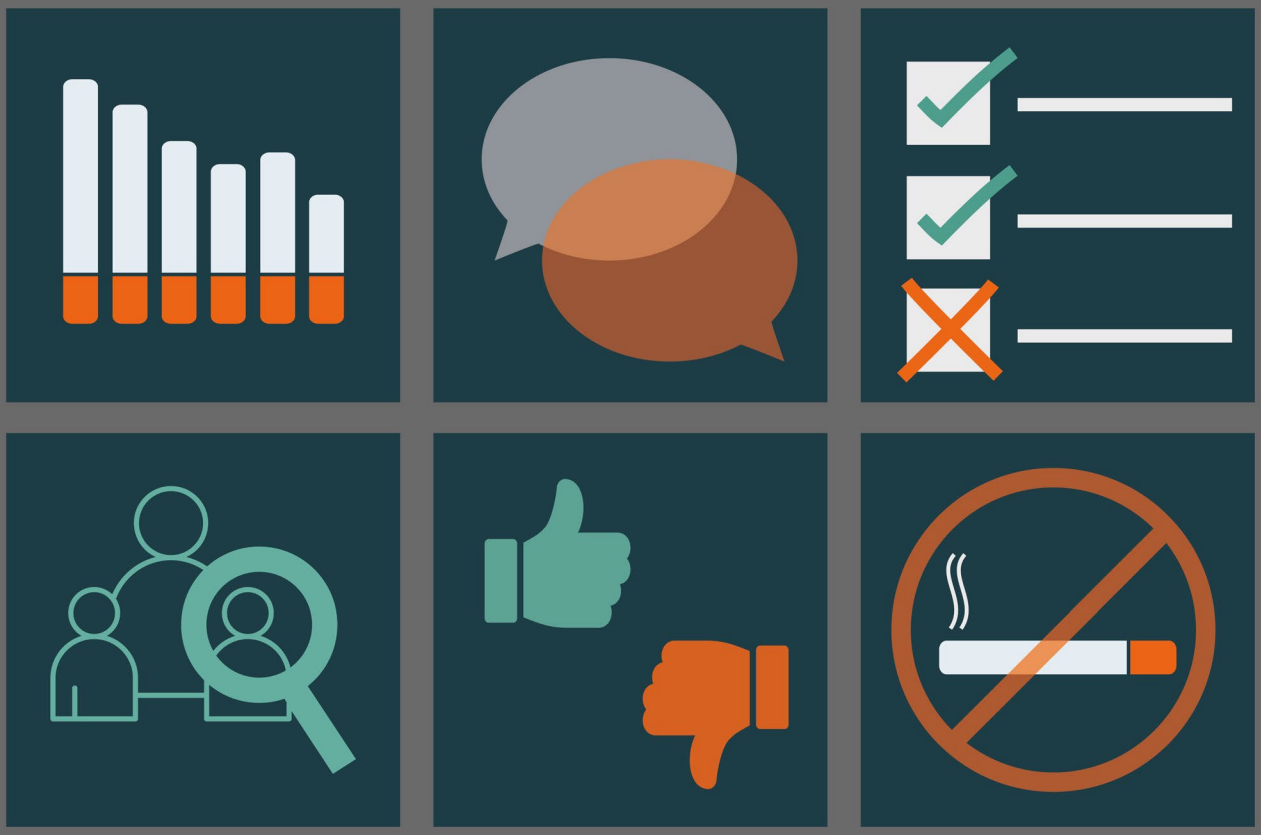
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

NHS England

Tobacco dependency community-based services for people with severe mental illness

An evaluation of NHS early implementer sites



Appendices to the report

Corrections, 27 November 2024:

- In Appendix 4, participant characteristics, time in role was amended from >2 to >3 years.
- In Tables 1–6, a formatting error was deleted from the table captions.

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Contents

List of abbreviations[a]

ELFT	East London Foundation Trust
ICB	Integrated Care Board
ICS	Integrated Care System
NCCMH	National Collaborating Centre for Mental Health
NCSCT	National Centre for Smoking Cessation and Training
NENC	North East and North Cumbria
NRT	Nicotine replacement therapy
SMI	Severe mental illness

[a] Glossary terms can be found in the main report.

Appendix 1. Copy of the site lead survey

This appendix contains a copy of the of the form that was sent to leads of the early implementer sites for the tobacco dependency community-based services.

Purpose of the questionnaire

The purpose of this questionnaire is to collect information from the early implementer sites as part of the evaluation of an NHS England pilot, to inform the next roll out of tobacco dependency treatment services in mental health trusts. This evaluation is being conducted by the National Collaborating Centre for Mental Health (NCCMH).

The questions will focus on what the early implementer tobacco dependency treatment services look like in practice, including configuration, staffing, working arrangements, and barriers and facilitators to implementation.

Useful information about filling in the form

This form is intended for the Early Implementer Site leads. If there is more than one site lead, each person can submit a form.

To complete the form, you will need access to information on staff numbers, training, planned future service outcomes and staffing, funding and stakeholders involved in the implementation of the service.

The form will take approximately 30–40 minutes to complete.

You may need to ask colleagues for any information you do not have. If the information asked for is not available, please state this in the further information boxes provided.

Additional comments or elaboration on any of the questions will be very helpful. Please use the text boxes for this purpose. If additional details are not available, please write N/A.

The form needs to be completed in one attempt as it is not possible to save and return to the form. Therefore, please ensure you have sufficient time to complete the survey and the information that you need to hand.

If you have any questions or need help with any part of the form, do not hesitate to contact us at: quitt@rcpsych.ac.uk

Please submit the completed form by December 16th, 2022, 9am

Section 1: Information about the trust

1) Please select the trust in which your Early Implementer Site is based
    a. Cornwall and Isles of Scilly
    b. East London
    c. Greater Manchester
    d. Sussex
    e. Nottingham & Nottinghamshire
    f. Norfolk & Waveney
    g. North-East and North Cumbria
2) Please provide your contact details (i.e. name, job title, email, telephone number), in case we require further clarification on any of your answers [open ended]
3) What is the current status of your trust's smoke-free policy?
    a. In force
    b. Suspended
    c. In development (not yet approved)
    d. Other (please describe)
4) In which year was the smoke-free policy written (if relevant)? [free text]
5) Please give a brief description of your trust's smoke-free policy (if relevant), and how it operates in community settings [free text]

Section 2: Implementation of tobacco dependency treatment services

Section 2.a: Pre-mobilisation

Please tell us what was already in place before pre-mobilisation of the tobacco dependency treatment services and how this facilitated the set-up of the service.

