**Manchester Health and Wellbeing Board**
**Report for Resolution**

**Report to:** Manchester Health and Wellbeing Board - 1 November 2017

**Subject:** The CURE Programme: Curing Tobacco Addiction in Manchester.

**Report of:** David Regan, Director of Population Health and Wellbeing
Dr Matt Evison, Consultant in Respiratory Medicine

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## Summary

This report outlines a ground-breaking, innovative and evidence based smoking cessation programme, intended to help the thousands of smokers who are admitted to Manchester hospitals each year. The **CURE** programme has been designed by Dr Matthew Evison, Consultant in Respiratory Medicine, Manchester University Hospitals Foundation Trust and Director of the Lung Pathway Board for Greater Manchester. Dr Evison has been supported by clinical colleagues including Dr Phil Barber who will deliver a presentation on the programme to the Board and Louise Brown from Pennine Acute Trust.

The benefits of the **CURE** programme would be reductions in the numbers of people who smoke in Manchester, improved health outcomes for our residents, saved lives and significant reductions in hospital admissions.

## Recommendations

The Board is asked to:

i) Endorse the programme
ii) Monitor and support the implementation of the programme in Manchester

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## Board Priority(s) Addressed:

| Health and Wellbeing Strategy priority | Summary of contribution to the strategy |
|---|---|
| Getting the youngest people in our communities off to the best start | |
| Improving people's mental health and wellbeing | |
| Bringing people into employment and ensuring good work for all | |
| Enabling people to keep well and live independently as they grow older | Smoking is the single largest cause of preventable deaths in England (1).Smoking prevalence is higher in Manchester than other parts of the country, reducing smoking rates will radically improve health inequalities in our city and improve health |

| | |
|---|---|
| | outcomes for individuals. |
| Turning round the lives of troubled families as part of the Confident and Achieving Manchester programme | |
| One health and care system – right care, right place, right time | The CURE programme embodies right care, right place, right time, for all patients who need support to stop smoking at the time of admission to hospital. It is followed up by timely and appropriate community smoking cessation support. |
| Self-care | |

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**Background documents (available for public inspection):**
None

## 1. Introduction

1.1 In England, each year, it is estimated that smoking costs the public £13.9 billion in terms of output lost from early deaths, smoking breaks, sick days, provision of NHS treatment, provision of social care, household fires and smoking litter.

1.2 Smoking is the single largest cause of ill health and preventable death in England and kills about half of all lifetime users. Sadly, Manchester has the highest rates of smoking attributable deaths in England.

1.3 Smoking prevalence rates have an inverse relationship to social gradient, a phenomenon seen nationally and internationally. This means that people who live in less affluent communities are more likely to smoke. Smoking will, in every case, worsen an individual's chance of having good health. Smoking therefore contributes to the health inequalities which exist in Manchester.

1.4 Smoking prevalence in Manchester has fallen year on year for a number of years. However, the decline is much slower than in other parts of the country. Indeed, current adult smoking prevalence in Manchester is 21.7%, versus an England average of 15.5 %.

1.5 In December 2016, the Director of Population Health and Wellbeing for Manchester established a Manchester Tobacco Alliance, which is a cross cutting, multi-agency approach to whole system tobacco control, including smoking prevention and helping people to stop smoking.

1.6 In July 2017 the government launched its new Tobacco Control Plan for England and in the same month, the first ever Tobacco Control Plan for Greater Manchester was published (A Tobacco Free Greater Manchester Strategy 2017-2021). In both plans, ambitious targets are set out for the further reduction in smoking rates and tobacco use in society. The Greater Manchester plan sets out a vision to reduce adult smoking prevalence to 13% by the end of 2020/2021.

1.7 Given our current smoking rates, Manchester must look at new ways of tackling smoking in the city if we are to reduce smoking prevalence and smoking related deaths in Manchester. We believe that the **CURE** programme, developed by Dr Matthew Evison, at the University Hospital of South Manchester (now part of Manchester University Hospitals NHS Foundation Trust (MFT)) would make a real difference, by helping thousands of smokers who go into hospital in Manchester to stop smoking.

## 2. Background

2.1 The burden of ill health and mortality caused by smoking in Manchester represents a significant population health issue:

- Around 21.7% of adults in Manchester currently smoke compared to a national average of 15.5% (see Appendix 1). This rises to 27.6% among adults in routine and manual occupations
- On average, there are approximately 820 deaths which can be attributed to smoking in Manchester each year (based on the period 2013-15). The rate of smoking attributable deaths in Manchester is the highest in England.
- In 2015/16 there were over 5000 hospital admissions attributable to smoking in people aged 35 and over in Manchester – a rate of 2,898 per 100,000 people compared with the England average of 1,726 per 100,000
- Around 11.6% of mothers are still smoking at the time they deliver their baby compared with 10.6% of mothers across England as a whole.

