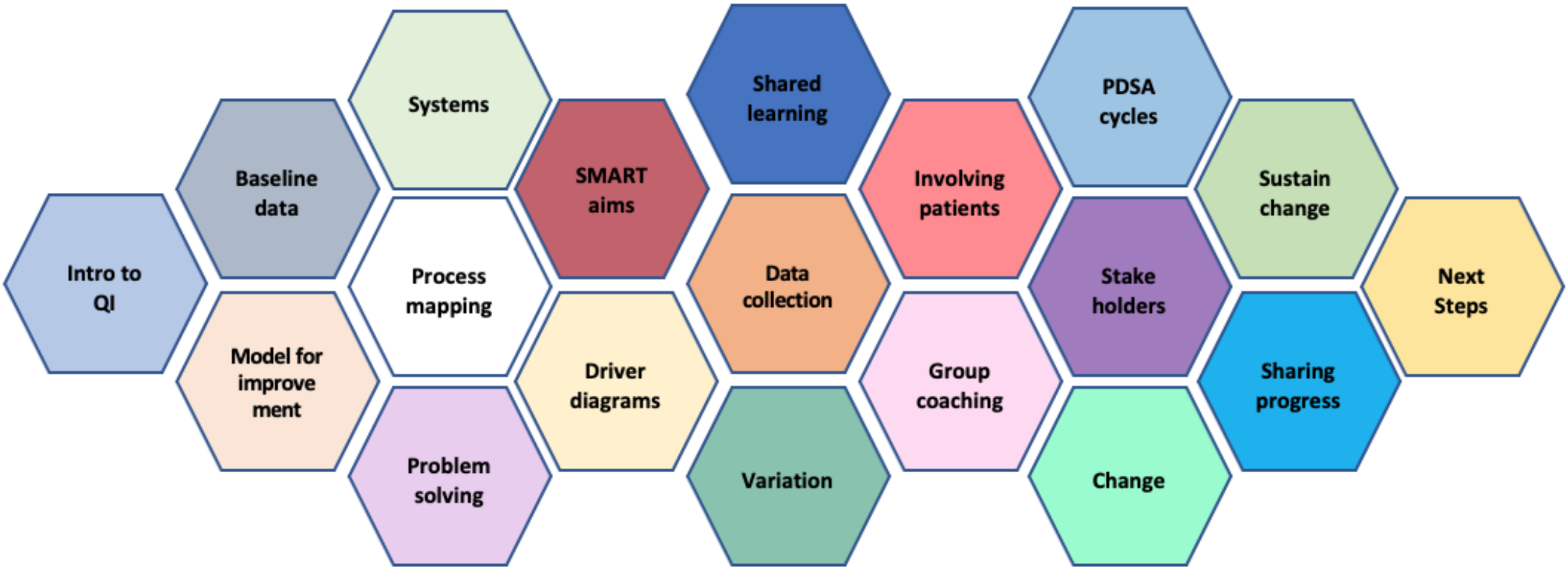
Background

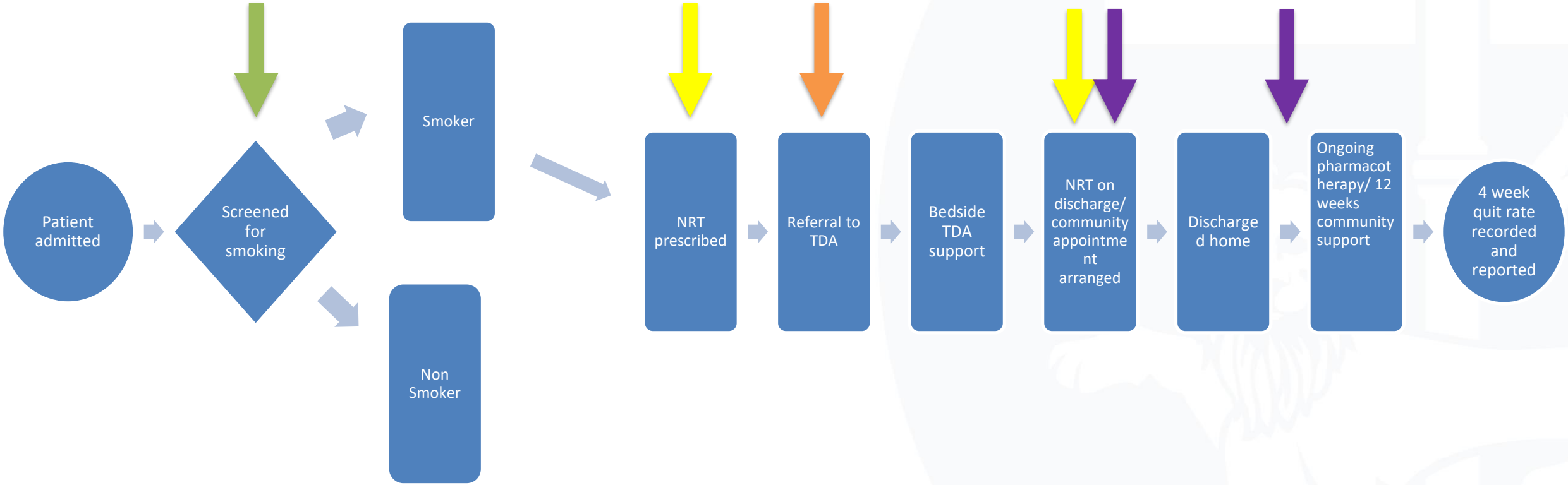
British Thoracic Society
National Smoking Cessation Audit 2021: Management of Tobacco Dependency in Acute Care Trusts: Audit Report

National Audit Period: 1 July – 31 August 2021
Audit leads: Dr Nikesh Devani, Dr Matthew Evison

The proposed solution

The programme





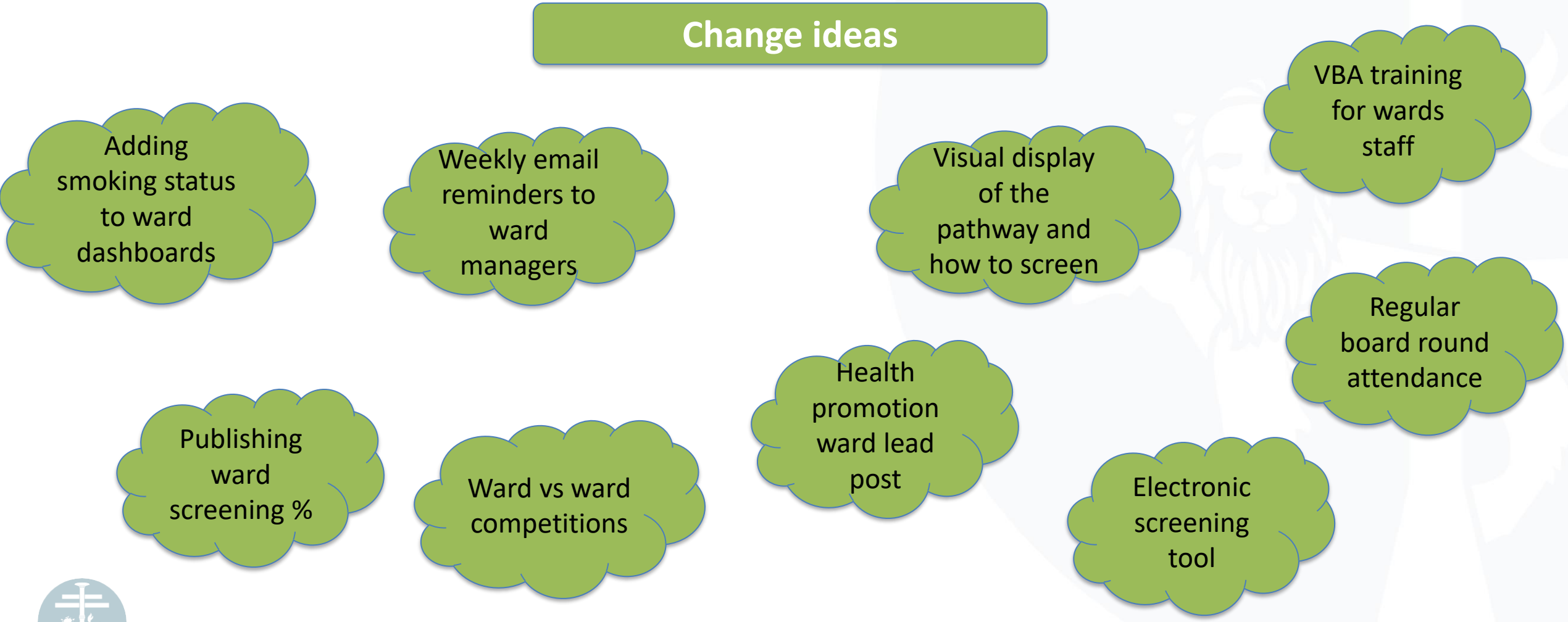
Smoking status screening

Referrals into the service

NRT

Transfer of care to the community

Smoking status screening



Referrals into the service

Change ideas

Patient self referrals with QR codes on posters

New referral routes- QR code, email, call

Department teaching

Screensaver advertising

Network of smoking cessation champions

Ward reminder posters

Use of a virtual booking clinic

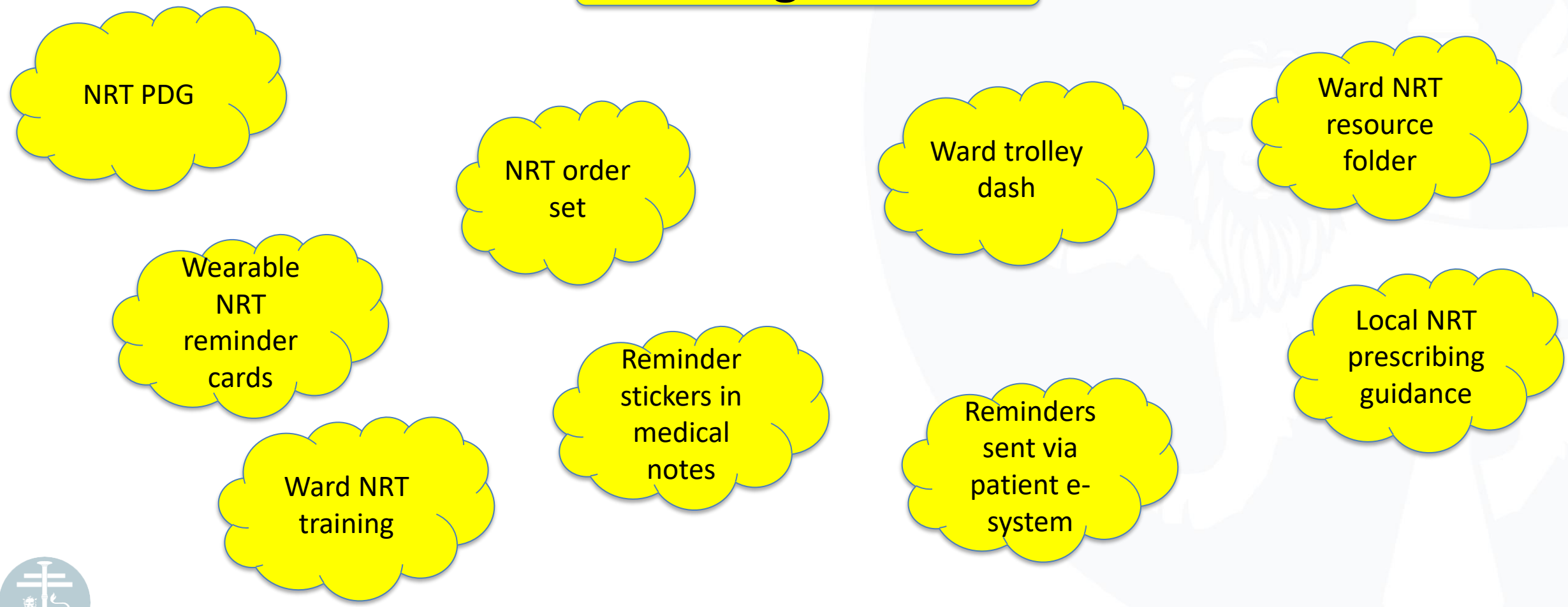
Service promoted at new staff inductions