6) Was there any funding already in place that helped to support the set-up of the service?
7) Please provide details about any funding already in place
8) Were any stakeholders already identified which supported the set-up of the service?
9) Please provide details about any stakeholders who were already identified
10) Were any tobacco dependency treatment protocols already in place which helped to support the set-up of the service?
11) Please provide details about any protocols already in place
12) Please provide details about anything else that was already in place or on the ground, which facilitated the set-up of the tobacco dependency treatment service

Section 2.b: Funding

13) Have any additional funds, alongside early implementer site funding, been allocated for the implementation of tobacco dependency treatment services?
    a. Yes
    b. No
14) Please provide details about the identification of additional funds, including the source of the funding if yes [open ended]
15) Do you link into the Integrated Care Board (ICB) around implementation of this service?
    a. Yes
    b. No
16) Please provide details about how the service links with the ICB. For example, do you know If a prevention and health inequalities board lead has been identified? [open ended]
17) Has a trust/service lead been identified to be a member of the Integrated Care System (ICS) prevention, health inequalities or tobacco steering group? Please tick all that apply.
    a. Yes – the ICS prevention group
    b. Yes – the health inequalities group
    c. Yes – the tobacco steering group
    d. None of the above
18) Please provide details about the identification of a trust/service lead to be a member of the ICS prevention, health inequalities or tobacco steering group. [open ended]
19) Please describe any facilitators to the identification of funds. [open ended]
20) Please describe any barriers to the identification of funds. [open ended]

Section 2.c: Ownership, partnership and coordination

21) Please indicate whether a senior manager has been assigned responsibility for endorsing the programme.
    a. Yes – the trust chief executive
    b. Yes – the trust chief operating officer
    c. Yes – the trust chief finance officer
    d. Yes – the trust head of nursing
    e. Yes – the senior responsible officer based within the trust
    f. Yes – the chair of the tobacco steering group
    g. Yes- other (please give details below)
    h. No
22) Please provide details about assigning a senior manager responsibility for endorsing the programme. [open ended]
23) Please indicate whether a trust clinical lead has been identified
    a. Yes

   b. No
24) Please specify who this person is (describe their job role and other responsibilities)
25) Please indicate whether a project manager has been assigned for the early implementation of the tobacco dependency treatment service – this person's responsibilities are to implement all aspects of the programme and work alongside the trust clinical lead.
   a. Yes
   b. No
26) Please provide details about assigning a project manager. [open ended]
27) Please select which of the following regional and local key stakeholders have been identified:
   a. Regional tobacco control leads (Office of Health Inequalities and Disparities [OHID])
   b. Regional respiratory clinical network leads
   c. Regional long-term plan prevention working group lead
   d. Local authority public health prevention lead
   e. Local Stop Smoking Service lead
28) Please provide any relevant details about the identification of regional and local key stakeholders. [open ended]
29) Please describe any facilitators to ownership, partnership and coordination. [open ended]
30) Please describe any barriers to ownership, partnership and coordination. [open ended]

Section 2.d: Programme planning

31) Has a service user referral and assessment protocol been developed?
   a. Yes
   b. No
32) Please provide details about any service user referral and assessment protocol in place, or reasons it is not in place/when it is planned to be in place [open ended]
33) Please select the people or services that can refer into your tobacco treatment programme.

   a. GP/other primary care healthcare professional
   b. On discharge from inpatient services
   c. Community mental health team (CMHT)
   d. Other physical health providers
   e. Self-referral
   f. Other (please specify)
34) Is a protocol for prescriptions in place?
   a. Yes
   b. No

35) Please provide details about any protocol for prescriptions, or reasons it is not in place/when it is planned to be in place. [Open ended]
36) Has a primary outcome measure been agreed?
    a. Yes
    b. No
37) Please provide details about the primary outcome measure, or reasons this has not yet been agreed. [open ended]
38) Has a digital system been put in place to collect data?
    a. Yes
    b. No – in planning stage
    c. No
39) Please provide details (if yes/in planning stage, please describe this system; if no/in planning stage please specify what barriers have prevented this system being put in place). [open ended]
40) Is there a plan to use outcomes for further service evaluation? (tick all that apply)
    a. Yes – for development
    b. Yes – for improvement
    c. Yes – other
    d. No
41) Please provide details about the use of outcomes for further service evaluation. [open ended]
42) Have key deliverables/milestones been agreed?
    a. Yes
    b. No
43) Please provide details about key deliverables/milestones (if yes, please state what and when these are; if no, please specify which barriers have prevented the agreement of these deliverables). [open ended]
44) Please describe any facilitators to programme planning. [open ended]
45) Please describe any barriers to programme planning. [open ended]

Section 2.e: Staff recruitment

46) Have you got an agreed specification for the composition of staff for the programme?
    a. Yes, and all staff roles have been filled
    b. Yes, but we are currently actively recruiting
    c. Yes, but we have not yet started staff recruitment
    d. No
47) Please provide details about the specification, or reasons for not having one. [open ended]
48) Please state: a) job title and b) training in tobacco dependency treatment of each staff member involved in the service. [open ended]

49) What additional roles are planned/are you still recruiting for? (please state job title and required training). [open ended]
50) Please state whether relevant staff have been trained in Very Brief Advice (VBA)
51) Please provide details about VBA training [open ended]
52) Please state whether relevant staff have been trained in prescription of pharmacotherapy as a treatment method
53) Please provide details about prescriptions training
54) Please state whether relevant staff have been trained in patient referral
55) Please provide details about referrals training. [open ended]

56) Which of the following additional team members **have been identified** and assigned roles and responsibilities?
    a. Tobacco dependency advisors
        i. Sufficient number have been recruited for trust size and budget
        ii. Some have been recruited but more to recruit
        iii. None
57) Please provide details about the identification of tobacco dependency advisors. [open ended]
58) Which of the following additional team members **have been identified** and assigned roles and responsibilities?
    a. Communications lead(s) to liaise and work to develop a communications strategy and resources
        i. Sufficient number have been recruited for trust size and budget
        ii. Some have been recruited but more to recruit
        iii. None
59) Please provide details about the identification of a communications lead. [open ended]
60) Which of the following additional team members **have been identified** and assigned roles and responsibilities?
    a. IT lead(s) to ensure all IT systems are in place
        i. Sufficient number have been recruited for trust size and budget
        ii. Some have been recruited but more to recruit
        iii. None
61) Please provide details about the identification of an IT lead. [open ended]
62) Please describe any facilitators to staff recruitment. [open ended]
63) Please describe any barriers to staff recruitment. [open ended]

Section 2.f: Interventions

64) Does your service plan on providing nicotine replacement therapy (NRT)?
    a. This is already being provided to service users
    b. This is planned
    c. This is not planned