2.2 Smoking can have a significant impact on respiratory illness and it is the major preventable risk factor for Chronic Obstructive Pulmonary Disease (COPD), asthma and other respiratory illnesses. Nationally, around 17% of COPD patients are known to be smokers. However, data from GP practices summarised in the table below, shows that 49% of patients with COPD in Manchester are recorded as smokers.

| Respiratory Condition | Current Smokers (%) | Ex-Smokers (%) | Combination – Ever Smoked (%) |
|---|---|---|---|
| COPD | 49% | 33% | 82% |
| Asthma | 24% | 14% | 37% |

2.3 The Manchester Population Health and Wellbeing Team is developing a cross-thematic "whole system" approach to Tobacco Control. This is based on the World Health Organisation Framework for Tobacco Control and is represented by the GMPOWER model in the Greater Manchester Tobacco Control Plan:

- **G** row a social movement for a Tobacco Free Greater Manchester
- **M** onitor tobacco use and prevention policies
- **P** rotect people from tobacco smoke
- **O** ffer help to quit
- **W** arn about the dangers of tobacco
- **E** enforce tobacco regulation
- **R** raise the real price of tobacco

Manchester has adopted GMPOWER as its own framework for tobacco control. Many elements of this model are already in place in the city. However, we believe that in order to reduce smoking prevalence at scale, we will need to consider new and different ways of working. In particular, we need to re-examine how we offer people help to quit and this is why we believe that the **CURE** programme, based on the successful Ottowa model of smoking cessation could help thousands of smokers who go into hospital in Manchester to give up their smoking addiction.

**CURE** is an acronym which describes the elements of Dr Evison's proposed approach to smoking cessation:

**C** - CONVERSATION : have the right conversation everytime.
**U** - UNDERSTAND : understand the level of addiction
**R** - REPLACE : replace nicotine to prevent withdrawal
**E**- EXPERTS & BEST EVIDENCE-BASED TREATMENT : for all patients

2.4 The **CURE** programme suggests that being admitted to hospital is a time when patients might be very motivated to give up smoking, for the following reasons:

- Being worried about their health
- Feeling too unwell to smoke
- Being in a hospital environment where they are not allowed to smoke.

The evidence base used for the **CURE** programme shows that:

"Inpatient treatment for tobacco addiction with appropriate community follow up increases the chances of long term smoking cessation by 60%."

2.5 The appalling health consequences of smoking are, in the main, caused by the toxic nature of tobacco itself, resulting in smoking related cancers, respiratory and circulatory disease. Smoking whilst pregnant is known to impact on infant mortality. Children exposed to second hand smoke are at much greater risk of cot death, meningitis, lung infections and ear disease and are more likely to start smoking as adults. However, smoking is an extremely hard habit to give up. This is because of the addictive nature of the drug, Nicotine, which is found in tobacco. Just knowing how dangerous smoking is, or having "willpower", does not make giving up smoking possible in many cases.

2.6 The **CURE** programme offers a more supportive approach to smokers, treating smoking as an addiction (to Nicotine) and offering all patients who smoke, immediate and comprehensive medical treatment to help them to stop smoking during their stay in hospital. The approach is further strengthened by a Smokefree hospital environment for all patients, visitors and staff. This gold standard level of treatment would be supported by appropriate ongoing support in the community on discharge. The **CURE** programme is very ambitious, but represents an opportunity to address smoking at scale.

## 3. How the CURE Programme Works

3.1 At the present time, most patients who smoke are not helped to "quit" when they are admitted to hospital. Some may be even continue smoking during their hospital stay, by going outside the hospital building to do so.

3.2 Currently, whether a person smokes, or not, is not routinely recorded or documented on admission to hospital. Although many health professionals will advise patients about the risk that smoking presents to their health condition, they are not routinely offered medication or psychological support to stop

smoking. The **CURE** programme would change this, fundamentally and systematically :

- All patients who are admitted to hospital would be asked whether they smoke and their response would be recorded.
- All smokers would be given appropriate Nicotine Replacement Therapy and medication to help them to cope with Nicotine withdrawal*. Patients would also be offered behavioural support and advice.
- All smokers would be referred to a community smoking cessation service on discharge from hospital.
- Hospitals and hospital grounds would become completely Smokefree environments for all, sending out a clear message about smoking and health not being compatible *and* supporting smokers in their "quit" attempt.

(*A combination of medication such as Nictotine Replacement Therapy, sometimes Varenicline and behavioural/ psychological support has been shown to be 4x more effective at helping people to give up smoking than giving up using "willpower" alone. It is the model used across England in Specialist Smoking Cessation Services).

