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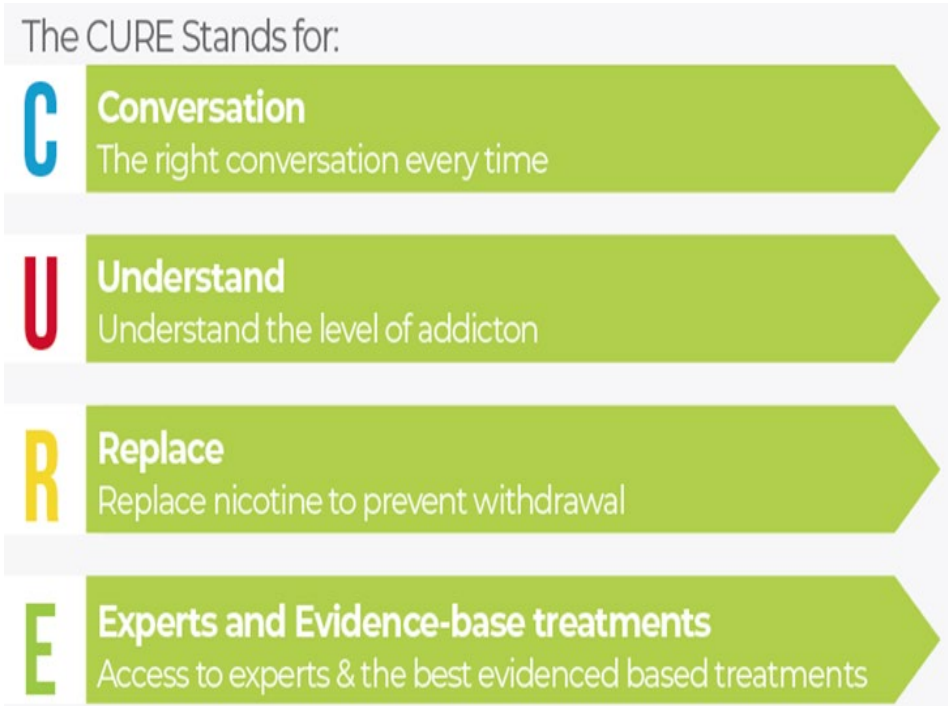
Understanding the implementation of the CURE stop smoking programme: qualitative study

Dr Angela Rodrigues, PhD
Senior Lecturer, Northumbria University
Email: angela.Rodrigues@northumbria.ac.uk

Full team: Angela Wearn[1,2], Anna Haste[2,3], Verity Mallion[4], Matthew Evison[5], Freya Howle[5], Catherine Haighton[1,2]

1 Northumbria University
2 Fuse: UKCRC Centre for Translational Research in Public Health
3 Teesside University
4 Public Health England
5 The CURE Project Team, The Christie NHS Foundation Trust

The CURE Model



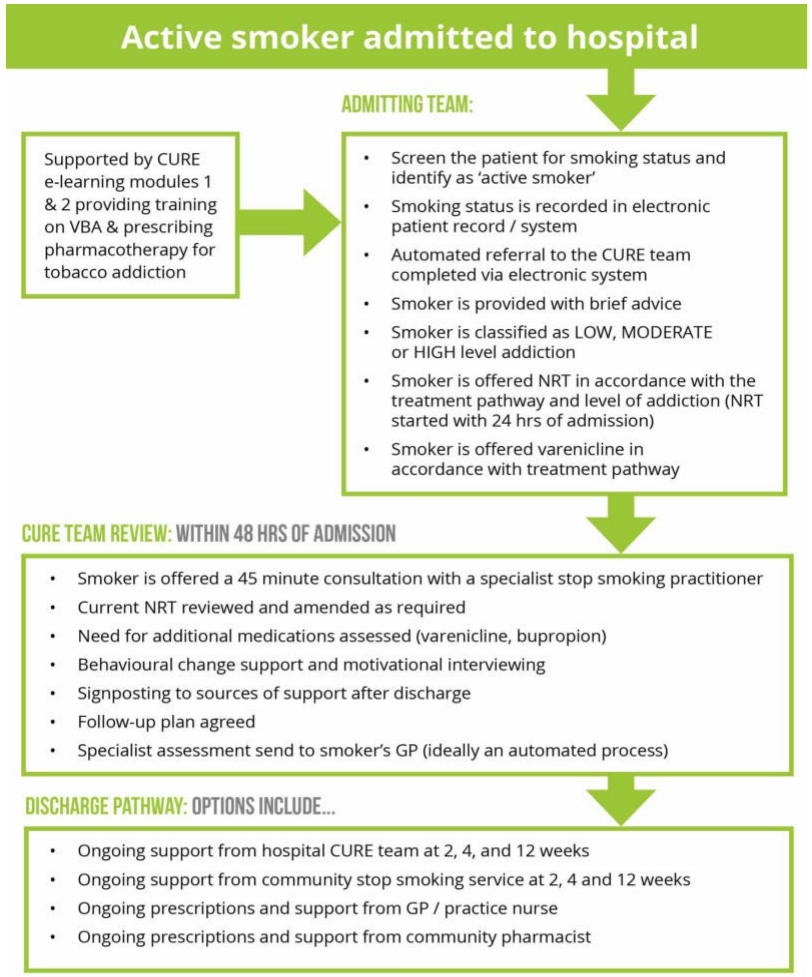
Healthcare professionals (HCPs) are encouraged to ask each patient the 3 CURE questions:

