South East Clinical Senate

Kent, Surrey and Sussex

South East Clinical senate

Helping Patients and Staff to Stop Smoking: The Essential Role of Acute Hospitals

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Report endorsed by Public Health England

Public Health England

Preface

Although smoking prevalence in England continues to decline, smoking remains the biggest killer and biggest single cause of health inequalities. The evidence for the adverse impact of smoking on health is long established and there is a well-publicised, robust evidence base for the cost effectiveness of interventions to support people to stop smoking.

Our work aimed to describe the state of play of stop smoking services in acute trusts within the South East. Although focussed on acute trusts our work identified the need for a system wide approach to the leadership and delivery of the smoke free agenda in local areas through Sustainability and Transformation Partnerships and integrated care systems. Contacts within acute trusts are just one of many opportunities to provide an effective stop smoking intervention and a co-ordinated approach across the system is needed.

Compared to many of the challenges dealt with by the NHS, effective action on smoking is relatively simple and cheap but it does require a cultural change in recognising smoking as an addiction rather than a lifestyle choice and treatment as the business of all clinicians.

Our review has identified many opportunities to ensure that a systematic approach to smoking is taken and we make practical recommendations to address these. The opportunities for improving the health of the population and reducing demand on the NHS are enormous and must surely be irresistible to system leaders and clinicians alike.

We would like to thank members of the Clinical Senate Working Group for contributing to this review and in particular Emma King, Public Health Specialty Registrar, for leading its drafting.

Dr Alison Barnett

Working Group Chair

Centre Director, Public Health England South East

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1. Background, and context for this report

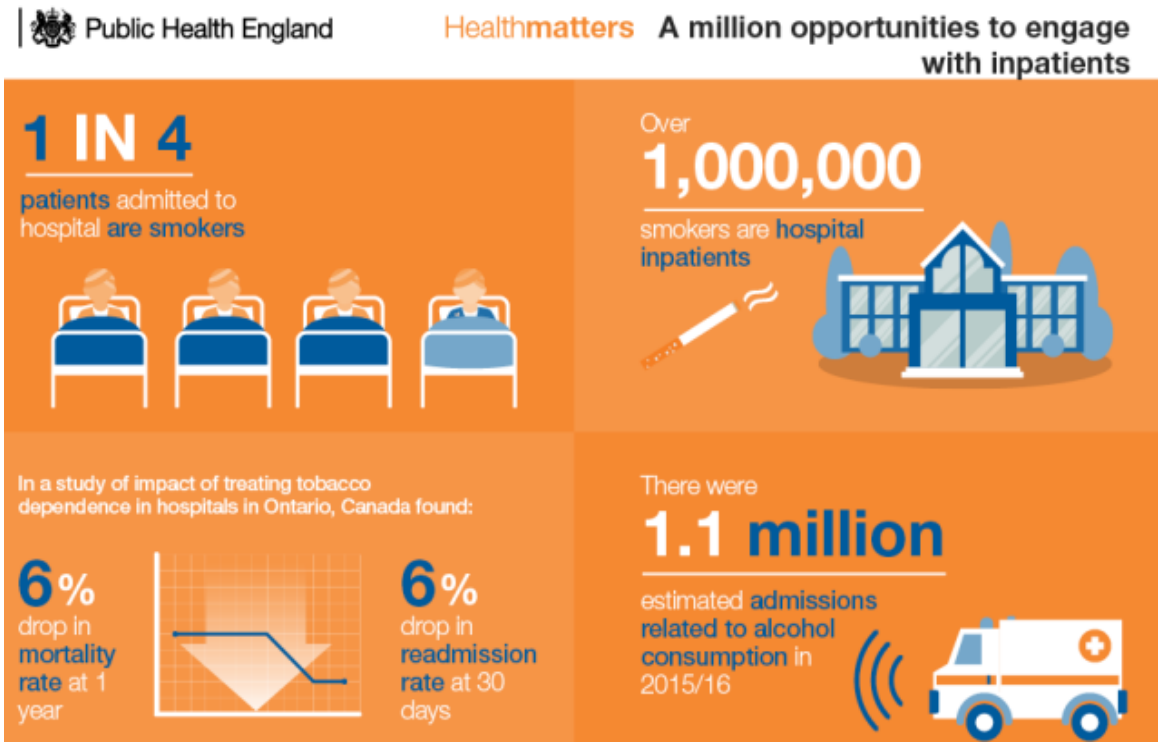
'As doctors we must … recognise that treating tobacco dependence, effectively and routinely, is our business. Smoking cessation should be incorporated, as a priority, as a systematic and opt-out component of all NHS services, and delivered in smoke-free settings. It is unethical to do otherwise.'

Professor Jane Dacre, President, Royal College of Physicians (RCP)[1]

Tobacco smoking remains the single greatest cause of preventable illness and premature death in England and costs the NHS an estimated £2bn a year[2]. The evidence base on the associations between smoking and individual disease is overwhelming: the recent RCP report 'Hiding in Plain Sight: Treating Tobacco Dependency in the NHS'[1] details the increase in relative risk from smoking for over 100 diseases, including 22 types of cancer, cardiovascular disease, mental health and complications of surgery.

Smoking is also the largest single cause of inequalities in health and accounts for around half of the difference in life expectancy between the lowest and highest income groups[3]. Smoking causes almost 80,000 premature deaths a year and contributes to 1.7m hospital admissions. The costs to society are enormous, with evidence suggesting that the adverse effects of smoking could cost £13.8bn each year[3].

Figure 1: Infographic from 'Health Matters', Public Health England (PHE) (2017)[4]



(NB: Reductions are absolute risk reductions.)

One in four in patients admitted to hospital are smokers, approximately 1,000,000 smokers are hospital inpatients[4]. For people using secondary care services, advantages of stopping smoking include fewer complications, higher survival rates, better wound healing, decreased infections, fewer re-admissions after surgery and potentially shorter hospital stays[3]. The 'Ottawa Model'[4] has shown just how effective hospital-initiated smoking cessation advice can be when offered to every person admitted to hospital regardless of what they are in for.

Using this model, those who received smoking cessation interventions compared to usual care were:

Using this model, those who received smoking cessation interventions compared to usual care were:

- More likely to have given up smoking after 6 months (35% versus 20%).
- 46% less likely to be readmitted to hospital for any cause after 30 days (13% vs 7%).
- 22% less likely to visit accident and emergency (A&E) after 30 days (21% vs 16%).
- Were 26% less likely to be hospitalised over 2 years (45% vs 33%).
- Had a 48% reduction in mortality over 2 years (15% vs 8%).

Secondary care providers have a duty of care to protect the health of and promote healthy behaviour among people who use, or work in, their services. This duty of care includes providing them with effective support to stop smoking or to abstain from smoking while using or working in secondary care services[3].

The Five Year Forward View[5] described how the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Subsequently the Sustainability and Transformation Plans produced within Kent, Surrey and Sussex have identified prevention as a key priority. The plans included tackling smoking and delivery through programmes including Making Every Contact Count (see footnote[1]).

