Preventing ill health: CQUIN Supplementary guidance

1. What is the purpose of this guidance?

This document outlines the need for the NHS to take action to address risky behaviours, with a focus on alcohol consumption and smoking. In doing so, we will highlight the reasons for taking action, drawing on the available evidence, whilst also providing specific clarification on the proposed interventions and material to support the implementation of the measures set out in the CQUIN indicator for preventing ill health by risky behaviours – alcohol and tobacco (prevention CQUIN).

In addition to this guidance NHS England, alongside Public Health England, will also provide further support during the year. If you require advice on this CQUIN during planning or delivery, please contact the CQUIN team as early as possible: e.cquin@nhs.net

Further guidance and information on the Preventing ill health CQUIN is available at: https://www.gov.uk/government/publications/preventing-ill-health-commissioning-for-quality-and-innovation

1.1. Why is it being issued?

This guide has 4 aims:

- To provide more context about why we should focus on tackling risky behaviours, and particularly alcohol consumption and smoking;
- To share more detail on the proposed interventions;
- To advise on implementation and references to further support;
- To outline current position on our approach to data collection.

2. Where do we need to get to: the vision for addressing key risky behaviours such as alcohol consumption and smoking?

2.1. Why focus on alcohol consumption and smoking?

Smoking and harmful use of alcohol are amongst the most significant risk factors in the global burden of disease in England.[1]

Smoking and harmful alcohol consumption costs the NHS an estimated £2bn[2] and £3.5bn[3] a year respectively. Smoking causes almost 80,000 premature deaths a

[1] Newton, John N., et al. "Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013." *The Lancet* 386.10010 (2015): 2257-2274.

[2] ASH (2015) The local cost of tobacco. ASH local toolkit [Ready Reckoner online tool: accessed Sept 2015] www.ash.org.uk/localtoolkit/docs/Reckoner.xls

year, and contributes to 1.7m hospital admissions. Alcohol consumption is responsible for an estimated 23,000 premature deaths a year and contributes to about 1m hospital admissions.

The costs to society are significantly higher. Evidence suggests that smoking and harmful alcohol consumption could cost c£13.8bn[4] and c£21bn[5] each year respectively.

Preventing ill health through smoking cessation and reductions in alcohol consumption can significantly reduce the burden on the NHS; premature mortality and morbidity; and will help to reduce health inequalities. This action can also contribute to the ambition set out in the Five Year Forward View (5YFV) around the need for a "…radical upgrade in prevention…" and to incentivise and support healthier behaviour.

2.2. The impact on patient care

The prevention CQUIN focuses on identifying and, where required, providing advice and offering referral to specialist services for inpatients in community and mental health trusts (2017-19) and all acute trusts (2018-19).

This CQUIN is intended to complement and reinforce existing activity to deliver interventions to smokers and those who use alcohol at harmful and hazardous levels.

Box 1: Tackling these behaviours has a positive impact on the NHS

- Inpatient smoking cessation interventions are effective, regardless of admitting diagnosis; they lead to a reduction in wound infections, improved wound and bone healing, and longer term reduced risk of heart disease, stroke, cancer and premature death.
- Inpatient alcohol identification and brief advice (IBA) is effective in hospital settings and likely to have an impact on future hospital admissions, and chronic disease management such as hypertension.

The implementation of the CQUIN will also ensure the implementation of guidance produced by National Institute for Health and Care Excellence (NICE), on reducing smoking in acute and mental health settings [PH48] and preventing alcohol use disorders [PH24].

2.3. The impact on NHS finances

The successful implementation of the CQUIN can lead to estimated net savings to the NHS of:

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[3] Written evidence from the Department of Health (GAS 01) to House of Commons Health Committee. "Government's Alcohol Strategy. Third Report of Session 2012–13." *House of Commons: London, UK* (2012). http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/132/132we02.htm

[4] ASH (2015) The local cost of tobacco. ASH local toolkit [Ready Reckoner online tool: accessed Sept 2015] www.ash.org.uk/localtoolkit/docs/Reckoner.xls

[5] Written evidence from the Department of Health (GAS 01) to House of Commons Health Committee. "Government's Alcohol Strategy. Third Report of Session 2012–13." *House of Commons: London, UK* (2012). http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/132/132we02.htm

- £13 per patient referred to stop smoking support and prescribed Nicotine Replacement Therapy (NRT) each year over 4 years; and
- £27 per patient receiving alcohol brief advice each year over 4 years, from reduced alcohol-related hospital admissions following improvements in morbidity[6].