1. Do you smoke currently?
2. How many cigarettes for you smoke a day?
3. How long have you been away before you smoke your first cigarette?

The CURE Nicotine Replacement Therapy (NRT) protocol determines patients' treatment plan.

Smokers are referred to the CURE tobacco addiction specialist nursing team.

The CURE Model



THE CURE PROJECT
CURING TOBACCO ADDICTION IN GREATER MANCHESTER

The CURE model (summarised right) was piloted within Wythenshawe hospital within NHS Manchester University Foundation Trust – launching 1st October, 2018 running until 31st March, 2019.

Following this, CURE was fully implemented into service at the pilot site.

CURE is currently in various stages of roll out within a further six hospitals across Greater Manchester.

Overview of aims

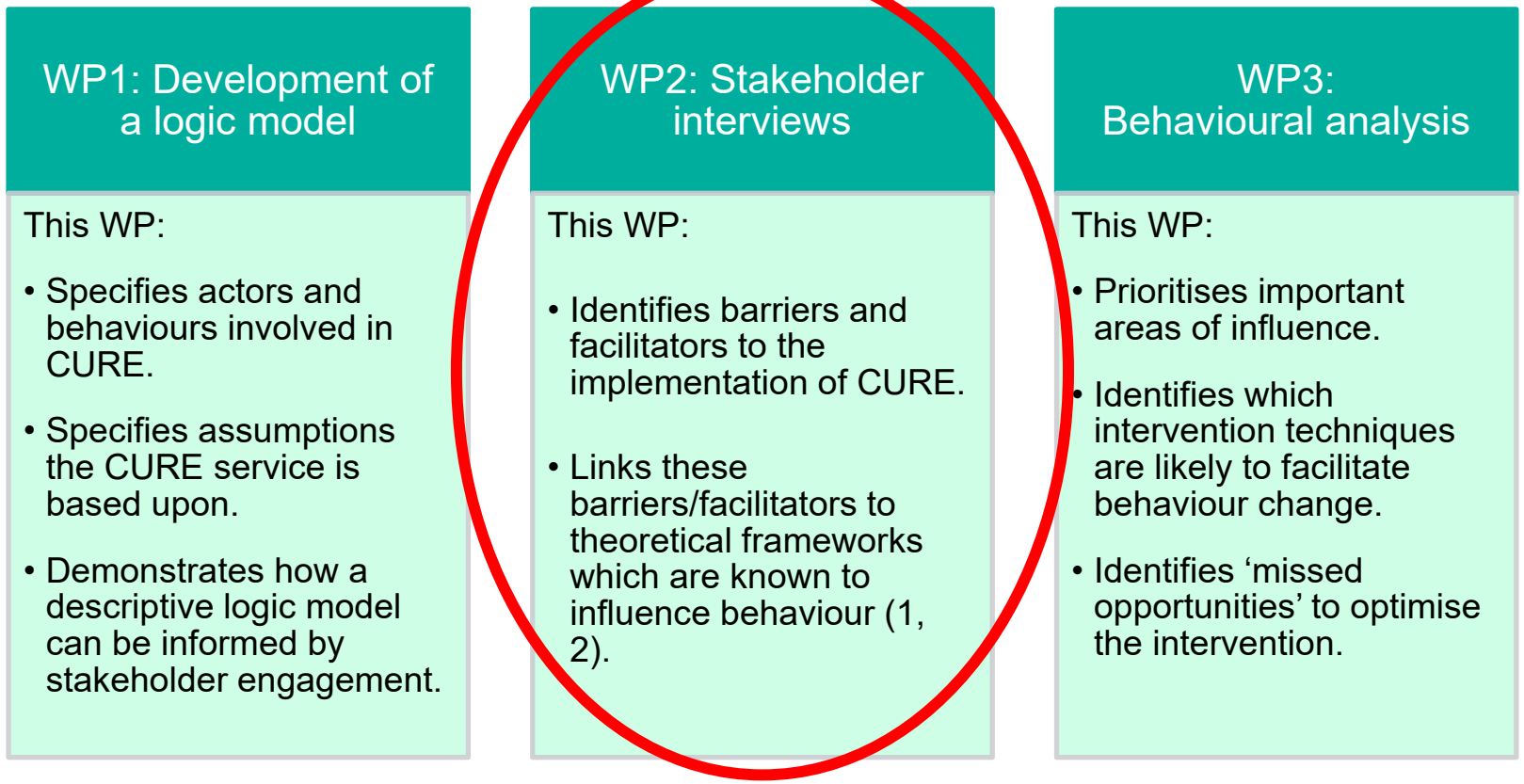
Aim: To describe the core elements of the CURE implementation strategy in the pilot site, particularly the activities directed at promoting behaviour change in healthcare practitioners and wider organisational implementation strategies.

