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NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

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Tobacco dependency community-based services for people with severe mental illness

An evaluation of NHS early implementer sites

Report

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Foreword

Helping smokers with severe mental illness quit is an urgent priority if we're to close the gap in life expectancy that steals years of life from people with mental health conditions. Smoking is likely the biggest factor in the difference in life expectancy between those with and without SMI and it is completely treatable. For many years we have had proven models, shown to work through both randomised controlled trials and in the real world, but we are yet to see these scaled up and embedded into mental health services.

This evaluation is an important step forward in showing how we can effectively embed support. It is clear that the system is ready, with senior managers generally supportive and engaged, referrals flowing when processes had been properly established, and patients welcoming the interventions. However, without sustained funding it is difficult to see how these services will be established at the necessary scale. Sustained funding provides sufficient time for service protocols to be defined and established, for the right staff to be recruited and trained and for referral routes to be bedded in. When funding appears fragile, it is challenging to make the commitment of time and resources needed to get these things right.

The Government has recently committed to create a smoke-free generation. This is an exciting vision, but we must not forget those who already smoke and those most at risk of smoking into the future. They need and deserve support to quit smoking or will otherwise be left behind yet again.

Hazel Cheeseman, Deputy Chief Executive, Action on Smoking and Health (ASH)

Executive summary

People with severe mental illness (SMI) are more likely to smoke tobacco than people who do not have a mental health problem, contributing to health inequalities. This report summarises an evaluation of early implementer community-based tobacco dependency services for people with SMI, set up as a preliminary step towards supporting people with SMI nationally to quit smoking. The evaluation was based on:

a. surveys conducted during the initial mobilisation of services with staff designated as leads for the service
b. interviews with staff providing treatment and referring into the service
c. surveys completed by patients using the service, and
d. feedback from quality improvement (QI) coaches working with some sites.

Key findings

Site lead surveys indicated that funding uncertainties had a significant impact on the success of services. Funding uncertainties have hindered the establishment of long-term protocols, staff recruitment and subsequent retention. Collaboration through pre-existing partnerships and with experienced stakeholders emerged as a key factor in facilitating successful mobilisation, through the use of protocols and by sharing workloads.

Staff interviews underscored the importance of:

- flexibility in treatment
- considering individual circumstances
- collaboration, both within the services providing treatment and referrals, and with other health services.

The need for time (to fully consider protocols, staffing, relevant training and logistics) was an important lesson from the early implementation. Some staff expressed ambivalence toward the goal of supporting patients with severe SMI to quit smoking. This often manifests as a lack of participation in training, which reduces the knowledge held by the services.

Patient survey responses revealed that choice in treatment format, cessation methods and prescriptions played a significant role in positive experiences. Crucial elements of staff interactions with patients that had a positive impact on experiences of quitting smoking were:

- regular engagement with empathetic staff
- offering support irrespective of setbacks
- displaying patience in accommodating extended timelines.

QI case studies echoed challenges related to time-limited funding, prescription protocols and the engagement of referral staff. They emphasised the importance of collaboration (particularly with external services, such as pharmacies) to successfully implement these services.

Recommendations

The results of the evaluation suggest that the following considerations would help in the future roll-out of nationwide tobacco dependency community-based services for people with SMI.

National:

- Provide a recruitment strategy for tobacco dependency community-based services and a training programme for staff at the national level. This would ensure that services can expand to meet referral demand over time. It would also ensure that all staff can consistently access (a) the required knowledge in mental health and related support, (b) the importance of smoking cessation in people with SMI, and (c) how to develop rapport with patients with SMI.

Regional/integrated care board (ICB):

- Develop and support wider smoking reduction strategies, to increase engagement and knowledge in tobacco dependency treatment. For example, the Fresh programme in the North East and the framework for local action in the Public Mental Health and Smoking report. This engagement between NHS and local authority services will create the right enabling framework for increasing support to disadvantaged populations of smokers who have additional needs.

Local:

- Establish a robust network of key stakeholders and experts who can support service set-up and delivery through their experience in the area.
- Before receiving referrals, implement an extended lead-in phase to ensure that all protocols are in place, including:
    - ensuring there is staff capacity to fulfil the required roles and engage in the required training
    - being able to directly supply nicotine replacement therapy (NRT)/vapes.
- Ensure that there is continuous communication and knowledge exchange between referral and treatment staff, regardless of the referral model This is to ensure that all staff are aware of the service and equipped with the motivation and knowledge to support their patients to access tobacco dependency treatment (for example, through sharing prescription protocols). Aligning referral and treatment clinic locations in some instances may also support successful referral.
- Consider having multiple referral sources for each service (for example from primary care, community mental health services and/or inpatient care).

Importantly, before the implementation of new services it is recommended that there is transparency about funding availability. This can ensure effective planning and staff recruitment. Longevity of this funding is also important to ensure sustainability of services, and support recruitment through the ability to offer longer-term contracts.

Contents

List of abbreviations

ELFT	East London Foundation Trust
ICB	Integrated Care Board
ICS	Integrated Care System
NCCMH	National Collaborating Centre for Mental Health
NCSCT	National Centre for Smoking Cessation and Training
NENC	North East and North Cumbria
NICE	National Institute for Health and Care Excellence
NRT	Nicotine replacement therapy
QI	Quality improvement
SMI	Severe mental illness

1. Background

People with SMI are three times more likely to smoke than the general population.[1] There is some evidence to suggest that they also smoke more cigarettes per day than the general population.[2] Alongside an already shorter lifespan than people without mental health problems,[3] increased prevalence of smoking contributes to further widening of health inequalities by adding an additional risk of morbidity and mortality for people with SMI.[1,3] Moreover, smoke-free policies continue to be unsupported by a large proportion of staff working in mental health settings.[4] This may be due to staff concerns about patients' right to smoke, deterioration of mental health and increased patient aggression and violence in the face of smoke-free policies.[4]

As a result, the NHS Long Term Plan outlines plans for tobacco dependency services for people with mental health problems, including both inpatient and community services for each integrated care system (ICS). Inpatient services are being rolled out nationwide, while as a first step towards nationwide availability of community services, seven early implementer sites have been set up in each region of England.