3. What will the trusts need to do: the proposed interventions?

3.1. The proposed interventions are effective and brief

This CQUIN incentivises non-specialist interventions for which there is sound evidence of effectiveness in reducing ill health and thereby the burden on health services, when delivered at scale.

The interventions are brief, and include components such as: short screening questions, brief or very brief advice on the benefits of drinking less or stopping smoking, and where appropriate referral to specialist services. For example, a single intervention (including screening) should be between 30 seconds and 5 minutes depending on the complexity or interest of the patient.

3.2. Alcohol identification and brief advice

Alcohol identification and brief advice (IBA) aims to identify and influence patients who are increasing or higher risk drinkers (i.e. those who drink above low-risk levels).

The intervention is most impactful when it helps identify and advise patients who are not dependent but whose drinking is increasing their risk of a wide range of ill health linked to drinking alcohol (i.e. c28% of population). In addition, the intervention will identify dependent drinkers who need further support.

Healthcare professionals can deliver the intervention as a short informal conversation, for example, while undertaking routine care or as part of assessment or discharge.

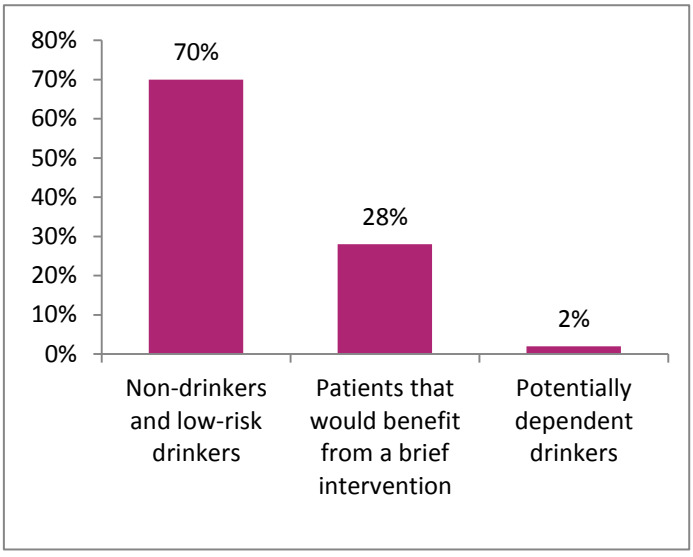


Figure 1: Proportions of the population by level of risk of health harm from alcohol

[6] These are very conservative estimates accounting for the reduced cost of hospital admissions only. There would also be wider NHS savings not considered here, such as reduced ambulance call outs and GP appointments.

Figure 2: An example of an AUDIT C scratch card

Healthcare professionals do not require a comprehensive knowledge about alcohol harm to deliver IBA well (see also Annex A). IBA is effective and comprises, in its simplest form:

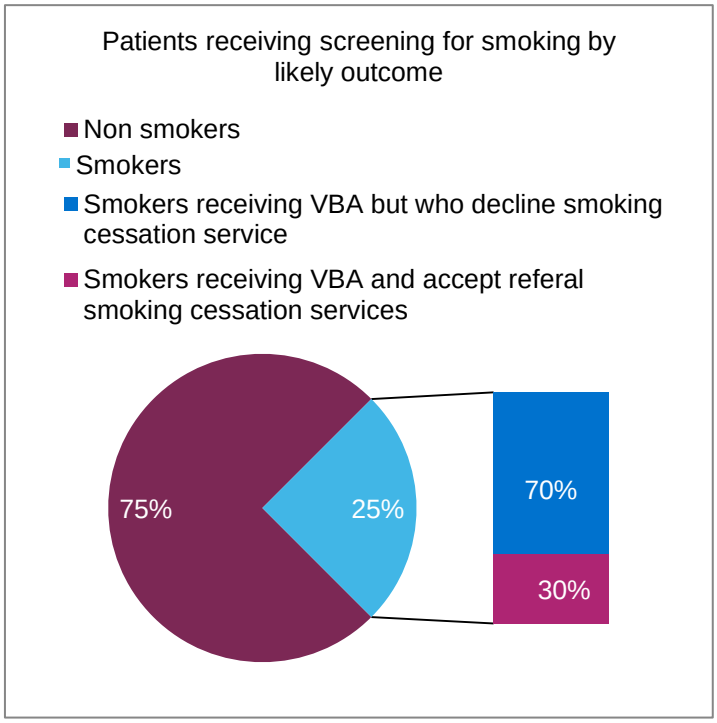
1. Giving patients an AUDIT-C scratch card [Figure 2] to complete or asking the AUDIT C three questions orally and scoring their answers
2. Feeding back to the patient what their score indicates about their health risk
3. Providing a patient information leaflet with information about harm, benefit and cutting down to patients who drink above low-risk levels (but are not dependent).