The Tobacco Control Plan for England[6], launched in 2017, calls on the NHS to lead by example in creating smoke free environments that help smokers using, visiting or working in the NHS to quit.

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[1] E.g. An Implementation Guide and Toolkit for Making Every Contact Count. NHS Midlands and East. https://www.england.nhs.uk/wp-content/uploads/2014/06/mecc-guid-booklet.pdf

The NHS CQUINs 2017-19[7] provide a further incentive to take action on prevention, particularly CQUIN 9 Preventing ill health by risky behaviours – alcohol and tobacco. This aims to support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.

The Regional Medical Director (South) of NHS England also wrote to Winter Planning leads in 2017/18 to encourage improving stop smoking interventions in acute trusts and emphasised the impact this has on reducing readmissions. There is a good evidence base for interventions to support people to stop smoking but they are not implemented consistently or at scale.

Smoking cessation within acute trusts has four main elements:

- Identifying people in both the inpatient and outpatient setting who smoke and offering them help to stop (including behavioural support and pharmacotherapy).
- Providing stop smoking training for frontline staff.
- Supporting staff to stop smoking.
- Developing and implementing smoke free policies.

The South East Clinical Senate considered that there was a vital need to help acute trusts focus on what they can do to help patients and staff to stop smoking. The clinical senate's purpose was to provide clear recommendations and a practical toolkit for NHS acute trusts to dramatically upgrade their provision of stop smoking interventions for their patients seen in both the inpatient and outpatient setting, and their employees.

This report does so by:

- Summarising current national guidance and the evidence base for smoking cessation in acute trusts.
- Showing what current interventions are in place in acute trusts and understanding local barriers.
- Providing recommendations to trusts, their clinicians, and other stakeholders.

2. Summary of current national guidance

The following national policy documents outline evidence and best practice for smoking cessation in acute trusts and provide recommendations for action.

2.1 National Improvement Objectives:

The British Thoracic Society (BTS) audit of smoking cessation for secondary care in 2016[13] found that the opportunity to reach smokers through health services was not being exploited. Key findings were that:

- Over 1 in 4 (27%) hospital patients were not even asked if they smoke.
- Nearly 3 in 4 (72%) hospital patients who smoked were not asked if they would like to stop.
- Only 1 in 13 (7.7%) hospital patients who smoked were referred for hospital-based or community treatment for their tobacco addiction.
- Half of frontline healthcare staff in hospitals were not offered training in smoking cessation.
- Only 1 in 10 hospitals completely enforce their fully smoke-free premises - rates of enforcement were even lower for hospitals which provided areas where smoking was allowed.
- Provision of nicotine replacement therapies and other smoking cessation treatments were 'poor' in hospital pharmacy formularies.
- Only 1.5% of smokers in acute hospital settings go onto make a quit attempt with stop smoking services.

The clinical senate's report aimed to find data and intelligence to discover if progress had been made in the areas highlighted above, as well as general improvements in smoking cessation across hospital trusts.

The BTS Smoking Cessation Audit 2016 summary recommends:

- All hospital patients who smoke are supported with a referral to a specialist stop smoking service to discuss and explore the option of smoking cessation.
- All hospital patients who smoke are prescribed nicotine replacement therapy to reduce symptoms of nicotine withdrawal and promote smoking cessation, unless contraindicated or patients wish to opt out.

- All Trusts should have a senior clinician, with clinical programmed activity, to lead a Trust-based smoking cessation service and implement the core standards of secondary care-based smoking cessation services, as set out in NICE PH48 and the BTS recommendations for secondary care.

- Trust boards should be held accountable by regulators in all four countries of the UK, to enforce smoke-free hospital policies that support quit attempts for patients, staff and visitors, and to reduce second-hand smoke exposure of staff and children[2].

2.2 NICE Public Health Guideline (2013)

NICE PH Guideline 48 'Smoking: acute, maternity and mental health services'[4] aims to support smoking cessation, temporary abstinence from smoking and smoke free policies in all secondary care settings. It recommends:

- Strong leadership and management to ensure secondary care premises (including grounds, vehicles and other settings involved in delivery of secondary care services) remain smoke free – to help to promote non-smoking as the norm for people using these services.
- All hospitals have an on-site stop smoking service.
- Identifying people who smoke at the first opportunity, advising them to stop, providing pharmacotherapy to support abstinence, offering and arranging intensive behavioural support, and following up with them at the next opportunity.
- Providing intensive behavioural support and pharmacotherapy as an integral component of secondary care, to help people abstain from smoking, at least while using secondary care services.
- Ensuring continuity of care by integrating stop smoking support in secondary care with support provided by community-based and primary care services.
- Ensuring staff are trained to support people to stop smoking while using secondary care services.
- Supporting all staff to stop smoking or to abstain while at work.
- Ensuring there are no designated smoking areas, no exceptions for particular groups, and no staff-supervised or staff-facilitated smoking breaks for people using secondary care services.

2.3 NICE Quality Standard (2015)

NICE Quality Standard 'Smoking: reducing and preventing tobacco use' QS82[8] covers reducing and preventing tobacco use in adults, young people and children. NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. The following quality standards are relevant to this paper:

- QS5: Healthcare services use contracts that do not allow employees to smoke during working hours or when recognisable as an employee.
- QS6: Healthcare settings do not allow smoking anywhere in their grounds and remove any areas previously designated for smoking.
- QS7: Secondary healthcare settings ensure that a range of licensed nicotine containing products and stop smoking pharmacotherapies is available on site for patients, visitors and employees.

2.4 NHS England CQUIN

The CQUIN indicator 'Preventing ill health by risky behaviours – alcohol and tobacco'[7] applies to community and mental health providers in 2017 to 2019 and to acute providers in 2018 to 2019. It covers adult inpatients only (patients aged 18 years and over who are admitted for at least one night) and excludes maternity admissions. It includes three indicators related to smoking:

- **9a Tobacco screening**: 'percentage of unique adult patients who are screened for smoking status AND whose results are recorded.'
- **9b Tobacco brief advice**: 'percentage of unique patients who smoke AND are given very brief advice.'
- **9c Tobacco referral and medication offer**: percentage of unique patients who are smokers AND are referred to stop smoking services AND offered stop smoking medication.

The CQUIN focuses particularly on giving 'Very Brief Advice' (VBA) which can be done in as little as 30 seconds and involves three steps- ASK, ADVISE, ACT- although public health benefits are maximised when healthcare professionals refer patients directly for an evidence-based smoking intervention (in the community or on site) with behavioural support and stop smoking medicines. Evidence indicating the likely outcomes of screening show that 30% of smokers receiving VBA accept referral to smoking cessation services.

2.5 PHE Tobacco Control Delivery Plan (2018)

This document[9] sets out actions for meeting the aims of the tobacco control plan for England and how progress will be monitored. Key actions for a 'Smoke free NHS' include:

- Promote and support NICE PH48 self-assessment tools for Trusts.
- Stoptober campaigns to include materials for Smoke free NHS.
- NHS England to track progress and sustainability of smoke free trusts to support areas of highest need.