TDA attend ward/board rounds

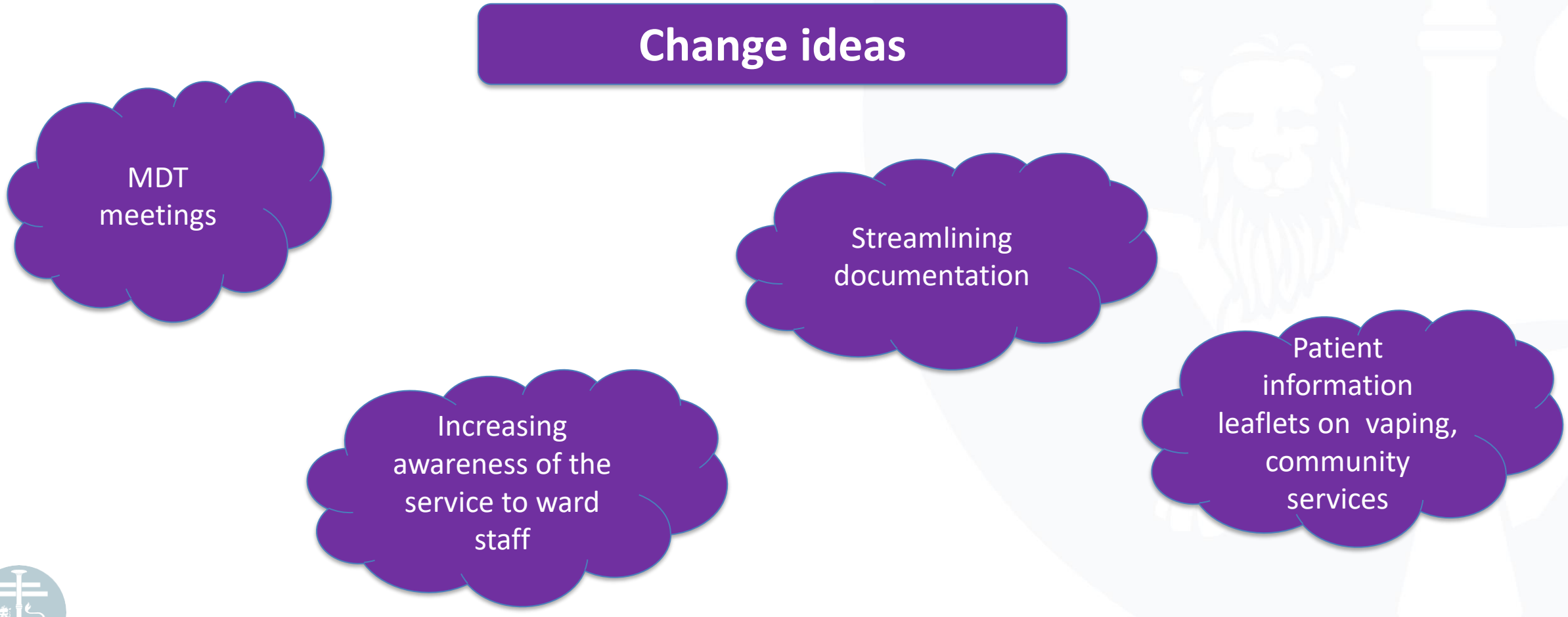
Mandatory form

NRT

Change ideas



Transfer of care to the community



Programme outcomes

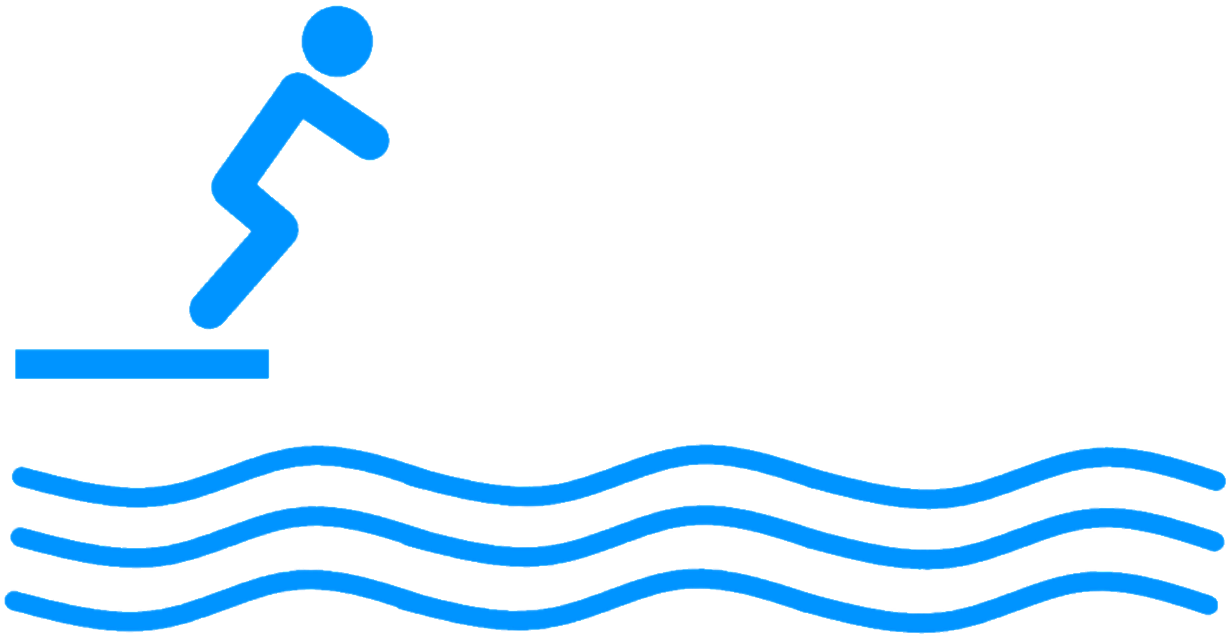
Barriers


conflicting priorities
nrt medicine management policy
cultural change
clinician awareness
change resistance
many short admissions
documentation variation
nhs pressures
staffing pressures
perceived importance by seniors
recruitment
paper systems
initiative fatigue
workload
competing challenges
pressured workforce
financial pressures
links with inpatient teams
unaware of service
capacity
competing pressures
staff shortages
staffing levels
qi skill
discharge focus
service awareness
resources
large complex organisation
culture
sustaining change
reluctance to change
organisational pressures
funds
policy education
morale
qi knowledge
nrt supply
staff attitudes
post covid fatigue
fatigue
other priorities
discharge emphasis
screening tool
long timescales
data access
clinical staff time
understanding importance
silo working
senior support
hospital pressures
training materials
external engagement
time
not prioritised
sickness
communication reach
electronic system changes
culture change
new electronic system
ward pressures
staff turnover
stressed system
nrt prescribing knowledge
prioritisation
nrt pdg awareness
winter pressures
staffing
staff engagement

Enablers


skilled workforce
pharmacy
experienced delivery team
effective partnership working
healthy competition
high level
meeting best practice guidance
ground presence
regular steering group meetings
better patient outcomes
established service to drive change
committed core team
clinical evidence
engaged executives
improve smoke free site compliance
contractual obligations
strong clinical engagement
better outcomes
clinical staff training
nhs tobacco dependency plan
on the ottawa model
consultant engagement
improved patient experience
high smoking rates locally
buy-in
organisational values
decrease pressure on the nhs
regular meetings
respiratory buy in
it buy in
motivated team
patient experience improvements
executive team
senior level support
nhs smoke free 2030 target
smokefree site
resiratory nurse input
strong regional relations for support
timely feedback
ward
long term plan alignment
business intelligence
ward staff
smoking training module
reduced readmissions
team
clear development areas
senior clinican input
governance
wide mdt involvement
governance structures
ics governance structure
senior buy in
experienced team
trust priority
relationship with ward staff
cost saving
established service
governance structure
relevant staff experience
experience in tobacco dependency change
local tobacco lead input
strong links smoking cessation leads
executive sponsor
multi-disciplinary team
tobacco dependency team all in post
involvement
clinical staff engagement
experience making change locally
support from medical directorate
experience in qi
service embedded in the trust
clear goals
improve efficiency
project team commitment
vba educational lead
pro-active team
ward champions
clinical leadership
leadership support
pharmacy input
clinical staff awareness
service user
reducing pressure on the hospital
trust board support
pharmacy buy
ics
group
long-term savings
teams buy in
quality of life
improve health
senior manager involvement
motivated team
data streams
wider mdt involvement
better health outcomes longer-term
ics focus on health inequalities
experienced

Reflections



”Start small, but start!”

Participant, 2023

Any questions?

FUNDED BY NIHR | National Institute for Health Research

NHS Sheffield Health and Social Care NHS Foundation Trust

University of York

SCEPTRE

SCEPTRE

Promoting **S**moking **CE**ssation and **P**reven**T**ing **RE**lapse to tobacco use following a smokefree mental health inpatient stay

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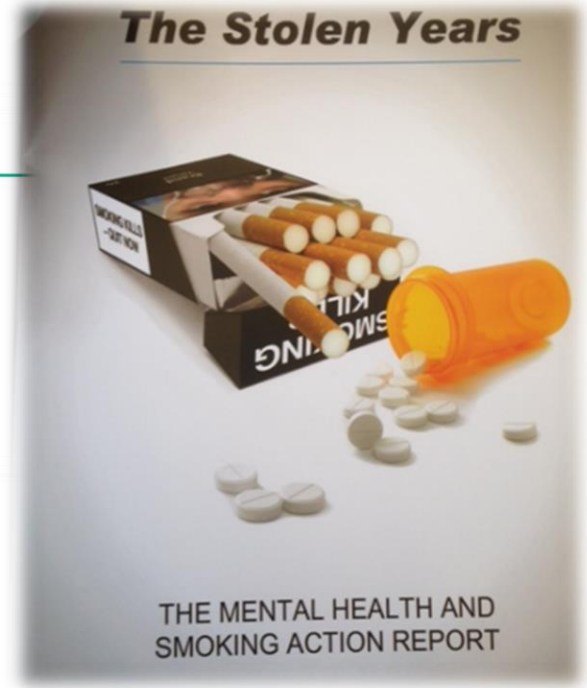
18TH SEPTEMBER 2023

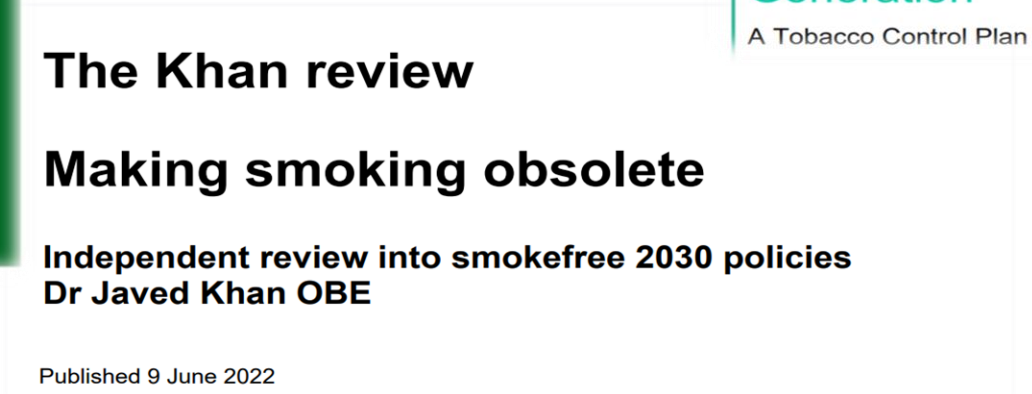
Background


Royal College of Physicians
RC PSYCH
Smoking and mental health
A joint report by the Royal College of Physicians and the Royal College of Psychiatrists
March 2013

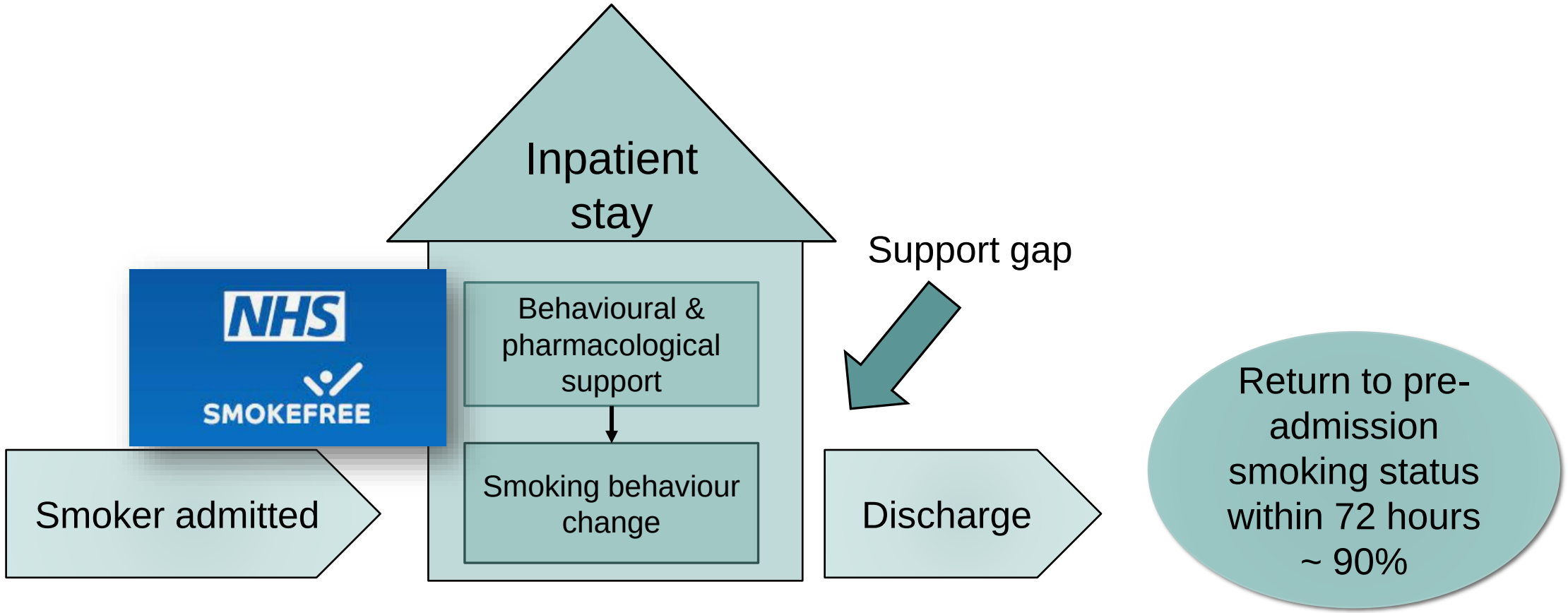

NHS
Long Term Plan


Department of Health
Towards a Smokefree Generation
A Tobacco Control Plan for England


The Stolen Years
THE MENTAL HEALTH AND SMOKING ACTION REPORT


The Khan review
Making smoking obsolete
Independent review into smokefree 2030 policies
Dr Javed Khan OBE
Published 9 June 2022

Persistent gaps (evidence and practice)



SCEPTRE Research Programme

Six-year National Institute of Health Research (NIHR) funded programme grant, hosted by Sheffield Health & Social Care NHS Foundation Trust.

