Camden and Islington NHS
NHS Foundation Trust

Assertive Smoking Cessation Outreach Team (ASCOT):

Year one report 2014

Camden and Islington NHS Foundation Trust

If you would like any further information on ASCOT or wish to discuss specific aspects of this report, please contact the Team Manager sandra.chakara@candi.nhs.uk or Service Manager simon.bristow@candi.nhs.uk

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Background to the service

ASCOT is a specialist smoking cessation service for people with psychotic disorders and bipolar disorder. It has been commissioned by Public Health Camden with funding provided by Camden Clinical Commissioning Group (CCG) as a pilot to run from 2013-2015, with the possibility of continued funding dependent on the delivery of agreed outcomes. The service was launched on 13/03/2013 to coincide with National No Smoking Day.

Smoking is the biggest cause of preventable death in the world (WHO, 2013), and 50% of all lifetime smokers die of a smoking related disease (Doll et al., 2004). Smoking kills roughly people 100,000 every year in the UK, and the cost to the NHS of treating smoking related diseases is between £2.7 billion (Callum et al., 2011) and £5.7 billion (Allender et al., 2009) each year.

The association between mental illness and smoking is complex and longstanding. Smoking is associated with the first-onset of mental illness (Cuijpers et al., 2007), and cigarettes have long acted as a form of 'economic, social and political currency' (Lawn, 2004) in mental health treatment facilities. The prevalence of smoking in people with mental health problems is estimated at between 40% and 80%, compared with 19.5% in the general population (Ruther et al., 2014). People with mental health problems consume 40% of cigarettes smoked in the UK each year, smoke more heavily than smokers in the general population (Page et al., 2001), and score higher in tools used to measure the levels of nicotine dependence (ONS, 2009).

There is a decreasing trend in the smoking prevalence of the general population in the UK, however despite evidence suggesting comparable motivation to quit for people with mental health problems (Siru et al., 2009) smoking behaviour has changed little in the last 20 years for this group (Royal College of Physicians, 2013).

People with psychotic illnesses are an especially marginalised subpopulation of people with mental health problems, with particularly poor health outcomes and the highest rates of smoking behaviour (Cooper et al., 2012). The death rate from respiratory disease caused by smoking in people with schizophrenia is ten times that of the general population (Joukamaa et al., 2001), and people with psychotic illnesses die up to 25 years younger than the general population (Lawn, 2012). Smoking is the largest contributing factor in this premature mortality (Royal College of Physicians, 2013) (Ruther et al., 2014).

In recognition of this unacceptable disparity in health outcomes, ASCOT has been developed as a pilot project by Camden & Islington NHS foundation Trust to deliver smoking cessation interventions to this population using an assertive outreach approach. ASCOT deliver both smoking cessation interventions and harm-minimisation through support for smoking reduction for service users across the care pathway, in accordance with NICE Guidelines (NICE, 2013b) (NICE, 2013c).

Are smoking cessation Interventions cost-effective?

Smoking increases the rate at which some medications commonly used to treat psychotic disorders are metabolised in the body, which leads to higher doses being required to treat symptoms, and increases the cost of treatment to the NHS by up to £40 million per year (Royal College of Physicians, 2013). Smoking cessation interventions are highly cost effective treatments, delivering large benefits in both quantity and quality of life gains for limited financial expenditure (Cornuz 2006).

The cost effectiveness of pharmacological smoking cessation interventions is also not significantly affected by the duration of treatment. The National Institute of Clinical Excellence (NICE, 2013a) determines which treatments should be available to NHS patients using an algorithm to calculate how much it would cost for a treatment to deliver one additional year of good health on a patient's life. This year is referred to as a Quality Adjusted Life Year (QALY), and the threshold NICE uses for determining if a treatment is cost-effective is £30,000 per QALY.

The harm reductions achieved through delivering lifelong substitution of medicinal nicotine is highly cost-effective when compared with continuing smoking, at around £8,000 per QALY gained for lifetime nicotine patch use and £3,600 per QALY for nicotine inhalators. (Royal College of Physicians, 2013)

As such, proactively addressing the high prevalence of smoking in people with mental disorders offers the potential to realise substantial cost savings to the NHS, as well as benefits in quantity and quality of life (Royal College of Physicians, 2013).

Service aims

The aim of the service is to reduce the morbidity and mortality rates for all tobacco users with a diagnosis of psychosis or bipolar affective disorder across the Borough of Camden, through the delivery of a smoking cessation/reduction service to individuals across both primary and secondary care settings.

We aim to provide an easily accessible and flexible service, delivering evidence-based interventions to support service users to quit smoking, or engage in a harm reduction plan by significantly reducing their tobacco consumption.

We will review to what extend we have achieved these objectives in this report, particularly in reporting on our ‘quit and reduction rates’, ‘how we engage with service users’, and ‘achievements to date’.

Team structure

All members of the team have extensive experience of working within Mental Health settings and promoting clients physical wellbeing.

- Consultant psychiatrist - Clinical lead
- 1 x Band 7 Team Manager - 0.5 WTE
- 2 x Band 6 Nurse Specialists- 1.0 WTE
- 1 x Band 6 Clinical Researcher – 0.5 WTE
- 1 x Band 4 Assistant Clinical Practitioner – 0.6 WTE

Reporting structure

The service has quarterly contract monitoring meetings attended by the Camden Clinical Commissioning Group, Camden and Islington NHS Foundation Trust (C&I), and Camden & Islington Public Health. We have also developed well established links with local, regional and national smoking forums, steering groups, charities and service user groups.

The programme we offer

The ASCOT model acknowledges the cognitive difficulties, high level of social exclusion, social incentivisation to smoke, and high levels of nicotine dependence often experienced by people with psychotic illnesses (Ashton

et al., 2010) and works with service users for a 6 month period, seeing people up to once a week. This allows time to engage in therapeutic work with service users to build the self-esteem and resilience required to make a quit attempt, or reduction in smoking, and sustain their identity as a non-smoker.