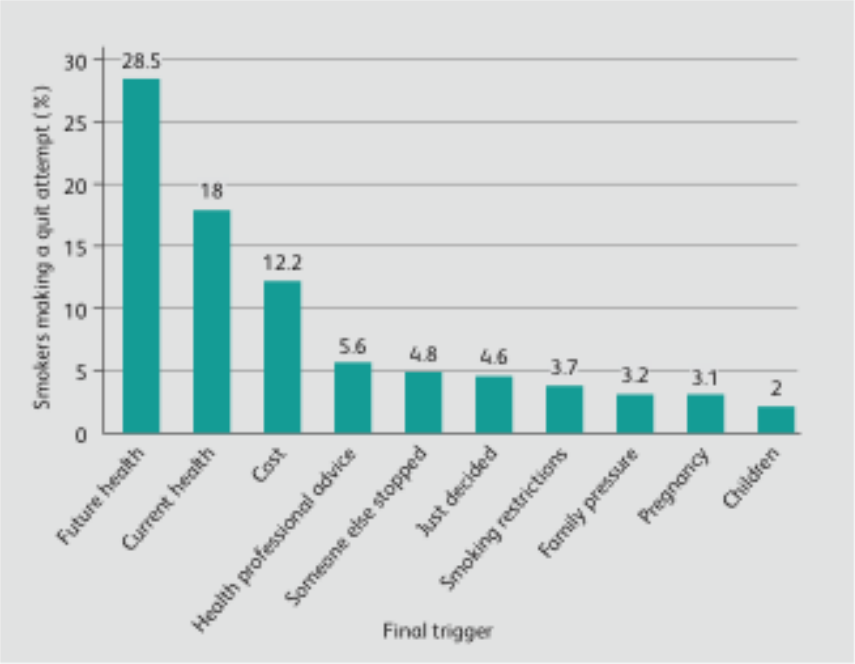
2.6 Royal College of Physicians Report: Hiding in Plain Sight (2018)

The major RCP report 'Hiding in Plain Sight: Treating tobacco dependency in the NHS', published in June 2018[1], provides an extensive summary of the evidence base for the the harms and costs arising from smoking and argues for a new approach to treating their addiction. The report demonstrates that clinicians working in almost all areas of medicine will see their patients' problems improved by quitting smoking, and that systematic intervention is a cost-effective means of both improving health and reducing demand on NHS services. The report argues that smoking cessation is not just about prevention - for many diseases, smoking cessation represents effective treatment.

It calls on doctors to recognise that identifying and treating tobacco dependence as their business, and to incorporate smoking cessation as a systematic and opt-out component of all NHS services, delivered in smoke-free settings.

It highlights the opportunity that staff in hospital have for influencing a quit attempt. Current or future health issues are powerful triggers for people to make a quit attempt (see Figure 2), and advice from healthcare workers influences the likelihood of making a quit attempt more than input from family or friends. Smokers using healthcare services are therefore likely to be relatively motivated to quit smoking.

Figure 2. Triggers reported as prompting the most recent quit attempt[1]



The report also reviews current teaching and examination on smoking in general, the delivery of brief opportunistic advice and more detailed smoking cessation treatments and support, in the undergraduate and postgraduate training of UK healthcare professionals. They argue that current training is inadequate, with little opportunity for practicing intervention and that without this, health professionals are unlikely to feel equipped to intervene in smoking and may have negative attitudes and beliefs about smoking cessation. They conclude that training in smoking cessation should be mandatory for all NHS health professionals and note that effective, evidence-based training for staff at all levels is readily available from the National Centre for Smoking Cessation and Training (NCSCT).

The report argues that smoking should be seen as a medical issue and not one of lifestyle, and that the evidence supports the clinical and cost effectiveness of treating smoking in the same way as other causes of serious illness, and medical ethics requires clinicians to do so.

2.7 Advice on E-cigarettes

A number of key points with respect to advice on E-cigarettes have been summarised in recent reports and advice. These have been detailed below:

In 2018, Public Health England released a commissioned evidence review on e-cigarettes and heated tobacco products[10], to underpin policy and regulation.

- Vaping poses only a small fraction of the risks of smoking and switching completely from smoking to vaping conveys substantial health benefits over continued smoking. Based on current knowledge, stating that vaping is at least 95% less harmful than smoking remains a good way to communicate the large difference in relative risk unambiguously so that more smokers are encouraged to make the switch from smoking to vaping. It should be noted that this does not mean e-cigarettes are safe.
- Misperceptions of the relative harms of nicotine replacement therapy and e-cigarettes compared with cigarettes need to be addressed, particularly among smokers who would benefit from switching to nicotine replacement therapy or e-cigarettes.
- Clear messages, based on current evidence about nicotine, its relationship with harms, and its addictiveness, compared with smoking, are necessary and could have a marked impact on public health.
- Policies on tobacco and e-cigarettes should have at their core the recognition that nicotine use per se presents minimal risk of serious harm to physical health and that its addictiveness depends on how it is administered.
- Despite some experimentation with these devices among never smokers, e-cigarettes are attracting very few young people who have never smoked into regular use.
- As recommended in 2015 and as per existing NICE guidance, all smokers should be supported to stop smoking completely, including 'dual users' who smoke and use e-cigarettes.
- Access to e-cigarettes should be improved for smokers in disadvantaged groups.
- Stop smoking practitioners and health professionals should provide behavioural support to smokers who want to use an e-cigarette to help them quit smoking.

A PHE press release from February 2018[11] outlined the steps trusts should take to become Smoke Free:

'To become truly smoke free, Trusts should ensure:

- E-cigarettes, alongside nicotine replacement therapies are available for sale in hospital shops.
- Vaping policies support smokers to quit and stay smoke free.
- Smoking shelters be removed.
- Frontline staff take every opportunity to encourage and support patients to quit.'

The government's new Tobacco Control Plan for England includes a commitment to 'maximise the availability of safer alternatives to smoking'.

It makes clear that e-cigarettes have an important part to play in achieving the ambition for a smoke free generation.

In March 2018, NICE updated its 'Stop smoking interventions and services' (NICE Guideline 92) with advice on e-cigarettes[12], noting 'The committee were concerned that people who smoke should not be discouraged from switching to e‑cigarettes, and as a result continue to smoke, because the evidence is still developing.'

3. What we know locally

3.1 National Centre for Smoking Cessation and Training data

The National Centre for Smoking Cessation and Training (NCSCT) offer a short, online Very Brief Advice on Smoking (VBA) training module, which is an open access resource available on the NCSCT website for health professionals[14]. VBA training is also available via British Medical Journal (BMJ) Learning.

A request was sent to the NCSCT for data on the number of health and social care staff accessing the training in the SE Clinical Senate geographical area. A total of 1360 health and social care staff completed the training between 2015-2017 in Kent, Surrey and Sussex. For the total for each local authority (LA) area, see Appendix 2. The number for each varied greatly: between 23 and 868.

The number trained in the SE Clinical Senate area per staffing group is outlined in the table below and is a small fraction of the staff working in acute trusts in Kent, Surrey and Sussex.