For patients who are identified as dependent drinkers, healthcare professionals will refer them to local specialist services.

3.3. Very brief advice for smoking cessation: ASK, ADVISE, ACT

Very brief advice for smoking cessation (VBA) aims to identify and influence patients who smoke to make a quit attempt.

Healthcare professionals can deliver VBA, in as little as 30 seconds. The intervention is made up of 3 core components: ASK, ADVISE and 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.



Healthcare professionals do not require a comprehensive knowledge about tobacco dependency to deliver VBA effectively, though some basic information may enhance the quality of delivery. In its simplest form, healthcare staff would:

1. ASK – and record smoking status - Is the patient a smoker, ex-smoker or a non-smoker?
2. ADVISE – on the best way of quitting - The best way of stopping smoking is with a combination of medication and specialist support.
3. ACT – by offering referral to specialist support and prescribing medication if appropriate. They are up to four times more likely to quit successfully with support.

Approximately 25% of patients are likely to screen positive for smoking (BTS, 2016) and up to 70% in psychiatric units (King's Fund, 2006)[7]. All people who smoke should be offered a referral to an effective smoking cessation intervention, of which 30% are likely to accept [Figure 3].

[7] Jochelson J and Majrowski B (2006) Clearing the Air: Debating smoke-free policies in psychiatric units. King's Fund. https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/clearing-the-air-debating-smoke-free-policies-psychiatric-units-karen-jochelson-bill-majrowski-kings-fund-18-july-2006.pdf

4. How will trusts implement these brief interventions: system-wide action to support implementation?

4.1. Commitment and engagement from local health and care leadership and staff

Implementing the CQUIN successfully requires commitment at all levels throughout the trust. It is important that there is active support for key aspects of implementation and delivery, including relevant healthcare professionals, clinical leads and hospital managers, and leaders involved in workforce development, performance management and data systems.

The challenges faced by different trusts will vary. This CQUIN applies to mental health trusts and community trusts from 2017/18, and to acute trusts from 2018/19.

We recommend that trusts identify champions for the implementation of the CQUIN at all levels of the organisation, including at board level. As part of this process, trusts should identify a team of clinicians and managers who will be responsible for the success of the CQUIN; including for example, clinical specialists, ICT and data managers, those with responsibility for training, and smoking cessation/ alcohol care teams both in hospitals and in the community – suggestions in table 1 below.

Table 1: Examples of key stakeholders who could be involved

	NHS Trust	Local authority
Governance	Governance lead	Director of Public Health
Contracts	Contracts manager	Contracts manager
Planning data	Head of Planning and Performance Data analyst	LA substance misuse commissioner, tobacco control lead
Clinical leadership	Medical Director and Director of Nursing (or deputies), Clinical directors/consultants in key areas	Public health consultant Clinical manager alcohol treatment service
Academics	Tobacco/alcohol researcher	Public health registrar
Specialist teams	Stop smoking specialist Alcohol care team/alcohol specialist nurse	Stop smoking coordinator Community alcohol treatment manager
Prescribing	Trust pharmacist	Stop smoking specialist
Care pathways and Workforce development	Ward managers, alcohol/tobacco specialist teams	Stop smoking coordinator Community alcohol treatment manager

Behavioural Insight: Staff engagement

Utilise commitment devices to engage staff: Staff may be more likely to engage in behaviours that contribute to the achievement of CQUIN if asked to make a public commitment. This could include, for example, asking staff to sign a commitment contract for the delivery of brief advice.