The aim of these community services is to provide tobacco dependency support and interventions informed by National Institute for Health and Care Excellence (NICE) guidance, with additional flexibility in accordance with the Smoking Cessation Intervention for severe Mental Illness (SCIMITAR+) model.[1] For example:

- tobacco dependency advisors with mental health experience/expertise
- a longer lead-in time to setting a quit date (when required)
- weekly appointments over a 12-week period (if needed, as opposed to 6–8 weeks recommended by NICE)
- the offer of weekly appointments being delivered as home visits
- close communication with the patient's GP regarding medicines management.

In 2022, the National Collaborating Centre for Mental Health (NCCMH; see the section listing the Developers of this report) was commissioned by NHS England to carry out an evaluation of the early implementer sites to communicate initial learning for future national roll-out.

1.1. Objectives and aims of the evaluation

The overall aim of the evaluation was to capture learning and good practice from the early implementer tobacco dependency community-based services to support other sites to mobilise community services in the future.

1.2. The early implementer sites

NHS Regional Leads and Office for Health Inequalities and Disparities Long Term Plan Tobacco Leads worked together to identify one early implementer site per region to pilot the set-up of tobacco dependency community-based services. These sites were selected based on the current tobacco dependency treatment offering, proposed changes to be made as a result of funding, governance structures and plans to provide data on the service. The following sites (in bold) were selected:

1. North East and Yorkshire: **North East and North Cumbria**
2. North West: **Greater Manchester***
3. Midlands: **Nottingham and Nottinghamshire**
4. East of England: **Norfolk and Waveney**
5. London: **East London**
6. South East: **Sussex**
7. South West: **Cornwall and Isles of Scilly**

*Greater Manchester was selected as an early implementer site later than other sites, and as such had a compressed mobilisation period.

1.3. Referral pathways

At the start of the evaluation, the early implementer tobacco dependency services broadly followed one of three identification and referral pathways:[a]

1. Primary care via physical health check for people with SMI or other routine primary care contact (model 1: Norfolk and Waveney, North East and North Cumbria)
2. Discharge from inpatient mental health settings or attendance at mental health outpatient clinics (model 2: Greater Manchester, Nottingham and Nottinghamshire, Sussex)
3. Community mental health services via Making every contact count (model 3: Cornwall and Isles of Scilly, East London).

Although each early implementer site followed one main model to begin with, patients identified via other routes were also referred to the services, and some sites used alternative models of referral over the course of the service mobilisation.

[a] It is possible that over time, referral models changed. Listed here are the models originally planned for services.

2. Evaluation methods

2.1. Site lead survey

To understand the context of each of the early implementer pilots, and the initial barriers and facilitators faced during mobilisation of the services, a survey of staff who were leading the mobilisation process in each site was conducted.

2.1.1. Aim

The aim of the survey of the site leads from each early implementer site was to gain an understanding of:

- the context in which the tobacco dependency services were introduced
- the main elements of the implementation of the services (configuration, staffing, working arrangements) and what affected their ability to complete this process
- barriers and facilitators to implementation.

2.1.2. Method

An online survey was developed on Microsoft Forms and sent by email to the site leads at the seven early implementer sites. Data were collected between 5 December 2022 and 12 April 2023.

Survey questions utilised multiple choice and free-text response boxes and covered the following overarching areas:

Respondent information

The early implementer site the respondent was based in, and details of any smoke-free policies that may have been in place within the mental health services.

Pre-mobilisation support in place

Whether any funding, stakeholder support, tobacco dependency treatment protocols or other supports were already in place within the setting before mobilisation of the services.

Funding

Additional funding, links with the ICB, and facilitators and barriers to the identification of funds.

Ownership, partnership and coordination

Assignment of responsibilities to senior staff, identification of regional and local stakeholders, and facilitators and barriers to identifying these roles.

Programme planning

Protocols for referral and assessment, prescriptions, data collection, identification of key deliverables, and facilitators and barriers to the planning of the programme.

Staff recruitment

Planned staff composition, current staff recruitment (including training and expertise) and facilitators and barriers to the recruitment of staff.

Interventions and measures to address inequalities

The content of the planned interventions, including specific treatments and the overall operational policy, and measures to address inequalities.

Things to do differently

This section asked broader questions about aspects that site leads felt could be done differently in future roll-out of tobacco dependency community-based services, and additional support needed to achieve sustainable services.

Analysis

Survey responses were narratively summarised. Site specific descriptions of the key aspects of mobilisation are presented alongside summaries of key implications for future roll-out of tobacco dependency community-based services across the sites.

The full survey is provided in **Appendix 1** and the findings from the survey responses are presented in Section 3.

2.2. Interviews with staff

Interviews with staff involved in the provision of tobacco dependency treatment at the early implementer sites, and staff involved in the identification and referral of patients to the service, were conducted to explore the key implications for future roll-out of tobacco dependency community-based services from those directly involved in the referral and treatment processes of the sites.

2.2.1. Aim

The aim of the interviews with staff was to gain an understanding of what staff delivering the services found helped or hindered the mobilisation of services and their implementation through an exploration of the common themes in staff experience.

2.2.2. Method

Interviews with individual members of staff (including those completing referrals, N=4 and those providing tobacco dependency treatment, N=7) were conducted by one of two NCCMH researchers to explore experiences of the early mobilisation and

implementation of tobacco dependency services. Questions were broad, to allow participants to speak freely about their experience, but were focused on:

- Training and expertise
- Experience of providing the intervention
- Experience of the referral process
- Supervision
- Team structure
- Overall experiences and additional action.