The programme offered is an adaptation of the 12-week treatment programme offered in mainstream smoking cessation services, commonly referred to as 'Level 2' intervention. The standard Level 2 programme has been shown through national service evaluations to be an effective delivery model for the general population (West et al., 2013). The ASCOT programme mirrors the 'Level 2' programme in that it involves setting a quit date, providing pharmacological support, providing support sessions throughout the quit attempt, and validating the quit through monitoring carbon monoxide (CO) levels in the lungs. To ensure parity with other smoking cessation services, the reporting and recording protocols have been developed in accordance with the Russell Standard (West et al., 2005), as adopted by the Department of Health.

During initial contact with a service user the team assesses smoking behaviour, motivation to change, and level of nicotine dependence. This enables the formation of a collaborative care plan, reflecting the service user's goals, identifying potential barriers to change, and seeking to elicit service user lead solutions to any obstacles. Appropriate pharmacological support through combination long and short acting nicotine replacement therapy (NRT), or varenicline are also identified and provided during this contact, in accordance with prescribing (NICE, 2013b) guidelines. CO monitoring is used throughout the quit/reduction attempt for validation of the quit and to provide feedback to service users on their progress.

When supporting service users in their quit/reduction attempts advisors use a range of interventions tailored according to individual service user needs, as identified during the assessment process. These include cognitive behavioural therapy (CBT), psychosocial interventions, systemic therapy based approaches and motivational Interviewing techniques. ASCOT also provides group therapy focused on smoking cessation, often referred to as 'Level 3' intervention.

Smoking cessation has an equally positive impact on the mental health of people with pre-existing mental health problems, as those without (Taylor et al., 2014). However, the process of nicotine withdrawal can cause temporary low mood and increased anxiety in any person undertaking a quit attempt.

To ensure that nicotine withdrawal is being adequately managed in our service users we use the Patient Health Questionnaire (PHQ9) to monitor mood and Generalised Anxiety Disorder Assessment (GAD7) to monitor anxiety throughout the quit attempt/reduction. These validated tools allow us to monitor and respond to any potential changes to a service user's mental state.

Smoking affects the metabolism of some common psychiatric medications such as clozapine, which we monitor blood plasma levels and modify doses for in accordance with Maudsley Prescribing Guidelines (2012). As an additional safeguard against increased side effects from other psychiatric medications which cannot be monitored through blood plasma levels, we use The Glasgow Antipsychotic Side Effect Scale (GASS) to monitor for any increase in side effects. We respond to changes in side effect profile by supporting the review of the service users treatment plan. We also routinely monitor all other medications used in the management of physical health conditions which may be affected by smoking.

The service has a research nurse embedded in the team who is conducting a comprehensive evaluation of the clinical outcomes, satisfaction with treatment, and the quality of life of service users. Research interviews are conducted face-to-face at the start of treatment and then by telephone within two weeks of discharge. The interviews comprise a battery of questions developed specifically for the study by the deputy director of research for the Trust, in collaboration with the clinical team and the service commissioners. In addition to these developed questions the interviews incorporate the following validated assessment tools.

- Manchester Short Assessment of Quality of Life (MANSA)
- EuroQoL-5D (EQ-5D)
- Client Satisfaction Questionnaire (CSQ-8)

How we take referrals and where we hold clinics

ASCOT is hosted within the Rehabilitation and Recovery division within the Trust and has an open and accessible referral system. We are proactively offering our service to people identified as smokers on the severe mental illness (SMI) registers in our local GP surgeries, and we promote access to the service at all Trust wellbeing events. Referrals of service users who meet the ASCOT service criteria that are made to local mainstream smoking cessation services are filtered directly to the team, and the team

accepts direct referrals from service users and health care professionals via the widely advertised team email and telephone numbers.

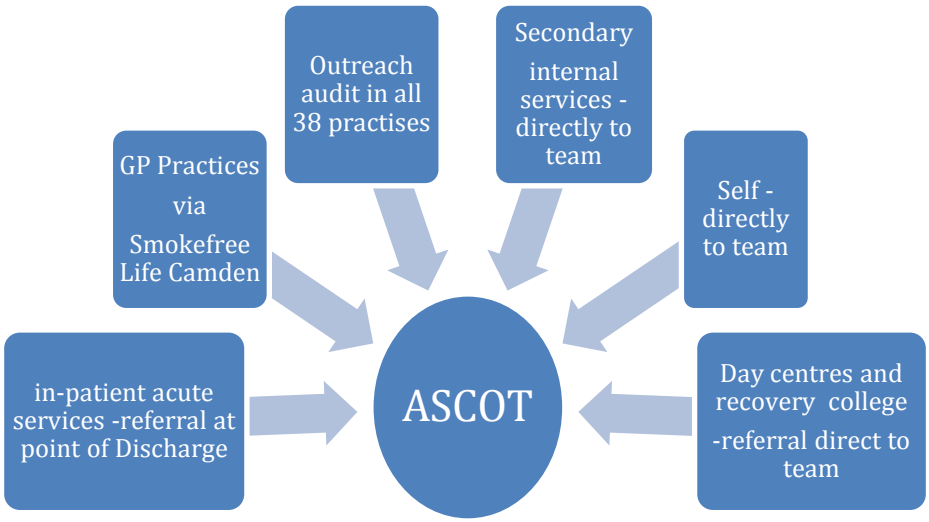

Figure 1 Referral routes

In recognition of the need for service flexibility to successfully traverse the diverse challenges faced by people with psychotic disorders in accessing services, we offer appointments at a number of Trust sites, as well as seeing clients in their homes and at community venues, according to service user preference.

1. Jules Thorne Day Centre
2. Highgate Day Centre
3. Barnes House in Camden
4. James Wigg Practice
5. The Hoo
6. Peckwater Centre

Referrals received

373 service users were offered the service, and 108 (29%) declined the service offer. 69 people (18%) did not meet the service criteria as either did not have a psychotic disorder or were not Camden residents. The remaining 196 people agreed to engage with the service at the point of referral.