Specific objectives:

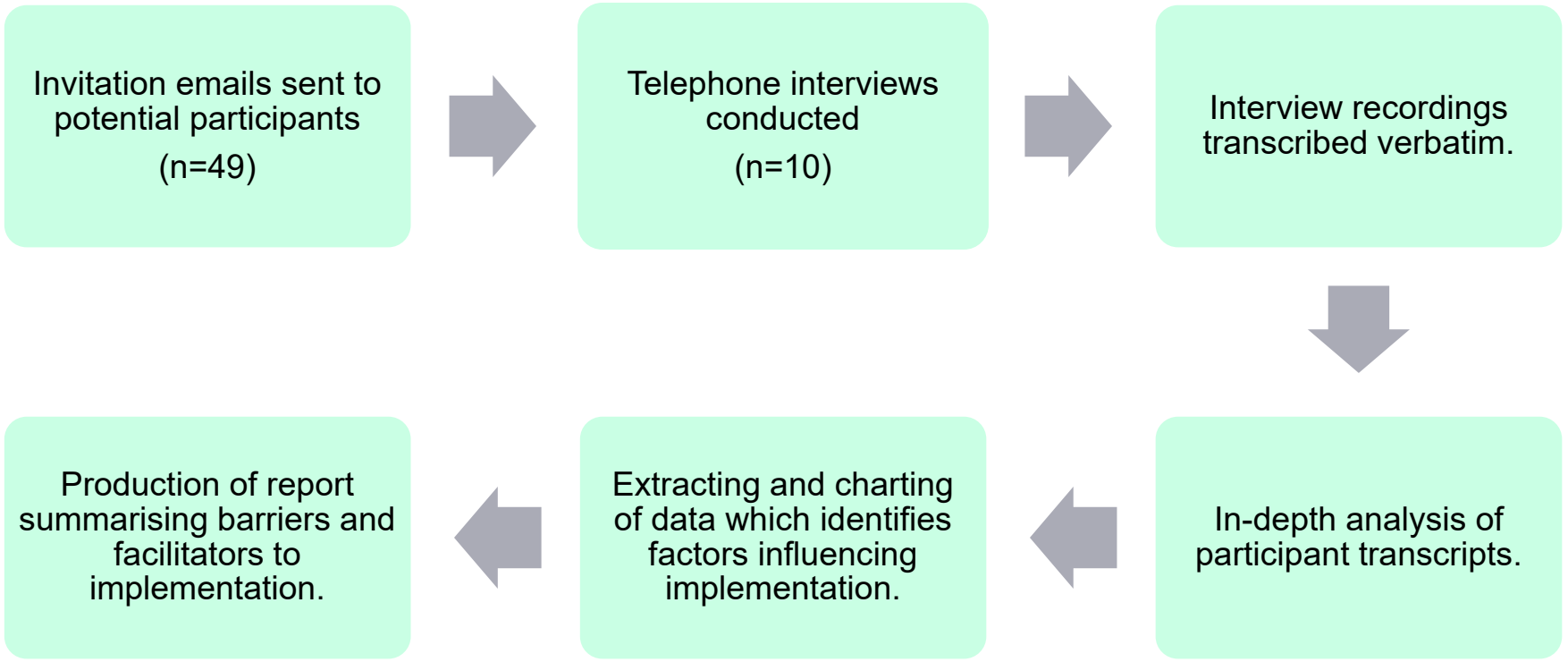
1. Identify the content of the implementation strategy for the CURE project in secondary care, using the BCW functions, policy categories, and the BCT Taxonomy (v1);
2. Explore to what extent the barriers and facilitators of CURE implementation are addressed by existing implementation strategy components;
3. Develop recommendations to support the refinement of the current implementation.