Throughout the interviews, the researchers prompted participants to reflect on learning to benefit future services. The full schedule used to guide interviews is provided in **Appendix 2**.

Analysis

Transcripts of interviews were analysed thematically, both deductively and inductively using Framework synthesis.[5] Themes were deductively structured around the questions asked; however, within this structure, themes were inductively developed and amended from the data. Framework synthesis allowed the specific experiences of treatment providers and referrers to be distinguished. As staff completing referrals had limited contact with patients once the referral had taken place, less data was analysed for this group (see **Appendix 2** for details).

One researcher developed an initial framework based on the topic guide and, in turn, the themes arising from the transcripts. This was then amended based on additional coding and double coding of transcripts by two additional researchers. Themes and sub-themes of staff experiences of implementation of the services which resulted from the analysis are described in Section 4.

2.3. Patient experience survey

To understand the experience of receiving treatment in the tobacco dependency services, a short survey was developed and provided to patients who had received treatment from the early implementer tobacco dependency community-based services.

2.3.1. Aim

The aim of the patient experience surveys was to gain an understanding of how patients found the process of accessing and using the tobacco dependency services.

2.3.2. Method

An online survey was developed using Microsoft Forms and sent to tobacco dependency treatment advisors to support their patients to complete. Data were collected between 18 October 2023 and 2 November 2023.

To be included in the analysis, patients were required to have been part of the service for enough time to be able to reflect on their experience and consent to the use of their anonymised data for this evaluation.

Survey questions utilised free-text response boxes and covered:

1. Experience of the referral process
2. How the service supported quitting smoking
3. Positive experiences of the service
4. Things the service could do differently to improve patient experience
5. Whether other tobacco dependency services have been used in the past, and any differences and similarities between services.

2.3.3. Analysis

Responses to the survey were summarised narratively and are presented in Section 5.

2.4. Site case studies

Two early implementer sites also participated in a separate QI programme aimed at inpatient SMI smoking services, despite having community services. Insights from QI coaches from working with these sites were summarised in the form of barriers and facilitators and are presented in Section 6.

3. Findings: site lead surveys

The survey was completed by all seven early implementer sites. As North East and North Cumbria is composed of four satellite sites, each site manager was individually invited to complete the survey. Three out of four of the satellite sites completed the survey. This resulted in a total of nine survey responses.

As a number of responses were significantly delayed, extending the timeframe in which survey responses were received, questions related to the stage of mobilisation are not described. This is because each site completed the survey at different points, and progress is therefore not comparable.

3.1. Description of sites

Sections 3.1.1, 3.1.2 and 3.1.3 provide an overview of each service.

3.1.1. Model 1: Primary care via physical health checks for people with SMI or primary care contacts

Norfolk and Waveney

The tobacco dependency service at Norfolk and Waveney receives referrals from GPs and other primary healthcare professionals. The service is embedded within the local authority smoke-free service and consists of a senior manager, a project manager, a Band 7 Specialist Tobacco cessation Manager, part-time wellbeing Mentors and an administrator. Prescriptions are provided externally via the statutory smoke-free service provided by Norfolk County Council.

North East and North Cumbria

Four satellite tobacco dependency services (Durham, South Tyneside, Middlesbrough[b] and Northumberland) have been set up in the North-East and North Cumbria area. Each service receives referrals from primary care networks in the area.

Durham

The Durham satellite service was developed from a local authority Stop Smoking Service in the area. It consists of a senior manager, a specialist stop-smoking advisor and an administrator. This service also developed communications to be sent to all those with a registered SMI on practice records within the primary care network.

Northumberland

Northumberland County Council public health already had an established service including staff delivering behavioural support, provision of NRT and referrals mechanisms in place. For their SMI stop-smoking pilot, they used a lot of staff who were already in post (existing staff roles were repurposed, and posts were backfilled).

[b] This service did not complete the survey, so is not presented here.

They have ICB involvement as well as lots of key stakeholders being involved. They receive referrals from GPs/other primary care healthcare professional, community mental health teams and SMI outreach teams.

South Tyneside

The South Tyneside satellite service utilised an existing community stop-smoking service in the area, which involved delivery of services by over 100 trained advisors alongside the primary care hub of 21 GPs. The funding from the community stop-smoking service was used to cover NRT, standard tariff payments, venue costs and incentives.

3.1.2. Model 2: Discharge from inpatient mental health settings or attendance at mental health outpatient clinics

Greater Manchester

Greater Manchester's service will be closely linked with their inpatient service. Patients whose treatment for tobacco dependency was initiated during their time as an inpatient will continue treatment in the community upon discharge. As a result, there is a lot of overlap in staff and protocols for inpatient and community treatment provision for tobacco dependency in people with SMI.

Nottingham and Nottinghamshire

Nottingham and Nottinghamshire's tobacco dependency service receives referrals from a variety of sources (not just from discharge from inpatient services), including through primary care, community mental health teams and self-referral. The service is set up to comprise a team leader, a trainer, three mental health smoke-free advisors and a team administrator.

Sussex

The tobacco dependency service at Sussex receives referrals for patients following discharge from inpatient services, as well as from community mental health teams. The service is set up to comprise a site lead, five tobacco dependency advisors, a support officer for the lead and a project manager. The service was set up from scratch although the trust premises introduced a smoke-free policy in 2017.

3.1.3. Model 3: Community mental health services via 'making every contact count'

Cornwall and Isles of Scilly

The tobacco dependency service in Cornwall and Isles of Scilly receives referrals via community mental health teams, voluntary sector mental health services, and drug and alcohol services. The service was built on an infrastructure of stop-smoking support delivered in other areas (for example, maternity). The service employs a project manager and eight stop-smoking advisors. Prescriptions are carried out externally.