65) Is NRT provided from within the service or externally?
    a. Within the service
    b. Externally (please provide details below)
    c. Not applicable
66) Please provide details about NRT (If NRT is planned or being provided: what forms of NRT are provided, where are these provided from and for how long are these offered? If NRT is not planned: what are the reasons for this?
67) Does your service plan on providing vapes/e-cigarettes?
    a. These are already being provided to service users
    b. This is planned
    c. This is not planned
68) Are vapes/e-cigarettes provided from within the service or externally?
    a. Within the service
    b. Externally (please provide details below)
    c. Not applicable
69) Please provide details about vapes/e-cigarettes. (If vapes/e-cigarettes are planned or being provided: what type of product; are these provided directly or via provision of vouchers; for what duration is the product provided; and what volume of liquid is provided? If not planned: what are the reasons for this?) [open ended]
70) Does your service plan on providing other pharmacotherapy, namely bupropion?
    a. This is already being provided to service users
    b. This is planned
    c. This is not planned
71) Please provide details about bupropion. (If bupropion is being provided: for how long is this provided and what quantity is prescribed? if it is not being provided, please describe reasons for this) [open ended]
72) Does your service plan on providing any other pharmacotherapy?
    a. This is already being provided to service users
    b. This is planned
    c. This is not planned
73) Please provide details about any other pharmacotherapy your service is planning on providing. [open ended]
74) Does your service plan on providing any other (non-pharmacological) interventions?
    a. These are already being provided to service users
    b. This is planned
    c. This is not planned
75) Please provide details about any other (non-pharmacological) interventions. [open ended]
76) Does your current operational policy include the following? (select all that apply)
    a. Delivery by a specialist advisor with mental health expertise

b. Tailored support (duration and intensity) to the person's needs
c. Systematic identification of people that smoke
d. Opt-out referral
e. Commencement of tobacco dependency treatment within 7 days of referral
f. A dedicated stop smoking/tobacco dependency advisor with mental health expertise
g. Flexibility in lead time for setting a quit date
h. Structured cut-down
i. Availability of NRT, e-cigarettes and pharmacotherapy prior to quitting
j. Flexibility in terms of how and where appointments are delivered
k. Communication between the service and the service user's clinical team
l. Discharge support – follow-up calls post-discharge from services to identify relapse prevention or referral needs
m. Relapse support – support for service users to re-enter services if they relapse
n. None of the above

77) Please provide details, including reasons for not including any of these aspects
78) What measures has your service taken to ensure that the service contributes to addressing health inequalities and how has planned service delivery been configured to achieve this? [open ended]
79) What indicators will you use to identify the effect of these measures on addressing health inequalities? [open ended]

Section 2.g: Take-home messages

80) Overall, given your experience of setting up the early implementer tobacco dependency treatment services, what would you do differently if setting up similar services in other trusts? [open ended]
81) What do you need to have in place to achieve sustainability of the community tobacco dependency treatment services within your trust after the NHS England funding period is over? [open ended]

Appendix 2. Copy of the interview topic guide

This appendix contains a copy of a topic guide that was used during interviews with treatment providers and referrers.

Note:
* indicates questions asked to referring staff
† indicates questions asked to staff providing treatment

Interview topic guide

[Before recording]

Introduce self, explain what the study is about, consent, confidentiality, no right or wrong answers, right to withdraw at any time

Remind that this is about the services in the community mainly

[Recording begins]

Intro*,†

1) Can you tell me a bit about your role within the tobacco dependency treatment service?

Training and expertise†

2) Can you tell me about the relevant training and expertise you came to the role with?
3) And what training were you provided as part of your role within the tobacco dependency treatment services?
    a. Has any training that has been provided been beneficial/or not?

Intervention†

4) Can you describe the interventions that **are being/will be** provided to patients who are referred into the tobacco dependency treatment service?
    a. IF HAVE SEEN PATIENTS, What have you found has worked particularly well?
    b. IF HAVENT What aspects of this do you think will work particularly well?
    c. What **have you found has been/do you think will be** challenging in providing the intervention?

5) What are your thoughts on the way that tobacco dependency treatment is provided to service users?
    a. How do you think service users find the treatment?
        i. Are there any aspects which you think don't work as well for them as it should?
    b. Can you tell me any ways which the treatment is tailored, or should be further tailored to people with SMI?
        i. E.g. is the treatment tailored to different ethnic groups or cultures?

Referral process*

6) Can you tell me about how patients **are/will be** referred into your service?
    a. Can you tell me a bit about how well you think the service adheres to the commencement of smoking cessation delivery within 7 days?
        i. Can you tell me a bit about why you think the service is (not) achieving this? What has helped or hindered this?

Supervision†

7) Can you describe the supervision structure for your role in your trust?
    a. Do you feel well-supported?
    b. Is supervision provided regularly enough?
    c. How has supervision contributed to improved tobacco dependency treatment?
8) Do you provide supervision?
    a. If yes: do you feel that the staff, you supervise are well-supported?
    b. Do you feel you have enough time to provide supervision sufficiently regularly?

Team structure†

9) (If have not already described this as part of the intervention section) Can you tell me a bit more about how your team is set up?
    a. Sufficient staff?
    b. Do you think the current set-up works well?
    c. Is there anything you think should be done differently?

Overall and additional action*,†

10) What have you found challenging in working within the tobacco dependency service?
11) What have you found enjoyable or useful in providing the services?
12) Is there anything which you think would benefit other teams when setting up similar services in the future?

   a. How do you feel your role contributes to reducing health inequalities in service users with mental health problems? What aspects of the service have helped to achieve this?
   b. What more could be done to ensure this?

13) Have you participated in or used any other wider activities to support the success of the tobacco dependency treatment services?
   a. Have you provided any communications to service users?
   b. Addressing tobacco dependency in other staff members?
   c. Work with others to facilitate the programme?
      i. E.g. regional tobacco control leads in the Office of Health Inequalities and Disparities
      ii. Local stop smoking services?
14) Is there anything else you would like to mention which you feel is important regarding working in the tobacco dependency treatment services?

Appendix 3. Site-specific facilitators, barriers and measures taken to address inequalities and sustainability

This appendix provides additional information on the site-specific facilitators and barriers to mobilisation of the services, reported in the site lead survey.

Model 1: Primary care via physical health checks for people with SMI or primary care contacts

Norfolk and Waveney

Facilitators of the set-up of the service:

- Acknowledgement across the area that the SMI population needed enhanced support in order to quit sustainably.
- Interest and support from local stakeholders, including Together for Mental Wellbeing, East Coast Community Healthcare and Norfolk County Council.
- Making use of infrastructure, such as protocols for care used by Smokefree Norfolk, digital infrastructure and data collection processes.
- Additional facilitation of set-up via receipt of extra funding from Norfolk County Council for additional pharmacotherapy support.