When approached by ASCOT, 140 of the 196 people (71%) contacted agreed to an initial appointment, and 113 of this 140 (81%) successfully engaged with the service.

Service users who are referred but do not meet the service criteria are offered the opportunity to be referred to mainstream smoking cessation services. There has been a reduction in the number of referrals not meeting the service criteria throughout the year as services have developed a better understanding of the eligibility for ASCOT services.

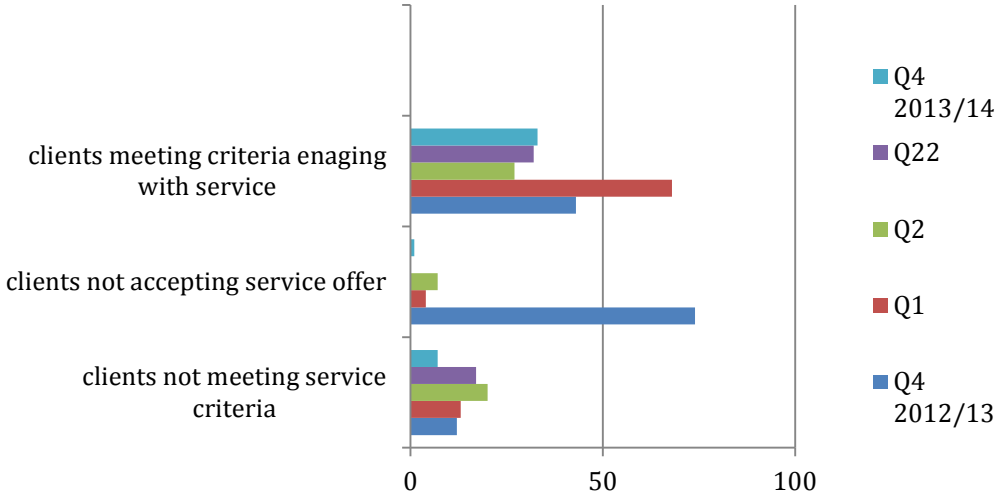

Figure 2 Referrals received per quarter

Demographics of the referrals received

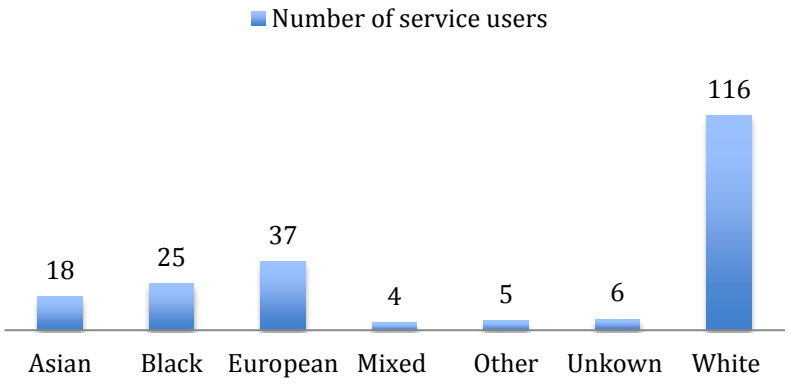

Figure 3 Referrals by ethnicity

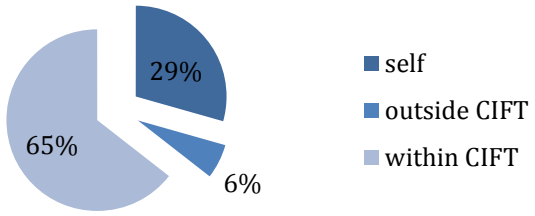

Figure 4 Referrals by source

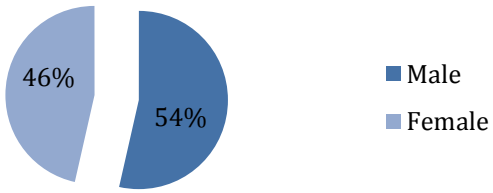

Figure 5 Referrals by gender

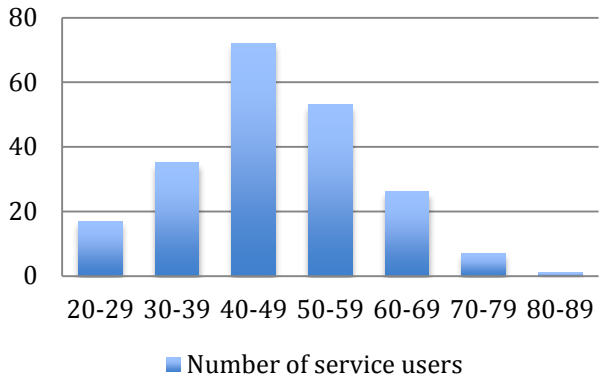

Figure 6 Referrals by age group

During the first year we have had referrals for people with a range of ethnicities and age groups as illustrated in the diagrams above. We have had more referrals for men than for women, which likely reflects a higher smoking prevalence in men in this population. To further improve accessibility we are in the process of translating our leaflets into languages other than English.

Our outreach plans for primary care

Our intention is to offer 90% of smokers identified on the SMI registers in all GPs in Camden to offer our service. Of the 3171 clients on the Camden SMI register, 50% (1427) are recorded as smokers. Of the 3171 in total, 1999 (63%) are treated in both primary and secondary care settings and are being identified and contacted through Trust services. The remaining 1172 (37%) are seen solely in primary care and can only be accessed through audit of the GP SMI registers.

To date 13 of 38 (34%) practices have been audited, accounting for 1283 of 3171 (40%) of people identified on the SMI registers. Of those audited, 44% have been found to be smokers. An average of 21.5% of primary care records on smoking status have been found to be out of date. This corresponds with the Public Health Survey of service users on the GP SMI register in Camden carried out in 2013. The majority of these out dated records were for service users who had been identified as non-smokers or had never smoked.