East London

East London Foundation Trust (ELFT) had a smoking dependency service in place prior to the funding but used this funding to expand the current service. ELFT receives referrals from a number of sources (not just community mental health services), including on discharge from inpatient mental health services, community mental health teams, other physical health providers and self-referrals. Staff involved in the service include tobacco dependency advisors (expanded from three advisors), a senior manager, a trust clinical leader, a project manager, a communications lead, a data analyst and peer supporters.

3.2. Key mobilisation processes

Section 3.2.1 to 3.2.6 provides an overview of the key aspects of the mobilisation of the services including the main barriers and facilitators. Additional detailed descriptions of key information from each individual site response are provided in **Appendix 3.**

3.2.1. Funding

Previous funding

Of the nine responses, four mentioned funding support from their universal Stop Smoking Service, usually provided by local councils. One site also mentioned pharmacotherapy-specific support, another mentioned funding specifically for primary care annual health checks, and one mentioned funding specifically for tobacco dependency treatment for people with SMI, on which the additional NHS England funding provided for this pilot was built.

Facilitators

Reported facilitators for the identification of funds included support from the ICB through regular meetings (n=4), and expansion of services to support further roll-out (n=1).

Barriers

Four sites reported that a major barrier has been a lack of confirmation of funding extension from NHS England. Respondents said this had a knock-on impact on the sustainability of the services, for example on recruitment and retention of staff, and on business case agreements.

3.2.2. Ownership, partnership and coordination

All sites reported that a senior manager had been assigned responsibility for endorsing the programme. Three sites reported that a trust clinical lead had also been identified: a deputy chief nurse, a senior manager and a medical director.

Regarding stakeholders, regional and local stakeholders were identified and engaged by all of the sites. Local Stop Smoking Service leads, and local authority public health prevention leads were identified by all nine responding sites. Regional stakeholders

identified included 'Tobacco Control Leads' from the Office of Health Inequalities and Disparities (n=6), 'Regional Long-Term Plan Prevention Working Group Leads' (n=4) and 'Respiratory Clinical Network' Leads (n=4).

Facilitators

Sites reported a range of facilitators of ownership, partnership and coordination. These included co-production being part of the design and delivery of the service (n=1), partnerships they have at the local and regional level (n=4), and regular meetings with working groups to support the mobilisation of the service (n=2). As part of a pre-existing partnership, one site reported support from a local secondary mental health trust, which facilitated additional promotion of the service and clinic space.

Barriers

Major barriers in terms of ownership, partnership and coordination included issues with different capacities across services (n=2), including having large workloads. This meant that it was difficult for partnerships to commit equally to the delivery of the project (n=1), for example, when relying on referrals from partner organisations (n=1).

3.2.3. Programme planning

Previous protocols

Three sites reported that they had protocols from the universal Stop Smoking Services, which they used as a basis for setting up the service. Other sites mentioned use of the Commissioning for Quality and Innovation frameworks, and protocols developed by the trusts' smoke-free steering group. Two services stated that their tobacco dependency service protocols were already set up and in place, and one service reported that protocols were not routinely followed prior to the set-up of the service.

Plans for outcomes monitoring

All sites reported that they planned to use outcomes for further service evaluation.

Facilitators

A common facilitator (n=6) was drawing on experienced site leads, such as supportive stakeholders and managers within universal Stop Smoking Services, to support programme planning, as this meant that they could develop protocols that suited wider tobacco dependency service delivery. Remaining sites did not report facilitators for programme planning.

Barriers

Reported barriers to effective programme planning were related to funding and capacity. Sites reported that programme planning was difficult when future funding was unclear (n=3), and this also had an impact on the planning of recruitment (n=2). Two sites mentioned that at the time of completing the survey, staff involved in delivery of the programme had limited time alongside their other responsibilities.

3.2.4. Staff recruitment

In describing the roles of staff within the new services, the following positions were mentioned by most sites: tobacco dependency advisors with relevant National Centre for Smoking Cessation and Training (NCSCT), service managers and administrators. One site also mentioned wellbeing mentors, and another mentioned psychosocial link workers.

All sites also reported that the relevant staff had been trained in Very Brief Advice.

Facilitators

Over half of sites reported that the main thing that facilitated recruitment of staff was the embedding of pre-existing roles into the service and/or recruiting in-house. Others mentioned using recruitment frameworks and comparing equivalent roles that were being advertised, to ensure advertisements were competitive.

Barriers

However, a major barrier to recruitment was the problem of short, fixed-term contracts due to lack of clarity on future funding extensions; this was reported by four sites. Another site mentioned that there was a lack of adequately qualified staff to advertise the post to, and another reported that delays to start dates were caused by pre-employment checks.

3.2.5. Interventions and measures to address inequalities

Nicotine replacement therapy

Five of the nine respondents reported that NRT was provided externally via GPs and pharmacies through prescription or voucher schemes, while the remaining four reported that NRT was provided within the service.

Vapes

All sites reported that as part of their programme, vapes would be provided. This was externally via GPs or pharmacies in five instances, externally at point of access via a vape provider in one instance, and within the service in four instances.

Pharmacotherapy other than NRT

Although most sites reported that use of pharmacotherapy had been planned, some reported that, at the time of completing the survey, bupropion (two sites)[c] had been suspended due to safety concerns (two sites) or was unavailable (three sites). Three sites reported that in some instances if bupropion was already being used, provision would occur via referral to the GP. Sites also mentioned being open to other NICE-recommended pharmacotherapies as an alternative if they become available, such as varenicline.

[c] Although bupropion was reported to be suspended by two sites, this is not currently the case. Champix (a brand of varenicline) is currently suspended due to safety concerns.

Other non-pharmacological interventions

Respondents also reported integrating signposting (n=1), wellbeing support and social prescribing (n=2) and peer support (n=1) into their treatment protocols.

