Early implementer stop smoking services in community mental health settings

Early learnings of the facilitators and barriers to set-up

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Background

Model 1: Physical Health Check for people with SMI AND may include Primary Care Contact

- North East and North Cumbria**
- Norfolk and Waveney

Model 2: Discharged from Mental Health inpatient setting AND may include patients attending MH outpatient clinic

- Nottingham and Nottinghamshire
- Sussex
- Greater Manchester

Model 3: Making every contact count embedded in CMHS

- North East London*
- Cornwall and Isles of Scilly

- *Responses not yet summarised
- ** Involving four satellite sites. 2/4 responses summarised

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Facilitators

What has supported the set up of the tobacco dependency services?

- Acknowledgement of enhanced support required by SMI population to quit [1]
- Stakeholder interest and support [5]
- Making use of existing infrastructure used by stop smoking services already running such as protocols, data collection tools, recruitment support and digital systems [4]
- Additional funding to facilitate aspects of the services e.g. pharmacotherapy support [1]
- Prior knowledge and experience of project leads, including key contacts [2]
- Supportive management [1]

Barriers

What has hindered the set up of the tobacco dependency services?

- Uncertainty of the sustainability of NHSE funding, resulting in issues with recruiting staff due to requirement for short term contracts [4]
- Very short expected timescales for the set-up of the service [1]
- Trouble finding people with the relevant experience, for example mental health expertise [1]
- Difficulties recruiting in certain areas and delays to start dates due to pre-employment checks [1]
- Lack of time and competing capacity to ser up the service alongside other responsibilities [1]

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What might services do differently?

- Longer timescales to set up the service [2]
- Early engagement of partners and stakeholders [1]
- Put key processes such as NRT and vape dispensing, and information sharing in place ahead of time [1]
- Ensure service is needs-led and personalized
  - For example, making services work across both inpatient and community services and reduce restrictions on referral pathways [2]
- Ensure the correct systems are in place for, and there is clarity on data collection requirements [1]
- Large scale communications strategy to ensure that all responsible for referring patients into the service are aware of it [1]

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