Example of use: In one study health professionals displayed signed letters, committing to the avoidance of inappropriate antibiotic prescribing, in examination rooms. During the intervention period, inappropriate prescribing rates decreased by 9.1%.[8]

4.2. System partners working collaboratively

The effective implementation of this CQUIN will require collaborative working across the health and care system, including local government.

4.2.1. Awareness of existing services and incentives

This CQUIN has been designed to incentivise interventions to address alcohol and smoking among inpatients. But it is already accepted good practice to screen and act on screening results for all patients when the opportunity arises. Therefore, trusts should aim to embed these interventions throughout their current systems.

This CQUIN is part of a suite of incentives that trusts will be working with, and a number of these incentives will be complementary. For example, CQUIN "for improving physical healthcare to reduce premature mortality in people with severe mental health illness" (PSMI CQUIN) includes a requirement for clinicians to undertake cardio metabolic assessment and treatment for patients admitted with psychosis for longer than 7 days, which covers smoking status and alcohol use. Trusts will therefore want to build on this internal good practice, and develop synergies across their work in delivering CQUINs to maximise the opportunities and reduce cost duplication.

Trusts will also need to be aware of the services being commissioned by Local Authorities (LAs), especially services that support smoking cessation and/ or seek to prevent and treat dependent drinking. It is therefore important to work closely with Directors of Public Health and commissioners to understand what is available.

4.2.2. Ensure effective care pathways

Trusts will need to work closely with Local Authorities to ensure there are effective care pathways for the successful implementation of the CQUIN.

[8] Meeker, D., Knight, T.K., Friedberg, M.W., Linder, J.A., Goldstein, N.J., Fox, C.R., Rothfeld, A., Diaz, G. and Doctor, J.N., 2014. Nudging guideline-concordant antibiotic prescribing: a randomized clinical trial. JAMA internal medicine, 174(3), pp.425-431.

In particular, trusts should ensure:

- The full pathway, from screening through to referral, can be delivered.
- Discussions take place with CCGs and LAs regarding the provisions of stop smoking interventions and alcohol specialist services.
- Stop smoking medications (ideally both NRT and Varenicline) are available on the hospital formulary and all relevant healthcare professionals are able to prescribe, or initiate an appropriate prescription.
- Activity to embed the CQUIN takes place across the trust and is linked to other relevant initiatives e.g. securing & sustaining a smokefree hospital campus, or enhanced pharmacy action on discharge medication.
- Swift attention to baseline information.

4.3. Workforce development

For those trusts with existing alcohol care teams and/or smoking cessation teams their specialist knowledge and skills will be invaluable in spreading good practice across the workforce, and working with patients in need of more than brief advice.

- Many trusts already have existing alcohol care and smoking cessation teams. Their specialist knowledge and skills will be valuable in supporting the skills development for other hospital staff to deliver the interventions; and supporting best practice.

Behavioural Insight: staff performance

Create opportunities for social comparison: We are influenced by how our performance compares with others, especially those with similar characteristics to ourselves. Provide groups of staff on a regular basis with their performance against the CQUIN target with other staff group. This could be achieved, for example, by displaying a relative ranking of each ward's performance on staff notice boards.

Example of use: PHE Behavioural Insights Team conducted a study which found providing GPs with their relative rank for antibiotic prescribing reduced prescribing by 3.3%, equivalent to 73,406 fewer antibiotics prescribed.[9]

- Brief interventions are non-specialist and do not require high levels of knowledge or skill. For example, healthcare professionals could be trained to deliver these routine interventions in less than an hour.

- Local training and education leads may be able to support the inclusion of smoking cessation VBA and alcohol IBA training at staff induction and part of training programmes, for example, for trainee doctors, pharmacists, nurses and allied health professionals.

    - Free to access on-line training resources are available from the National Centre for Smoking Cessation & Training. The very brief advice (VBA) training takes only 20 minutes and the intervention can take as little as 30 seconds to complete in a real consultation. http://elearning.ncsct.co.uk/vba-launch.