The audit process entails searching the Quality Outcome Framework (QOF) SMI register on the electronic patient records (EPR) system used by Camden GPs, for details of all service users identified as smokers. ASCOT practitioners then examine this cohort list, identify those whose status is out of date and inform the practice, and contact all eligible service users to offer our service. This is outlined in a proforma that was agreed by the Local Medical Council (LMC) at the start of the service.

This is currently a labour intensive process for the ASCOT team, so to expedite this a search has been added to the GPs EPR system. This provides the option for practices to run the search prior to the team attending the practice.

The most efficient methodology would be for practices to run the search automatically and send the results to the ASCOT team electronically, however this requires agreement at practice level, which will be discussed at the July 2014 contract review meeting. The audits for all 38 practices will be completed by the end of the 2014/15

Within the last year we have had contact with at least one client from each of the GP practices across Camden. We have been working to increase the level of activity for service users in primary care through the development of GP based clinics to increase our capacity to see service users. The first ASCOT clinic based in a GP practice will commence on

25/04/2014 at the James Wigg Practice, with a plan to replicate this in GP practices across the borough in 2014/2015.

How well do we engage with service users?

Research has suggested that appointment non-attendance rates vary amongst people with mental health problems between 10% and 60%, and that generally a third of appointments are missed (Lefforge et al., 2007). In a study of community based appointment attendance rates in Camden (Killaspy et al., 2000) found that 40% of appointments were missed, and individuals with psychotic disorders and bipolar disorder were at greatest risk of non-attendance. Comorbid substance dependence is frequently noted as an additional predictor of lower attendance rates, and predicts up up to treble the drop-out rate for services compared to those without comorbid dependence (Mitchell and Selmes, 2007).

Through using an assertive outreach approach ASCOT has managed to achieve an average appointment attendance rate of 81% in 2013-2014, while delivering an intensive programme of substance dependence interventions to a population with a high rate of disengagement with treatment.

Service users are offered at least three opportunities to engage with the service, and if service users elect not to engage they are re-offered the service after 6 months. Service users are discharged in the event of non-attendance at three consecutive appointments, with an open door policy giving individuals the option to re-refer when they feel ready. We believe we have observed a trend for service users who decline to work with the service at the point of offer to agree to a follow up at a later date, or to re-approach the service as a self-referral after a period of time. The number of clients with this pattern of engagement will be indicated in the final service evaluation

Service users also have the option to take a break from treatment for an agreed time frame, for example in instances where they may be heading towards highly stressful situations or need to go into hospital for a period of time. Breaks from treatment have been taken up by less than 10% of our service user group.

Treatment outcomes for service users who have been discharged from the service have been highly positive with 55 (67%) service users out of 82 successfully completing their treatment. The remaining 27 (33%) have

been service users who have either disengaged or died as shown in Figure 7.

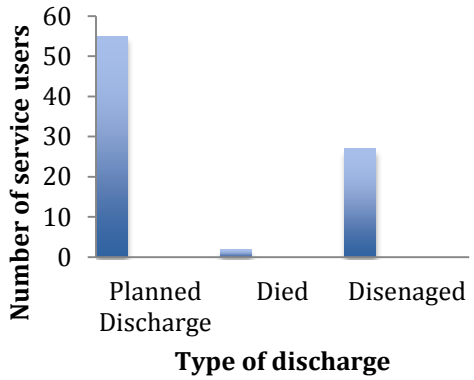

Figure 7 Disengagement from the service in year one

ASCOT is currently carrying out an audit to profile and better understand the themes for service users who disengage from treatment. Findings from this will be reported in the final service evaluation.

Our quit and reduction rates

Quit rates at 4 weeks for mainstream smoking cessation services using Level 2 and Level 3 interventions are circa 34% (West et al., 2013). There is limited evidence on the efficacy of Level 2 smoking cessation interventions in mental health specific settings, though a recent study of smoking cessation interventions delivered by mental health professionals in community based secondary care teams found quit rates to be 15% (Parker et al., 2012).

113 service users have engaged with our service to date, 65 of these service users have either stopped smoking or reduced their smoking by at least 50% as evidenced by a validated carbon monoxide meter reading. This means 58% of service users have reached the thresholds set to measure our clinical objectives. (See Figure 8 on page 15)

Of these 65, 18 service users have stopped completely, resulting in a 4 week quit rate of 16% for year one, which is comparable to research conducted on a similar model (Parker et al., 2012). The remaining 47 service users (42%) have reduced their smoking by at least 50% and are either still receiving treatment or have been discharged from the service. This is significantly higher than the 26% of service users who achieved a 50% reduction in smoking in the Parker et al. (2012) study. Complete

smoking cessation often requires multiple quit attempts, and we believe the achievement of 50% reduction rates to be an important predictor of future quit behavior. This is supported in the evidence base on predicting quits, which suggests that self-efficacy (Smit et al., 2014) reduction (Broms et al., 2008) and previous quit attempts (Vangeli et al., 2011) are all predictors of future quit attempts.

Our total cost per quit for 2013-2014 was £9000. This is higher than mainstream smoking cessation services, however the service is designed to access a population with complex health and engagement problems beyond the reach of mainstream services. Due to the high risk of death by diseases caused by smoking in this population, the cost of the service delivered by ASCOT would be likely to remain well within NICE (2013a) thresholds for cost effective interventions during an economic evaluation.

The service has found that the longest period to achieve a quit has been 188 days (27 weeks) and the shortest 42 days (6 weeks). The average number of days has been 95 (14 weeks) and one quitter did not attend any of their initial three appointments and achieved their smoke-free status by themselves. We believe our average time to quit figure provides initial evidence to support our hypothesis that service users in this population require longer term support than mainstream services are able to provide.

The maintenance of cessation is imperative for service users to be able to realise the health benefits, and only 25% of people who have achieved 4 week quits with mainstream services remain smokefree at 12 month follow up in the general population (Ferguson et al., 2005).