Measures taken to address health inequalities

Sites offered examples of a range of strategies they had taken to address health inequalities, including:

- population health management to identify opportunities to provide additional support across the region (n=1)
- setting up the services in areas of high deprivation based on local statistics (n=1)
- financial incentives, and free vapes and NRT vouchers, for patients to support ongoing engagement (n=2).

The following were also mentioned, to further ensure that patients were supported with additional issues related to deprivation:

- a personalised approach, for example extended provision of treatment past the standard of 12 weeks according to a personalised approach to care (n=2)
- provision of easy read literature about treatment and support for tobacco dependency (n=1)
- social prescribing training for staff (n=1).

3.2.6. Things to do differently

When asked what they would do differently if setting up similar services again, respondents suggested a range of approaches. Broadly, these related to:

- collaborative working in the set-up of the service, engaging partner organisations early to ensure their buy in and support (n=3)
- a 'no wrong door' approach, where all referral pathways are integrated (n=2)
- expand definitions of service eligibility, for example making the service definition of SMI diagnosis clear or including additional diagnoses in eligibility criteria such as eating disorders or personality disorders (n=2)
- further work in overcoming the resistance of medical professionals and other NHS staff towards reducing tobacco dependency in people with SMI, particularly in those staff that smoke (n=1)
- processes and protocols being in place ahead of time, for example prescriptions (n=1) and IT systems (n=1)
- longer timeframes to develop the early implementer pilot (n=1).

When asked what was required to ensure that the sustainability of the new services after the NHS funding period, respondents mentioned:

- confirmation of additional funding to extend the programme (n=3)
- support and buy in from primary and secondary care services (n=2)
- evidence of impact, including: feedback on patient experience to improve and implement changes to the service, to ensure acceptability and personalised care (n=3); impact of the service on outcomes (n=2); and opportunity to learn from other services (n=1)
- more awareness that the service exists through a larger-scale communications strategy to encourage more referrals (n=2)
- additional pathways between primary care and tobacco dependency services (n=1)
- clear protocols and guidance on the use of vapes (n=1)
- more staff hired to work in the community to ensure all who may benefit from the service are referred (n=1).

3.3. Summary of findings

Early implementer tobacco dependency services reported using a range of pharmacological interventions, and some also integrated psychosocial support. Overall, the site lead survey highlighted several key implications for the mobilisation of future tobacco dependency community-based services.

First, funding was identified as a major influencer of success across a range of mobilisation aspects. For example, the lack of certainty prevented establishment of longer-term protocols and plans, staff recruitment and retention.

Second, it was clear that collaboration via pre-existing partnerships and experienced stakeholders, alongside experienced managers, contributed to reduced additional workload. This was through use or knowledge of pre-existing protocols, sharing of workloads with partner organisations, and the ability to draw on previous experience to reach out to additional stakeholders.

4. Findings: Staff interviews

Eleven interviews with staff were conducted. Of these, nine were one-to-one interviews, while two included two members of staff (from the same early implementer site). Nine participants (from seven interviews) provided treatment to patients referred to the tobacco dependency service and four participants completed referrals for people with SMI who were eligible for the service. The participants were from North East and North Cumbria, Norfolk and Waveney, Sussex and East London. As North East and North Cumbria included four satellite sites with separate treatment and referral teams, these were treated as separate services. Three of the four sites within North East and North Cumbria responded and are represented in the staff interviews. Further information on participant characteristics is in **Appendix 4**. Interviews lasted between 30–45 minutes.

4.1. Data structure

Based on the questions asked, overarching themes of 'training and expertise', 'reducing health inequalities' and 'setting up the service' were utilised. This framework was inductively expanded to include 'importance of flexibility', 'team communication and collaboration' and 'the SMI population'. In total, these six overarching themes included 25 sub-themes. These themes are summarised in Sections 4.2 to 0. Additional detail on the themes arising is in **Appendix 5**. While 17 of the 25 sub-themes were endorsed by both treatment providers and referrers, seven were endorsed by treatment providers only, and one was endorsed by referrers only.

4.2. The importance of flexibility

Participants emphasised the importance of flexibility when treating patients with SMI. This took a number of forms. A strong theme underscored the significance of patience in the quitting process, acknowledging the challenges of relapses and the need to extend timelines:

> *'One of the challenges is the repeat, because people say, "Yeah, I'll stop, I'll stop", and then start smoking again. Then they'll stop…'* [Referrer]

Both referral and treatment staff also highlighted the importance of flexibility in the format and location of treatment services, as well as in providing options for NRT and vapes. Being able to directly supply medications was mentioned as a means of ensuring immediate access to chosen treatment options:

> *'Direct supply. Breaking down that barrier, of someone having to go to a pharmacy and pick up medication. You can hand it to them there and then.'* [Treatment provider]

While two treatment providers noted potential impacts on data collection quality, most appreciated the opportunity for a flexible approach despite some challenges in implementation. A person-centred approach was raised as an important element of utilising this flexibility in treatment, but also in encouraging and referring patients who may be willing to consider quitting smoking:

> *'Whenever I see somebody, I try and talk about their physical health. I try and talk about any habits that they might have around smoking, alcohol, drug use...I'll always discuss whether they ... feel ready to stop or have some support with that process... it is a bit of a journey that maybe they're not ready to stop immediately, but they're willing to engage in that process.'* [Referrer]

4.3. Intervention training and expertise

Participants were asked about their training and expertise in the role, both pre-existing and acquired post-appointment. All treatment providers felt that having some experience or knowledge of the SMI population was important and helpful to perform their role, although they didn't feel that this was a necessary pre-requisite if adequate training was provided:

> *'Because what we've certainly found is you can add the stop-smoking knowledge and specific stop-smoking skills as long as you've got that baseline there, which can come from a variety of backgrounds...I don't think it's necessarily important to recruit staff from a mental health background.'* [Treatment provider]