Aim: To develop and assess the feasibility, effectiveness and cost-effectiveness of an intervention to promote smoking cessation and prevent relapse after a mental health inpatient stay.

Overview of the SCEPTRE Programme

- Identification & mapping of components
- Co-design of intervention content & delivery pathways

Stage 1
Development

- Piloting of intervention & materials
- Randomised controlled feasibility study

Stage 2
Piloting & Feasibility

- RCT of the SCEPTRE intervention
- Economic analysis & modelling

Stage 3
Testing

- Quantitative process evaluation
- Qualitative process evaluation

Stage 4 (a)
Process Evaluation

- Integration of findings & final intervention refinement

Stage 4 (b)
Implementation

Milestones

ADDICTION

SSA SOCIETY FOR THE STUDY OF ADDICTION

REVIEW

doi:10.1111/add.15452

Supporting smoking cessation and preventing relapse following a stay in a smoke-free setting: a meta-analysis and investigation of effective behaviour change techniques

Emily Shoesmith[1], Lisa Huddlestone[1], Fabiana Lorencatto[2], Lion Shahab[3], Simon Gilbody[1] & Elena Ratschen[1]

Department of Health Sciences, University of York, Heslington, York YO10 5DD, UK,[1] Centre for Behaviour Change, University College London, London, UK[2] and Department of Behavioural Science and Health, University College London, London, UK[3]

Nicotine and Tobacco Research, 2022, **24**, 945–954
https://doi.org/10.1093/ntr/ntac004
Advance access publication 8 January 2022
Review

SRNT OXFORD

A Systematic Review of Mental Health Professionals, Patients, and Carers' Perceived Barriers and Enablers to Supporting Smoking Cessation in Mental Health Settings

Lisa Huddlestone PhD[1], Emily Shoesmith PhD[1], Jodi Pervin BSc[1], Fabiana Lorencatto PhD[2], Jude Watson PhD[1], Elena Ratschen PhD[1]

[1]Department of Health Sciences, University of York, York, UK
[2]Centre for Behaviour Change, University College London, London, UK

Corresponding Author: Emily Shoesmith, PhD, Department of Health Sciences, Faculty of Sciences, University of York, Heslington, York Y010 5DD, UK. Telephone: 01904 321765; E-mail: emily.shoesmith@york.ac.uk

Nicotine and Tobacco Research, 2023, **25**, 729–737
https://doi.org/10.1093/ntr/ntac242
Advance access publication 17 October 2022
Original Investigation

SRNT OXFORD

Promoting and Maintaining Changes in Smoking Behavior for Patients Following Discharge from a Smoke-free Mental Health Inpatient Stay: Development of a Complex Intervention Using the Behavior Change Wheel

Emily Shoesmith PhD[1], Lisa Huddlestone PhD[1], Jodi Pervin BSc[1], Lion Shahab PhD[2], Peter Coventry PhD[3], Tim Coleman MD[4], Fabiana Lorencatto PhD[5], Simon Gilbody PhD[1,6], Moira Leahy MSc[7], Michelle Horspool PhD[7], Claire Paul MSc[8], Lesley Colley[9], Simon Hough[10], Phil Hough[10], Elena Ratschen PhD[1]

Randomised controlled feasibility study

Aim and objectives

Aim: To determine the feasibility, acceptability, and potential impact of delivering a multi-component smoking cessation intervention in mental health services. Specifically, the objectives are:

1. Address uncertainties related to the intervention's delivery and the research process's conduct (including the use of research measures).

2. Assess central parameters for the design of a randomised controlled trial.

3. Obtain feedback from all stakeholders relating to the research participation process and the acceptability of the intervention (as a whole and in terms of single components).

4. Based on the above, refine the intervention in readiness for further assessment.

Methods

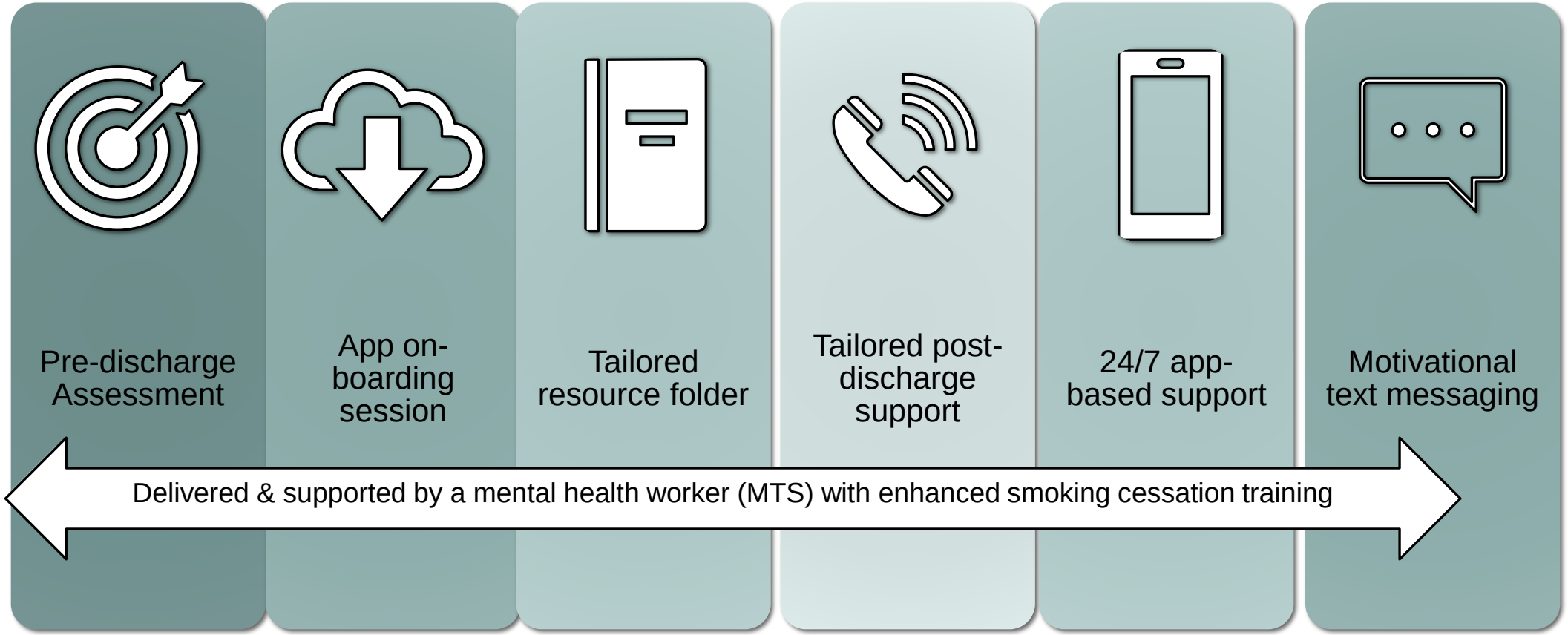
Design: Randomised controlled feasibility study (SCEPTRE intervention vs usual care)

Settings: NHS acute adult mental health inpatient wards

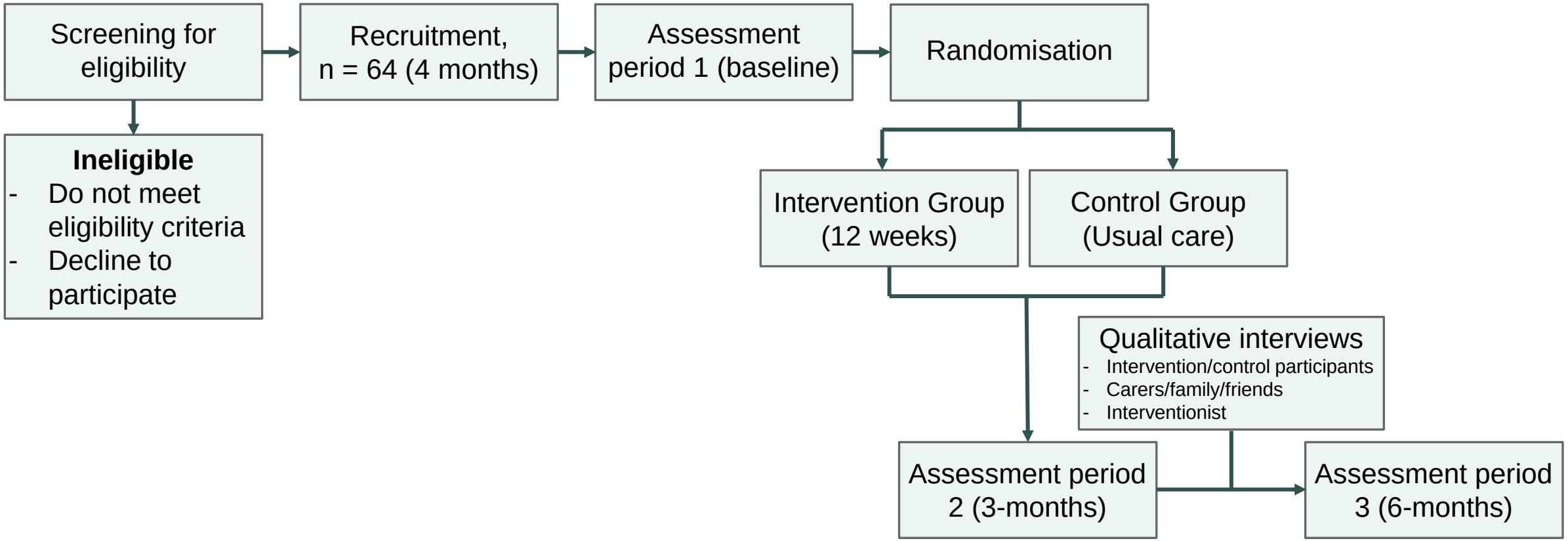
→ approx. 12 sites at 8 Trusts in England

Participants: Inpatients who reported being smokers on admission

SCEPTRE intervention

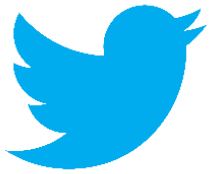


Trial protocol: overview



Thank you for listening!

Dohs-sceptre@york.ac.uk



@SCEPTREresearch

www.sceptreresearch.com

Lunch

12.40-13.20

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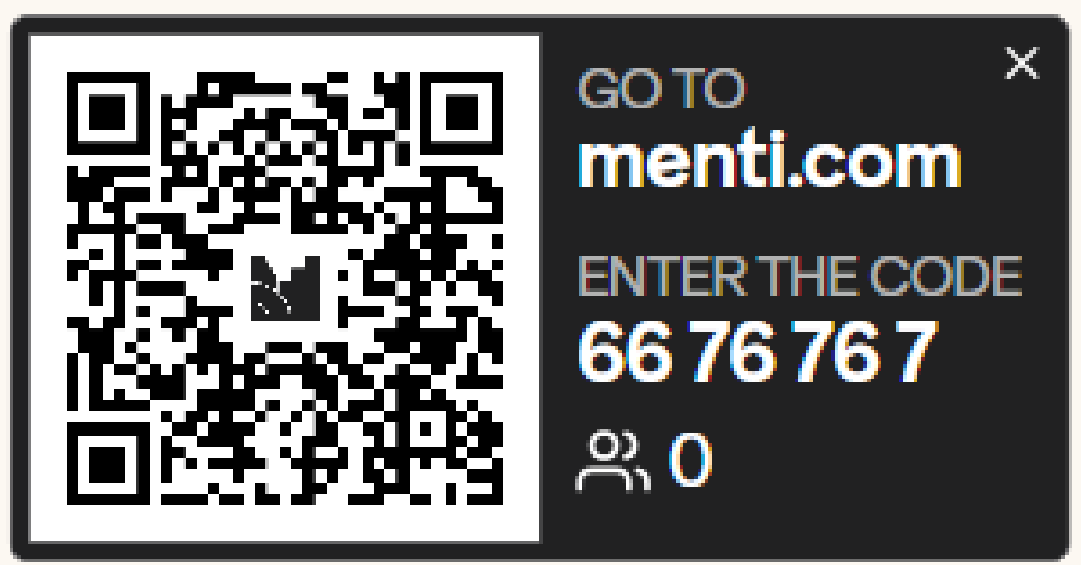
- If you would like to ask questions about data, you can put questions on Menti



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Data for improvement

QI Team, NCCMH

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How this session will work

Everyone:
Overview of data for improvement and measurement in QuITT

Round 1 teams:
Understanding control charts, looking at your own data

Main room (1.7)

Round 2 teams:
Getting ready for your QuITT project

Room 1.2

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“Why are we collecting all these numbers and what are we doing with them?”