Barriers to the set-up of the service:

- Uncertainty of sustainability of NHS England funding (as this was required to sustain the service),
    - Resulting requirements to recruit for short fixed-term posts.

Measures taken to address inequalities:

- Completion of assessments of inequalities that are then addressed.

Requirements for sustainability:

- Adopting a collaborative approach with providers.

North East and North Cumbria

Durham

Facilitators of the set-up of the service:

- Set-up of the service in an area being engaged with to develop a community mental health transformation hub, meaning the tobacco service could be developed in conjunction with news ways of working already being established
- Support from regional and local stakeholders who were already working towards supporting tobacco dependency treatment in the area.
- Sharing of infrastructure from ABL Health, who were contracted to support smoking cessation in the area:
    - In-house recruitment
    - Prescription protocols, e.g. use of e-vouchers for pharmacotherapy (this was adapted to provide an additional internal option to help engage those with SMI).

Barriers to the set-up of the service:

- Delays in recruitment.
- Uncertainty of sustainability of NHS England funding.
- Short expected timescales for the set-up of the project.

Measures taken to address inequalities:

- Dedicated advisor working with those with a registered SMI to provide additional support.

Things to do differently next time:

- Longer timescales to set up the service.
- Early engagement of partners to get buy-in.
- Put partnership working, information sharing, and NRT and vape dispensing processes in place ahead of time.
- Reduce meetings attended to maximise time available.

Key requirements for sustainability:

- Evidence of impact of the pilot in order to add this into future Stop Smoking Service reviews.
- Pathways embedding between primary care and specialist stop smoking support.
- Engagement of community mental health transformation teams to support a ‘no wrong door’ approach to stopping smoking with a registered SMI.

South Tyneside

Facilitators of the set-up of the service:

- Support from local stakeholders in the set-up of the service, who helped via provision of tried and tested incentive schemes, offers of behavioural support, stop smoking advisors and advice resulting from experience providing NRT.
- Use of financial incentives and behavioural support- this was already being provided in the general stop smoking provision in the area.

Barriers to the set-up of the service:

- Uncertainty and delays in NHS England funding.

Measures taken to address inequalities:

- Dual training of staff in the service as both social prescribing link workers **and** smoking cessation advisors:
    - This enabled them to support people in tackling the wider challenges related to determinants of health experienced by people with SMI which may prevent them from making health changes.
- Longer NRT provision (up to 24 weeks).
- Free e-cigarette provision.
- Provision of literature in an easy-read format.
- Personalising the intervention in terms of method, duration, intensity and length.

Things to do differently next time:

- Ensure service is needs-led and personalised, e.g. make the services work across both community and inpatient settings.
- Be more specific around differences between mental health and severe mental illness.
- Ensure correct IT systems are in place, and that there is clarity on the data that is required at the point of mobilisation.

Key requirements for sustainability:

- National and regional commitment to smoking cessation being a priority area, resulting in more availability of funding and resource.
- Opportunity to learn from other areas who have set up similar services.
- Clarity in how to reduce duplication of effort across inpatient and community smoking cessation service offers.
- Provision of assurance around the use of e-cigarettes.
- Additional updates to NRT guidance to make more person-specific.
- Additional guidance on how provision of tobacco dependency services will be linked to the Quality and Outcomes Framework for referring GPs.

- Additional personalisation of protocols for supporting people with SMI to quit smoking.

Northumberland

Facilitators of the set-up of the service:

- Local partnerships between council and ICB were already well established.
- Senior staff in Northumberland County Council and ICB were involved in project planning. Identified staff in Stop Smoking Service dedicated to the pilot.
- Using staff when recruiting.

Barriers to the set-up of the service:

- Ownership at practice level has proved challenging to establish as different partners have different capacity and competing demands.
- With their approach to staff recruitment, backfill processes take time, and staff frequently move to alternative jobs.

Measures taken to address inequalities:

- Universal training of mental health practitioners across the region, combined with targeted referrals pathways and specialist interventions.
- Primary care networks located in both rural and urban locations for comparisons.
- SMI outreach services.
- Demographic data is collected on all users of the Northumberland Stop Smoking Service, to allow for consideration of demographics when looking at the data.

Things to do differently next time:

- Not reported.

Key requirements for sustainability:

- Not reported.

Model 2: Discharge from inpatient mental health settings or attendance at mental health outpatient clinics

Sussex

Facilitators of the set-up of the service:

- Having key contacts in the area of tobacco cessation, and prior knowledge from previous jobs.
- Supportive management.

Barriers to the set-up of the service:

- Trouble recruiting people to short fixed-term roles and trouble finding people with relevant experience, e.g. mental health expertise.

Measures taken to address inequalities:

- Provision of free vapes.
- Taking treatment at the pace of the patient.

Things to do differently next time:

- Allow sufficient time for development of all relevant protocols.
- Form a large-scale communications strategy to ensure that all referrers are aware of the service.

Key requirements for sustainability:

- Ensure that all clinical teams referring patients are aware of the service.

Nottingham and Nottinghamshire

Facilitators of the set-up of the service:

- Involvement of the smoke-free lead and ICB in supporting with the set-up.

Barriers to the set-up of the service:

- Uncertainty and delays to NHS England funding:
    - This impacted on staff recruitment and retention.

Measures taken to address inequalities:

- Making the service opt-out.
- Robust training.

- Visible presence on wards.

Things to do differently next time:

- Receiving funding early in the financial year is crucial for setting up the service.

Key requirements for sustainability:

- Robust referral pathways for the services.

Greater Manchester

Facilitators of the set-up of the service:

- The set-up of a smoke-free steering group, which involves many stakeholders and is system-wide.
- Having local arrangements in place to facilitate recruitment.
- Having an experienced team in place during mobilisation.

Barriers to the set-up of the service:

- None stated.

Measures taken to address inequalities:

- Not in place yet.

Things to do differently next time:

- Not reported.

Key requirements for sustainability:

- Modelling of patient flow via data.
- Business case.

Model 3: Community mental health services via 'making every contact count'

Cornwall and Isles of Scilly

Facilitators of the set-up of the service:

- Having infrastructure in place via Healthy Cornwall who were already delivering stop smoking support in other areas:
    - This facilitated development of the service, recruitment, communications and IT
    - This also meant that protocols were available to be put in place.
- Support of stakeholders (alongside Healthy Cornwall) also facilitated the set-up.