Many treatment providers said they had received generic stop-smoking treatment delivery training in the form of NCSCT training. They tended to find it helpful, although additional training (for example, to facilitate more in-person care) was also felt to be beneficial. However, three treatment providers said they had problems accessing even basic training:

> *'It has been challenging to get my new staff to do the SMI and NCSCT course because of funding, and because we had it rolled out to us in January, we didn't have our full complement of staff. We've had to then beg, borrow and steal to try and get them into other courses I've delivered like a brief, light touch of that to the staff... We shouldn't really have a barrier to specific training in the SMI. You know, that's surprised me.'* [Treatment provider]

4.5. Reducing health inequalities

Reduction of health inequalities was a topic covered in the interviews. In response, both referral and treatment staff reported that they felt the tobacco dependency service contributed to this reduction through improved accessibility to treatment (both the tobacco dependency treatment and additional physical health and social services):

> *'It's about that signposting, it's about making every contact count. And [it's] not just dealing with the stop smoking, because sometimes they have bigger issues than the smoking, which we try to assist in every way we can.'* [Treatment provider]

Furthermore, the free or subsidised provision of NRT and vapes was often mentioned, as patients who may not have been able to afford this medication were then able to quit smoking:

> *'[They were] able to manage to negotiate a discount with [company name] that we use as well. So, if people do want to self-fund further on beyond the end of the program, there is a really good discount that they can access as well. So, there is no barrier financially there for people across the course of the vape scheme.'* [Treatment provider]

Treatment providers mentioned that the services had had a positive impact on people's lives. This was particularly rewarding to be part of given the inequalities faced by the SMI population:

> *'I think it's nice being able to see [people with SMI] achieve something because for a lot of them, they don't really leave the house. They might not have much social contact or anything very positive going on in their lives.'* [Treatment provider]

4.6. Setting up the service

A number of ideas arose relating to how future services could be set up. Referral and treatment staff discussed staffing, and how any expansion of their current offering would mean that they were understaffed. Problems with recruitment and staff turnover may also have an impact on this:

> *'Recruitment is difficult. I think these are two very specific areas of specialism, smoking cessation and mental health, that don't often come together. They don't often meet, so it's been a case of finding staff that have done one or the other. And then trying to blend that skill by giving them extra training, and really mentoring them and letting them shadow each other to gain more speed and ground with their skills and their learning. And recruitment is hard.'* [Treatment provider]

Participants expressed the belief that future services would benefit significantly from having all protocols and staff in place and confirmed. For example, making sure that staff know the eligibility criteria for referrals, availability of rooms for face-to-face sessions and agreed prescription dispensing protocols. Many participants mentioned that a longer lead-in time, as well as confirmation of the amount of funding before the launch of the service, would have facilitated the planning of these processes:

> *'I think it would have been better if we'd had a little bit of lead-in time, so we could have planned the project first.'* [Treatment provider]

The referral route and process were also discussed. Referral staff said that a simple referral process was imperative, to ensure they were able to complete referrals alongside their usual roles. However, treatment providers were keen to ensure everyone who may benefit from the services could be referred, discussing proactive means of contacting patients outside of referral routes and accepting referrals from multiple referral pathways:

> *'Although we are a primary care model, we do accept referrals from secondary care. Because we'd rather accept referrals from just about anyone, so that we help as many people as possible. We also have self-referrals.'* [Treatment provider]

4.7. Team communication and collaboration

The importance of communication and collaboration was discussed in the form of supervision, communication between treatment and referral staff, and staff attitudes and their impact on service provision. Communication between those staff completing referrals and those staff providing treatment was seen as key for the successful running of the service. This was in the form of information on patient progress being passed back to referrers, engagement in training to understand the new service and who is eligible, and mutual understanding of each role in the overall provision of treatment for tobacco dependency:

> *'They were very slow to respond to uptake of training offer, and then the GP practices were saying, "We haven't got time to attend training", particularly even for brief advice training, "We don't want that". Then, when the referrals start to come through, they were just coming through, and some, believe it or not, didn't understand what SMI stood for.'* [Treatment provider]

> *'The other thing that the other colleague mentioned was just that they valued shadowing some of the nurses who do some of the health checks, just to see where they were coming from. And then a little bit of "vice versa" in the early stages. My colleague, who was doing it earlier on, was shadowed by a couple of the nurses as well, just to try and develop that understanding just from a referral standpoint.'* [Treatment provider]

Staff spoke of a range of support systems and managerial involvement, and mentioned that, ideally, support systems that included supervision from more experienced staff as well as peer support or team meetings were important to support both professional roles and personal wellbeing.

> *"We have team meetings, and we have peer support once every week for 45 minutes to an hour. We are really conscious of going and talking about their weekly experience and debriefing on anything they need to debrief on.'* [Treatment provider]

Although the issue of staff attitudes about smoking was raised, with a suggestion that some staff may not feel that smoking in the SMI population needed their attention or concern, descriptions of supervisory support suggested that those committed to the work were well supported via both managers and peers.

4.8. The SMI population

A theme emerged from the data relating to the specific difficulties associated with supporting patients with SMI and necessary considerations. For example, relating to the flexibility in treatment required, treatment providers and referrers noted that patient motivation to quit could fluctuate, resulting in missed appointments and attendances. This could have an impact on logistics, such as room bookings, and also further indicated the need for flexibility in non-attendance regulations (for example, additional outreach). Financial incentives were suggested as a successful motivational tool, both in terms of the money saved from quitting and also vouchers for appointment attendance. On the other hand, some staff felt that the planned opt-out referral process was instead an opt-in process. As a result, they felt these patients were highly motivated to quit, and required less support:

> *'They would turn up to the clinic 20 minutes late and you've already got someone else and then they wouldn't sit and wait. So that's something that causes a bit of chaos and the clinics, sometimes their lifestyles are chaotic.'* [Treatment provider]

A facilitator to successfully motivating patients to quit was the timing of conversations, or 'seizing the moment'. Strategies such as follow-up questions when patients seemed more open to the idea of quitting and running the service on the same day as other clinics used by SMI patients, were highlighted. This latter approach allowed for immediate referrals and consultations while patients were already present. Participants also emphasised the positive influence of peers and others who expressed interest in the service, emphasising the importance of seizing these opportunities:

> *'We've got the stop smoking service in here every Wednesday so we can make direct... because we run a clozapine clinic we can say, "Do you fancy stopping?", "Oh, yes". So, we can get them straight in. So [it's] locations, and I think it's understanding. It's seizing [the moment].'* [Referrer]

4.9. Patterns in the data

4.9.1. Differential experiences of referral and treatment staff

Most themes were endorsed by both referral and treatment staff, but there were notable differences in some instances.