    - Training on alcohol IBA takes less than an hour, and the intervention (including screening) can take as little as 2 or 3 minutes. Training is available on the Learning for Healthcare Hub here.

    - Resources and training forming part of Making Every Contact Count may also be useful in the development of skills to enable behaviour change.

- **Food for thought:** Are there others in the organisation leading and enabling behaviour change skills in the healthcare delivery workforce? For example, in North London staff are able to access Co-Creating Health training: a behaviour

[9] Hallsworth, M., Chadborn, T., Sallis, A., Sanders, M., Berry, D., Greaves, F., & Davies, S. C. (2016). Provision of social norm feedback to high prescribers of antibiotics in general practice: a pragmatic national randomised controlled trial. The Lancet, 387(10029), 1743-1752.

change skills development programme for clinicians developed by the Health Foundation.

Behavioural Insight: staff engagement

Provide personal feedback to staff about the outcomes of their actions: Staff may feel disconnected from the achievement of the CQUIN as the incentive is at an organisational level but the behaviour required is at an individual level. Providing staff with personalised feedback regarding the outcomes of their actions, such as feeding back whether a patient they provided brief advice to has taken up the offer or quit smoking, may increase staff participation in the behaviour and allows reflection on the quality of individual interactions.

Example of use: In one study researchers found that providing GPs with post-it notes and written feedback about the appropriateness of their referrals decreased inappropriate referrals by 7.2%.[10]

4.4. Frequently Asked Questions on implementing the CQUIN

- **Should these interventions only be delivered to inpatients?** This CQUIN incentivises the delivery of the interventions to inpatients, but they can and should be delivered more widely in line with NICE guidance on reducing smoking in acute and mental health settings [PH48] and preventing alcohol use disorders [PH24].

- **Does age or diagnosis impact whether the interventions should be delivered?** No. All adult inpatients that are not in a maternity ward are eligible to receive the interventions. That is, adult patients of any age who present with any condition should be offered very brief advice and alcohol IBA. This ensures that all patients receive the best care and are provided with a full range of options.

- **Who can deliver these interventions?** Both alcohol IBA and very brief advice for smokers should be delivered by healthcare professionals. Patients expect to be asked about, and will not resent the questions and advice coming from professionals that are involved in their health care.

- **When should the interventions be delivered?** The interventions should be delivered at any point in the patient journey that makes sense. There is some evidence that doing it during the initial assessment is beneficial; for example, as

[10] Eccles, M., Steen, N., Grimshaw, J., Thomas, L., McNamee, P., Soutter, J., Wilsdon, J., Matowe, L., Needham, G., Gilbert, F. and Bond, S., 2001. Effect of audit and feedback, and reminder messages on primary-care radiology referrals: a randomised trial. The Lancet, 357(9266), pp.1406-1409

part of a "Stop before the op" programme. However, this may not always be appropriate, such as for patients admitted with severe mental health illness. Keep in mind that in smoke free services, providing tobacco very brief advice early in the patient journey will be important to ensure the patient is supported to stop smoking or manage nicotine withdrawal.

- **Are there times when you shouldn't do the intervention?** At times it may not be appropriate to deliver the interventions to patients, for example while they are intoxicated. However, keep in mind that it is important to help patients to manage nicotine withdrawal as soon as possible.

- **What is a unique patient?** Unique is defined as a non-repeat admission of a patient during the duration of the CQUIN (FY 2017/2018 and 2018/2019) who has not already received the intervention within the period of the CQUIN. Examples:

  For indicator 9a, if a patient is admitted in Q1 and is **not** screened for smoking, then the patient is included in the denominator but **not** the numerator for Q1.

  For indicator 9a, if a patient who was not screened in Q1 is readmitted in Q2 and this time is screened for smoking, then the patient is included in the numerator and denominator for Q2.

- **Which screening tools are appropriate?** There are a range of evidence-based screening tools for alcohol harm that can be used, we would recommend AUDIT-C for brevity, but so long as it follows NICE guidelines, the decision on which tool to use is one for providers to make. For smoking the NCSCT have produced a briefing on the clinical case for providing stop smoking support to hospitalised patients - http://www.ncsct.co.uk/usr/pub/hospitalised-patients.pdf; and other tools such as the Lester tool could be appropriate and are already being encouraged, for example, by the PSMI CQUIN.

