



LOCAL STOP SMOKING SERVICES

Key updates to the 2011/12 service delivery and monitoring guidance for 2012/13

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ABOUT THIS DOCUMENT

This document provides an update on the key developments and changes since the publication of *Local stop smoking services: service delivery and monitoring guidance 2011/12*. This update does not supersede the previous guidance but, rather, should be read in conjunction with it.

INTRODUCTION

This introduction focuses on key policy developments. These include: the publication of the national Tobacco Control Plan, the shift of many public health responsibilities into local government, the publication of the Public Health Outcomes Framework and the establishment of Public Health England in April 2013.

Five-year Tobacco Control Plan

Smoking cessation, as set out in the Government's five-year Tobacco Control Plan, published in 2011¹, is an important component of comprehensive tobacco control. England is currently considered to be a global leader in helping people to stop smoking. The Tobacco Control Plan recognises the ongoing need to increase access to evidence-based support for people who are prepared to stop smoking. This is particularly true for groups with high smoking prevalence, such as routine and manual workers, and for groups where smoking poses heightened risks – for example, pregnant women and those with pre-existing conditions that are made worse by smoking, such as asthma or Chronic Obstructive Pulmonary Disease (COPD).

The support provided by local stop-smoking services continues to offer some of the best opportunities to stop smoking, proving up to four times more effective than attempting to stop unassisted and twice as effective as the provision of a stop-smoking medicine by a healthcare professional². It is therefore important that evidence-based, high-quality stop-smoking support, configured to meet the needs of the local population, and delivered by qualified and well-trained service providers, is available to those who require it. Whilst stop-smoking services are highly cost-effective³, there are currently variations in practice resulting in a wide range of four-week success rates (29% to 60%)⁴. There is, therefore, a need to reduce the disparity between the most effective and least effective services. It is important that local areas commission services that deliver high-quality interventions, which maximise value for money and which are based upon clear and appropriate outcome measures. Stop-smoking services also play a vital part in supporting broader tobacco control activity, such as providing support for quit attempts generated by mass-media campaigns or interventions tackling illicit tobacco.

Local intelligence, including demographics, smoking prevalence rates, four-week quit outcomes and customer satisfaction, can be used to inform local commissioning and service provision. Best-practice guidance, such as this document and the 2011/12

1 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917

2 Smoking Toolkit Study, www.smokinginengland.info

3 Godfrey C, Parrott S, Coleman T, Pound E (2005) The cost-effectiveness of the English smoking treatment services: evidence from practice. *Addiction* 100 (Suppl 2): 70-83

4 www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-england-april-2010-march-2011

guidance, the quality principles (see page 14) and the training standards developed by the National Centre for Smoking Cessation and Training (NCSCT) (see page 15) should also inform and be included within local planning.

Public health in local government

In December 2011, the Department of Health published a series of factsheets to provide greater detail about the design of the new public health system, including the role and responsibilities of local government in public health, the operating model for the new executive agency Public Health England and an overview of how the whole system will work. The factsheets can be accessed from healthandcare.dh.gov.uk/public-health-system/.

These changes will take effect from April 2013, although local action to engage in the new systems is encouraged during 2012/13. The changes will see many public health responsibilities transferred to local authorities, which will take responsibility for improving health and coordinating local efforts to protect the public's health and wellbeing, as well as ensuring that health services promote population health effectively. Local authorities will become responsible for commissioning a range of interventions, including tobacco-control and smoking-cessation services, although this will be at the discretion of the local area, guided by the Public Health Outcomes Framework, the local joint strategic needs assessment and the joint health and wellbeing strategy.

Public Health Outcomes Framework

In January 2012, the Government published the 2013-2016 Public Health Outcomes Framework⁵, which focuses on two high-level outcomes:

1. Increased healthy life expectancy
2. Reduced differences in life expectancy and healthy life expectancy between communities.

To measure progress year-on-year against these overarching outcomes, a set of supporting indicators were developed and grouped into four domains: improving the wider determinants of health; health improvement; health protection; and healthcare public health and preventing premature mortality.

There are three specific smoking-related outcomes within the 'health improvement' domain:

- 2.14 Prevalence of smoking among persons aged 18 years and over
- 2.3 Smoking status at time of delivery per 100 maternities
- 2.9 Prevalence of smoking among 15-year-olds.

5 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

These indicators are in keeping with the national ambitions of the Tobacco Control Plan and will help to focus understanding of progress over time. The indicator for prevalence of smoking among 15-year-olds is currently a placeholder indicator whilst options for collecting this data at local-authority level are explored.

In addition, although it is not specifically stated, comprehensive tobacco control would contribute significantly to a number of mortality-based indicators within the 'healthcare public health and preventing premature mortality' domain.

Public Health England

Public Health England will be established from April 2013 to provide strategic leadership and vision for the protection and improvement of the nation's health. Through the application of research, knowledge and skills, Public Health England will lead nationally and enable a local transformation in the health expectations and, in time, outcomes of all people in England regardless of where they live or the circumstances of their birth. Public health expertise is being embedded in councils across England. Public Health England will be the professional voice for that expertise nationally, working with local government as an active partner in its local leadership for health and wellbeing.

In July 2012, Public Health England's chief executive designate, Duncan Selbie, outlined his vision for the new organisation, alongside its structure. These are published here:

healthandcare.dh.gov.uk/vision-phe/

healthandcare.dh.gov.uk/phe-structure/

The case for local action on tobacco

Working together, ASH, the Faculty of Public Health, the Local Government Group, Fresh (Smoke Free North East), Tobacco Free Futures (formerly Smokefree North West), Smokefree South West and the Department of Health have produced a set of materials for Directors of Public Health to use with key Councillors to help ensure that tackling tobacco use is high on the local public health agenda.