Or round 2 teams, “why will we need to collect numbers?”

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ROYAL COLLEGE OF PSYCHIATRISTS

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Measures in QuITT

- Measure 1: proportion of patients screened for smoking status on admission
- Measure 2: proportion of smokers engaged in tobacco dependence treatment
- Measure 3: proportion of smokers who quit smoking at 28-day follow up
- Measures 4-6: patient experience measures (from patient survey)
  - Feeling empowered to quit
  - Proportion reporting the tobacco dependence support was quite good/very good
  - Feeling the support was tailored to their needs

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Why are we measuring these 6 measures in the QuITT Collaborative?

- Three minutes to discuss

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Why do we measure anything in quality improvement?

- So you can know if changes you are testing are leading to an improvement
- Data for improvement is collected and displayed in real-time
  - Monthly in QuITT
  - Visualise your data as your project progresses and see the effect your change ideas are having
- Identify variation
  - Is it random variation or does it have a cause?

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So what do we do with the numbers?

- Visualise them – in a chart for each measure
- This helps to see patterns, and see if changes are just random, or if they have a likely cause
  - We can understand what is the “norm” and what is “different”
- There is quality improvement science behind how these charts work

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SPLIT TIME!

Round 2 teams move to room 1.2

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Breakout Session: Round 1 teams

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NHS England

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NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Questions so far?

- We know that data can feel tricky

- It may not part of your normal job or role
- It can be unfamiliar
- Maybe you didn't like maths at school!
- It's ok if you don't follow everything here
- Your QI Coach is here to support you with data
- It gets easier as you get used to it!

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Types of Variation on a Quality Improvement Chart

Random

Probability based rules indicate variation is due to chance

i.e. the difference between the dots is no more than we would expect to happen in the usual experience of the current system

VS

Non-Random

Probability based rules indicate variation is not due to chance

i.e. something new has happened, which has affected the performance of the current system

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Why might non-random variation occur?

Non-random variation could be:

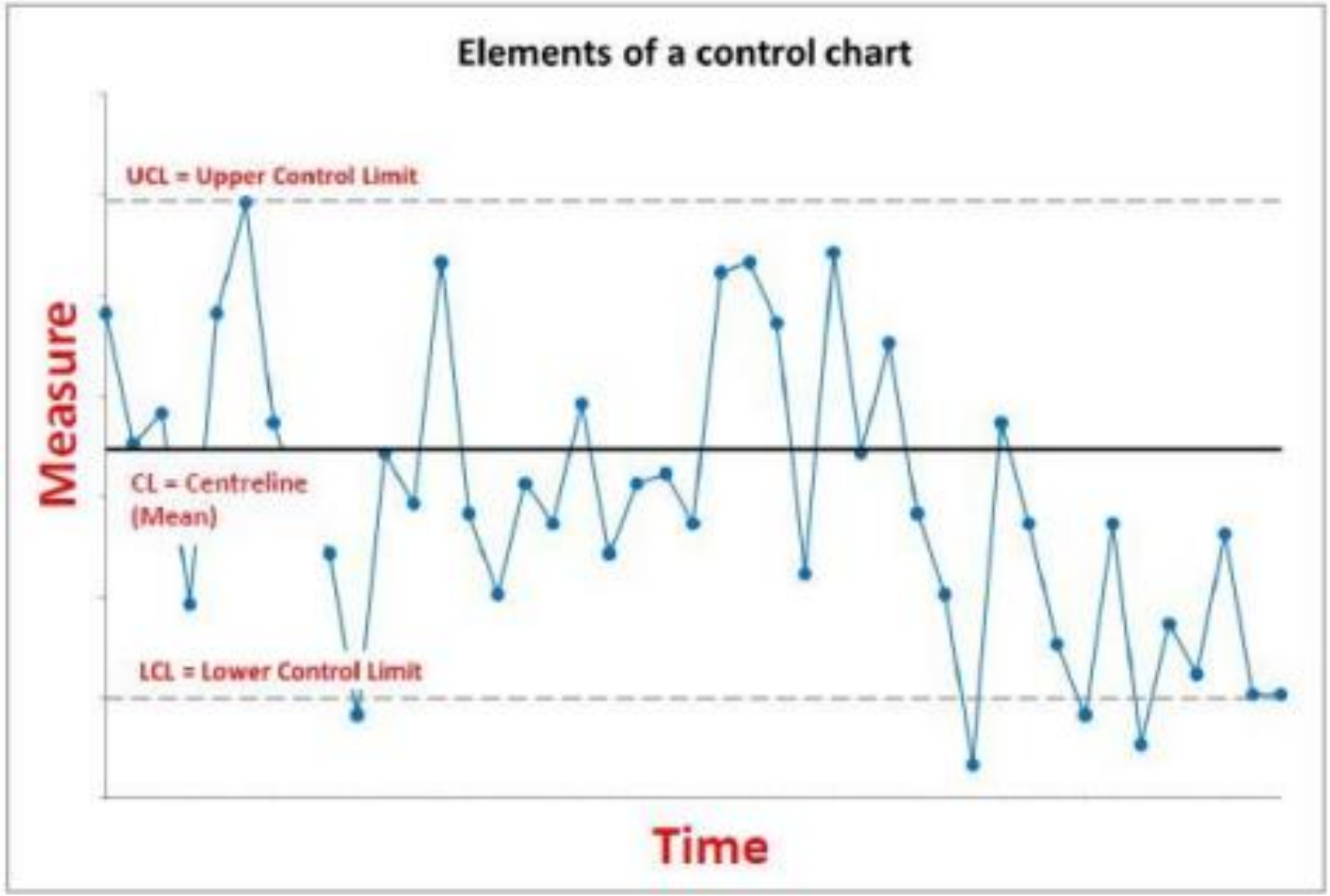
- improvements resulting from our work
- unintended consequences from our work
- new factors affecting system

Types of Quality Improvement Charts

- Run Charts

- Statistical Process Control (SPC) charts
  - Many different types
  - P chart = proportion or percentage chart

What makes up a Control chart?



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Rules of SPC charts

There are 5 rules, we are going to look at 3

- Trends
- Shifts
- Astronomical data points (three sigma violation)

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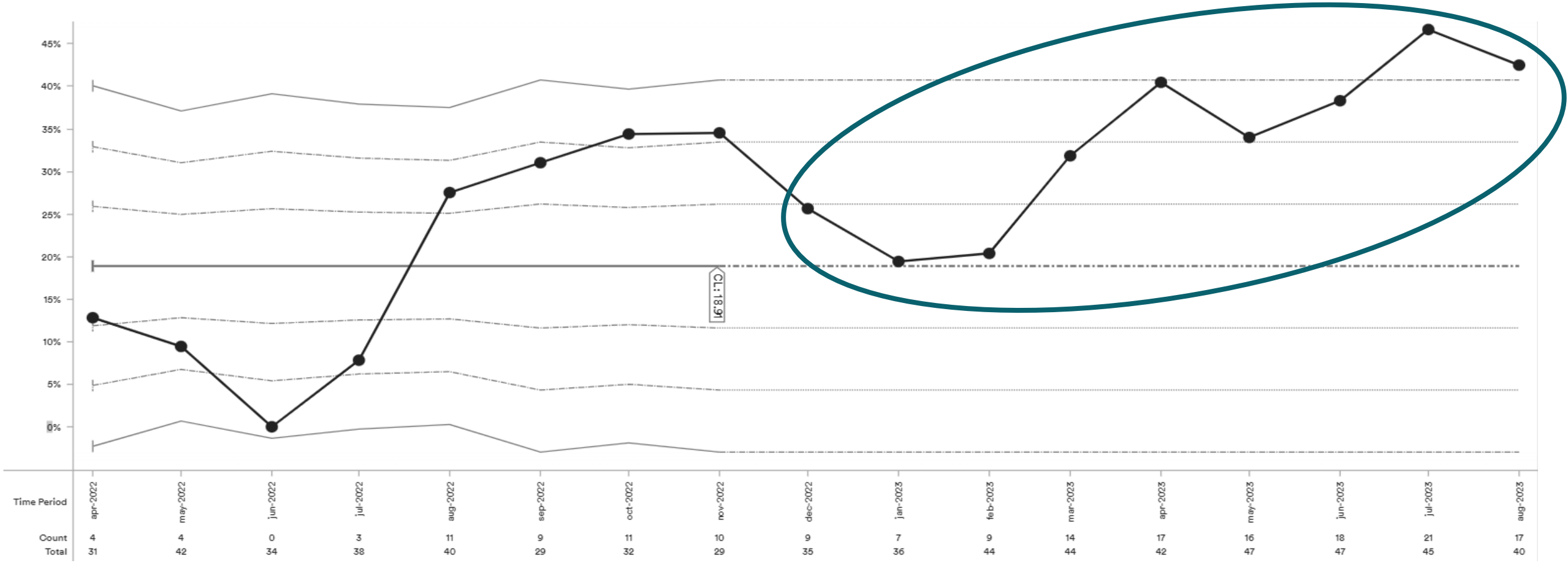
Trend

- Six or more consecutive points all going up or all going down
- (ignore consecutive points that are the same value)

Shift

- Eight or more consecutive points all above or below the centre line
- (ignore points that are exactly on the centre line)

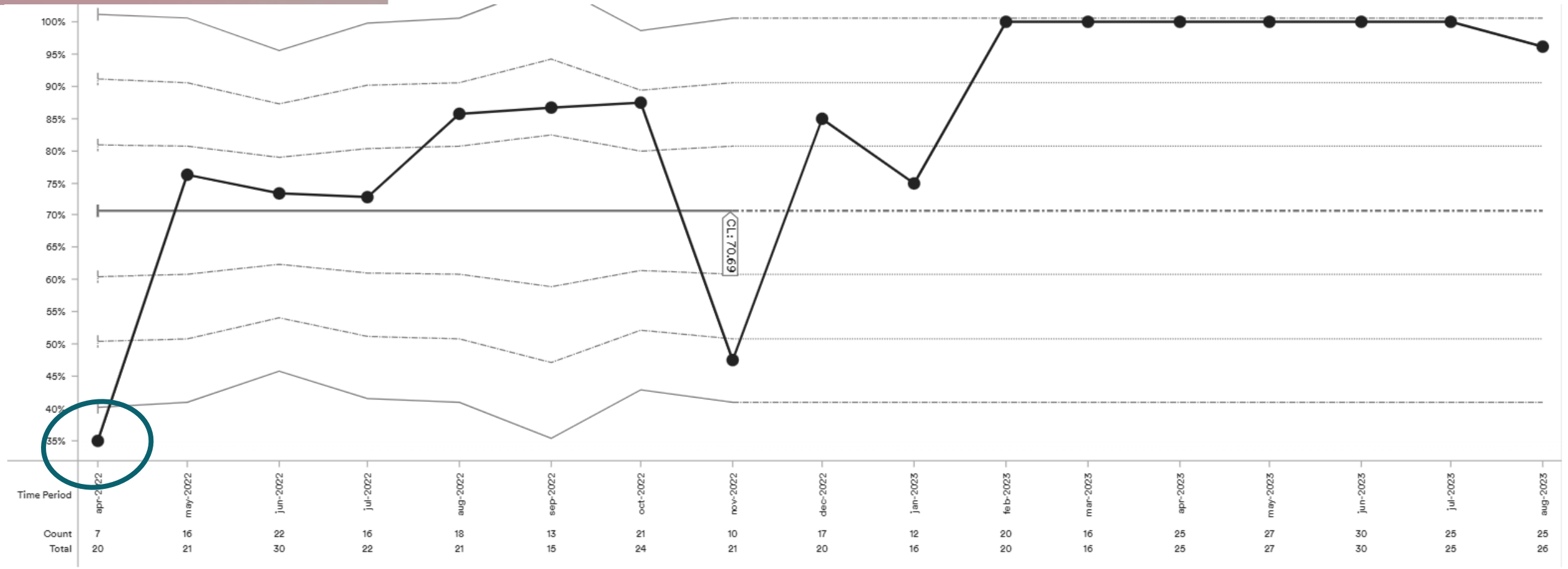
Measure 2: The percentage of patients engaged with a tobacco dependency treatment service