Barriers to the set-up of the service:

- Difficulties recruiting in certain areas and delay of start dates due to pre-employment checks.
- Lack of time and competing capacity to set up the service alongside other responsibilities.

Measures taken to address inequalities:

- Use of population health management (use of data to identify groups with specific needs and how these can be addressed) to identify opportunities to further support patients.

Things to do differently next time:

- Reduce restriction on point of referral to allow additional referrals which are not from the community.

Key requirements for sustainability:

- Confirmation of additional funding.

East London

Facilitators of the set-up of the service:

- Expansion of pre-existing services.

Barriers to the set-up of the service:

- Some roles being fixed-term, and the service needs to make them permanent; however, this is not possible due to lack of funding.

Measures taken to address inequalities:

- East London Foundation Trust has a public Health team in which the Director of Public Health would identify health and population health inequalities.
- Additional funds were used to run a pilot in city and hackney directorate to provide free vapes for community service users to use closed pods systems for 100 patients and to be reviewed and continued provision as part of tackling inequalities.

Things to do differently next time:

- Ensuring that there are enough staff to cover costs and areas that may have become popular, e.g. child and adolescent mental health and administration.

Key requirements for sustainability:

- More staff in the community (East London is large community with five directorates; therefore, it is a challenge to capture all patients).

Appendix 4. Staff interview participant characteristics

This appendix provides information on the staff members who took part in interviews.

Participant characteristics (N=13)	N	%
Role		
Treatment providers	9	69.23
Referrers	4	30.77
Sites	6	46.15
North East and North Cumbria: Durham	2	15.38
North East and North Cumbria: South Tyneside	2	15.38
North East and North Cumbria: Northumberland	2	15.38
Norfolk and Waveney	3	23.08
East London	2	15.38
Sussex	2	15.38
Referral model		
Primary care	9	69.23
Community mental health	2	15.38
Discharge from inpatient services	2	15.38
Time in role		
<1 year	4	30.77
1–3 years	4	30.77
>3 years	5	38.46
Gender		
Male	4	30.77
Female	9	69.23
Ethnicity		
English, Welsh, Scottish, Northern Irish or British	12	92.31
African	1	7.69

Appendix 5. Staff interviews: theme description and additional detail

This appendix provides additional information and supporting quotes for the six themes that came from the qualitative analysis of staff interviews.

Table 1: The importance of flexibility

Subtheme	Participant group	Example quotes
Extended timeline and patience with process	Referral and treatment	A referrer and six treatment providers spoke about the importance of patience with the extended 'timeline' of the quit process in the SMI population. Built-in flexibility for multiple quit attempts and a longer lead-in to setting a quit date were seen as facilitators to supporting patients effectively. *'I think one of the challenges is the repeat, because people say, "Yeah, I'll stop, I'll stop", and then start smoking again. Then they'll stop. They'll start smoking...fortunately, the Stop Smoking Service is quite flexible. They know people will start smoking again, but it's encouraging them and they're quite open...if you want to come back, just give us a shout and we'll see you again.'* [R4] *'[He] says, 'Well miss, I do wanna give up. But I do feel that, you know, I need more time and I feel I'm always given a fixed time to give up smoking.'* [TP7]
Format and location	Referral and treatment	Flexibility with format and location were also deemed important for the success of the services. A referrer and six treatment providers discussed flexibly adapting treatment format to suit patient needs, for example visiting people in their homes if face-to-face appointments are needed, or providing telephone options if this is possible and desired. Where this wasn't possible, treatment providers felt this was a barrier to care. *'And so, I think that is the barrier in a sense, we don't have the flexibility of doing home visits, yeah.'* [TP5] Similarly, a referrer and treatment provider mentioned that a facilitator they had experienced was working in the same location as clozapine clinics as it meant patients could be seen straight away if referred from this service.

		'We've got the Stop Smoking Service in here every Wednesday, so we can make direct [referrals]. Because we run a clozapine clinic, we can say, "Do you fancy stopping?" "Oh, yes". So we can get them straight in…' [R4] However, two treatment providers highlighted that travelling to homes reduced the number of patients that could be seen and was not always efficient, which could be problematic for services with larger catchment areas and could raise some safety concerns for staff. *'It's quite a big area to cover and take a few hours to drive from one end to the other, so we do a lot. … you have to obviously really plan your days so you're in the same area …if you've got one person that's an hour and a half away and they're the only person in that area, it takes half a day to just to go and see them.'* [TP6] *'So, they're obviously a cohort with a lot of different challenges and then we don't specifically have a sort of venue to use or to utilise, so we would either be meeting people in the community somewhere or and in some cases doing home visits. But then on that also comes with certain a sort of risks and safety…'* [TP3]
Impact of flexibility on outcome data recording	Treatment	One consideration raised by two treatment providers was the impact of this needed flexibility on data, and outcome monitoring. It was felt that current practices were not equipped to deal with the extended process of the treatment in SMI populations. *'So, in terms of data, we're looking at 28 days and you'll find with our population they need more than 28 days…I'm not sure if it's showing the true reflection of the work that we are doing'* [TP5]
NRT and vape options	Referral and treatment	A referrer and two treatment providers described flexibility and a range of options in terms of NRT and vape options for patients as a key facilitator. *'The fact that they've got a range of access [to] NRTs, because you know if you talk to people, they say, "When I tried to give up last time, I didn't like the gum", and you think, "Well, that's one part of it, but there's a whole lot more to it than that."'* [R2] Within this theme, a referrer and treatment provider mentioned that being able to directly supply vapes and NRT

		rather than asking patients to go to a pharmacy was important in supporting them with their treatment. *'Direct supply, breaking down that barrier of someone having to go to a pharmacy and pick up medication, you can hand it to them there and then.'* [TP1]
Staff perceptions of taking a flexible approach	Treatment	Four treatment providers reported appreciating the opportunity to take this flexible approach, although three highlighted that in some instances it was difficult to apply this way of working when used to the standard tobacco treatment protocols. *'I suppose it's nice to have that flexibility to feel like what you're providing can be that little bit more patient centred.'* [TP1, NENC; Durham] *'Well, in the beginning I wasn't even told what the time frames were, so it was like, wait, OK, do I just let the person decide when they actually do want to set a quit date?'* [TP4]
Taking a person-centred approach	Referral and treatment	The importance of taking a person-centred approach to flexibly adapt support provided was highlighted in both referral and treatment processes. Staff felt that consideration of other stressors that affected patients' ability to quit smoking or begin treatment in the first place facilitated positive outcomes and patient engagement. *'Whenever I see somebody, I try and talk about their physical health. I try and talk about any habits that they might have around smoking, alcohol, drug use...I'll always discuss whether they, ... feel ready to stop or have some support with that process... it is a bit of a journey that maybe they're not ready to stop immediately, but they're willing to engage in that process.'* [R2] *'...Connecting in with something in the community or a service that might be useful, or giving them a couple of links, or just hearing out, you know, some of the challenges that they're facing...there is still you know a lot of challenges within keeping someone engaged and sort of continuing with the treatment and things as well. But yeah, I would say that our personal model seems to work quite well for engagement of the patients that we did have.'* [TP3] A referrer and three treatment providers specifically mentioned that building rapport was an important aspect

		of this person-centred approach to encourage engagement. *'I have that bit of banter and that bit of chat with them first… they can see I'm putting them at ease then I ask about the smoking and the alcohol and the drugs a little bit later in my chat with them.'* [R3]

TP = Treatment provider; R =Referrer.