Project methods

The aims and objectives of this study were achieved across three work packages (WP):



Method: Stakeholder interviews



Findings: Stakeholder interviews

10 participants took part in telephone interviews (N=7 management/leadership, N=3 deliverers).

Table 1 provides a broad overview of participant role and stage of involvement, specific detail on occupational role is not presented here to maintain anonymity.

Table 1. Overview of participant roles and stages of involvement in CURE implementation.

Participant	Role	Stage of involvement
1	Management/leadership	Planning – present
2	Management/leadership	Planning
3	Management/leadership	Planning – Pilot
4	Deliverer	Pilot – present
5	Deliverer	Pilot – present
6	Deliverer	Pilot –present
7	Management/leadership	Planning – present
8	Management/leadership	Evaluation
9	Management/leadership	Planning – present
10	Management/leadership	Planning – present

Findings: Stakeholder interviews

There were 8 over-arching areas of influence (themes) identified throughout the stakeholder interviews. These themes were reflective of domains within the Theoretical Domains Framework (1, 2) – broad, evidence-based factors known to influence behavioural change.

Incorporating this framework into the analysis in this way therefore ensures relevant and potentially impactful barriers/facilitators will be identified. The relevant domains in this case are:

Environmental context and resources	- Any circumstance of an individuals situation or environment that discourages or encourages, in this case, CURE implementation.
Goals	- Outcomes that an individual wants to achieve.
Professional role and identity	- A set of behaviours or personal qualities of an individual in a work setting.
Social Influence	- Interpersonal factors that cause an individual to change their thoughts, feelings or behaviour.
Reinforcement	- A dependant relationship between a behaviour and an incentive.
Beliefs about consequences	- Beliefs about the outcomes of CURE implementation/delivery.
Skills	- An ability acquired through practice.
Knowledge	- An awareness of the existence of something.

Findings: Stakeholder interviews

Sub-themes (see Table 2) offered insight into more specific barriers and facilitators to CURE implementation.

The influence of 'Environmental Context and Resources' was most frequently mentioned and elaborated on across all interviews.

Table 2: An overview of barriers and facilitators to the successful implementation of the CURE model in Greater Manchester.

Major theme	Barrier	Facilitator	Mixed barrier/facilitator
Environmental Context and Resources	• Establishing standardised discharge pathways • Integration with Primary care and external organisations • Access to pharmaceuticals • Time pressures • Office resources for delivery staff	• Data storage systems • CURE Branding • Flexibility of service	• Staffing Resources • Access to CURE related knowledge and training. • Funding for all stages of support • Delivery environment
Goals	• Managing competing goals and priorities • Identifying and evaluating outcomes	• Adhering to a service specification	• Promoting CURE

Findings: Stakeholder interviews

Table 2. (continued) An overview of barriers and facilitators to the successful implementation of the CURE model in Greater Manchester.

Major theme	Barrier	Facilitator	Mixed barrier/facilitator
Goals	• Managing competing goals and priorities • Identifying and evaluating outcomes	• Adhering to a service specification	• Promoting CURE
Professional role and identity		• Commitment to encouraging patient choice • Leadership in planning and oversight	• Professional identity
Social Influences	• Changing the culture around smoking cessation	• Peer leadership	• Teamwork
Reinforcement		• Reflecting on rewards of CURE involvement	• G.P Incentives to engage with CURE
Beliefs about consequences		• CURE improves outcomes. • Positive impact of personalised support	
Skills			• Previous experience and skills.
Knowledge		• Knowledge of supporting evidence.	

Findings: Stakeholder interviews

Key barriers

The most commonly identified barriers were consistent across participants, referring to challenges integrating CURE within the existing healthcare environment i.e. Establishing standardised discharge pathways and Integration with Primary care and external organisations.