Astronomical data point (three sigma violation)

- One data point that is outside of the upper or lower control limit

Measure 1: The percentage of patients screened for a recorded smoking status on admission



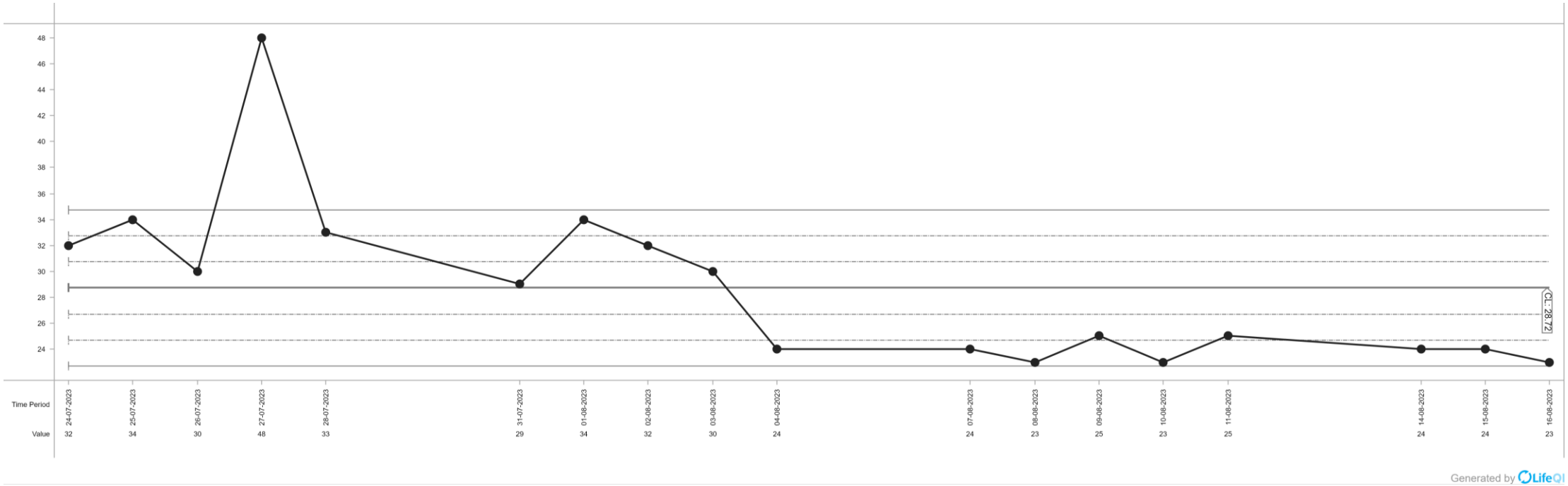
Practice!

- Sonya's journey to work
- Pete's Yorkshire puddings

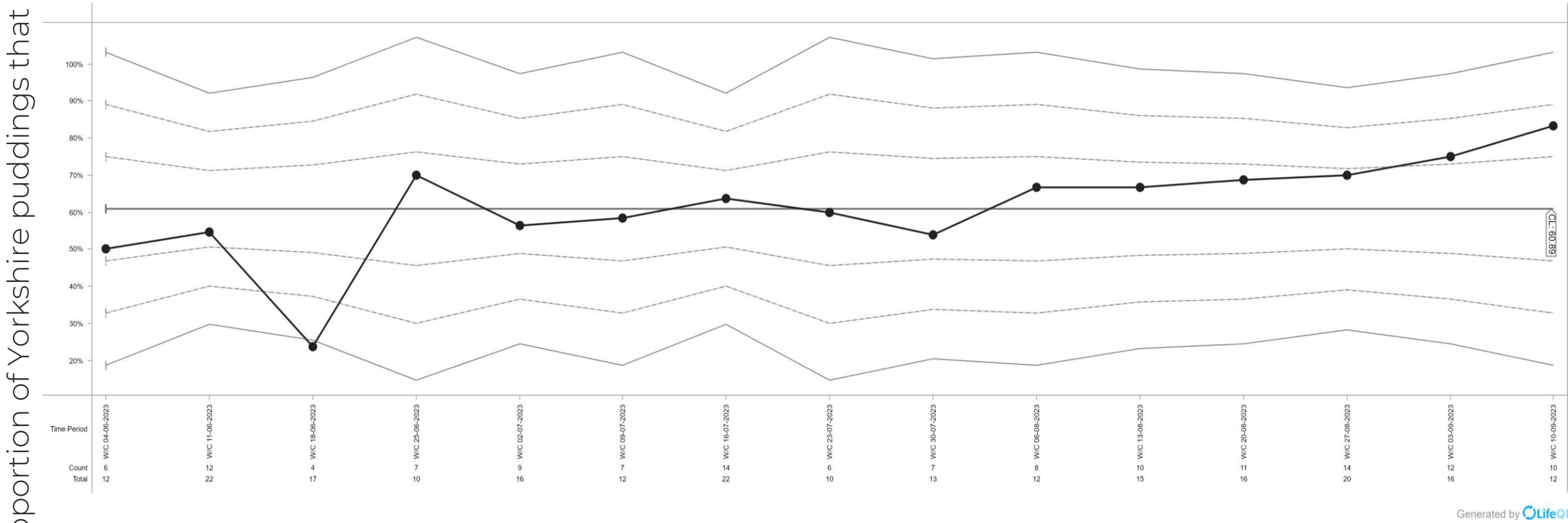
- Is this random or non-random variation?
- What might be causing what you can see?

Sonya's journey to work (I chart)

Number of minutes from leaving home to arriving at work



Pete’s Yorkshire Puddings - P chart

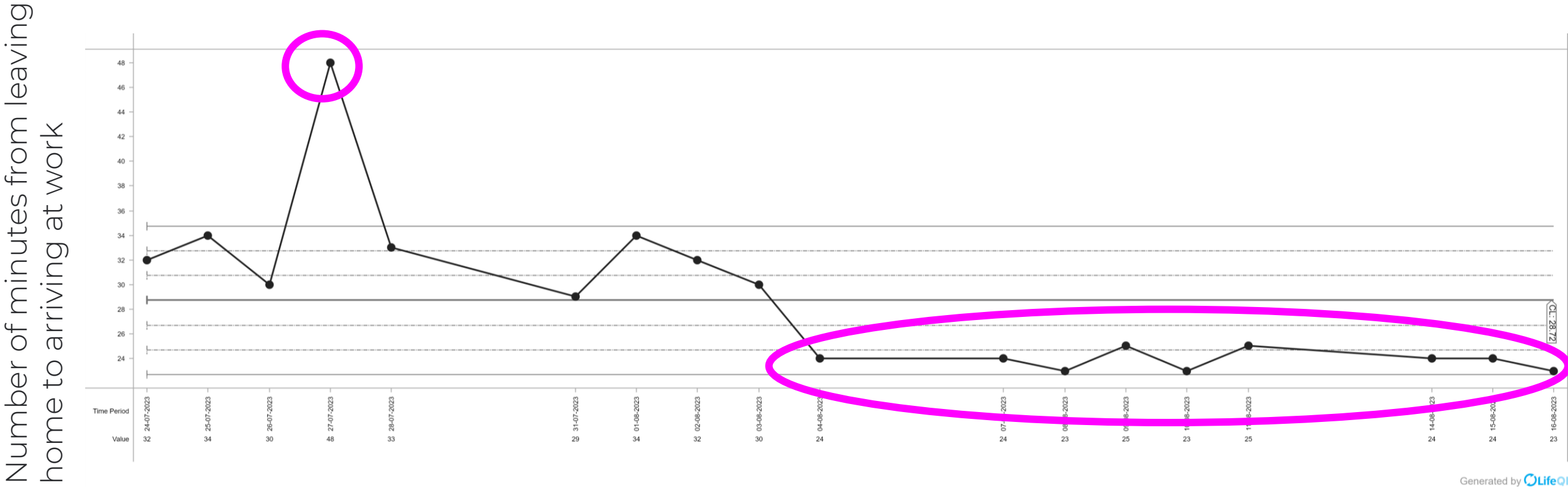


Generated by LifeQI

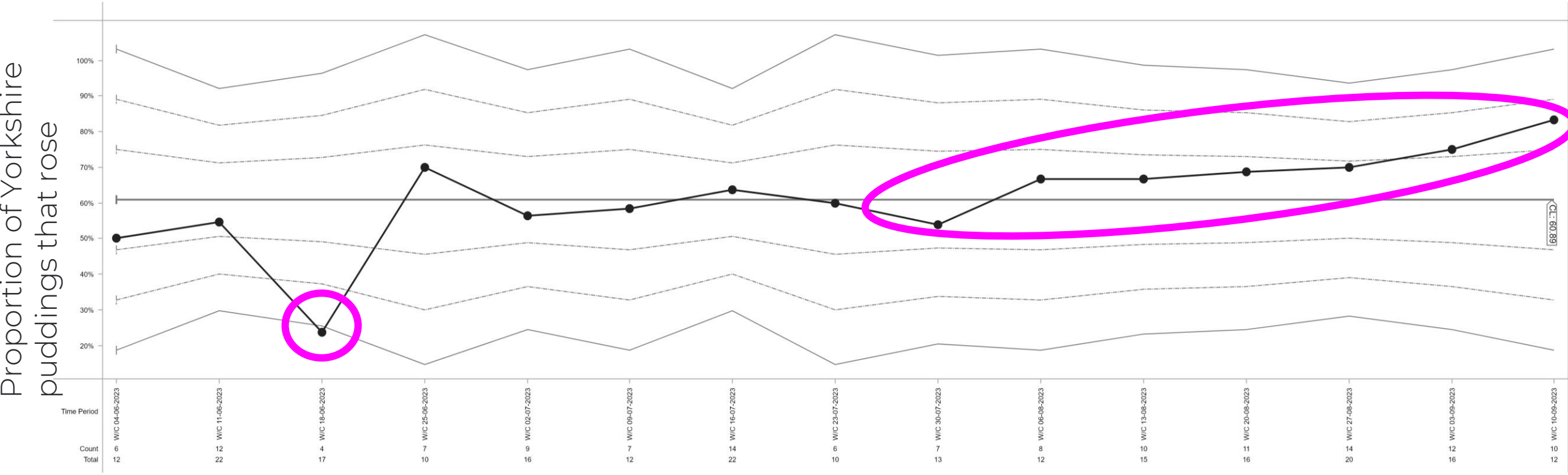
What could you identify?

- Trends?
- Shifts?
- Three sigma violations?

Sonya's journey to work (I chart)



Pete’s Yorkshire Puddings - P chart



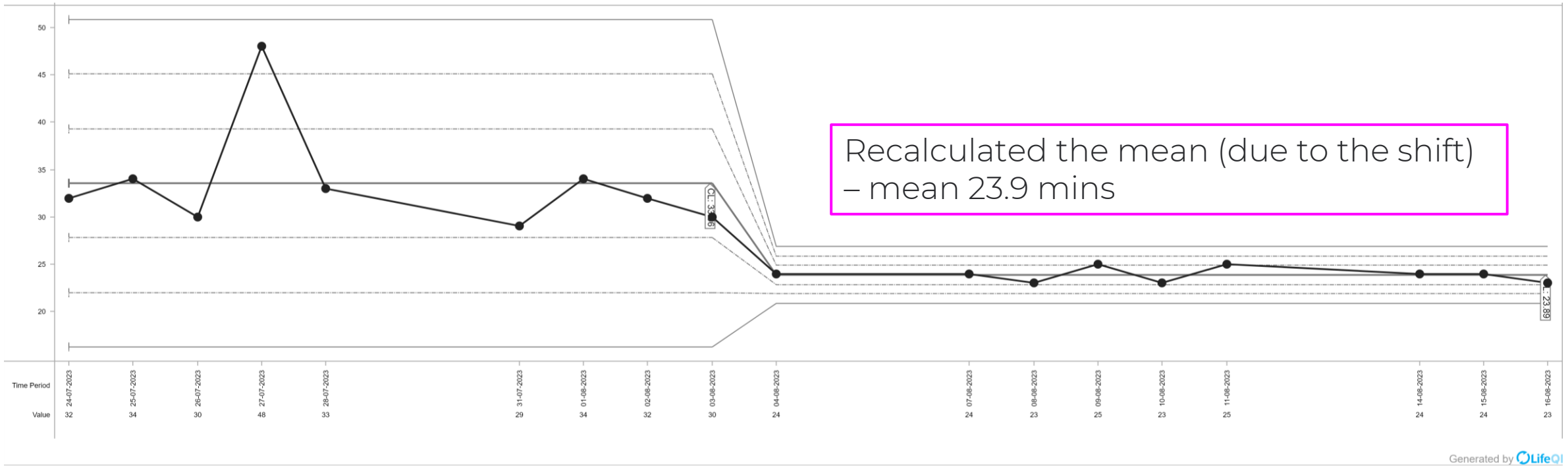
Setting and shifting the centreline

- We set a baseline mean, usually at least 8 data points
- If there is a sustained **shift** (8 or more points above or below the mean), we create a new mean for the new level of performance