Table 2: Training and expertise

Subtheme	Participant group	Example quotes
Mental health specific experience	Treatment	On experience with SMI populations, all treatment providers acknowledged the value of an understanding of this group. However, most felt that this understanding could be gained through training rather than serving as a mandatory prerequisite for their roles, suggesting that mental health specific experience does not need to be an inherent requirement for professional roles in the EIS services. *'I think it's all about understanding all the different nuances and combinations of conditions that our patients have and been able to fully support those, you know, completely, diversely and inclusively.'* [TP2] *'Because what we've certainly found is you can add the stop smoking knowledge and specific stop smoking skills as long as you've got that baseline there, which can come from a variety of backgrounds…I don't think it's necessarily important to recruit staff from a mental health background.'* [TP1]
NCSCT training as a starting point	Referral and treatment	A referrer and four treatment providers referenced the NCSCT training when discussing their training experiences, generally expressing its utility. *'So, when we first start, so we done the NCSCT…So you do the very brief advice and then you do the Level 2 training…I think that training, especially cause I had mine on my first week, it really did help me to kind of get an idea of what I meant to do and how to structure the sessions and so forth.'* [TP5]

Additional training	Referral and treatment	A referrer and three treatment providers described the advantages of additional training beyond the standard NCSCT, for example to facilitate more person-centred care, or learning more about vapes and their impacts to improve understanding: '*But we as social prescribers, at least in [place name], have the training within the conversational frameworks. But things like using open questions and motivational interviewing, and considering certain goals, and that type of positive way of thinking.*' [TP3, NENC; South Tyneside] *'One thing that's been really interesting for me is finding out about vapes, because you tend to think they are a safe version of smoking. But actually, some of them... if you're getting through a disposable vape a day, that's equivalent to 20 cigarettes a day.*' [R2]
Uncertain access to needed training	Treatment	Three treatment providers expressed difficulties in accessing all the necessary training required to effectively fulfil their roles within the service. *'It has been challenging to get my new staff to do the SMI and NCSCT course because of funding, and because we had it rolled out to us in January, we didn't have our full complement of staff. We've had to then beg, borrow and steal to try and get them into other courses I've delivered like a brief, light touch of that to the staff... We shouldn't really have a barrier to specific training in the SMI. You know, that's surprised me.*' [TP2]

TP = Treatment provider; R = Referrer.

Table 3: Reducing health inequalities

Subtheme	Participant group	Example quotes
Access to smoking support for all	Referral and treatment	A referrer and four treatment providers emphasised the significance of ensuring accessibility to the services for all potential recipients. For example, one mentioned the establishment of clinics in various areas across the catchment region to effectively reach individuals: *'Let's say [our region], there's 1000 patients, maybe 400 of them are smokers and then maybe 80 to 100, them will engage. Where are they located? How accessible are these services geographically'* [TP7] Another provider acknowledged the limitations in the areas covered by the services, recognising that some people could be being excluded from accessing these services. 'We *are only working in four PCNs [Primary Care Networks] across a big county...you're very conscious then that it is the sense of a post code lottery that only certain postcodes and areas are eligible for the service. We're very conscious that there are other patients within SMI...the main service will help those patients, but it isn't the same program model. It isn't 6 months of support. It's only 3 months of support. So, we are very conscious of that also.'* [TP2]
Additional support with access to other health or social support or services	Referral and treatment	Two referrers and four treatment providers felt that the tobacco dependency service contributed to reducing health inequalities by enabling access to additional services that support health and wellbeing. *'So, it's about that signposting, its about making every contact count and not just dealing with the stop smoking because sometimes they have bigger issues than the smoking which we try to assist in every way we can.'* [TP4]
Free or subsidised access to NRT and vapes	Referral and treatment	A referrer and four treatment providers perceived free or subsidised vapes offered by the service as a way of lessening disparities associated with financial constraints. Some sites had successfully negotiated a discounted price for patients requiring ongoing NRT post-discharge.

		'*I think one of the benefits [of the service] is having is e-cigarettes. I think because they are now issuing for SMI, free vapes. So, it's encouraging people to actually stop the nicotine and go onto the vapes. And it's also a selling point…people like something for nothing.*' [R4] '*[they were] able to manage to negotiate a discount with [company name] that we use as well, so if people do want to self-fund further on beyond the end of the program, there is a really good discount that they can access as well. So, there is no barrier financially there for people across the course of the vape scheme*' [TP2]
Rewarding to see benefits	Treatment	Four treatment providers mentioned that it was rewarding to support the SMI population to quit given the myriad of challenges and inequalities that individual in this demographic often encounter. *'I think it's nice being able to see [people with SMI] achieve something because for a lot of them, they don't really leave the house. They might not have much social contact or anything very positive going on in their lives. So, it's nice to see them succeeding and really seeing that boost in their self-esteem. Once they've finished the program, they're always very grateful for our support. And that always makes you feel a bit fulfilled in your job.'* [TP6]

TP = Treatment provider; R = Referrer.

