HEALTH AND WELLBEING BOARD

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WORKING ACROSS THE LOCAL HEALTH AND SOCIAL CARE SYSTEM TO REDUCE RISKS AND IMPROVE THE EFFECTIVENESS OF CARE BY ENCOURAGING AND ENABLING SMOKING CESSATION

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Summary

Board member support is sought for the development of proposals to enable a system-wide approach to reduce the risks to, and to improve the effectiveness of, a variety of types of care for patients/clients through the encouragement and enablement of smoking cessation before treatment, or during it, as clinically appropriate. There is strong scientific evidence that this will not only improve people's health but will free-up resources so that more people can benefit from available services.

If this is to be taken forward, as a first step it will require commissioners and providers to: (i) explore the implications for contracts and service provision; (ii) undertake a diversity impact assessment; and (iii) undertake modelling to develop a robust business case.

1. Budget and Policy Framework

1.1 Local authorities have a duty to improve the health of their populations and to reduce health inequalities. Smoking cessation is one of the most effective ways to achieve this. Medway Council provides smoking cessation services; Medway Hospital Foundation Trust is in the process of establishing a smoking-free site; and Medway CCG recognises the importance of

encouraging and enabling people to stop smoking and wishes to promote this.

1.2 This paper proposes that local health and council organisations work together to develop ways to encourage and enable many more people to stop smoking to both reduce the risks and improve the effectiveness of a wide range of care. This fits well with the council's policy and budgetary framework.

2. Background

2.1 Smoking tobacco is the single greatest cause of preventable death and ill health.[1] It is also a significant cause of avoidable treatment complications, treatment failures and prolonged hospital stays. For example:

- people undergoing surgery who smoke are more likely to have pulmonary, circulatory, and infectious complications; impaired wound healing and wound infection; delayed bone union and complications to fracture healing[2,3,4,5,6,7,8,9] are more likely to require admission to an intensive care unit;[10,11] are more likely to have lower respiratory tract infections; and are more likely to die;[11]
- people with diabetes who smoke will have higher levels of insulin resistance[12] which, if they quit smoking, will reduce[13] leading to improved diabetes control;[14]
- people with mental health problems who are taking psychotropic medication and who smoke require higher doses of drugs to control their symptoms because chemicals in tobacco smoke affect one of the body's enzyme systems and this leads to a reduction in drug effectiveness;[15] and
- people with chronic obstructive pulmonary disease who continue to smoke are twice as likely to be admitted to hospital (quitting halves this likelihood, but just cutting down has no effect).[16]

By extension, we can anticipate that such improvements will also contribute to improving people's independence and thus reduce their need for social care.

2.2 Of particular note is the fact that quitting smoking before planned surgery has substantial benefits. For example, in a randomised controlled trial of smoking cessation 6-8 weeks before surgery the statistically significant differences between quitters and the control group (which continued smoking) were, respectively:

- overall post-operative wound complications – 18% vs 52%;
- wound-related complications – 5% vs 31%;
- cardiovascular complications – 0% vs 10%; and
- need for secondary surgery – 4% vs 15%.[17]

2.3 It may be that quitting smoking even later than 6-8 weeks before surgery can be beneficial. For example, stopping smoking just four weeks before surgery has been shown in another randomised trial to reduce post-operative complications,[18] and stopping smoking at least three weeks before surgery

has been shown to reduce the incidence of poor wound healing following plastic surgery procedures.[19]

2.4 It is also noteworthy that the deleterious effects of smoking are not confined to the post-operative period. For example, in a long-term follow-up study of 1,041 people undergoing coronary artery bypass grafting, smoking cessation after surgery was an important independent predictor of a lower risk of death and of fewer further coronary interventions during the 20-year follow-up period when compared to patients who continued to smoke.[20]

2.5 Apart from improving people's health, there is also a lot of money to be saved by encouraging and enabling people to quit smoking before surgery and/or as part of the care of a wide range of diseases. Such savings could be used for the care of others. For example, as long ago as 2006, the then London Health Observatory calculated that across London, if all patients admitted for elective surgery quit smoking beforehand, each year this could save 2,600–4,000 bed days, £0.5–1.1m for NHS commissioners, and £0.9–2.8m for health care providers.[21] These figures are now out of date but the sums to be saved and re-invested remain considerable, as will be the number of bed days.