Table 1: Number of staff trained in Kent, Surrey and Sussex per staffing group

Staff Group	Number trained (2015-17)
Nurses	427
Health Care Assistants/Support Workers	145
Doctors	97
Psychology	93
Pharmacists	66
Administrator/Receptionist	44
Stop Smoking Practitioners	35
Counsellor/Therapist	35
Health Promotion Officer	32
Occupational Therapists	27
Case Worker	22
Social Workers	21
Dental	14
Outreach	12
Midwives	7
Health Visitors	3
Physiotherapists	3
Other/Not Specified	277
TOTAL	**1360**

3.2 Local Authorities

A request was sent to Directors of Public Health in each of the six local authorities in Kent, Surrey and Sussex for information on four aspects of smoking cessation practices in relation to acute trusts. Responses were received from all six.

3.2.1 Stop smoking training for acute hospital trusts staff

All local authorities (LA) stated that training was available for trust staff, with 5/6 having face-to-face training available. Three LAs mentioned online/NCSCT training. With regard to staff groups who receive training, 4/6 mentioned those who provide support to pregnant women, with other staff groups including cardiology, cardiac rehabilitation, A&E and pharmacists. The training available to trusts varied greatly from only online training to training for multiple staff groups at different levels.

3.2.2 On site stop smoking interventions for staff

Each of the LAs noted that stop smoking provision was available within the trusts in their area, though this was not always available in every trust (approximately 9/12 trusts have some provision). Limited service hours were noted in some trusts (6-10 hours a week) and in one trust there was limited take up by staff. In one trust this was delivered by an external provider.

3.2.3 On site stop smoking interventions for patients

Five of six LAs stated that on site stop smoking provision was available for patients, though similarly not in every trust (approximately 10/12 trusts have some provision). Only one LA described a comprehensive service delivery, with others noting limited provision or take up. In one trust this was delivered by an external provider.

3.2.4 Referral pathways to community based stop smoking services

All LAs outlined some form of referral pathway to community based stop smoking services, although this varied from very little referrals being made (delivery mostly at the hospital) or only signposting in place, to robust electronic referral systems. Three of six LAs mentioned an electronic referral system and 3 stated that their referral pathways were being reviewed or developed.

3.3 British Thoracic Society Audit for Trusts

Between April-May 2016, the BTS initiated an audit of Smoking Cessation activity in all acute hospital trusts[13]. Part one involved screening patient notes regarding identification and offering help re smoking, and part two looked at the organisational infrastructure required to deliver those interventions.

As part of this work, in April 2018 acute trusts were asked to repeat Part Two of the audit. A response was received from 7 of the 12 acute trusts in Kent, Surrey and Sussex, and the results are presented below. For detailed information on responders see Appendix 2.

3.3.1 Smoke free grounds

Of the 7 responding trusts, 2 (29%) had a designated smoking area; this is compared to 41% nationally. For those with a designated smoking area, restrictions outside the area were either 'rarely' or 'not at all' enforced. For those without a designated area, smoking restrictions were enforced in 3/5 of trusts.

3.3.2 Access to smoking cessation

All 7 trusts had access to a smoking cessation service, with 5 having access to a hospital based service (one for staff only). Of those with a hospital based smoking cessation service for patients, 3/4 could 'always' or 'mostly' provide access to inpatients and 2/4 for outpatients. After hospital discharge, all trusts had a hospital or community smoking cessation service that could follow them up.

3.3.3 Leadership of a service and dedicated hospital smoking cessation partners

Three out of seven, (43%) trusts had an identified senior medical leader for their smoking cessation service (compared to 26% nationally), though only one had hours specifically dedicated to the service. Three out of seven (43%) trusts had a dedicated Hospital Smoking Cessation Partner (HSCP) who worked between 4-37.5 hours a week (nationally 51% of trust had a dedicated HSCP). One of three hospital smoking cessation services did not have dedicated office space, though all had an email address or phone line. Only two trusts had both a senior medical leader and a dedicated HSCP.

3.3.4 Pharmacotherapy

6/7 trusts reported that pharmacotherapy was available for patients, with one trust unable to provide this information. 3/7 trusts were able to provide Varenicline or Bupropion, and/or a range of Nicotine Replacement Therapy (NRT) products. Nationally, most trusts are described as not being able to provide basic pharmacotherapy. The number of local trusts with each type of pharmacotherapy available is outlined in the table below.

Table 2: Number of trusts where each type of pharmacotherapy was available

Pharmacotherapy type	Number of trusts where it was available (out of 6 responders)
NRT – Inhalators	6
NRT – Patches	6
NRT – Lozenges	4
NRT – Gum	4
Varenicline	3
NRT – Mouth spray	3
NRT – Nasal spray	2
Bupropion	2
NRT – Microtabs	1

Of the 3 trusts that had HSCPs, 2 were able to prescribe pharmacotherapy to in-patients and none were able to prescribe to out-patients.

3.3.5 Training of staff in smoking cessation

4/7 (57%) institutions offered regular smoking cessation training to frontline staff, with consultants having less training than junior doctors, nurses or pharmacists. This is compared to 44% nationally.

3.4 Staff Questionnaire for Local Intelligence

South East Clinical Senate Council Members were asked to circulate a questionnaire to colleagues working in acute trusts to get an understanding of the experience of hospital staff on smoking cessation. 10 responses were received from staff in 4 different acute trusts (doctors, nurses and allied health professionals) and the answers are summarised below. Whilst the sample is small it is helpful to note the key themes arising from this survey:

- Staff mostly or always ask new patients whether they smoke but are less likely to offer advice on quitting
- Barriers to making a referral to stop smoking services included
  - Knowing about services or how to make the referral
  - Limited time
  - Lack of training
- Very few staff had had training or knew whether it was provided in their trust
- Many staff reported seeing patients and staff smoking on site

4. Recommendations

This report has identified that there are multiple opportunities to enhance smoking cessation in acute trusts across the region. Our recommendations relate to the key themes in the NICE guidance.

4.1 Leadership

Initiating and embedding the culture change needed to make smoking 'everybody's business' requires system-wide leadership across our local health and care systems. This includes acute, mental health and community trusts, CCGs and local authorities, collaborating at STP and integrated care system levels. For an acute trust this means that the board, clinicians and senior managers need to be on board and promoting change. We found that only a few local trusts surveyed currently have a senior medical leader for their smoking cessation service, and only one had specifically dedicated hours.

In January 2018 the Smokefree Action Coalition launched the NHS Smokefree Pledge [16]. The Pledge is designed to be a clear and visible way for NHS organisations to show their commitment to helping smokers to quit and to providing smoke free environments which support them. Of the CCGs and NHS trusts in this area, only Kent and Medway NHS and Social Care Partnership Trust (mental health trust) has signed up.

R1. System leaders should prioritise smoking cessation, and agree shared objectives. This should be at the STP and integrated care system/place based levels, to ensure that all organisations take a joined up coordinated approach.