Table 4: Setting up the service

Subtheme	Participant group	Example quotes
Expansion of services and impact on staffing	Referral and treatment	A referrer and two treatment providers raised concerns regarding how their current staffing levels may manage further expansion of the services. One expressed the belief that the 'opt-out' protocol had not been adhered to, and that if it had, their service might have been overwhelmed. *'We kept thinking, if it was an opt-out scheme from the health checks then I think capacity would have potentially been an issue, because of how frequently patient contact would be required. Because of the checking the carbon monoxide reading every week to start off with and things.'* [TP3]

		Recruitment challenges were highlighted as well. One treatment provider discussed the difficulties in recruiting for a role requiring expertise in two areas, and the resulting need for on-the-job training. Another mentioned that staff turnover can complicate the processes of the service. '*Recruitment is difficult. I think these are two very specific areas of specialism, smoking cessation and mental health, that don't often come together. They don't often meet, so it's been a case of either finding staff that have done one or the other and then trying to blend that skill by giving them extra training and really mentoring them and letting them shadow each other to gain more speed and ground with their skills and their learning. And recruitment is hard.*' [TP2] '*One of the issues is on our side because it's slightly changed the personnel within it.*' [TP3]
Have protocols and team in place	Referral and treatment	A recurring theme emphasised the importance of having well-defined guidelines, protocols and teams from the outset, to facilitate a smoother set-up and subsequent operation of the service. One referrer noted uncertainty regarding the eligibility criteria for the tobacco dependency services, while a treatment provider highlighted challenges because of frequent changes in data collection protocols which made consistent outcome data reporting difficult. Four treatment providers identified prescription protocols for NRT and vapes as problematic, underscoring the need for a confirmed process before commencing patient interactions. *'Getting hold of nicotine replacement therapy has been the hardest challenge throughout this. When we started there was no protocol to order NRT ourselves, so we had to get GPS to prescribe it for us.'* [TP6] Despite this, one treatment provider addressed this problem by identifying pharmacies capable of quick dispensing and opting for dispensing larger quantities each time (a month's supply). Two treatment providers also discussed issues with space for face-to-face appointments, feeling that these logistics should have been considered earlier.

		'Space, rooms, where we were gonna actually deliver these sessions, was not established. So, it was a lot of running around and a lot of time wasted. Confirming all of the logistics to set that up, and in setting up how you're gonna promote the service.' [TP5] Three treatment providers summarised these issues, suggesting that future services could benefit from a more extended longer lead-in time before launch to allow for comprehensive planning and preparation. *'I think it would have been better if we'd had a little bit of lead-in time, so we could have planned the project first.'* [TP4]
Importance of simple processes	Referral	Two referrers mentioned that a simple means for them to refer SMI patients to the service facilitated this process. *'It's brilliant because all you need to do is send an email with the persons identification number as the message and what their current smoking is or what they're smoking has been over the past 6 months and that's it. There's no form. Some of our services, I think, have a deliberately long referral form just to discourage you making referrals.'* [R2]
Multiple referral routes	Referral and treatment	It was clear that although early implementer sites were using one of the three models of referral, they proactively extended their reach to maximise patient inclusion. A referrer mentioned that there was an initiative to engage individuals at day skills centres to encourage self-referral. A treatment provider detailed a new system enabling them to utilise patient data to identify eligible smokers with SMI to proactively reach out to them. There was a sense that a 'no wrong door' approach was important and beneficial. *'So, referrals can come from either primary care, although we are a primary care model, we do accept referrals from secondary care, cause we'd rather accept referrals from just about anyone. So that we help as many people as possible, and we also have self-referrals.'* [TP2]

TP = Treatment provider; R = Referrer.

Table 5: Team communication and collaboration

Subtheme	Participant group	Example quotes
Collaboration is key	Treatment	The importance of collaboration in the success of the early implementer sites was raised by six treatment providers. One example of this was ensuring all involved in the service are on-board, at every level, to provide support for the service. '*I think it does help in terms of other service managers, operational leads, consultants, and probably borough leads and so forth being involved, and making their staff aware. I guess the higher you are up, the more say you have, or people listen to you.*' [TP5] Collaboration was also discussed in relation to facilitating shared learning by two treatment providers, for example through reflective practice with other sites, or working in collaboration with social workers. In general, staff felt that collaboration was a key facilitator in ensuring that the work required was completed. '*Everyone sort of makes decisions together and it's very sort of collective and well, self-managed in that case.'* [TP3]
Communication between treatment and referral staff	Referral and treatment	Effective communication between referral and treatment services significantly influenced success regardless of the chosen model. Two referral staff expressed a desire for feedback on the progress of patient's post-referral, while a treatment provider mentioned role-shadowing to improve mutual understanding between referrers and treatment providers. '*I would actually like to know the outcomes, if the patients are participating and reducing*' [TP3] *'The other thing that the other colleague mentioned was just that they valued shadowing some of the nurses who do some of the health checks just to see where they were coming from. And then a little bit of vice versa…'* [TP3] Almost all treatment providers spoke of the importance of promoting the service to staff

		responsible for referrals. One highlighted the effectiveness of incorporating service promotion into regular team meetings at referral sites. However, translating managerial buy-in into actions by staff on the ground remained a challenge for some, with two treatment providers citing difficulties in engaging some staff to learn more about the service. *'So, we have a weekly team meeting where we all get together really multidisciplinary, everyone comes together…a gentleman came in who was involved in the pilot project. He came and did some teaching about smoking cessation in general and also how to refer into their service.'* [R1] *'You can get the buy-in at the [primary care network] level, but actually getting the staff on the ground to refer in and get those pathways embedded and have them valuing the service enough, that's the challenge.'* [TP1] A referrer suggested that some of the issues raised relate to striking a balance between the necessity for training and the risk of overtraining or inappropriate training, to ensure active participation. *'I think it's more training. But also if you get over-trained as well, people don't go to another irrelevant training course. I'm not interested, that's not for me because that's a couple of hours of my time up I could have done this, and this, and this.'* [R4]
Staff attitudes and behaviours about smoking	Referral and treatment	Three referrers and three treatment providers raised the issue of staff attitudes towards smoking, e.g., a lack of understanding of the difficulties of quitting due to no personal experience, or the prevalent perception that individuals with SMI might be resistant to smoking cessation efforts. *'You know, it's made a big difference and in a population of people who don't seek out support in secondary care for things like cigarette smoking and I think that in lots of ways there's a,*

		not laziness exactly, but a kind of 'Oh, you know, they're always gonna smoke.' [R2] *'I think it's more helpful because I don't smoke. I think because quite a lot of people say "Oh, well, you don't have any experience". Yeah, I probably don't because I've never started smoking. I can't really say what helps or what doesn't, and I think within the team – nobody smokes. It's an example, but we don't have that lived experience supporting people to stop.'* [R4]
Supervision and managerial support	Treatment	Five treatment providers spoke of a range of support systems and managerial involvement for their wellbeing. It was mentioned that the challenging nature of the work necessitated a good support system that addresses both professional roles and personal wellbeing. One-to-one supervisions, team meetings and peer support were all mentioned as integral components, showcasing a commitment to ongoing dialogue and support. *'We're really conscious that the teamwork with those with SMI can sometimes be heavy work, so they have supervision one-to-one every 6 weeks with me. They can have it earlier if they want it. We have team meetings, and we have peer support once every week for 45 minutes to an hour. We are really conscious of going and talking about their weekly experience and debriefing on anything they need to debrief on.'* [TP2] Despite this, the level of supervision varied between sites, with others indicating that managerial support was less hands-on, meaning that support from colleagues was more important. *'Yeah, that the sort of isn't there, there isn't a great deal of supervision that we do have within our organisation…So you've got your colleagues and we…do often sort of have meetings and try and often try and get peer support or things…and then there is a support team available If anything else has cropped up, or if there's any other consideration to have, but in terms of being*

	shadowed, or in terms of sort of supervision of other things there isn't, there isn't really very much that we do have. We sort of just get on with the work basically so.' [TP3]

TP = Treatment provider; R = Referrer.