Of the ASCOT clients who quit in the first 6 months of 2013/2014, 69% have remained smoke free after 6 months, and 83% of our initial cohort of quitters from Q1 remain have remained smoke free at 12 months. These initial figures from the quitters who began their quit attempt more than 6 and 12 months ago respectively suggest highly promising maintenance rates for ASCOT service users in comparison with the general population. We believe this is initial evidence is beginning to demonstrate the ability of a specialised service delivering interventions over an extended period to achieve lasting health improvements in this population.

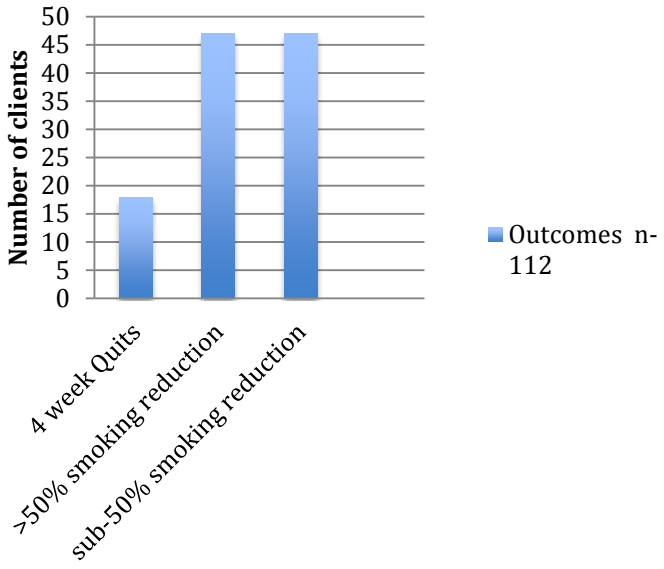

Figure 8 Quit/reduction rates

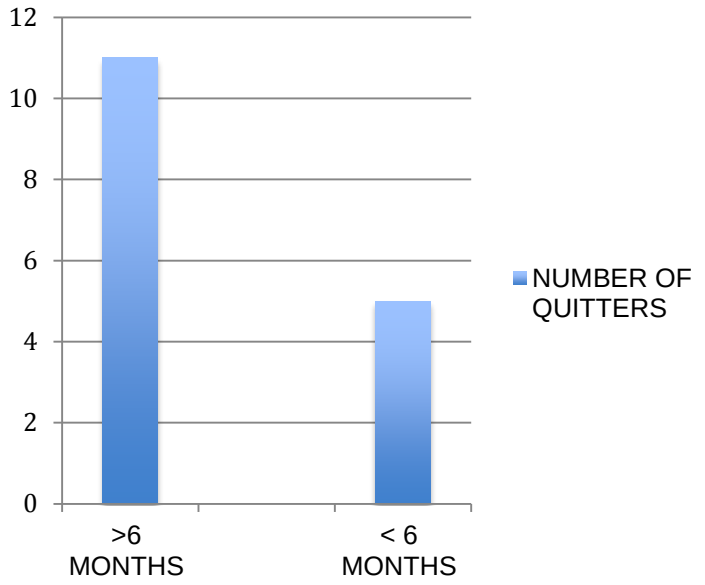

Figure 9 Number of quits maintained by service users eligible for 6 month evaluation

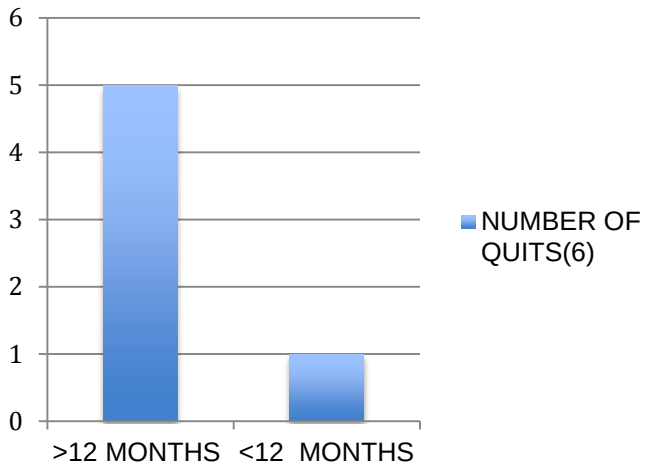

Figure 10 Number of quits maintained for service users eligible for 12 month evaluation

Our quit rates have to date been highest in the 60-69 ages category, despite receiving fewer referrals than in younger age categories. A higher proportion of men than women have successfully quit, this may be related to the higher number of referrals received for men.

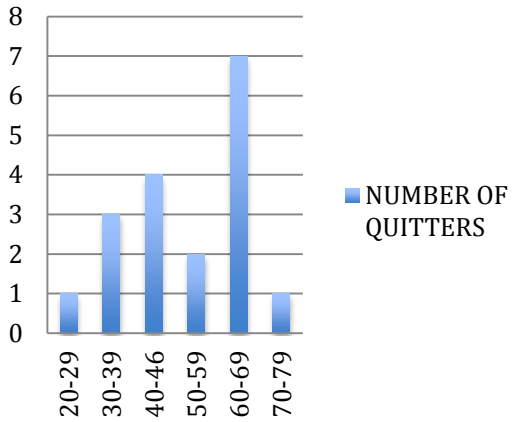

Figure 11 Quits by age group

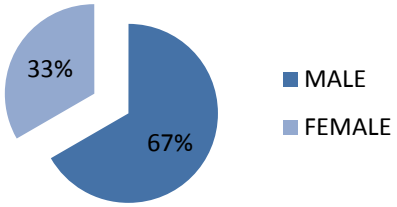

Figure 12 Quits by gender

Our service users experiences

Some of our service users have been able to stop smoking after decades of severe nicotine dependence, with our heaviest successful quitter having smoked 140 cigarettes a day at the point of accessing our service.

The ASCOT model works to support people in making the incremental changes to their self-efficacy and engagement with services which are crucial in realising the dramatic improvements in health outcomes this population are often excluded from.