R2. Trusts should work closely with local authorities' Directors of Public Health and the stop smoking services that they provide or commission in order to ensure a consistent approach to service provision, training and pathways.

R3. Commitment and leadership from the trust board (to include a board champion) and from senior clinicians and service champions is required to establish the culture, embed smoking cessation interventions across all services, and to achieve a smoke free site.

R4. A senior consultant should be in place with dedicated job planned time and administrative support to lead smoking cessation across the trust.

R5. Stop smoking support for patients and staff, and the smoke free hospital status, should be promoted and communicated effectively to initiate a cultural change within the organisation.

R6. All trusts and CCGs should sign up to the NHS Smokefree Pledge [17]

R7. Commissioners should actively support the implementation of national policies and incentives aiming to reduce smoking prevalence and ensure that they are implemented.

> *'What really helps is being on site daily, out and about, carrying out ward rounds and making sure that staff are reminded of the service. I have encouraged the addition of smoking history on ward handovers and I provide the latest local smoking prevalence information and 4 week quit rates are briefly shared to keep stop smoking message positive and interesting. The Cardiac Rehab team are really proactive, producing the majority of hospital quits. They are all Level 2 trained advisors, and have a CO monitor. There is active support and encouragement to keep the motivation going.'*
>
> *Stop Smoking Advisor, Brighton and Sussex University Hospitals NHS Trust*

4.2 On site Smoking Cessation Services, and links to community based services

To reduce the current burden of death and disability caused by smoking it is necessary to encourage as many current smokers as possible to make a quit attempt, and to ensure that when they do, as many as possible use the most effective methods[1]. Smoking cessation interventions are highly effective and cost-effective in treating tobacco dependence; and also far more cost-effective than many of the interventions used for smoking-related diseases[1].

> *'A key element to... (meeting the NICE guidance)... relates to a robust electronic referral pathway which MFT has in place. The electronic referral form can be used for Patients, Staff and Visitors and is located on the staff intranet. It is also easily accessible throughout the trusts IT system. All referrals are sent to the local Medway Stop Smoking Service who will respond to the referral within 3 days of receipt, however, most referrals are processed within 24 hours.'*
>
> *Medway NHS Foundation Trust*

Not all trusts in the region have onsite stop smoking provision, with only two trusts being able to provide a service for both inpatients and outpatients.

R8. A system-wide approach should be taken when planning provision of smoking cessation services, to ensure integration across community and acute settings. Ideally, hospital based and community based services should be fully integrated.

R9. A smoking cessation service should be in place within each trust with specialist advisors with dedicated hours, phone line and office space.

R10. All clinical staff should be made aware of how to access and refer patients to the trust's smoking cessation service. This should be included in staff induction, and staff should receive regular reminders and prompts.

R11. People who smoke should be offered a referral to an evidence-based smoking cessation service, and there should be a robust system in place (preferably electronic) to ensure continuity of care between secondary care and local stop smoking services for people moving in and out of secondary care.

R12. Hospital inpatients who smoke should be referred to the trust's smoking cessation service in the first instance. Outpatients identified as smokers should be offered referral to their local community-based service.

R13. A clear pathway should be in place for each geographical area to ensure continuity of care; stop smoking services should be more integrated across secondary care and the community including follow up of patients and prescribing.

R14. An electronic referral system to both the trust's and to community based smoking cessation services should be available within each trust. Patients should be given the choice of continuing with the trust-based service if started whilst in hospital, or being referred to their local service.

4.3 Availability of pharmacotherapy within the hospital

"While an inpatient at Medway NHS Foundation Trust my Consultant asked me if I had ever tried to give up smoking, at the time I didn't think I could do it alone or that I had the willpower. My Consultant let me know I could speak to someone from the Stop Smoking Service while in Hospital and offered to refer me to Medway Stop Smoking Service. I accepted the referral and was visited in Hospital by a Stop Smoking Adviser from Medway Stop Smoking Service, I decided to quit smoking. The Hospital provided me with some nicotine patches and a nicotine containing mouth spray during my stay. I was in Hospital for a while so I was visited by the Stop smoking team on more than one occasion and by two different members of their team to see how my quit attempt was going. I didn't get on well with the nicotine patches but found the nicotine containing mouth spray was working well. When I was discharged from Hospital I attended the Smokefree Advice Centre in Chatham to continue with the support and they provided me with the nicotine replacement therapy I had been getting from the Hospital. After a few weeks I was readmitted into Medway Hospital and let them know I had quit smoking and was using a nicotine containing mouth spray, I was provided with a mouth spray quickly by the ward. During this time I also received phone support from the Stop Smoking Service."

Medway NHS Foundation Trust Inpatient

NICE Quality Standard 7 states that secondary healthcare settings should ensure that a range of licensed nicotine-containing products and stop smoking pharmacotherapies is available on site for patients, visitors and employees. The local availability of pharmacotherapy for patients mirrors the national results, with only three trusts providing the range of products recommended by NICE. It is worth noting that the most effective interventions combine behavioural therapy with pharmacotherapy, therefore ensuring that staff can offer support alongside the prescription is important.

The range of nicotine replacement and pharmacotherapies available for smokers is summarised in table 2 (see page 17). This includes nicotine-containing gum, inhalers and patches, e-cigarettes, bupropion and varenicline.

R15. Ensure an agreed range of options for inpatients are readily available on all wards.

R16. Introduce means by which nurses and doctors can easily prescribe and provide NRT whilst an inpatient. NRT products should be part of the stock drugs on wards.

R17. Ensure a range of licensed nicotine-containing products are available for sale in hospital to visitors and staff.

R18. Trust and community pharmacy and medicines management leaders should work together to agree the range of products available for prescription in the hospital setting, and how prescriptions and dispensing will continue after discharge. A common approach across trusts within individual STPs is recommended, and a common template for formulary applications should be considered.

> *'I think the training we get on the subject isn't very thorough and I think we should know more about what patients can access in regards to smoking cessation treatments. When I realised how little I knew about this topic I did a Smoking Cessation teaching module on NHS e-learning - they have a good short teaching module on it which takes you through different treatments and general guidance you can give to patients. I think I could have a conversation with a patient about quitting smoking however it is often a difficult subject to approach and there is often not enough time given for it.*
>
> *I believe there is also a smoking cessation service at the hospital itself but I have not referred to them myself. I did not hear much about them when I first started working here and I have only just been informed that they are available!'*
>
> *Foundation Doctor KSS*

4.4 Training of staff in acute hospitals

On a national level, training for health professionals in smoking cessation is considered to be 'inadequate'[1], and training was not available in all trusts surveyed. However, at all levels stop smoking interventions are among the most clinically- and cost-effective available in healthcare and it is recognised that opportunistic brief advice from a health professional can be one of the most important triggers for a quit attempt[1].

R19. All hospital staff should be made aware of their trust's smoking cessation service and how to access it, for patients or themselves.

R20. All clinical staff (doctors, nurses and AHPs) should know how to refer patients to a smoking cessation service, and 'very brief advice' (VBA) training should be offered. This should be considered as a component of mandatory training.