- **Is alcohol IBA about identifying dependent drinkers?** No, while a small number of dependent drinkers will be identified and should receive a referral to specialists for further assessment, the significant benefits to the health system will come from identifying and providing brief advice to those drinking at increasing risk and or higher risk levels.

- **What do we mean by referral?** To see the anticipated benefits from the smoking cessation intervention, smokers must be referred (not just signposted) to somewhere they can receive an effective stop smoking intervention. Existing local services can be found through this link. For alcohol, unless the screen suggests the patient may be drinking at dependent levels there is no need for a referral – the delivery of brief advice is sufficient. Where someone may be dependent a referral can be made either to the alcohol care team (if available) or to the local community alcohol treatment service. Local specialist alcohol services can be found here and clear pathways will need to be put in place to these services before commencement of activity.

4.5. Additional supporting resources for trusts

4.5.1. Smoking cessation

- PHE has published a NICE endorsed tool to support mental health trusts in assessing their progress towards being smoke free. A tool aimed at acute trusts has also been developed.
- British Thoracic Society (2013) The Case for Change: Why dedicated, comprehensive and sustainable stop smoking services are necessary for hospitals
- National Centre for Smoking Cessation and Training; including the clinical case for proving stop smoking support to hospitalised patients
- London Clinical Senate programme: Helping Smokers Quit: Adding value to every clinical contact by treating tobacco dependence

4.5.2. Alcohol harm reduction

- Links to e-learning courses for delivering alcohol IBA in hospital settings.
- IBA Training Resources – These include screening tools (including AUDIT-C), training tools, and a structured tool for brief advice.

5. Data collection

NHS England will work with partners and reflect further on our proposal for data collection, which, as set out in the CQUIN indicator, is for providers to audit patient records and submit data to CCGs on a quarterly basis. Providers with searchable electronic patient records will be expected to audit all patient records as relevant; and those that do not have searchable electronic patient records conduct audits of a random sample of patient records.

For Trusts using patient records:
All trusts are different, so it is recommended that all Trusts conduct an audit of existing information systems in order to determine the best approach for the Trust to record and collect the required data. We have worked with colleagues and providers to develop a data collection tool to simplify the process, prompt data collection and limit the burden on providers. Use of these tools is optional. The tools available are:

- Data collection form – used to record delivery of the interventions
- Data collation template – used to collate and report on indicators
- Guidance for using these tools

The tools can be found on the GOV.UK website.

Behavioural Insight: data collection

Ensure prompts for screening and data collection are built into existing systems: To reduce the friction costs of participation ensure prompts are built into current systems. This could be, for example, adding a prompt onto a frequently used clinical checklists or building prompts into IT systems.

Example of use: PHE Behavioural Insights Team introduced prompts on GP IT systems increased uptake by a relative 65% in Southwark. Prompts remind clinical staff to invite eligible patients to complete their NHS Health Check in a timely manner. Since many clinical systems have the facility to add prompts, no/minimal additional costs are required.

Adrian Brown, an alcohol specialist nurse who has led CQUIN work on alcohol IBA in in two busy London trusts (one mental health and the other acute), fed back that adequate data collection is achievable, if challenging, even with paper-based systems. He also points out how CQUIN requirements can address long-standing clinical information needs by standardising recording.