The first analysis of our service user satisfaction data from the CSQ-8 was received in Q4. This has shown a high level of satisfaction with the service, rating us at 29 out of a possible 32 points, scores of above 25 indicate high satisfaction with a service.

Thanks from one of our successful quitters

Below is an email received by the team from one of our successful quitters:

“I have the honour to know you and graduated with flying colours from your Smoking Cessation assertive course. I was fortunate to be motivated and moved to quit smoking by an excellent expert. I hope the higher authorities will note this to be the best gain to my health and well-being that happened to me for a long time. I was a chain smoker for over 35 years, and attempted many times to quit with no success. Top Nurse, Jenny, must have a magic touch and wicked understanding of my behaviour to facilitate for me to stop my live long smoking habit in a few cessions. Jenny I salute you and God Bless you and goodbye.

I wish all addicts like me to have access to Jennys expertise and skills. Please forward this email to all your line managers."

Case studies

Below are two examples of work we are currently engaged in with service users, which have been pseudonymised to maintain confidentiality.

1. Mr Ahmed

Mr Ahmed is a 65-year old gentleman who suffers with schizophrenia. He has been taking clozapine for around 20 years, and has smoked 30 cigarettes a day for around 50 years. During our routine screening Mr Ahmed advised us he hasn't seen his GP in over 5 years, and his lung functioning indicated symptoms consistent with a possible diagnosis of chronic obstructive pulmonary disease (COPD).

Following feedback from his assessment and screening, Mr Ahmed's motivation to quit smoking increased significantly, and he has begun to engage with us. He has since sustained a reduction in his cigarette consumption to 10 per day for the past 2 weeks.

We are also working with in collaboration with Mr Ahmed to access respiratory services for formal diagnosis and treatment for his respiratory problems. We believe that it is unlikely he would have received this screening, or had access to smoking cessation support without an assertive outreach approach.

2. Mr James

Mr James is a 42-year old gentleman who also suffers from schizophrenia. He has smoked 30 cigarettes per day for the last 25 years. Our work has centred around using CBT to support Mr James to build an understanding of what maintains his smoking routines.

Mr James' level of motivation to quit has increased through this work, and has been reflected in his scoring on our motivational assessment scales. He has set a quit date and has been working to reduce his smoking level in preparation for his quit date.

He has used the knowledge developed during our preparatory work to prevent situations arising which trigger his smoking, such as friction with

family or visiting the pub. He also reports being able to better relate to situations when they arise through using mindfulness techniques as alternative coping strategies in times of stress.

Things we do that aren't reported on

ASCOT has developed and delivered a training package to enable Trust clinicians to support smoking cessation through educating service users to about the relationship between smoking and mental health, the health benefits of stopping, and provide brief advice and signposting for those motivated to quit. This is commonly referred to as 'Level 1' intervention and 36% of staff in the Trust are currently trained at this level.

The service has been presented to all three primary care locality groups in Camden and the referral and information forms have been distributed to all practices.

We aim to share our learning on what has been effective, and the barriers which need to be overcome to maximise the positive outcomes for service users, and hope this can be used to shape future service provision.

We have engaged with partners in health improvement programmes both locally and nationally to share our experiences and knowledge, and to promote our service and seek referrals where appropriate. These have included the London Tobacco Control Network, Public Health England, Smokefree life Camden, Smokefree Alliance of Camden and Islington, Bipolar UK , MIND, Level 2 advisors network Camden, Voluntary Action Camden (mental Health), and Mental Health Wellbeing Centre.

The service has become an essential specialist resource for clinicians in both C&I and other services working with this client group in Camden by delivering training for staff of all disciples in both clinical and residential settings, and providing advice on treatment provision for service users who do not have psychotic disorders.

We have provided training opportunities for qualified clinicians and students. In 2013-2014 we provided short 'spoke' placements for students from both our academic and clinical partner organisations, and in 2014-2015 we will begin to offer full 'hub' placements to pre-registration nursing students. We will also begin to develop training with our partner university for both undergraduate and postgraduate health students, to ensure delivering smoking cessation interventions is integrated into the syllabus for future cohorts.

In addition to the formal monitoring of changes in mood, medication concentrations and side effect profile, we have found that service users often want to use up to 80% of the appointment time discussing their mental health. As we are staffed by experienced mental health professionals we are skilled at working flexibly and collaboratively with service users to identify and manage physical and mental health problems that are commonly experienced by this population of people. We routinely provide mental health support alongside smoking cessation support, taking account of fluctuating levels of symptoms, and seeking to support the development of resilience. We also routinely work alongside families and carers to support the service users informal care network, which is often so vital to our service users.

The challenges we have faced

1. Balancing outreach and throughput

The assertive outreach model seeks to access the most disengaged and disadvantaged people within the targeted service user population, and there is evidence that it gives high levels of service user satisfaction (Killaspy et al., 2006). However, it is time intensive by design as requires clinicians to travel between multiple locations each day to visit service users. We have been successful in obtaining referrals for service users seen by secondary care services, and have successfully worked to increase our capacity to see these service users though the introduction of regular clinics in secondary care settings such as Jules Thorn Recovery Centre, Highgate Day Centre, Barnes House, and St. Mungos residential settings.

We have a performance target of supporting 100 service users to achieve four week quits by the end of 2014/2015, which based on the 16% quit rate achieved in 2013-2014 would necessitate us supporting an additional 513 service users in 2014/2015.

At James Wigg Practice we have negotiated access to run an open clinic based in the surgery for 6 months, to improve our capacity to see patients identified via the SMI register audit. Service users identified as smokers will be contacted via telephone and letter to arrange attendance. We anticipate an increase in contact with service users based only in primary care from the GP audit process, however it would not be possible to conduct one-to-one community based visits for these service users with the current team structure, so success of the GP based clinics for this sub-population of our service users is vital to the effectivenss of this model.

The service specification has been adapted to increase the assistant practitioner availability to the service from 0.2WTE to 0.6WTE, which has provided additional clinical capacity within the team.