2.6 That said, many hospital and primary care clinicians still do not advise their patients to quit smoking before planned surgery and/or when they have other conditions affected by smoking or refer them to a suitable service.

2.7 There seem to be few, if any, studies of UK hospital doctors' attitudes to smoking and to their recommending and referring patients to quit, especially before surgery. Elsewhere, studies have shown that many surgeons do not recommend that their patients quit smoking before surgery, even though studies show that 75% of smokers who undergo surgery wish to quit.[22] And whilst most surgeons know that smoking cessation improves clinical outcomes many seem not to know that providing brief advice and referring to smoking cessation services, or prescribing nicotine replacement therapy, can help their patients to quit.[23] This behaviour is not confined to surgeons: in another study, 89% of physicians reported taking a smoking history from their patients but only 39% reported 'always' treating their patients' tobacco dependence.[24] A variety of reasons were put forward for this, including 'lack of time', 'patient unreadiness to change', and 'inadequate resources'.[25] However, just brief advice from a clinician is known to motivate people to quit[26,27] with substantially higher quit rates being achieved through concomitant referral to specialised services, and smoking cessation advice has been shown to be both possible and efficacious in A&E departments and in both surgical and medical units.[28,29]

3. Options

3.1 Medway Council directly provides smoking cessation services and commissions others from some GP practices and community pharmacies. This can go some way to helping people who smoke to quit, but to have a big impact on improving people's health and significantly freeing-up resources the services require a step change in the number of referrals from clinicians. This approach could also be extended to other acute and mental health services providers.

3.2 With a combined drive from commissioners to encourage smoking cessation (through contracts) and to enable it (through services) there is scope to substantially increase the number of people who quit smoking and thereby benefit both their health and the effectiveness of care provided to them. This can also be expected to increase people's independence and thus reduce their need for social care services because of the rapid benefit on health that occurs with stopping smoking.

3.3 There are two main ways to achieve this:

(i) prior to referral, GPs and their staff need to refer a greater number of patients to council-commissioned/provided smoking cessation services to increase the effectiveness of their subsequent treatment; and

(ii) prior to treatment, acute hospital clinicians and mental health service clinicians need to refer a greater number of patients to council-commissioned/provided smoking cessation services to reduce the risks of their recommended treatments (notably anaesthesia and surgery) and to increase the effectiveness of other treatments (notably drugs adversely affected by the chemicals in tobacco smoke).

3.4 A potential difficulty here is the 18-week referral-to-treatment (RTT) target that requires 90-95% of patients to start any needed treatment that is not urgent within 18 weeks of being referred where a consultant retains overall clinical responsibility for the patient's care. In addition to the time it takes to assess and investigate a patient in an outpatient clinic following referral, a course of smoking cessation support to enable quitting usually takes some six weeks. Some people require several attempts before they can quit successfully. And to gain benefit for surgery, a person needs to quit at least some four weeks beforehand, and preferably six to eight. Thus, there is little time between referral and definitive treatment to meet the RTT target if smoking cessation is to be achieved within our current pathways.

3.5 However, RTT clock stops for 'non treatment' are permitted "when it is clinically appropriate to return the patient to primary care for any non-consultant-led treatment", or if it is decided to 'start a period of active monitoring', or if the patient is referred to an interface service (that is one that incorporates 'any intermediary levels of clinical triage, assessment, *and treatment* between traditional primary and secondary care' [emphasis added].[30] It would thus seem entirely possible, within the RTT regulations, to offer patients smoking cessation treatment to increase the effectiveness of their planned treatment and to reduce their risks.

4. Advice and analysis

4.1 If we are to reduce avoidable treatment complications, treatment failures and prolonged hospital stays and avoidable increased dependency, then we need to increase the number of people who quit smoking.

4.2 There is an important synergy between this and Medway Hospital FT's plans to become a smoking-free site and to encourage and enable more staff, patients and visitors to quit smoking.