Such an approach is simple in concept, but would require significant changes in procedure, documentation, practice and training for all health care staff. Behaviour change on the part of all smokers, be they staff, patients, or visitors will be needed in order for whole hospital sites to become completely Smokefree.

3.3 All patients who are admitted to hospital will be asked predetermined questions about their smoking status and level of addiction. The responses will be recorded within a standard proforma (which all hospitals and staff will use). This information will allow clinicans to determine the level of Nictotine Replacement Medication needed and to presribe immediately. The intention is that no patient who smokes will have to endure Nictotine withdrawal symptoms. Patients would then also be offered support to understand their addiction, why and how to stop smoking. This means that the patient will have been offered and evidence based, effective level of support to help them to stop smoking during their hospital stay.

3.4 When the patient is discharged from hospital, they will be given a clear plan for ongoing community support to help them in their journey to be free from their addiction to smoking. Discharge documentation will detail the medication already prescribed (so that it can be continued if needed) and other relevant clinical information.

3.5 At the present time, the Manchester Population Health and Wellbeing Team is actively working to put new, Specialist Stop Smoking Services in place in Manchester. Starting with North Manchester in November 2017, we hope to roll out services across the city during 2018/2019. This will supplement other support available in the city, but crucially, will offer medication and behavioural support in one setting (as in hospital). We will ensure that Healthcare

Professionals can make direct referrals from secondary care, to the new services.

3.6 Although simple in concept, implementing **CURE** will neccessitate cross cutting system change. For example, all health care professionals must be aware of **CURE** and trained appropriately. All clinicians and prescribers in hospital will be trained to prescribe Nicotine replacement and Varenicline and the medication will be available across all wards. There will be enough staff trained to offer behavioural support around smoking to all patients who want it. Standardised recording systems and documentation must be implemented across all hospitals and subsequently accepted into community settings.

## 4.0 **Potential Benefits.**

4.1 Experience in Ottowa has shown that when the above model was implemented, the number of patients who were re-admitted to hospital within 30 days of discharge was halved. Furthermore, mortality rates amongst the same cohort of patients was halved within one year.

4.2 Data contained with Manchester Health and Care Commissioning's data warehouse provides us with the ability to link data on patients registered with GP practices in Manchester who are recorded as being smokers, ex-smokers or non-smokers with data on these patient's use of secondary care. This allows us to look at how the use of hospital services by patients who currently smoke is different from that of patients who are ex-smokers (i.e. patients who have quit smoking at some point in the past) and lifelong non-smokers and, hence, what the benefits might be from helping smokers accessing secondary care to quit.

4.3 In this way, the data allows us to quantify and apply the benefits of the CURE model (as seen in Ottawa) to the Manchester population. The results of this analysis show that there were:

- 118,967 patients registered with Manchester GP practices who are recorded as being current smokers
- 15,326 non-elective hospital admissions among smokers registered with GP practices in Manchester in the 12 months up to the end of June 2017
- Just over 10,000 individual patients admitted to hospital who are current smokers. This is equivalent to 1.53 admissions per patient compared with 1.43 admissions per year among non-smokers.

4.4 Therefore, based on the Ottowa experience:

- If we reduced the proportion of smokers who were readmitted within 30 days after they were discharged from hospital 13.3% to 7.1%, we would <u>save 600 hospital admissions in 30 days</u>

- If we reduced the proportion of smokers who were readmitted within 1 year after they were discharged from 38.4% to 26.7 % we would save 1,171 hospital admissions at 1 year

- If we reduced the proportion of smokers who died within a year of their being discharge from hospital from 11.4% to 5.5%, we would save 610 lives in 1 year

- 3,503 smokers would have successfully quit smoking

4.5 The cost savings asssociated with the benefits above, would potentially be considerable and would, it appears, offset the costs of implementation and the ongoing programme. If successful the programme would reach thousands of the most poorly smokers in Manchester every year ensuring that they receive a tried and tested model of specialist stop smoking support, but in a much more targetted and systematic way.

## 5. Conclusion & Recommendations

5.1 We believe that the **CURE** Programme could be a flagship for Tobacco Control in Manchester and beyond. The intention is to start the programme at the Wythenshawe site and roll it out as part of the MFT arrangements. There are also discussions underway with colleagues at North Manchester General Hospital to ensure that patients admitted there also benefit.

5.2 Finally, the Tobacco Free Manchester Plan, based on the GMPOWER model will be presented to the Board in March 2018.

5.3 The Board are asked to:

i) Endorse the programme
ii) Monitor and support the implementation of the programme in Manchester

## Appendix 1

SMOKING

- Prevalence of smokers in Manchester continues to fall but at slightly slower rate than England from 2015 to 2016.
- Manchester has higher proportion of adults who have never smoked, but a lower proportion who are ex-smokers
- Manchester's smoking related mortality higher than England's