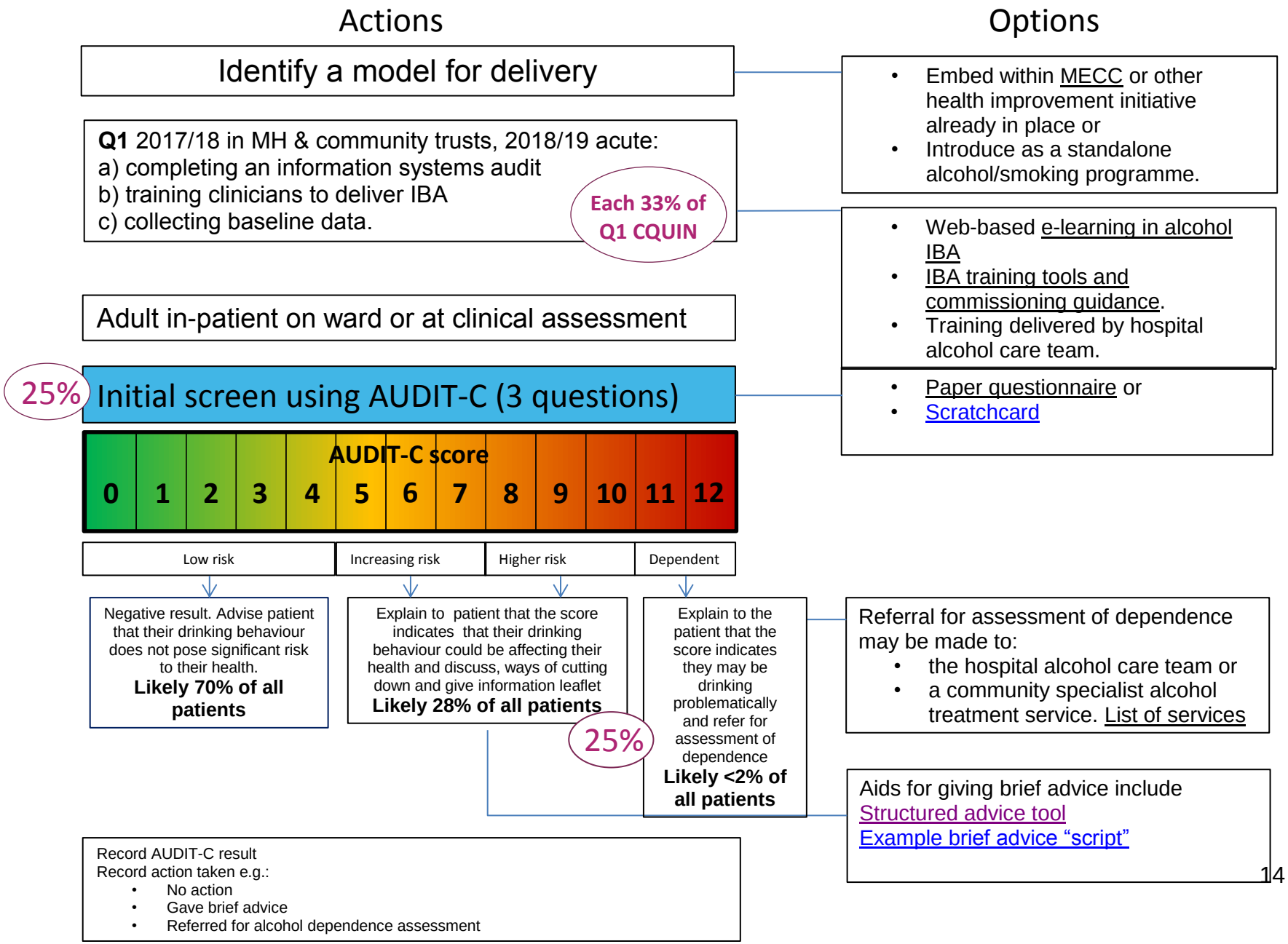
"My experience was that ward and emergency department teams were able to quickly adopt a standard screening (AUDIT-C) and we were able to find straightforward ways to integrate this in standard forms. (We hoped to make this electronic, and some work was done with the trust's information department as they were moving towards a new database.)

In the mental health trust, we have standard protocols for screening smoking and alcohol and we are currently piloting an updated version. This is a standard requirement so the first parts of each [prevention] CQUIN will be achievable.