2. Working with new partners

Challenges in accessing clinical information from local partners have been identified, as GP surgeries have expressed concerns regarding client confidentiality in relation to the transportation of data sets from GP practices to Trust systems.

Current practice has been to complete an audit in each practice individually and undertake a new search each time. We have worked with partners in to develop a standardised search which has been set up on the GPs EPR system and this can be accessed by all GP practices.

To fully resolve the access issue and make the best use of ASCOT resources, we aim to seek an agreement with practices to remotely generate the required data sets and share them via secure e-mail. This will be further discussed in the next contract-monitoring meeting with commissioning partners.

3. Prescribing arrangements

In secondary care advisors are currently required to access a Trust medical colleague to sign prescriptions, then subsequently obtain the medication from the Trust pharmacy. We are currently in the process of developing a patient group directive (PGD) which will allow nursing clinicians to prescribe nicotine replacement therapies under specific clinical conditions, which will make this process more resource effective.

In primary care, prescribing arrangements need to be agreed with each GP practice individually, which forms part of the negotiations during the process of planning the clinic. In the James Wigg Practice, prescriptions will be signed by the duty doctor and service users will then collect them from the practice and take them to their local pharmacy.

4. Collecting data in an innovative service

Delivering a new service through a different model to mainstream smoking cessation services has led to challenges in the development of reporting and recording arrangements. Referrals, contacts and quits must be captured in a way that satisfies both the reporting arrangements in place

for smoking cessation services to the Department of Health (DH), and the mechanisms for recording and reporting clinical information within the Trust. The development of data capture and reporting systems has been an ongoing project throughout the first year. Our system is now set that all clinical contact is recorded using a specially developed care plan library built into the Trust EPR, and successful quits are reported to DH via Camden Smokefree Life, the mainstream smoking cessation service.

5. Knowing how we are doing

Some service users have struggled to understand some of the rating scale aspects of the quality of life measures over the phone, largely due to cognitive difficulties caused by their illness. Some have also experienced questions on the validated mood assessment scales relating to the presence or absence of sexual drive as intrusive questions to be asked during a phone conversation received from an anonymous number.

The clinical team has attempted to assist the researcher in engaging with service users at their initial interview and post-discharge interviews through coordinating appointments with researcher availability, and providing additional explanation to service users regarding the process of evaluation.

However, as a result the evaluation has been more time consuming than originally anticipated, which given the anticipated increase in throughput poses a risk to engagement and subsequently to data quality for 2014-2015. To conduct face-to-face interviews would likely be a more acceptable methodology to service users, and would enable visual representations of the rating scales to be used which would aid understanding, however this would require further investment.

In a further attempt to ensure an adequate level of engagement throughout 2014-2015 service users will begin receiving financial incentives to encourage participation in the study, pending ethics approval.

6. Covering sickness and absences

The small size of the service gives limited capacity to absorb the impact of any absences from posts. Periods of unforeseen absence from posts have required increased clinical activity from other members of the team, in the majority of cases the team manager has needed to absorb clinical work to ensure that service users continue to receive a high quality service.

This has however impacted on management and administration time, which has led to delays in responding to local partners to promote, develop and establish the service. The team now has a full staffing compliment.

Conclusion

What we have achieved

We have supported a significant percentage of the service users we have worked with to make significant changes to their self-management of exposure to the biggest cause of premature morbidity and mortality in the population, with 58% of our service users achieving clinically significant outcomes.

The service has made a significant impact in the personal-recovery of service users through working collaboratively with service users to achieve self-directed goals. This is difficult to quantify in numerical analysis, however we believe the narrative of this service is crucial to demonstrate its value, and will be evidenced in the final evaluation.

We have achieved a quit rate comparable with an evaluation of a similar service, and have a 52-week maintenance rate that we predict will significantly exceed mainstream services.

We have achieved a higher rate of >50% reduction in smoking in comparison to previous studies within our service user group which achieved 26% (Parker et al., 2012) compared to our 42%.

Initial figures from the quitters who began their quit attempt more than 6 and 12 months ago respectively suggest highly promising maintenance rates for ASCOT service users. 69% of our quitters have remained smoke free after 6 months, and 83% of our initial cohort of quitters from Q1 remain have remained smoke free at 12 months, compared with 25% at 12 months in mainstream services.

We have delivered a service which has proved highly acceptable to service users, as evidenced by our appointment attendance rates and CSQ-8 scores.

What we intend to do

We will work with partners to reduce the administrative burden on the team of auditing the SMI register.

We will work with partners to expand the ASCOT clinics based in GP practices to increase our capacity to see an increased number of service users treated solely in primary care.

We will continue to review the processes, reporting and recording arrangements, and administrative functions of the team to maximise data quality and the clinical resources available to service users.

We will work towards supporting 100 service users to quit smoking by Q4 2014, and to support at least an additional 100 service users to reduce their smoking by 50% with a validated CO reading.

We will develop the service webpage to include useful resources to be accessed by both health care practitioners and service users.

Further training provision for both clinicians and service users to support the Trust implementation of the revised NICE guidelines in secondary care.

We will increase service user involvement through the provision of bi-annual updates to service user forums, and contribution to publications aimed at service users.

We will continue to develop health awareness posters for staff and service users for both Trust and primary care sites

We will seek to publish articles on the development and delivery of ASCOT services to date in journals and present the service at this the Network for Psychiatric Research Conference 2014.

We will seek inclusion of the ASCOT service on the ‘Map of Medicines’ primary care referral pathways for Camden to seek to increase GP referrals.

References

2012. *The Maudsley Prescribing Guidelines in Psychiatry,* London, Wiley-Blackwell.

Allender, S., Balakrishnan, R., Scarborough, P., Webster, P. & Rayner, M. 2009. The Burden of Smoking-Related Ill Health in the Uk. *Tob Control,* 18**,** 262-7.

Ashton, M., Lawn, S. & Hosking, J. R. 2010. Mental Health Workers' Views on Addressing Tobacco Use. *Aust N Z J Psychiatry,* 44**,** 846-51.