> *…the variation in support after discharge across Greater Manchester is huge. So, we had to deal with that and that is probably the biggest ongoing challenge that there is. And it varies also dependant on the senior decision makers and their opinion on the importance of a project can have a massive difference.* **– P7, management.**

In addition to this, core nursing staff highlighted common barriers to delivery (i.e. time pressures, hospital delivery environment and patient access to pharmaceuticals).

> *We found that the follow up calls were very, very difficult to keep up with. To be truthful we're only just catching up on them now and we've had help from an admin person who screens the calls first, see if patients want to be followed up*.**- P6, deliverer.**

Findings: Stakeholder interviews

Key mixed barriers/facilitators

The importance of adequate staffing resources, access to CURE related knowledge and training and funding for all stages of support were also prominent throughout the interviews, although there were mixed views regarding whether these helped or hindered implementation of CURE.

Broadly, these factors often facilitated delivery within the core hospital team, but sometimes posed barriers for wider healthcare staff.

> *CURE obviously recruited nursing people so they had their built team around that, I think, which is essential because it brought bodies in to do something, and they would do it and it would work. And that is always then challenge that was given to us, that you guys have got a team to do this, and if you send [patients] home [primary care] don't have any teams. You're relying on the existing teams to do it. So just offering money won't help. We need bodies and we need people and we need the funding to do it.* ***– P10, management.***

Findings: Stakeholder interviews

Key facilitators

Across participants, the most commonly identified facilitators referred to the importance of peer leadership and staff commitment to encouraging patient choice.

[The clinical lead] was an incredibly persuasive individual, and he, for me, not only when he was selling it within the hospital, and certainly within this group, his leadership was incredible. **– P2, management.**

*I always felt that CURE should be talking to the patient, you know, the patient's choice is where he wants to go, she wants to go. If she wants to go to the community service, then yes. If she wants to stick with secondary care, then we should be able to help them. If they want to come back to the GP the GP should be able to help them.***- P10, management.**

For managerial staff, leadership in planning and oversight was a key facilitator of implementation.

The project management is one of the cornerstones to [implementing CURE]. And actually, if you've got really good and a full-time project management support then that clinical lead does…I think can be that leader and flex to where they're needed for clinical reasons…And that's been critical. **- P1, management**.

Findings: Stakeholder interviews

Key facilitators (cont.)

For delivery staff, teamwork, the intrinsic rewards of CURE involvement and beliefs surrounding the positive impact of personalised support, were also key facilitators of CURE delivery.

I introduce certain things myself…within the team, of things that I've done before. So, we do share knowledge as well.… [I send] information over to other colleagues, less experienced colleagues who then get regular updates on that. ***– P5, deliverer.***

Most [patients] do want to quit. You want to see the benefits of that and yeah, that keeps you going really. And also, when they do manage to quit, we become so pleased. I've had patients that say even whatever they spend buying cigarettes, tobacco, each week they put money in the jar and it's that financial benefits as well. But I think it's the main, that their long-term health benefits **– P4, deliverer.**

…medication, it's just the tip of the iceberg I think really. It's all that extra support, I think, you can give them. **–P6, deliverer.**

Recommendations

Identify champions of the CURE service

- To encourage staff engagement and culture change. Clinical champions seemed particularly effective in engaging and motivating staff members across all levels of seniority and could be influential in changing unhelpful cultural beliefs around smoking cessation.

Patient choice

- Focus on patient choice and shared decision making within CURE should also be emphasised when aiming to engage stakeholders, as participants indicated this approach was in line with their professional identity and also aligns with current NHS guidance.

Discharge pathways

- Although CURE is secondary care-led, increased integration within the wider healthcare environment has the potential to maximise impact. Effective patient discharge pathways rely on collaboration with general practitioners, community pharmacists and stop smoking services. It is therefore integral to ensure efforts to engage healthcare professionals and decision-makers go beyond hospital-based teams.

Conclusions

1. Evidence about current practice in the pilot site that can inform implementation strategy improvement and the implementation of an NHS-funded tobacco dependence treatment and policy in secondary care in England.

2. Recommendations provided may optimise and inform future implementation strategies.

3. Need for small scale **qualitative evaluation** involving national roll-out/new sites to identify specific barriers/facilitators.

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Thank you for listening!

For the open access article see:

Wearn, A., Haste, A., Haighton, C. , *Mallion, V. & Rodrigues, A.* Barriers and facilitators to implementing the CURE stop smoking project: a qualitative study. *BMC Health Serv Res* **21**, 481 (2021). https://doi.org/10.1186/s12913-021-06504-2