For example, while the importance of flexibility in treatment for patients with SMI was highlighted by both referral and treatment staff, when it came to the referral process specifically, making the process as simple as possible to enable treatment to start quickly was seen as helpful. As some treatment staff mentioned the importance (and difficulties) of engaging some referral staff with the process, this is an important point to consider when setting up future services, because many referral staff have limited time, making complex referral processes a challenge.

Furthermore, while most themes discussed only by treatment providers were treatment-specific (for example, the need for mental health experience to perform the role), there was less reference from referral staff to cross-team collaboration. This is important as many treatment staff discussed their efforts to promote the service with referral staff, and a lack of engagement in any training or information provided.
It is possible that the lack of communication about patient progress once referral was completed meant that referral staff did not feel part of the overall team involved in the success of the community services.

4.9.2. Site and referral model differences

Appendix 6 demonstrates the differences by site in endorsement of themes.
Most staff interviewed were working in services using a primary care referral model (see Section 3.1). Although some services had sufficient referrals, leading to workforce pressures (see Section 4.6), others expanded their referral routes to cover additional avenues because of low numbers of referrals. This overlap in models meant that there were few differences in views across sites and, on the whole, all sites contributed information to each of the themes. We did not therefore find differences in the themes emerging from sites with different original referral models.

4.10. Summary: Staff interviews

Overall, the staff interviews highlighted a number of key themes relating to successful service implementation.

Prioritising flexibility in every aspect of treatment, including consideration of individual circumstances, was a key theme, although referral staff also wanted a simple referral process prior to this.

Another significant facilitator was the support garnered through collaboration, not only within the service to manage workload, but also with other health services to provide person-centred care.

Collaborative efforts between treatment and referral staff are also likely to improve the number of referrals.

However, staff reported experiencing barriers in the form of logistical problems which had not been considered before seeing patients, such as time for home visits and data collection, and uncertainty about opt-out or opt-in referral practices.

Finally, it was suggested by some that ambivalence towards the goal of supporting patients with SMI to quit remained common, most often taking the form of lack of participation in training and information provision about the service.

5. Findings: Patient survey

Thirteen patients who had received support and treatment from the early implementer sites consented to complete the survey. While respondents indicated that they had spent between 3 and 30 weeks using the services, more than half said that they had been under the care of the service for over 5 months. Sections 5.1 to 5.4 describe the responses to the survey.

5.1. Referrals process

Respondents rated the referral process as being positive because it was easy, quick and straightforward. Different processes of referral were reported, for example, some patients reported being supported to self-refer through a website or phone number (n=6), while others were referred to the tobacco dependency service by a healthcare professional with whom they were working (n=5). Three respondents spoke about being contacted by the tobacco dependency service 'straight away' following a referral.

5.2. Support provided to stop smoking, and positive experiences

A lot of people indicated that this was their first experience of a tobacco dependency service. For those who had previous experience, they described their experience of the early implementer sites as being more regular, with contact continuing for a longer period of time. The resulting offer of more extended pharmacological treatment and more comprehensive support was described as helpful.

Respondents described what they liked about the service and the support that they were offered to help them quit. Responses covered treatment and the characteristics of staff, described in Sections 5.2.1 and 5.2.2, respectively.

5.2.1. Treatment

Respondents appreciated having a choice of quit options, for example abrupt quits or cut-down-to-quit (n=3). Most respondents felt that the provision of vapes and NRT, and the possibility to try an alternative if they didn't suit them, contributed to their positive experience of the service and ability to quit smoking (N=11):

> *'I got to change vapes as I did not like the first device.'*

One respondent also found the addition of behavioural support a positive experience.

Respondents mentioned the impact of their appointment location on their experience. Six respondents appreciated the option to have home and/or telephone contacts based on their preference and schedule. Regular contact between appointments was mentioned as a key part of quit success (n=4):

> *'The weekly calls I am offered really helps to keep me on track and makes me hold myself accountable.'*

Being able to liaise with other services that patients were under, such as requesting blood tests and also being able to signpost to other services, was reported as being helpful (n=2). Two respondents found the rapid referral process to be a positive experience.

5.2.2. Characteristics of staff

Respondents talked about the characteristics and techniques of the staff that they worked with being encouraging, supportive, positive and non-judgemental (n=8). This contributed to continued accessibility of the services for patients, as it meant that they did not feel rushed, and were not given up on if they relapsed:

> *'I like the friendly approach my mentor has and not giving up with me as I am not the easiest to get hold of.'*

5.3. Ideas for change

The only suggestion for improving the services was better communication with pharmacies. The person who suggested it said that their early implementer site had been able to achieve this.

5.4. Summary: Patient experience

Responses to the patient survey provided valuable insights into effective practices to support patients with SMI to quit smoking. Two predominant themes emerged from the findings.

The concept of choice, encompassing aspects such as treatment format, cessation methods and prescriptions, emerged as a noteworthy factor significantly contributing to more favourable experiences. Simultaneously, regular engagement with empathetic staff, offering support to respondents in their quit journey irrespective of potential setbacks, and displaying patience in accommodating extended timelines, arose as another crucial element influencing experiences.