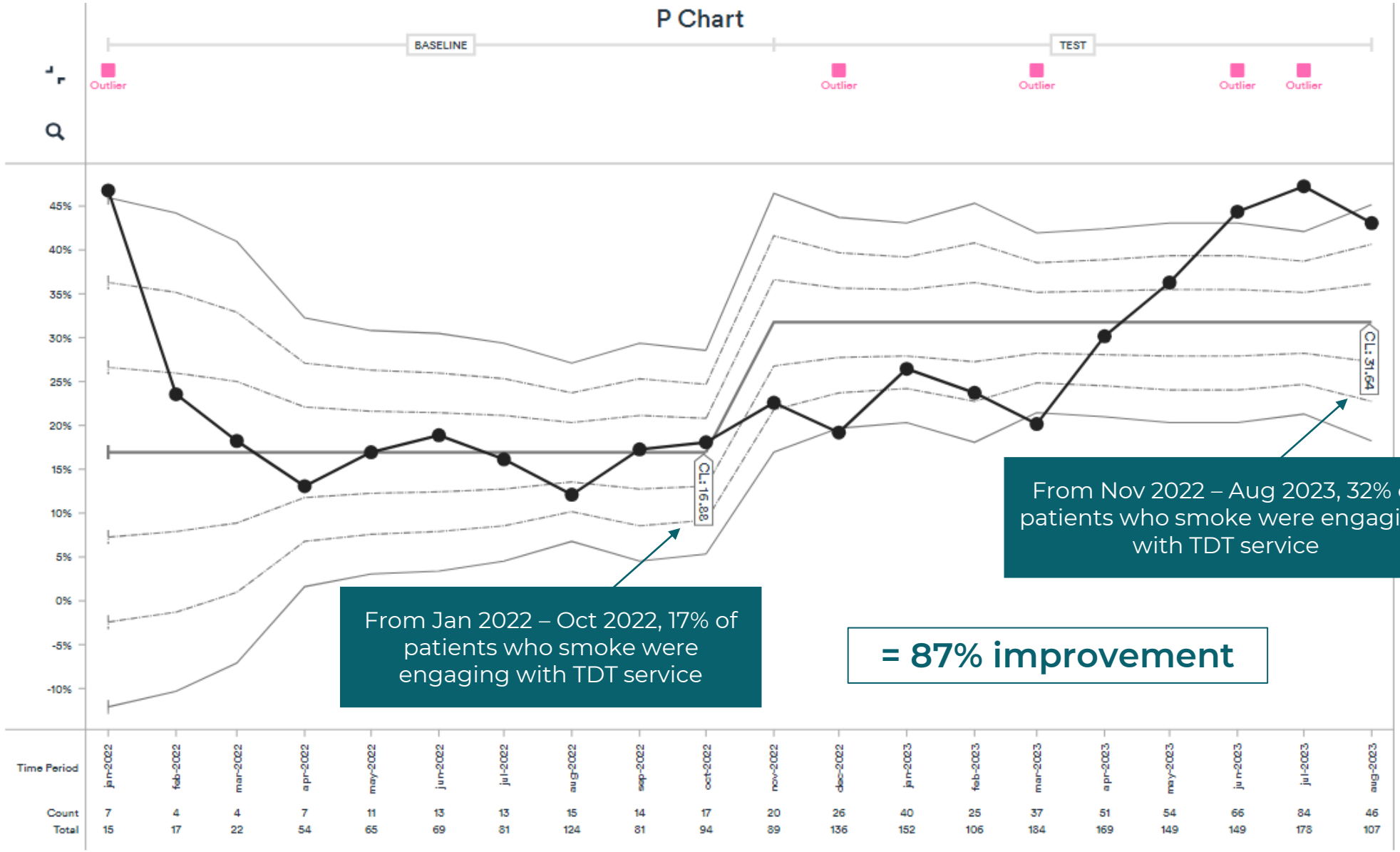
Sonya's journey to work (I chart)

Set the baseline – mean 33.6 mins

Recalculated the mean (due to the shift) – mean 23.9 mins



Measure 2: The percentage of patients, who smoke, engaged with a tobacco dependency treatment service (aggregate)



From Jan 2022 – Oct 2022, 17% of patients who smoke were engaging with TDT service

From Nov 2022 – Aug 2023, 32% of patients who smoke were engaging with TDT service

= 87% improvement

Direction of improvement

Your turn – your data

- Can you identify any patterns on your charts?
- What are your thoughts about your data?
  - Annotate or stick post-it notes on

- QI team are here to answer your questions about your charts

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Your turn – your data: what next?

- Agree and write down one action you will take as a result of reviewing your data
- This could be:
  - A way to improve your data collection
  - An idea to help collect more surveys
  - A way to make your data more accurate
  - A new change idea inspired by your data

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Learning from each other

- Spread your charts out on your table
- Ensure the action you are taking is visible

- What can you learn from other teams' data and actions?

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Breakout Session: Round 2 teams

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Getting ready for your QuITT project

QI Team, NCCMH

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About the QuITT collaborative

- A national quality improvement collaborative to **increase the proportion of patients on inpatient mental health wards, who smoke, who undertake meaningful tobacco treatment.**

- NHS/other healthcare teams, from England will share ideas and work alongside each other to trial new approaches

- Led by NCCMH at the Royal College of Psychiatrists

- Tailored QI Coach support for each team; shared measurement; access to data, reports and guidance.

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Eligibility criteria for close QI coaching

1) Have an inpatient tobacco dependency treatment service that is currently supporting inpatients, or the service is due to launch by January 23rd 2024.

2) Be submitting data monthly into the NHS Tobacco Dependency Dataset, or will be submitting this data by January 23rd 2024.

3) Attend quarterly learning events held in-person at the Royal College of Psychiatrists in London.

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Options for support if not eligible

Development network:

- To support trusts that do not have a service in place yet, and to learn from trusts that have established their service.

Learning community:

- You will also be invited to attend our in-person learning events and virtual workshops with our Round 1 and Round 2 teams.

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Things you need in place for QuITT R2 by January 2024

- **A tobacco dependency treatment service** - established (or due to go live by January 2024)
- **1-3 wards identified -** which wards and things to consider
- **Project team** – who should be in the team and what is the expectation of joining
- **Lived experience** – who can you contact?
- **Data** – what is it, how often, feedback forms

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1-3 wards identified

- Any adult inpatient ward (R1 examples inc. acute, rehab, admissions, mother and baby)
- Ward manager and staff buy in
- Staff allowed time to do the work
- The right balance between need and capacity

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Project team

1) Senior Sponsor

2) Project Lead

3) Team members (inc. data champion and person with lived experience)

Lived experience

- **Who could you reach out to?** Participation team, families and carer networks, peer support work

- Check Trust policy on payment for this work (and budget for this)

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Data

You will collect data for 6 outcome measures

Measures 1 – 3

- The same data you enter into the NHS Digital Tobacco Dependency dataset

- Outcome measure 4-6 will be collected via the patient feedback

Measures 4 – 6

- Patient experience questionnaire upon discharge/transfer from the ward(s)

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Question 1. Do you feel able to quit or continue to be smoke free?

(Please tick the box next to your answer)

- Yes ☐
- No ☐
- I don't know ☐

Question 2. How was your experience of the tobacco treatment service during your admission?

(Please tick the box next to your answer)

- Very bad ☐
- Quite bad ☐
- Neither good nor bad ☐
- Quite good ☐
- Very good ☐

- Not applicable – I was not aware of the service ☐
- Not applicable – I did not want the service ☐

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Question 3. Do you feel the support to quit smoking was tailored to your needs and preferences (including your ethnicity, disability, sexuality, cultural background, or other personal characteristics)?

(Please tick the box next to your answer)

- Yes ☐
- No ☐
- Not sure ☐

Question 4. Please share any other thoughts or feedback on your experience of support around smoking during your admission. This could include how were your needs understood, what was helpful or unhelpful to you or how the service could be improved.

If you did not wish to receive support from the tobacco dependency treatment service, your feedback on why would be helpful, if you would like to tell us:

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Discussions and questions

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Next steps

- Complete the worksheet
- Book QI meeting with coach
- Start forming your project team

Questions?

- Feel free to raise your hand or put questions on Menti

QuiTT
Quality Improvement in Tobacco Treatment

Translating national policy into local action

Dr Peter Byrne
Consultant Liaison Psychiatrist
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Follow NICE guidelines
on tobacco use
https://www.nice.org.uk/ng209

Brief intervention /
behavioural support

Offer combined NRT
and/or *varenicline

Referral to Smoking
Cessation service

Stop smoking

Anticipate impact on
antipsychotic drug
metabolism; alter
dose appropriately

OVERCOMING OBSTACLES TO SMOKING CESSATION IN GENERAL HOSPITALS: NATIONAL → LOCAL ACTIONS

PETER BYRNE, CONSULTANT LIAISON PSYCHIATRIST, ROYAL LONDON HOSPITAL

FOCUS OF THIS TALK: CHALLENGES OF INCREASING, INTERSECTING INEQUALITIES > SOLUTIONS (NEED MORE)

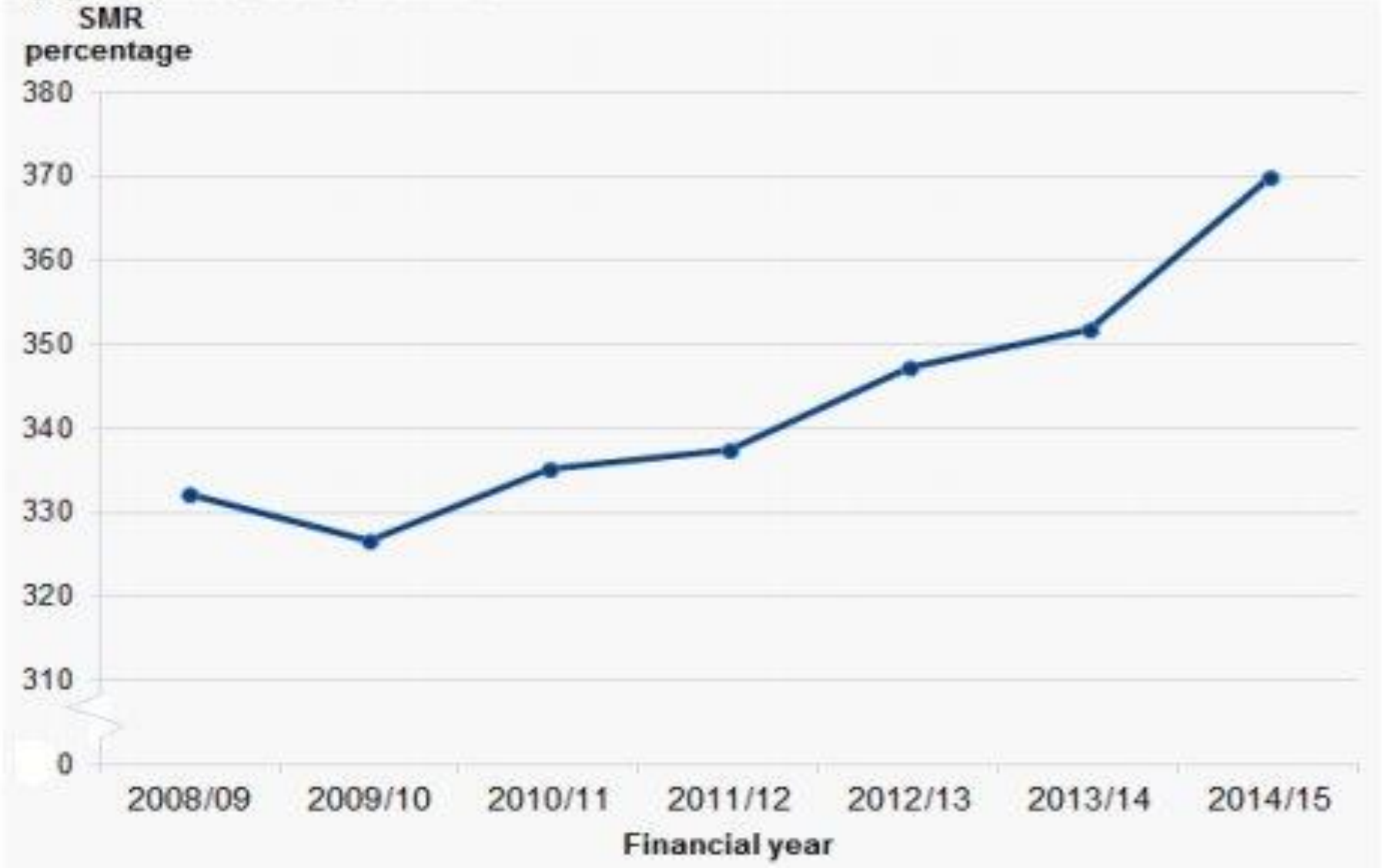
- **Nationally, falling smoking rates (<15%) except in people with mental health (MH) conditions** evidence of return to smoking / increased rates in severe mental illness (SMI) rates during pandemic, pandemic's secondary effects on health / care services and ongoing cost of living crisis. Start with data & known comorbidities → harm.
- **General hospitals**: even before Covid but increasing since the end of lockdowns people with SMI / dementia / ID / PD / Addictions etc. are admitted more often to general hospitals than psychiatric hospitals. (Shorter stays / unfamiliar teams)
- **Treatment gap in MH conditions** (other than psychosis, only a minority get any treatment) has a parallel with **policy-practice gap in general hospitals**
- **Synergy:** present in why (poorer) people smoke, smoking harms (alcohol, liver impairment in smokers) but where not much synergy in our interventions
- Capturing the public debate about MHiAP (MH in All Policies), Supporting excluded people, properly resources (NOT stop-start) Prevention… wider PMH Strategy