4.3 For this revised approach to be effective, council-commissioned and provided smoking cessation services must be easily accessible and have sufficient

capacity, and NHS commissioners and providers must be willing to enable and to support changes in the ways that clinicians provide services such that, as is clinically appropriate, people who smoke can be enabled to quit before starting their definitive treatment. This would substantially improve health outcomes, reduce pressure on, especially, a number of hospital services, and save NHS and local authority funds that could be shifted to other health and social care services.

4.4 This will require effective joint working between NHS and council commissioners and service providers, including primary care contractors, in order to transform aspects of service provision and to ensure sustainability.

4.5 As a first step, this will require commissioners and providers to: (i) explore the implications for contracts and service provision; (ii) undertake a diversity impact assessment; and (iii) undertake modelling to develop a robust business case.

5. Engagement activity

5.1 In the first instance, it will be necessary for NHS and council commissioners and providers to identify the scope of changes required to the way that both services are provided and people are encouraged and supported to quit smoking. This is likely to require the development of new referral policies that emphasise the purpose of increasing patient/client safety and the effectiveness of care and not the reduction of access to care. It will also require the support of partner organisations in implementation.

6. Risk management

6.1. Risk management is an integral part of good governance. The council has a responsibility to identify and manage threats and risks to achieve its strategic objectives and enhance the value of services it provides to the community. Using the following table this section should therefore consider any significant risks arising from your report.

Risk	Description	Action to avoid or mitigate risk	Risk rating
Misperception that the purpose is to reduce people's access to care or to discriminate against people who smoke	Similar approaches have been successfully implemented elsewhere (such as at Guy's and St Thomas's hospitals). The research evidence supporting the benefit of encouraging and enabling people to quit smoking to improve the safety and effectiveness of various types of care is substantial. However, it is possible that this could be misinterpreted.	Adequate engagement and publicity and support for people to be able to quit smoking	C3

Failure to be consistent in approach across all health and social care services in Medway	Health improvement initiatives such as smoke-free public places (which have led to statistically significant reductions in heart attacks within 12 months of implementation) have, in part, succeeded by their consistent application in all places. Consistency of approach across the health and social care economy in Medway is likely to increase the success of this proposal	Adequate understanding of public, clinician and other health and social care provider perceptions of the proposed approach with the adequate provision of information and support to enable its effective implementation	D3
Insufficient priority being given to the approach	Especially in the context of stopping smoking before elective surgery, as clinically appropriate, this will have a statistically significant benefit to individual patients and to the health and social care system within 4-6 weeks. Coupled with the established substantial cost-effectiveness of smoking cessation, it should be possible to establish a good business case for this proposal	Development of a robust business case that shows the benefit of the level of support required and the benefit to services as well as to individuals' health	C2

7. Consultation

7.1. The need for any formal or informal consultation is to be determined subject to the outcome of a diversity impact assessment. No services are being proposed for reduction or decommissioning.

8. Financial implications

8.1 In the event that is apparent that more investment in current smoking cessation services is required this will be part of the overall business case for taking this proposal forward in the context of other priorities.

8.2 The current annual expenditure on smoking cessation services is £722,000. This is approximately 4% of the public health budget of £18.1m.

9. Legal implications

9.1 The Health and Wellbeing Board has a statutory obligation under section 195 Health and Social Care Act 2012 to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner for the purpose of advancing the health and wellbeing of the people in Medway. Supporting the development of proposals to reduce health risks and free-up resources through the encouragement and enablement of smoking cessation before treatment is therefore within the

remit of the Health and Wellbeing Board.

10. Recommendations

10.1. It is recommended that board members identify how they might encourage and enable commissioners and providers, including GPs, to make it possible for many more people to quit smoking in sufficient time before planned surgery, and to quit smoking to increase the effectiveness of other care.

10.2. Board members are also recommended to encourage commissioners and providers to: (i) explore the implications of a systems wide approach for contracts and service provision; (ii) undertake a diversity impact assessment; and (iii) undertake modelling to develop a robust business case for this approach.

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Appendices

Appendix 1 – References

Background papers

None

Appendix 1

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