Table 6: The SMI population

Subtheme	Participant group	Example quotes
Patient motivation	Referral and treatment	Patient motivation was mentioned as an important element of service success. Three treatment providers noted that despite flexibility being integral to the treatment model, patient engagement remained challenging, resulting in late or non-attendance. *'They would turn up to the clinic 20 minutes late and you've already got someone else and then they wouldn't sit and wait. So that's something that causes a bit of chaos in the clinics; sometimes their lifestyles are chaotic.'* [TP4] One referrer and one treatment provider spoke about money being an incentive, in terms of savings through quitting smoking, and, in one service, monetary rewards for attending services. The importance of timing conversations, making the most of opportunities and 'seizing the moment' were also seen as impactful. This included follow-up questions when patients seemed more open to the idea following physical health checks and running the service on the same day as other clinics used by people with SMI, so that patients could be referred and seen straight away while they are already there. '*We've got the Stop Smoking Service in here every Wednesday so we can make direct… because we run a clozapine clinic, we can say do you fancy stopping? "Oh yes", so we can get them straight in so yeah, locations and I think it's understanding, as I said its seizing [the moment].'* [R4] Three treatment providers also spoke about the services working better as opt-in, as it meant the patients that were engaging were more motivated to

		stop smoking. Where people did not want to engage, treatment providers spoke of offering information, or letting patients know that they could come back to the service in the future if they wanted to. *'What we found is the people who were referred in were already quite motivated to begin with because we think it was more of an opt-in than an opt-out, so there was less need for some of our wider support because often they were saying, well, what matters to me is quitting smoking.'* [TP3]
Perceptions of patient experience	Referral and treatment	A referrer and four treatment providers shared their perceptions of patients' experiences with the tobacco dependency service, all highlighting reasons for its success. They felt the patients' experience had been positive. Factors contributing to perceived positive experiences included patients having autonomy in their treatment, finding flexibility helpful, and not feeling rushed or pressured to set a quit date. *'We have quite good results because they're not being rushed in and out. They're finding less pressure because they're not being asked to give a particular date to stop smoking there and then.'* [TP4] However, the referrer acknowledged that the process can be long. This takes significant commitment from patients who have a lot of contact, increasing the risk of disengagement. The ability to re-refer to the service was emphasised as an important aspect to address this concern. *'Some people have found that the extra contact from people has been too much so. It seems like a bit of a multi team thing, so even if they break off in the initial process, that hopefully we will re-refer at a later stage and as long as they'll be open to seeing them again, that would be.'* [R1]
Reaching patients	Referral and treatment	Two referrers and two treatment providers felt that patients with SMI were often difficult to reach once they were referred. This suggested that it may be necessary to make additional outreach considerations. There were efforts to make prompt contact with patients post-referral. But frequent address or phone number changes, and not having a phone, would lead

	to the challenge of needing to find the right contact details. Thinking about how or when to contact patients is also important. This includes the method of contact (some patients don't want correspondence to their address) and when to contact patients (e.g., what time of day). One treatment provider also spoke of being cautious not to contact patients too much, as sometimes people can interpret this as being harassed. *'We've had to extend the time because obviously with this client group, what we find is, you know, some of them don't have their own phone, or they are sharing phones or they're not out of bed first thing in the morning. And so therefore you suddenly have to contact them more frequently to get them in the first place'* [TP4]

TP = Treatment provider; R = Referrer.

Appendix 6. Site differences in theme endorsement

This appendix provides information on which themes were endorsed by staff working at different early implementer sites.

Northumberland, South Tyneside and Durham were satellite sites in North East and North Cumbria.

'Yes' signifies that at least one reference was coded to this theme by at least one staff member.

	Northum-berland	South Tyne-side	Dur-ham	Nor-folk and Wave-ney	ELFT	Suss-ex
Importance of flexibility						
Extended timeline and patience with process	Yes	No	Yes	Yes	Yes	Yes
Format and location	Yes	Yes	Yes	Yes	Yes	Yes
Impact of flexibility on outcome data recording	No	Yes	Yes	No	No	No
NRT and vape options	No	Yes	No	Yes	Yes	Yes
Staff perceptions of taking a flexible approach	Yes	Yes	Yes	Yes	Yes	No
Taking a person-centred approach	Yes	Yes	Yes	Yes	Yes	Yes
Intervention training and expertise						
Additional training	No	Yes	No	No	Yes	Yes
Mental health specific experience	Yes	Yes	Yes	Yes	Yes	Yes
NCSCT training as a starting point	No	Yes	Yes	Yes	No	Yes
Uncertain access to needed relevant training	No	Yes	No	No	Yes	Yes

	Northum-berland	South Tyne-side	Dur-ham	Nor-folk and Wave-ney	ELFT	Suss-ex
Reducing health inequalities						
Access to smoking support for all	Yes	No	Yes	No	Yes	Yes
Additional support with access to other health or social support or services	Yes	Yes	Yes	No	No	Yes
Free or subsidised access to NRT and vapes	Yes	No	Yes	No	Yes	Yes
Rewarding to see benefits	Yes	No	Yes	No	Yes	Yes
Setting up the service						
Expansion of services and impact on staffing	No	Yes	No	No	Yes	No
Have protocols and team in place	Yes	No	Yes	Yes	Yes	Yes
Importance of simple processes	Yes	No	No	No	No	Yes
Multiple referral routes	Yes	Yes	No	No	Yes	No
Team communication and collaboration						
Collaboration is key	Yes	Yes	Yes	Yes	Yes	No
Communication between treatment and referral staff	Yes	Yes	Yes	Yes	Yes	Yes
Staff attitudes and behaviours about smoking	Yes	No	Yes	Yes	No	Yes
Supervision and managerial support	Yes	Yes	Yes	No	Yes	Yes
The SMI population						
Patient motivation	Yes	Yes	Yes	No	Yes	Yes
Perceptions of patient experience	Yes	Yes	No	Yes	Yes	Yes
Reaching patients	Yes	Yes	Yes	No	No	Yes