6. Findings: QI case studies

QI coaches working with two services (sites at Norfolk and Waveney, and Cornwall and Isles of Scilly) provided additional information on barriers and facilitators experienced at those services.

6.1. Barriers

At Norfolk and Waveney, a primary care model, staff have experienced challenges in:

- balancing new and existing referrals (as a result of the provision of long-term and person-centred care)
- establishing their data collection protocol during initial set-up.

Cornwall and Isles of Scilly, a community mental health model, faced barriers such as:

- a lack of support from the mental health services tasked with referring patients
- time-limited funding, which affected recruitment
- lack of protocols for NRT prescription, which disrupted the supply chain
- the closure of pharmacies, which disrupted the supply chain.

The separation of administrative functions from the referring mental health service was a major challenge, as engagement and communication with referral staff were difficult. To overcome this, there has been a shift to a primary care model, and an increase in communication between the tobacco treatment service and referral services.

Uncertainty about eligibility for the Stop Smoking Service was a barrier to referrals, as community mental health services do not see patients based on their diagnosis. Cornwall and Isles of Scilly have tackled this barrier by using a broad definition of inclusion.

6.2. Facilitators

While there were difficulties with prescription protocols and closure of pharmacies, Cornwall and Isles of Scilly found the following helpful:

- Positive relations with pharmacies, as they could support NRT-related training.
- Integration with the universal Stop Smoking Service, as referrals from individuals with SMI were gained from these general services.
- Improved communication between treatment provider and referring staff (for example, by having one-to-one conversations that build trust, and attending events), has improved referral rates through community mental health teams.

6.3. Summary: QI case studies

Many themes identified in the interview and survey data were echoed by QI coaches working with Norfolk and Waveney, and Cornwall and Isles of Scilly:

- Time-limited funding remained a key problem for establishing the sustainability of the services.
- Absence of clearly defined protocols around prescription was an issue raised by staff from other services in interviews.
- Difficulties engaging referral staff was also a key theme in interviews.
- Finally, collaboration with referring services and pharmacies (or other external services) was found to be a facilitator, once again echoing the importance of team-working and collaboration in the successful set-up of these services.

7. Overall learning from the evaluation

The results of this evaluation indicate learning for the future roll-out of tobacco dependency community-based services for people with SMI. The primary facilitators can be summarised as: (a) adequate funding and planning; (b) collaboration; and (c) person-centred and flexible provision of treatment and support for tobacco dependency.

7.1. Funding and planning

Reports from both site leads and case studies indicated that clarity on, and longevity of, funding availability would be a significant facilitator to successful service set-up in the future. This is because protocol development, staff recruitment and staff retention are impacted by the length of funding availability.

Furthermore, staff and case studies illustrated the importance of adequate time in the initial phase of service set-up, to establish and confirm protocols and guidance. In particular, this related to prescriptions (for example, having a direct supply of medication rather than via a third-party) and simple referral processes. It also related to the potential for additional routes of receiving referrals, staff capacity and accessible mental health training for all staff before seeing patients.

Given the potential for extended quit lengths, logistical issues with outcome measurement should also be considered. This 'lead-in' phase should be extended in future service set-ups.

7.2. Collaboration

It was made clear by site leads, staff and case studies that having good collaborative relationships (between referring and treating staff, with expert stakeholders and with other community services supporting patient health and wellbeing) was an important facilitator of successful services. Therefore, development of a network of key stakeholders is a necessary part of the service set-up.

As part of developing this network, it is important to plan for a model of referral that includes ongoing communication and knowledge exchange between referral and treatment staff (regardless of the origin of the referral).

7.3. Person-centred and flexible tobacco dependency treatment

Patients and staff felt that a good rapport between treatment provider (or referrer) and patient helped support consideration of additional factors that are having an impact on patients. A good rapport also ensures that patients feel listened to and supported.

Related to this, the following were flagged as important by staff and a key driver of positive experiences by patients:

- integrating allowance for extended quit length
- choice of appointment location
- choice of format of appointment
- medication
- patience and understanding.

Training in mental health and related support on the importance of smoking cessation in the SMI population, and how to develop rapport with patients, are likely to help with the points above. It may be best for the training to be developed and delivered at the national level, so it can be accessed by all on a rolling basis and there can be consistency of knowledge

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Glossary

Integrated care system (ICS) and integrated care board (ICB)

ICSs are partnerships of organisations that come together to plan and deliver joined-up health and care services, and to improve the lives of people who live and work in their area.[6] ICSs include integrated care partnerships and ICBs. ICBs are responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area. Integrated care partnerships also include upper-tier local authorities in the ICS area, and are responsible for producing integrated care strategies.

National Centre for Smoking Cessation and Training (NCSCT)

A social enterprise that supports the delivery of effective evidence-based tobacco control programmes and smoking cessation interventions provided by local Stop Smoking Services.

Nicotine replacement therapy (NRT)

Medicines that provide low levels of nicotine, without tar, carbon monoxide and other poisonous chemicals present in tobacco smoke. They can help to reduce withdrawal effects.[7]

Primary care network (PCN)

PCNs build on primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care for people, close to home.[8]

Quality improvement (QI)

QI is a systematic approach to improving the safety and effectiveness of healthcare and patients' experience of healthcare. It uses a recognised method that involves designing, testing and implementing changes using real time measurement for improvement. QI coaches are trained professionals who work with healthcare teams to design, test and implement the change ideas.

Severe mental illness (SMI)

A mental, behavioural or emotional disorder, such as psychosis, schizophrenia and bipolar disorder, resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.[9]

Vapes

Electronic devices, also called 'e-cigarettes', which deliver nicotine in a vapour that doesn't contain tar or carbon monoxide.[7]