R21. Smoking cessation interventions should be included in all undergraduate and postgraduate clinical curricula.

4.5 Supporting Staff to Stop Smoking

The Public Health NICE Guideline suggests that all staff should be supported to stop smoking or to abstain while at work, and this is strengthened by NICE Quality Standard 5 which states that healthcare services should use contracts that do not allow employees to smoke during working hours or when recognisable as an employee. Local results indicate that around 75% of trusts in the region have some stop smoking provision for staff, although the level of provision varied. Trusts should review staff contracts to ensure they meet NICE QS5

Sussex Partnership NHS Foundation Trust became smoke free on 8 March 2018 – National No Smoking Day which means that patients, visitors and staff will no longer be able to smoke anywhere on our sites. This includes gardens, car parks and doorways, and there will no longer be designated smoking areas.

To support staff stop smoking there are three monthly Staff Wellbeing Days where several aspects of wellbeing are addressed including smoking cessation. There are also visits by specialists in smoking cessation who provide advice, support and information re smoking cessation. There is an online module on smoking cessation available to staff on the Sussex Partnership Intranet which takes around 1-2 hours to complete and sets out the key things that staff need to know if they want to stop smoking.

Sussex Partnership NHS Foundation Trust

R22. Hospital staff should not smoke on hospital premises during working hours and should be encouraged not to smoke off-site when in uniform. Trusts would need to decide how this will be promoted and enforced.

R23. Smoking cessation support for staff should be in place within the trust, with attendance allowable during paid time without loss of pay, and with initiation of NRT provided by the trust.

R24. Ensure staff are aware of stop smoking support available both on-site and in the community through e.g. trust intranet, staff newsletters etc.

R25. Advise staff who are not ready or able to stop smoking completely to use licensed nicotine-containing products to help them abstain during working hours and provide advice on where to obtain them.

4.6 Identifying patients who smoke, and auditing the impact of interventions

Systems in which smokers are systematically identified and offered treatment on an opt-out basis generate approximately double the quit rates achieved by opt-in approaches. Making opt-out treatment of tobacco dependency a systematic and routine component of all NHS care is therefore likely to increase smoking cessation dramatically among NHS patients[1]. Information from a small number of staff showed that although most staff ask patients about their smoking status, not all are offering advice. This should improve with the introduction of the CQUIN which requires screening for smoking status, recording of status and very brief advice to be given. Guidance from PHE is also available for clinicians to support their conversations with patients, outlining the different options available for stopping smoking (e.g. unassisted quitting, quitting with expert support etc.) and their effectiveness[15]

R26. Enable smoking status of inpatients and advice offered to be recorded on IT systems (as per NICE QS82) at a ward and department level to enable a quality improvement approach to be taken. This could most readily be achieved by making it a requirement of discharge summaries, and a CQUIN could incentivise this activity.

R27. Data should be collected on the proportion of people asked about their smoking status, and proportion of those who receive advice on how to stop (as per NICE QS82) at a ward and department level to enable a quality improvement approach to be taken.

R28. Using a recognised quality improvement methodology to embed and spread best practice across all wards and outpatient clinics.

Successfully going smoke free takes more than a single decision by a single manager. It requires support from staff, patients and local community to achieve, with all audiences and stakeholders wanting to make a positive change to benefit everyone's health.

Leadership was a key factor in the success of going smoke free. From its initial conception through to its eventual delivery, the Trust's Chief Executive fully supported the drive to become smoke free and was willing to use her influence to motivate staff at all levels – including other senior managers - to engage with and support the smoke free initiative.

Leadership only works when it is visible. As well as the signage, announcements, posters and other communications about going smoke free, it was our smoking champions who made going smoke-free a success. Members of staff volunteered from different staff groups across the Trust, clearly identified as a champion through prominently displayed badges, and challenged smokers on site to put out their cigarettes – showing clearly that all of our staff were committed to stopping smoking on the hospital site, working with estates staff to enforce the smoking ban on site as well as signposting and supporting smokers to access stop smoking services.

A key learning point for the Trust after going smoke-free has been that it requires continued effort to maintain smoke free status. There is no 'mission accomplished' moment with smoke free, and ensuring that smoking stays off the hospital site is a challenge that Trusts must accept as part of their day-to-day activities into the long term.

Medway NHS Foundation Trust

4.7 Making hospitals smoke free sites

A smoke free site is an important pillar of tobacco control within NHS trusts. NICE suggests that there should be no designated smoking areas and that patients should not be taken out for smoking breaks. Two trusts in the region reported having designated smoking areas and smoke free areas were not always enforced. Only a few trusts had information for patients on their website about whether patients and visitors can smoke or vape on site.

R29. It is strongly recommended that trust sites are smoke free zones, and every effort should be made to enable smokers who need it to obtain nicotine replacement by other means.

R30. All acute trusts need a policy on e-cigarettes and vaping that is distinct from that for tobacco smoking.

R31. Inpatients wishing to smoke on hospital premises should be strongly discouraged, and offered alternative NRT. Consequently, staff should not take patients outside to smoke .

R32. Develop, deliver and maintain an effective communications strategy to support the trust's smoke free policy.

R33. Hospital staff should be prohibited from smoking on the trust's premises.

R34. All acute trusts have their smoking and e-cigarette policies available to the public online, including simple information on the support available for smoking cessation.

R35. Information on the Trust's smoking and vaping policies and signposting to support for quitting smoking should be included in patient materials such as appointment and admission letters.

R36. NRT products should be available to purchase for visitors and staff on site.

5. Conclusion

All providers of healthcare have a role to play in supporting people who smoke to stop. Acute hospitals have a pivotal but under-utilised potential to help their patients (inpatients and outpatients) and staff to quit smoking, based on the overwhelming evidence of harm from tobacco smoking, and the opportunities that arise from hospital attendance.

The recommendations within this report provide practical and effective steps for acute trusts that can be taken to fulfil their shared moral duty as health care providers in helping people addicted to tobacco to give up and reap the benefits from reduced future illness.

Implementation will require commitment and conviction from clinical and non-clinical leaders, partnership with primary care, local authorities and public health, and engagement and consultation with staff. Failure to act should not be an option.