STALLING UK LIFE EXPECTANCY, FALLING IN POOREST

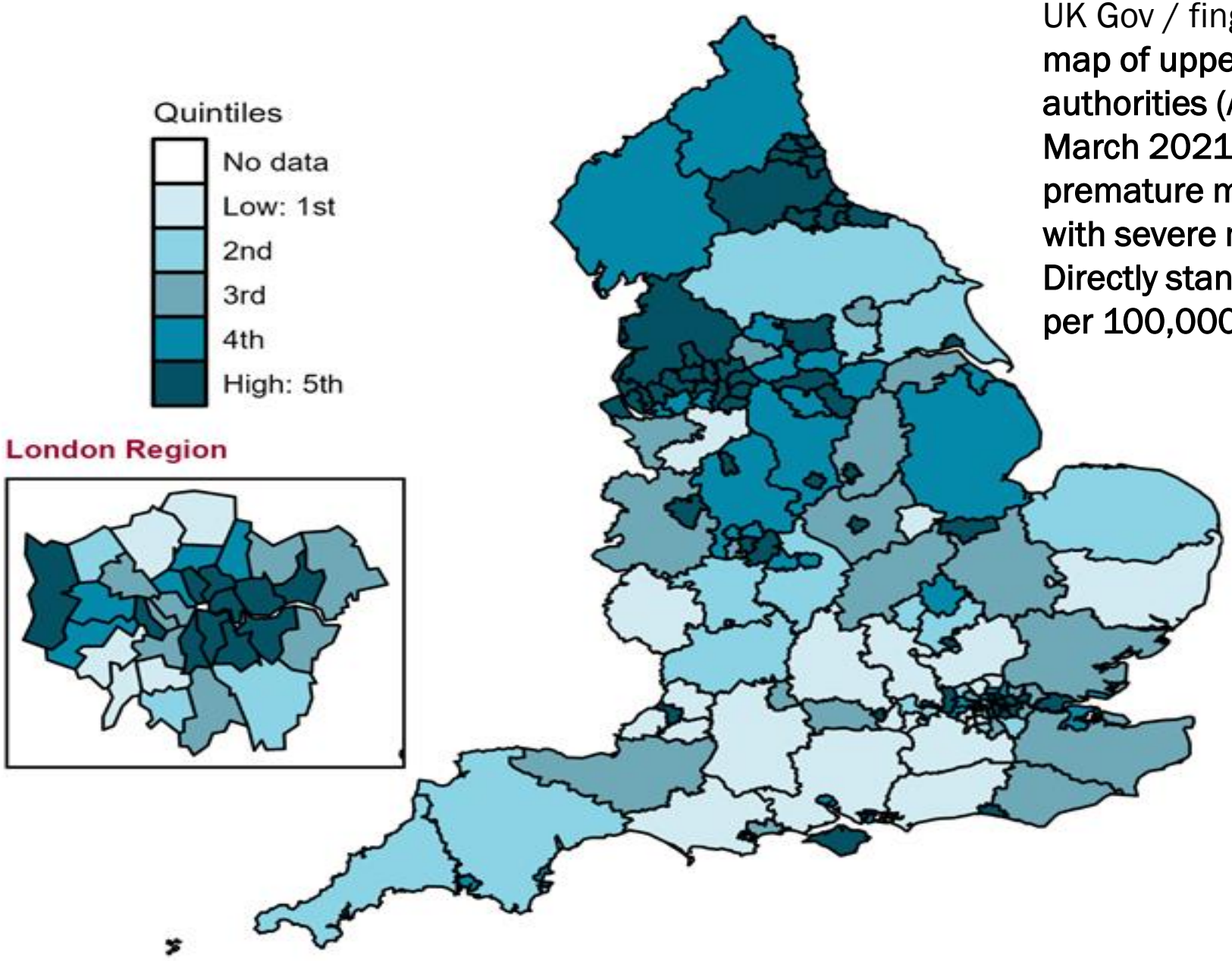
- Institutionally slow release of data from OHID (formerly PHE): 2020 fingertips
- ONS (Office of National Statistics) released England mortality data to January 2023:
- Mortality: 769 / 100K least deprived…. 1430/ 100K most deprived areas
- Mortality: 1079 / 100K high earners…. 1884/ 100K long term unemployed
- (Largest ethnicity differences in Diabetes deaths: Bangladeshi 422 versus 119 white)
- Analysis per BMJ 2023; 382: p2011: COPD, then lung cancer & asthma <DIFFS++>
- All three are caused by, with asthma made worse by smoking: WHY still this bad?

➢ How do we present Death Graphs in a way to engage ppl and change the systems?

Figure 1: Standardised mortality ratio (SMR) between general adult population and individuals with a serious mental illness (indicator 1.5.i) by year, 2008/09 to 2014/15



UK Gov OHID data as Fingertips SMI and Public Health Outcomes Framework 3 years to 2018: "adults with SMI were **2.5 to 7.2** times more likely to die before aged 75… two thirds from preventable physical diseases"



UK Gov / fingertips, PHOF
map of upper tier local authorities (April 2020 to March 2021) in England for premature mortality in adults with severe mental illness. Directly standardised rate - per 100,000, 2018 to 2020

REFRAME AS YEARS OF LIFE LOST (STOLEN YEARS)

Olson 2015: US study, 35 states, 1.14m insured people with schizophrenia

- 38.3 years from suicide (more likely in first five years of illness – therefore ↑ years of life lost)
- 29 years from liver diseases
- 27.3 diabetes
- 25.6 ischaemic heart disease
- 24.9 stroke, and
- 24 years from each of COPD and lung cancer

Study authors		Chang et al, 2011; south London GP	TK Laursen et al, 2013: – Scandinavia case register study of ppl with ANY service contact – some NOT be in treatment		
Subjects (n=)		32,164 *GP	66, 088 schizophrenia + 39,375 bipolar		
Location		London	Denmark	Finland	Sweden
Schizophrenia	Men	14.6	20	17.1	18.9
	Women	9.8	16.5	15.6	16.9
Bipolar	Men	10.1	16.5	15.5	16.9
	Women	11.2	11	16.2	12.6
Substance use	Men	13.6	NA	NA	NA
	Women	14.8	NA	NA	NA

ARE PEOPLE WITH MENTAL DISORDERS (1 IN 4 OF US) A DIFFERENT SPECIES? NO, BUT SOME SOLUTIONS DIFFER

- It only took seven decades to reduce smoking rates - taxes on products, bans on advertising, fall in tobacco production (incl State subsidy) & more - achievements by public health, ASH…
- People with severe mental illness (SMI) have smoking rates of 40%; Addictions, PD, ID even higher
- Alongside more MH awareness, better coping strategies other than cigs. Growing awareness that smoking **adds** to mental disorder symptom burden (smoking is not a relief against these)
- More addicted to nicotine, more vulnerable to complications of smoking (especially if alcohol excess) and further negatives (↑Meds doses; tobacco poverty; social isolation) *but* **ppl with MH probs want to quit just as much** as other smokers
- Evidence-based treatments +++ and quits even in lock up psychiatry wards do NOT increase violence/aggression
- General hospitals speak of “patient journey” – true, but it’s less a country stroll and **more of a roller coaster**

Seven drivers of Premature Mortality in people with severe mental illness. (SMI)