Broms, U., Korhonen, T. & Kaprio, J. 2008. Smoking Reduction Predicts Cessation: Longitudinal Evidence from the Finnish Adult Twin Cohort. *Nicotine Tob Res,* 10**,** 423-7.

Callum, C., Boyle, S. & Sandford, A. 2011. Estimating the Cost of Smoking to the Nhs in England and the Impact of Declining Prevalence. *Health Econ Policy Law,* 6**,** 489-508.

Cooper, J., Mancuso, S. G., Borland, R., Slade, T., Galletly, C. & Castle, D. 2012. Tobacco Smoking among People Living with a Psychotic Illness: The Second Australian Survey of Psychosis. *Aust N Z J Psychiatry,* 46**,** 851-63.

Cuijpers, P., Smit, F., ten Have, M. & de Graaf, R. 2007. Smoking Is Associated with First-Ever Incidence of Mental Disorders: A Prospective Population-Based Study. *Addiction,* 102**,** 1303-9.

Doll, R., Peto, R., Boreham, J. & Sutherland, I. 2004. Mortality in Relation to Smoking: 50 Years' Observations on Male British Doctors. *BMJ,* 328**,** 1519.

Ferguson, J., Bauld, L., Chesterman, J. & Judge, K. 2005. The English Smoking Treatment Services: One-Year Outcomes. *Addiction,* 100 Suppl 2**,** 59-69.

Joukamaa, M., Heliovaara, M., Knekt, P., Aromaa, A., Raitasalo, R. & Lehtinen, V. 2001. Mental Disorders and Cause-Specific Mortality. *Br J Psychiatry,* 179**,** 498-502.

Killaspy, H., Banerjee, S., King, M. & Lloyd, M. 2000. Prospective Controlled Study of Psychiatric out-Patient Non-Attendance. Characteristics and Outcome. *Br J Psychiatry,* 176**,** 160-5.

Killaspy, H., Bebbington, P., Blizard, R., Johnson, S., Nolan, F., Pilling, S. & King, M. 2006. The React Study: Randomised Evaluation of Assertive Community Treatment in North London. *BMJ,* 332**,** 815-820.

Lawn, S. 2012. In It Together: Physical Health and Well-Being for People with Mental Illness. *Australian and New Zealand Journal of Psychiatry,* 46**,** 14-17.

Lawn, S. J. 2004. Systemic Barriers to Quitting Smoking among Institutionalised Public Mental Health Service Populations: A Comparison of Two Australian Sites. *International Journal of Social Psychiatry,* 50**,** 204-215.

Lefforge, N. L., Donohue, B. & Strada, M. J. 2007. Improving Session Attendance in Mental Health and Substance Abuse Settings: A Review of Controlled Studies. *Behavior Therapy,* 38**,** 1-22.

Mitchell, A. J. & Selmes, T. 2007. Why Don't Patients Attend Their Appointments? Maintaining Engagement with Psychiatric Services. *Advances in Psychiatric Treatment,* 13**,** 423-434.

NICE 2013a. Guide to the Methods of Technology Appraisal 2013. London.

NICE 2013b. Smoking Cessation - Acute, Maternity and Mental Health Services.

NICE 2013c. Tobacco: Harm-Reduction Approaches to Smoking (Ph45). *In:* EXCELLENCE, N. I. O. C. (ed.). London.

ONS 2009. Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey. NHS Information Centre.

Page, A., Hooke, G. & Rutherford, E. 2001. Measuring Mental Health Outcomes in a Private Psychiatric Clinic: Health of the Nation Outcome Scales and Medical Outcomes Short Form Sf-36. *Australian and New Zealand Journal Psychiatry,* 35**,** 377 - 381.

Parker, C., McNeill, A. & Ratschen, E. 2012. Tailored Tobacco Dependence Support for Mental Health Patients: A Model for Inpatient and Community Services. *Addiction,* 107 Suppl 2**,** 18-25.

Physicians, R. C. o. 2013. Smoking and Mental Health (Cr178): A Joint Report by the Royal College of Physicians and the Royal College of Psychiatrists.

Ruther, T., Bobes, J., De Hert, M., Svensson, T. H., Mann, K., Batra, A., Gorwood, P. & Moller, H. J. 2014. Epa Guidance on Tobacco Dependence and Strategies for Smoking Cessation in People with Mental Illness. *Eur Psychiatry,* 29**,** 65-82.

Siru, R., Hulse, G. K. & Tait, R. J. 2009. Assessing Motivation to Quit Smoking in People with Mental Illness: A Review. *Addiction,* 104**,** 719-733.

Smit, E. S., Hoving, C., Schelleman-Offermans, K., West, R. & de Vries, H. 2014. Predictors of Successful and Unsuccessful Quit Attempts among Smokers Motivated to Quit. *Addictive Behaviors,* 39**,** 1318-1324.

Taylor, G., McNeill, A., Girling, A., Farley, A., Lindson-Hawley, N. & Aveyard, P. 2014. Change in Mental Health after Smoking Cessation: Systematic Review and Meta-Analysis. *Bmj,* 348**,** g1151.

Vangeli, E., Stapleton, J., Smit, E. S., Borland, R. & West, R. 2011. Predictors of Attempts to Stop Smoking and Their Success in Adult General Population Samples: A Systematic Review. *Addiction,* 106**,** 2110-2121.

West, R., Hajek, P., Stead, L. & Stapleton, J. 2005. Outcome Criteria in Smoking Cessation Trials: Proposal for a Common Standard. *Addiction,* 100**,** 299-303.

West, R., May, S., West, M., Croghan, E. & McEwen, A. 2013. Performance of English Stop Smoking Services in First 10 Years: Analysis of Service Monitoring Data. *Bmj,* 347**,** f4921.

WHO 2013. Who Report on the Global Tobacco Epidemic. *In:* ORGANISATION, W. H. (ed.). Geneva.