References

1. Royal College of Physicians. (2018). Hiding in plain sight: Treating tobacco dependency in the NHS. Available online: https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs
2. NHS England (2017). Preventing ill health: Commissioning for Quality and Innovation (CQUIN) supplementary guidance. Available online: https://www.england.nhs.uk/publication/preventing-ill-health-cquin-supplementary-guidance/
3. NICE (2013). Smoking: acute, maternity and mental health services; Public Health Guideline 48. Available online: https://www.nice.org.uk/guidance/ph48/chapter/2-Public-health-need-and-practice
4. Effectiveness of a hospital-initiated smoking cessation programme: 2-year health and healthcare outcomes. Mullen K et al. Tobacco Control (BMJ Publications) 2017;26:293-299. https://tobaccocontrol.bmj.com/content/26/3/293
5. NHS England (2014). Five Year Forward View. Available online: https://www.england.nhs.uk/publication/nhs-five-year-forward-view/
6. Department of Health. (2017). Towards a SmokeFree Generation: a Tobacco Control Plan for England. Available online: https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england
7. NHS England. 2017/19 CQUIN Guidance. Available online: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/
8. NICE. (2015). Smoking: reducing and preventing tobacco use; Quality Standard 82. Available online: https://www.nice.org.uk/guidance/qs82
9. PHE. (2018). Tobacco Control Plan: delivery plan 2017 to 2022. Available online: https://www.gov.uk/government/collections/tobacco-and-smoking-policy-regulation-and-guidance
10. PHE (2018). Evidence review of e-cigarettes and heated tobacco products 2018: executive summary. Available from: https://www.gov.uk/government/publications/e-cigarettes-and-heated-tobacco-products-evidence-review/evidence-review-of-e-cigarettes-and-heated-tobacco-products-2018-executive-summary
11. PHE. (2018). Press release, 6th February 2018. Available from: https://www.gov.uk/government/news/phe-publishes-independent-expert-e-cigarettes-evidence-review
12. NICE (2018). Stop smoking interventions and services (NG92). Available from: https://www.nice.org.uk/guidance/ng92
13. British Thoracic Society. Information available from: https://www.brit-thoracic.org.uk/standards-of-care/quality-improvement/smoking-cessation/
14. National Centre for Smoking Cessation and Training. Information available from: http://www.ncsct.co.uk
15. PHE. (2018). Stop smoking options: guidance for conversations with patients. Available from: https://www.gov.uk/government/publications/stop-smoking-options-guidance-for-conversations-with-patients
16. Information on the NHS Smokefree Pledge is available from: http://smokefreeaction.org.uk/smokefree-nhs/nhs-smokefree-pledge/
17. NHS Smokefree Pledge http://smokefreeaction.org.uk/wp-content/uploads/2018/01/smoke-free-pledge_v13.pdf

Appendix 1: Summary of recommendations and checklist

Recommendations	Acute Trusts	Commissioners (CCGs and local authority)	Other
Leadership			
1. System leaders should prioritise smoking cessation, and agree shared objectives. This should be at the STP and integrated care system/place based levels, to ensure that all organisations take a joined up coordinated approach			STP
2. Trusts should work closely with local authorities' Directors of Public health and the stop smoking services that they provide or commission in order to ensure a consistent approach to service provision, training and pathways.			STP
3. Commitment and leadership from the trust board (to include a board champion) and from senor clinicians and service champions is required to establish culture, embed smoking cessation interventions across all services, and to achieve a smoke free site.			
4. A senior consultant should be in place with dedicated job planned time and administrative support to lead smoking cessation across the trust.			
5. Stop smoking support for patients and staff, and the smoke free hospital status, should be promoted and communicated effectively to initiate a cultural change within an organisation.			
6. All trusts and CCGs should sign up to the NHS Smokefree Pledge(1).			STP
7. Commissioners should actively support the implementation of national policies and incentives aiming to reduce smoking prevalence and ensure that they are implemented.			STP

On site Smoking Cessation Services, and links to community based services			
8. A system-wide approach should be taken when planning provision of smoking cessation services, to ensure integration across community and acute settings. Ideally hospital based and community based services should be fully integrated.			STP
9. A smoking cessation service should be in place within each trust with specialist advisors with dedicated hours, phone line and office space.			
10. All clinical staff should be made aware of how to access and refer patients to the trusts smoking cessation service. This should be included in staff induction, and staff should receive regular reminders and prompts.			
11. People who smoke should be offered a referral to an evidence-based smoking cessation service, and there should be a robust system in place (preferably electronic) to ensure continuity of care between secondary care and local stop smoking services for people moving in and out of secondary care.			
12. Hospital inpatients who smoke should be referred to the trust's smoking cessation service in the first instance. Outpatients identified as smokers should be offered referral to their local community-based service.			
13. A clear pathway should be in place for each geographical area to ensure continuity of care; stop smoking services should be more integrated across secondary care and the community including follow up of patients and prescribing.			STP
14. An electronic referral system to both trusts and to community based smoking cessation services should be available within each trust. Patients should be given the choice of continuing with the trust based service if started whilst in hospital, or being referred to their local service.			
Availability of pharmacotherapy within the hospital			
15. Ensure an agreed range of options for inpatients are readily available on all wards.			
16. Introduce means by which nurses and doctors can easily prescribe and provide NRT whilst an inpatient. NRT products should be part of the stock drugs in wards.			

17. Ensure a range of licensed nicotine-containing products are available for sale in hospital to visitors and staff.			
18. Trust and community pharmacy and medicines management leaders should work together to agree the range of products available for prescription in the hospital setting, and how prescriptions and dispensing will continue after discharge. A common approach across trusts within individual STPs is recommended, and a common template for formulary applications should be considered.			
Training of staff in acute hospitals			
19. All hospital staff should be made aware of their trust's smoking cessation service and how to access it, for patients or themselves.			
20. All clinical staff (doctors, nurses and AHPs) should know how to refer patients to a smoking cessation service, and 'very brief advice' (VBA) training should be offered. This should be considered as a component of mandatory training.			
21. Smoking cessation interventions should be included in all undergraduate and post-graduate clinical curricula.			Relevant medical school and post-graduate deans
Supporting Staff to Stop Smoking			
22. Hospital staff should not smoke on hospital premises during working hours and should be encouraged not to smoke off-site when in uniform. Trusts would need to decide how this will be promoted and enforced.			
23. Smoking cessation support for staff should be in place within the trust, with attendance allowable during paid time without loss of pay, and with initiation of NRT provided by the trust.			
24. Ensure staff are aware of stop smoking support available both on-site and in the community through e.g. trust intranet, staff newsletters etc.			
25. Advise staff that are not ready or able to stop smoking completely to use licensed nicotine-containing products to help them abstain during working hours and provide advice on where to obtain them.			

Identifying smokers in hospital and auditing impact of interventions			
26. Enable smoking status of inpatients and advice offered to be recorded on the IT systems (as per NICE QS82) at a ward and department level to enable a quality improvement approach to be taken.			
27. Data should be collected on the proportion of people asked about their smoking status, and proportion of those who receive advice on how to stop (as per NICE QS82) at a ward and department level to enable a quality improvement approach to be taken.			
28. Using a recognised quality improvement methodology to embed and spread best practice across all wards and outpatient clinics.			
Making hospitals smoke free sites			
29. It is strongly recommended that trust sites are smoke free zones, and every effort should be made to enable smokers who need it to obtain nicotine replacement by other means.			
30. All acute trusts need a policy on e-cigarettes and vaping that is distinct from that for tobacco smoking.			
31. Inpatients wishing to smoke on hospital premises should be strongly discouraged, and offered alternative NRT. Consequently, staff should not take patients outside to smoke.			
32. Develop, deliver and maintain an effective communications strategy to support the trust's smoke free policy.			
33. Hospital staff should be prohibited from smoking on the trust's premises.			
34. All acute trusts have their smoking and e-cigarette policies available to the public online, including simple information on the support available for smoking cessation.			
35. Information on the Trust's smoking and vaping policies and signposting to support for quitting smoking should be included in patient materials such as appointment and admission letters.			
36. NRT products should be available to purchase for visitors and staff on site.			