Byrne, 2023: *Irish Journal Psychological Medicine*

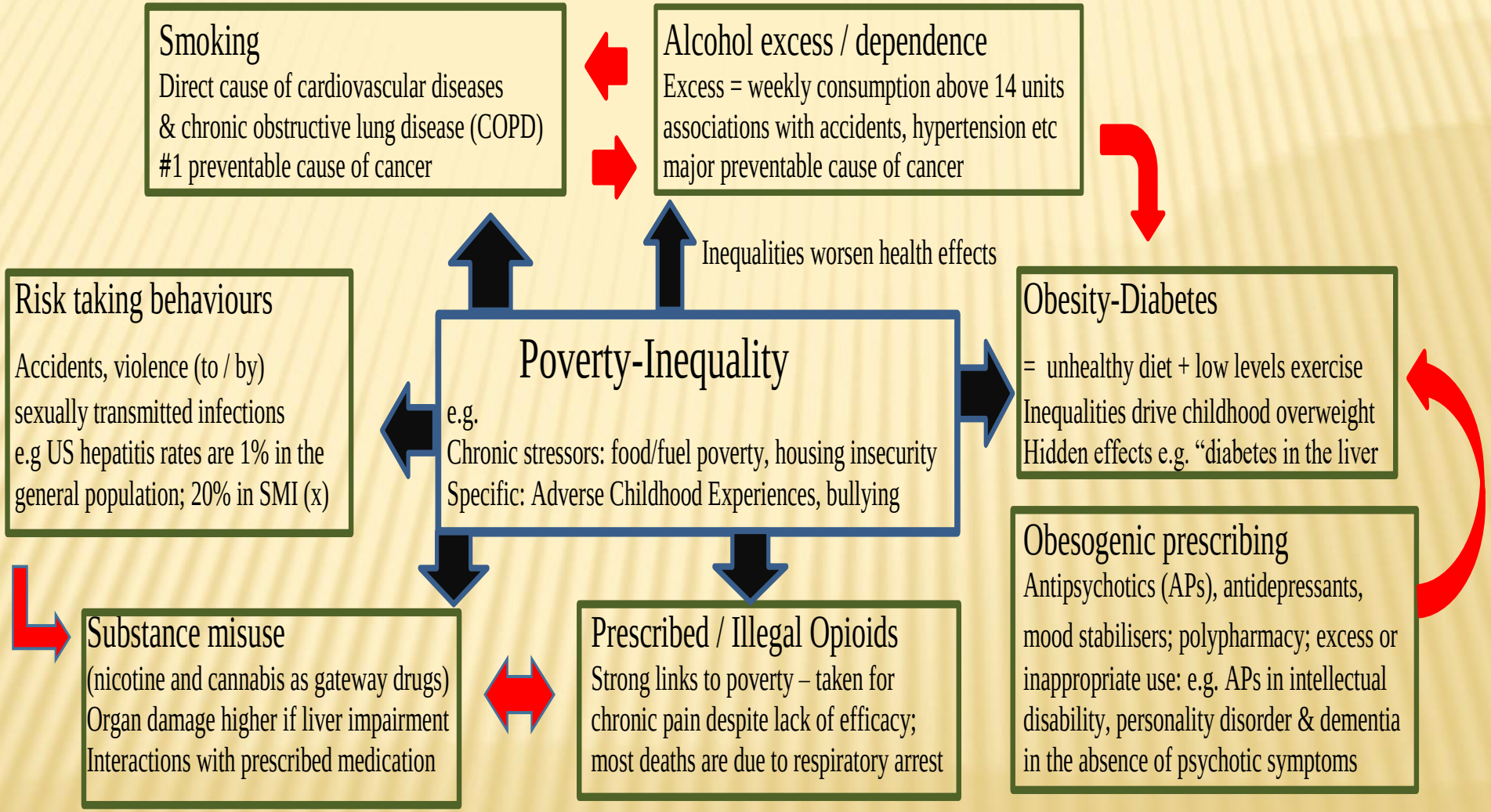
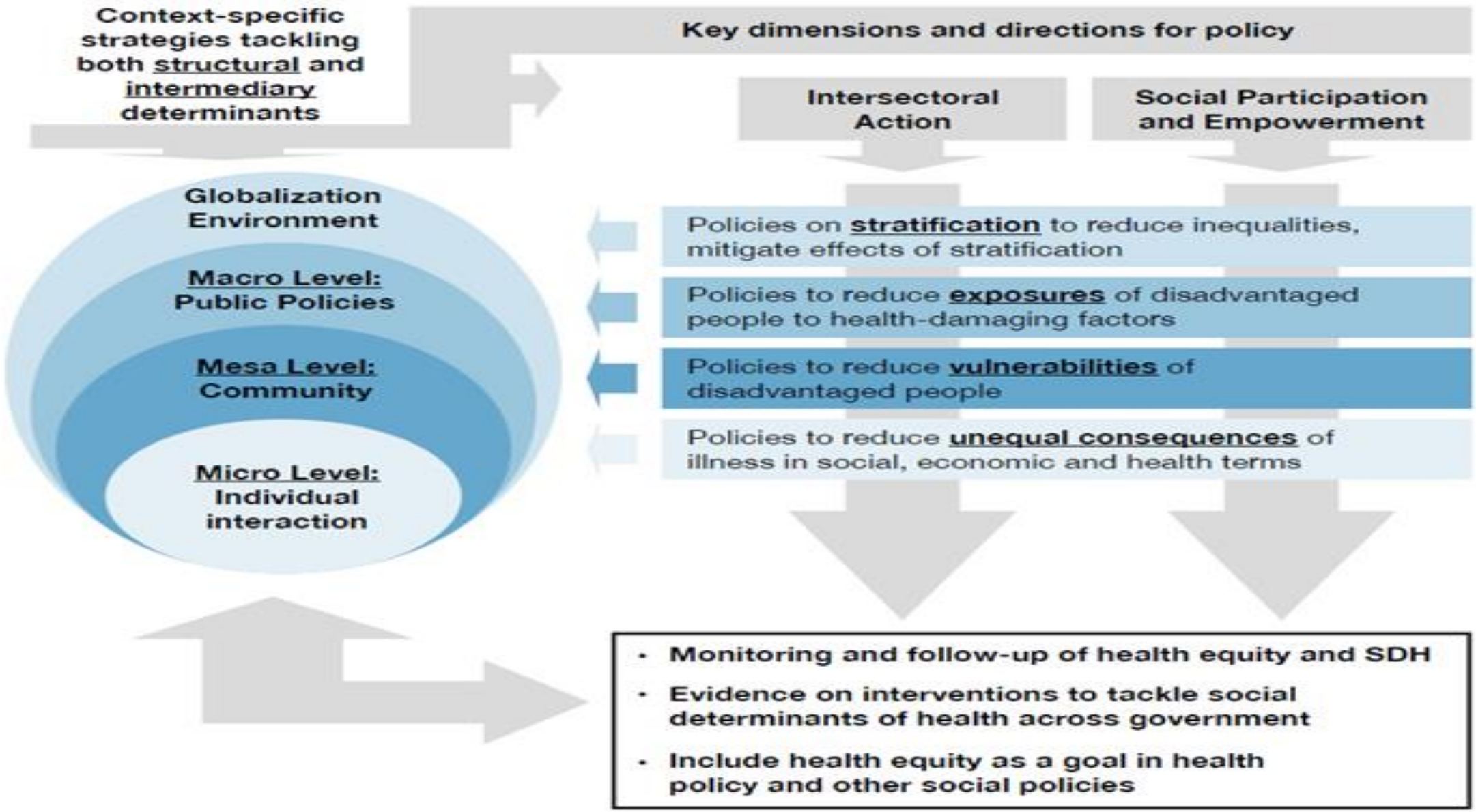
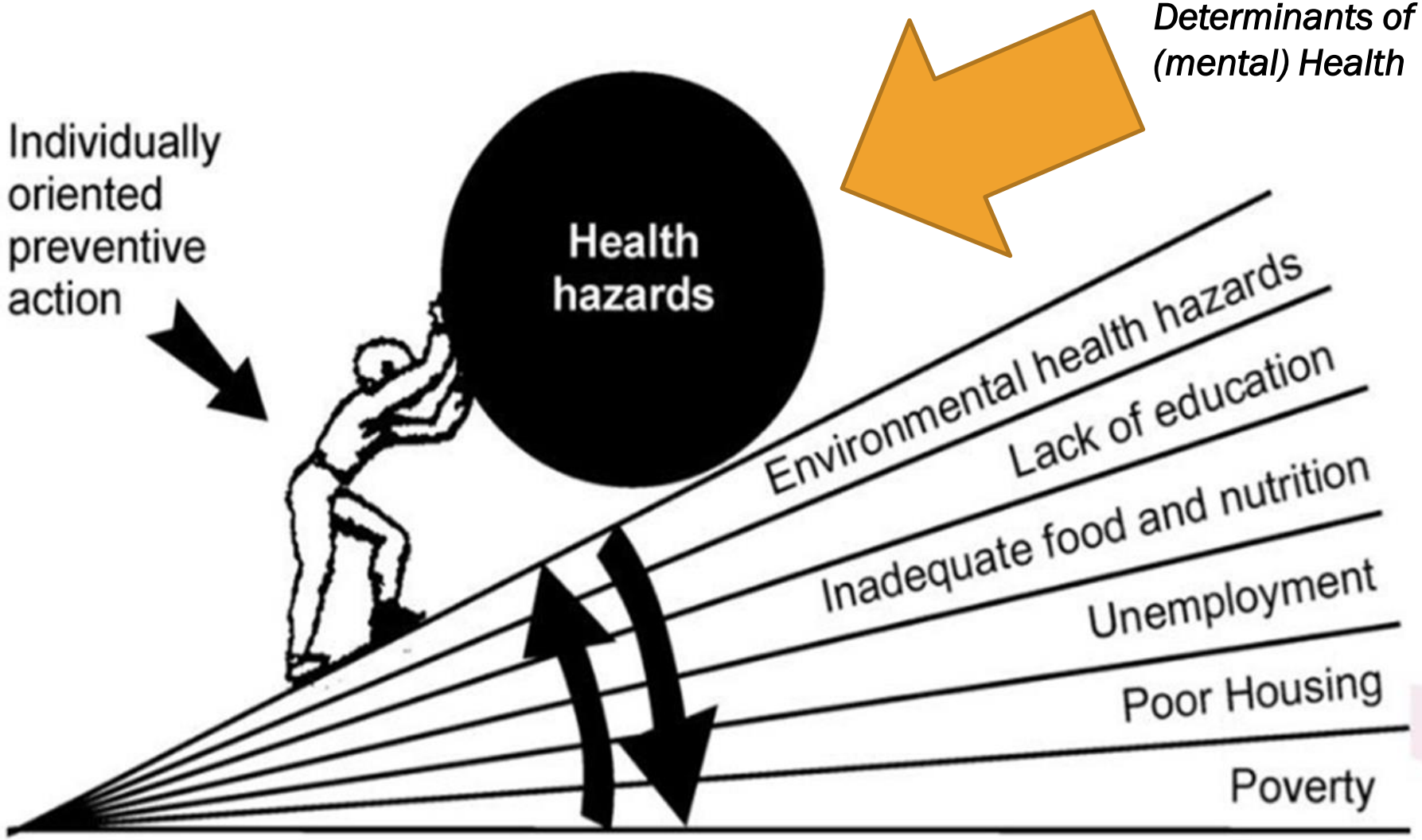


Figure B. Framework for tackling SDH inequities



The Health Gradient



Source: adapted from Making Partners: intersectoral action for health.

LEADERSHIP AT ALL LEVELS, AND NOT STOP-START

- At individual level, the patient-clinician relationship: “to help people to live the lives they have reason to value”. Is smoking a choice? Really? Return the focus to health
- We are NOT forcing inpatients or staff into Nicotine withdrawal: generous NRT (2 sources), E Cigs and anti-nicotine craving medications; **pair break from ward with NRT**
- How organisations communicate SmokeFree Policies and enforce them: NO SMOKING means no smoking; close the smoking shelters, meeting points, end “fresh air breaks”
- The inequalities of Smoking and the inequalities of access / preventable smoking deaths are part of problem. Resource staff with time: training & practice, “supervision”
- At the top, we have Dr Bola Owalabi’s **CORE 20 plus 5** (tobacco crosses all five) and the NHS Tobacco Dependence Stakeholder Group (Chair, Dr Sanjay Agrawal) … NCCMH / RCPsych’s QUiTT programme pilot sites (comm MH and acute Trusts)

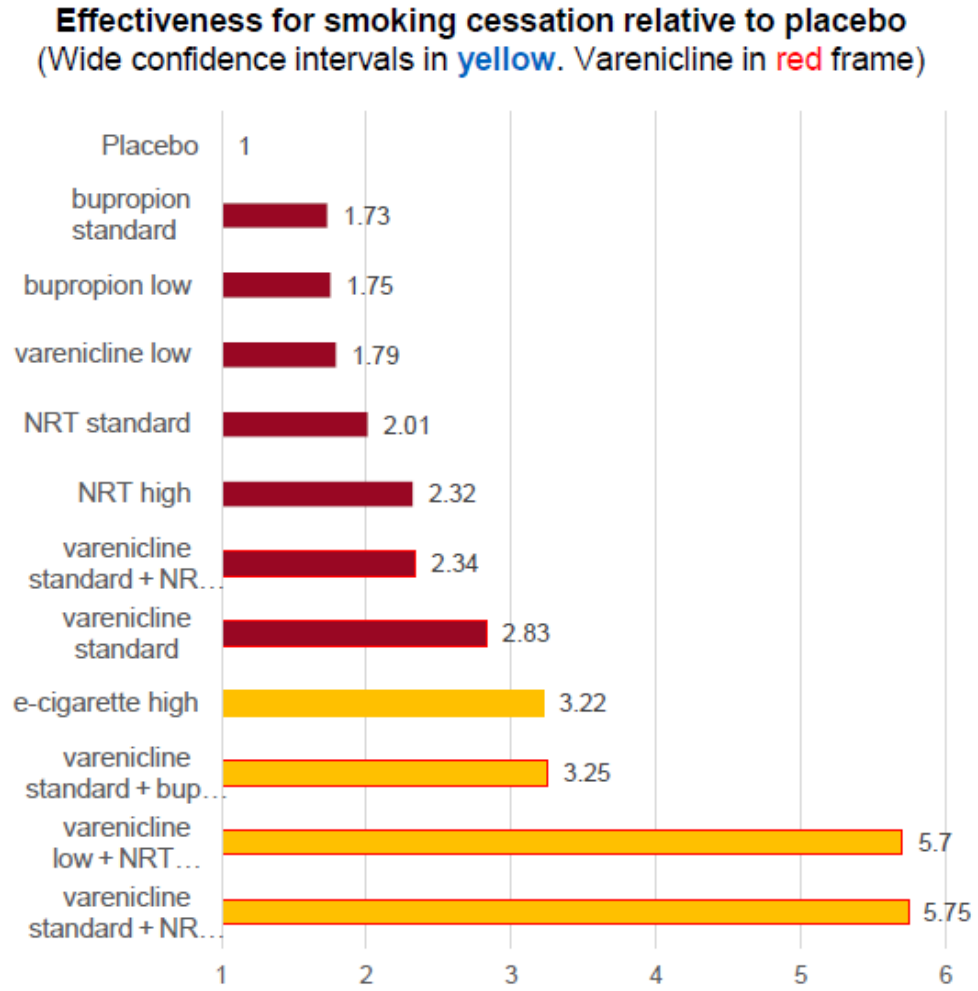
6 Licensed medicines: Unblocking supplies

Some of the most cost-effective stop smoking treatments we have are not currently available in England.

We are working closely with suppliers to give access to prescribers, to put licensed medications in the hands of those who would benefit the most from them.

For example, we need to ensure the availability of proven smoking cessation medicines such as Varenicline and Cytisine.

Next step: We will shortly be communicating with the system on how they can access supplies of generic Varenicline and make it available to quitters *in advance* of a full marketing authorisation.



Driving change / key areas

Keeping tobacco on every agenda across fragmented health / care services

Comorbidities: resp and MH and cardiac and liver. NO MORE either / or thinking

Snapshots of rates of smoking and training: hospital Comms; challenges of directive-fatigue

Electronic and supervision reminders for clinicians, all patient-facing staff

Policy → Practice

Very brief advice, Vaping and Varenicline

Carrot and stick: when to activate enforcement (no smoking rules); refusnik staff??

Novel approaches: free vapes, peer support workers, coproduced interventions / prevention

Feedback and close

Matt Milarski
Senior Quality Improvement Advisor
NCCMH

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Next sessions

Your next meeting with your QI coach

Online workshop

Thursday 12th October – 11am-12pm

Next learning set

Celebration event for Round 1 teams & launch of Round 2 - 23rd January 2024

See you then!

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Quality Improvement in Tobacco Treatment

- Registration for Round 2 is now open!

- All NHS Trusts in England, not currently registered for QuITT, are encouraged to sign up

Quality Improvement in Tobacco Treatment

How did you find today's event?

We value your feedback as this helps us to continue to improve these events and ensure topics covered are meaningful and relevant to you.

Please use the QR code to access the online form. Paper copies are also available on your tables.

Feedback Form: Quality Improvement in Tobacco Treatment QI Collaborative

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