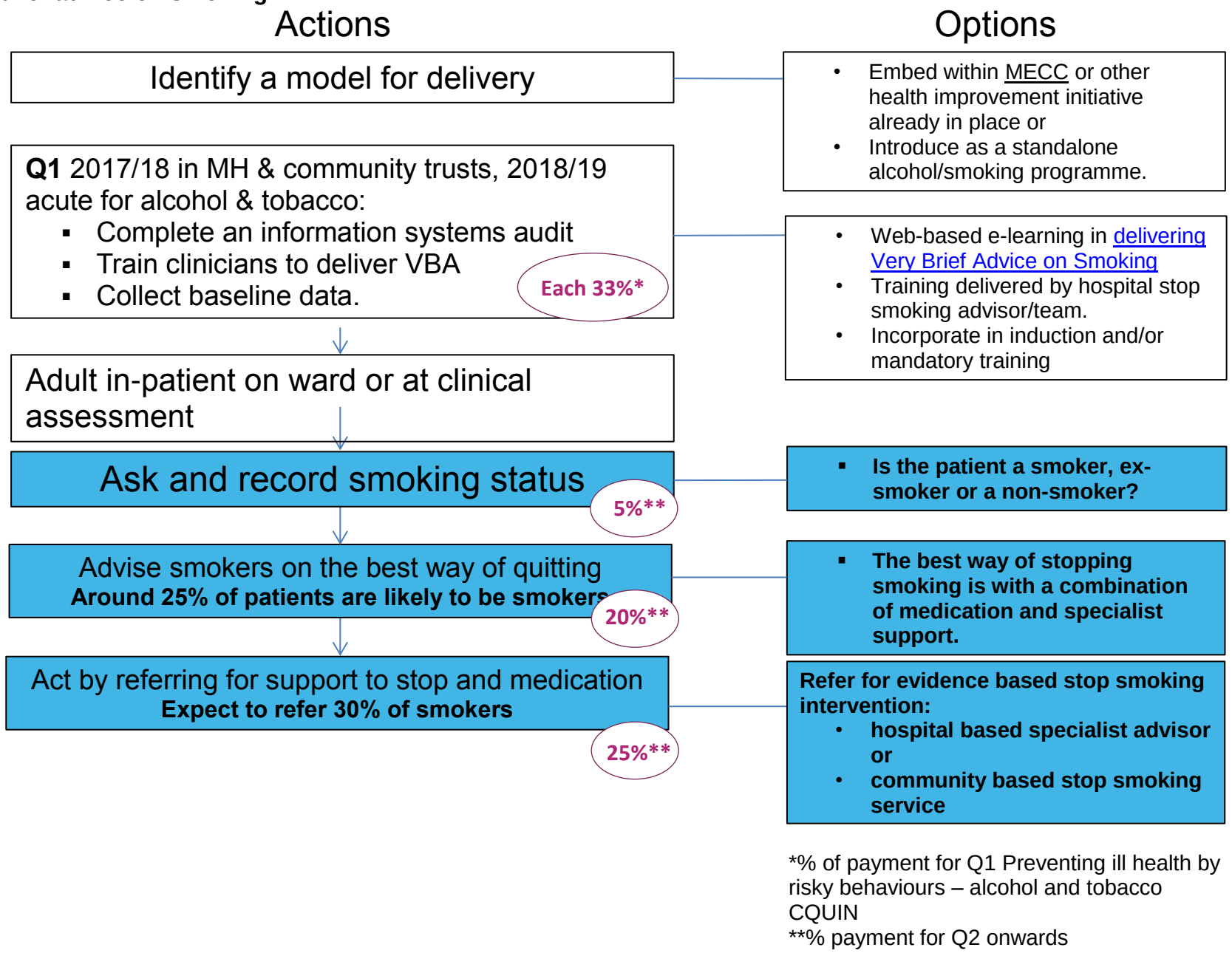
I completed very thorough audits of Emergency Department and Acute Assessment Unit notes for an existing local CQUIN [in an acute trust], so am happy to share that process (e.g. where to look in the notes, and what's an acceptable record for the baseline purposes).

Elsewhere, in my hospital-based work, it's been a constant bugbear that standard questions are not employed, so we don't get comprehensive smoking histories (e.g. years, amounts, type, etc.) and the alcohol question (if it is there) is simply 'occasional', 'social' or something even more vague."

Annex A: Alcohol identification and brief advice



Annex B: Very brief advice on smoking



*% of payment for Q1 Preventing ill health by risky behaviours – alcohol and tobacco CQUIN

**% payment for Q2 onwards

Aids for giving brief advice include:

- Clinical case for providing stop smoking support to hospitalised patients
- VBA Flow chart