(1) NHS Smoke Free Pledge. http://smokefreeaction.org.uk/smokefree-nhs/nhs-smokefree-pledge/

Appendix 2: Responses to questionnaires by local authority and acute trust

Local Authority	Acute Trust	BTS Audit received	Staff questionnaires returned	NCST trained health professionals (2015-2017)
Brighton & Hove	Brighton and Sussex University Hospitals NHS Trust	YES	3	23
Notes **LA:** Wide range of training carried out. Low NCST uptake. Smoking cessation provision for staff. Inpatient service available with online referral. **TRUST:** On site smoking restrictions rarely reinforced. Hospital smoking cessation service available with formal referral pathway (FT hours) and able to prescribe to inpatients. No senior consultant supporting smoking cessation. Limited pharmacotherapy (no varenicline/ buproprion). Smoking cessation training is offered to multiple staff groups. **STAFF FEEDBACK:** All 3 staff who responded rarely or never provided advice on quitting, had not received training and did not know if it was available. One noted they did not know where to refer and what is effective.				
Surrey	Ashford and St Peters Hospitals NHS Foundation Trust	YES	0	868
	Frimley Health NHS Foundation Trust	NO	3	
	Royal Surrey County Hospital NHS Foundation Trust	NO	0	
	Surrey and Sussex Healthcare NHS Trust	NO	0	
Notes **LA:** Staff encouraged to take online training; good uptake in this area. Frimley and Royal Surrey have onsite advisors who can offer limited training. Quit 51 can also offer group training. Royal Surrey and Frimley offer a limited smoking cessation service to staff and patients. East Surrey Hospital offers patient provision through Boots Pharmacy. Referrals go to either onsite advisors where available, or via email/phone to Quit 51. **TRUST (ASPH):** On site smoking restrictions rarely reinforced. No hospital smoking cessation service				

available. Access to community service with formal referral pathway. Senior consultant supporting smoking cessation, but no dedicated hours. Limited pharmacotherapy (no varenicline/ buproprion). No onsite training available.

STAFF FEEDBACK (Frimley): All 3 staff who responded always or mostly provided advice on quitting. All noted they did not know where to refer or how. 2/3 had received training, but none knew if it was available at their trust.

East Sussex	East Sussex Healthcare NHS Trust	YES	3	86

Notes

LA: Some training carried out. Low NCST uptake. Smoking cessation provision for staff and patients delivered by One You East Sussex with online referral.

TRUST: Designated smoking area; rarely reinforced. Access to community service with formal referral pathway. No senior consultant supporting smoking cessation. Unknown pharmacotherapy. No smoking cessation training available.

STAFF FEEDBACK: All 3 staff who responded always or mostly provided advice on quitting, had not received training and 2/3 did not know if it was available. Barriers noted were time, no training and where to signpost/refer.

West Sussex	Western Sussex Hospitals NHS Foundation Trust	NO	0	35
	Queen Victoria Hospital NHS Foundation Trust	YES	0	

Notes

LA: Only online training available; low NCST uptake. Smoking cessation provision for staff and patients available in QVH only. Signposting available and developing referral pathway.

TRUST (QVH): On site smoking restrictions mostly reinforced. Hospital smoking cessation service available (4 hours per week) with formal referral pathway and able to recommend pharmacotherapy to inpatients and outpatients. A senior consultant was supporting smoking cessation (4 hours per week). Limited pharmacotherapy (no varenicline/ buproprion). Smoking cessation training available for a wide range of staff.

Kent	Dartford and Gravesham NHS Trust	YES	1	322
	Maidstone & Tunbridge Wells NHS Trust	NO	0	
	East Kent Hospitals University NHS	YES	0	

	Foundation Trust			

Notes

LA: Lots of opportunities for staff working with pregnant women and all staff encouraged to take online training; good uptake in this area. Smoking cessation service offered to staff and patients with limiting uptake. Referral pathways in place for pregnant women and developing others.

TRUST (DARTFORD): On site smoking restrictions mostly reinforced. No hospital smoking cessation service available. Access to community service with formal referral pathway. No senior consultant supporting smoking cessation. Good range of pharmacotherapy (including NRT and varenicline/ buproprion). No onsite training available.

TRUST (E.KENT): Designated smoking area; rarely reinforced. Hospital smoking cessation service available with formal referral pathway. Senior consultant supporting smoking cessation but with no dedicated hours. Good range of pharmacotherapy (including NRT and varenicline/ buproprion). Training available onsite for multiple staff groups.

STAFF FEEDBACK (DARTFORD): The staff member who responded rarely provided advice on quitting. Barriers noted were time and no clear hospital contact to refer to. They had not received training and didn't know if it was available at their trust.

Medway	Medway NHS Foundation Trust	YES	0	26

Notes

LA: Very brief advice offered to wards; low uptake of NCST in this area. Smoking cessation service offered to staff as drop in. No service for patients. Robust electronic referral pathways in place for patients to community service.

TRUST: On site smoking restrictions completely reinforced. Hospital smoking cessation service available for staff only. Access to community service with formal referral pathway. No senior consultant supporting smoking cessation. Good range of pharmacotherapy (including NRT and varenicline). Onsite training available for some staff groups.

Appendix 3: Smoking Cessation Working Group Membership

Name	Roles
Busola Ade-Ojo	Chief Pharmacist/ Director of Pharmacy, Medway NHS Foundation Trust
Mandy Assin	Consultant Psychiatrist, Sussex Partnership NHS Trust
Alison Barnett	Working Group Chair Centre Director, Public Health England South East
Nandita Divekar	Consultant Anaesthetist, Medway NHS Foundation Trust
Anna Fairhurst	Smoking Cessation Service Lead Brighton and Sussex University Hospital NHS Trust
Antony Frew	Professor of Allergy and Respiratory Medicine, Brighton and Sussex University Hospital NHS Trust
Lawrence Goldberg	Clinical Senate Chair Consultant Nephrologist, Brighton and Sussex University Hospitals NHS Trust
Gillian Guclu	Health Improvement Manager, Frimley Health NHS Foundation Trust
Larisa Han	GP, Merrow Park Surgery, Guildford
Timothy Ho	Medical Director and Consultant Respiratory Physician, Frimley Health NHS Foundation Trust
Emma King	Public Health Specialty Registrar, Public Health England, South East
Jennie Leleux	Health & Wellbeing Programme Manager Public Health England South East
Amy McCausland	Senior Pharmacist Western Sussex Hospitals NHS Trust
Ali Parsons	Associate Director, South East Clinical Senate (K,S&S)
Aneetha Skinner	Clinical Director of Adult Specialist Rehabilitation Services, Sussex Community NHS Foundation Trust
Julia Thomas	Senior Public Health Manager Stop Smoking, Health Checks, Advice Centre and Tobacco Control. Medway Council