Together, these resources assist in demonstrating:

- the scale of the harm caused locally by tobacco use and the contribution this makes to health inequalities
- the cost to local communities, local economies and service providers
- the evidence of effectiveness of local action on tobacco and health.

The materials are designed to allow easy integration of local data from the Association of Public Health Observatories (APHO) local tobacco-control profiles, as well as a new reckoner for local economic impacts, and are available from www.ash.org.uk/localtoolkit. They allow estimates of the costs associated with smoking to be made at local-authority level.

The tobacco profiles on the London Health Observatory website are also a useful source of local tobacco-related information and intelligence. These are available at: www.lho.org.uk/lho_topics/analytic_tools/TobaccoControlProfiles/default.aspx.

PART 1: COMMISSIONING SERVICES

This section summarises key elements of service delivery that commissioners will wish to consider when designing local service provision. It includes a description of: the levers that can be used to support the identification and referral of smokers to effective stop-smoking support; communications and marketing; intervention quality principles; measuring success; and return on investment.

Identification and referral of smokers

Considering that 15.5%⁶ of all smokers in 2011 opted for the least effective method of stopping smoking (going unassisted), it is clear that systematic identification of smokers at every opportunity, the delivery of very brief advice (VBA) and referral of smokers into effective support continues to be of paramount importance. There are a vast number of potential referral sources, many of which are highlighted in the 2011/12 service and monitoring guidance.⁷

VERY BRIEF ADVICE

The NHS Future Forum report '*The NHS's role in the public's health*', published in January 2012, emphasised the importance of healthcare professionals using every patient contact as an opportunity to maintain or improve that individual's mental and physical health and wellbeing. In particular, the report recommended targeting the four main lifestyle risk factors: tobacco, diet, physical activity and alcohol.

6 Smoking Toolkit Study (West R, Brown J (2012) Smoking and Smoking Cessation in England 2011. London. www.smokinginengland.info)

7 See pages 12–16: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125389

To support this and to encourage the delivery of VBA (Figure 1), the Department of Health commissioned the NCSCT Community Interest Company (NCSCT CIC) to develop a VBA training programme. The training module, which focuses primarily on encouraging GPs to deliver VBA, was launched in February 2012 and is available online at www.ncsct.co.uk/VBA. The training begins with an introductory film, which is also available on YouTube (www.youtube.com/user/NCSCCTfilms). The module itself includes key facts, examples of delivery via film clips, links to supplementary information and a short multiple-choice assessment.

Figure 1:

Very Brief Advice on Smoking

30 seconds to save a life

ASK and record smoking status

Is the patient a smoker, ex-smoker or non-smoker?

ADVISE on the best way of quitting

The best way of stopping smoking is with a combination of medication and specialist support.

ACT on patient response

Build confidence, give information, refer, prescribe. They are up to four times more likely to quit successfully with NHS support.

Refer them to their local NHS stop-smoking service

ELECTRONIC REFERRAL SYSTEMS

Ensuring that referral pathways are quick and easy to use is essential if systematic local delivery of VBA and referrals is to be achieved. Secondary care is one setting that has often been regarded as a 'missed opportunity' when it comes to the identification and referral of smokers, and it has recently been the focus of key national initiatives such as the Quality, Innovation, Productivity and Prevention (QIPP) and Commissioning for Quality and Innovation (CQUIN) agendas. The NCSCT CIC is currently testing the use of electronic referral systems in hospital settings; to date this has resulted in over a 600% increase in referrals to local stop-smoking services. Work is under way to test a similar

system for the identification and referral of pregnant smokers, and the results of both projects will be made available by autumn 2012. However, these studies also show that people need to be prepared for a referral, because increasing the number of referrals does not, in itself, increase the number of people attending services or going on to make successful quit attempts.

REFERRAL LEVERS

Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP practices in England, which forms part of GP contracts. Although participation in QOF is voluntary, participation rates remain very high. The objective of QOF is to improve the quality of care that patients receive by rewarding practices for the standard of care they provide.

A number of changes have been made to smoking-related QOF indicators for 2012/13. As a result, from April 2012, the indicators will be:

- **Asthma 10** – The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months
- **Smoking 5** – The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months
- **Smoking 6** – The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record of an offer of support and treatment within the preceding 15 months
- **Smoking 7** – The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months
- **Smoking 8** – The percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months
- **Information 5** – The practice supports smokers in stopping smoking by a strategy, which includes providing literature and offering appropriate therapy
- **Primary Prevention 2** – The percentage of patients diagnosed with hypertension (diagnosed after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.

Further information about these changes can be accessed through the 'Summary of QOF changes for 2012/13' on the NHS Employers website.⁸

Quality, Innovation, Productivity and Prevention

In light of the new NHS and public health architecture and a review of the National QIPP Workstreams, work on the proposed National QIPP Prevention Workstream will be used to inform emerging health policy. This work is initially focussing on alcohol interventions as part of a pilot programme across the NHS Northern Cluster to test implementation and assess current commissioning levels. Further work, including the smoking interventions, will be piloted early in 2013 and will focus on high-impact actions concerned with tobacco and other prevention interventions where strong evidence exists for the realisation of savings and efficiency gains. The work will include:

- A technical evidence base for the setting of priorities
- Advice for clinical commissioning groups on the prioritisation process – governance and best practice
- Areas of lower-value interventions and enable the value of competing demands to be assessed
- An appraisal of the evidence to support the development of clinical prioritisation policies for populations and individuals
- Ongoing horizon scanning to further assist with prioritisation, in partnership with the National Institute for Health and Clinical Excellence (NICE) and the other QIPP Workstreams.

Commissioning for Quality and Innovation

The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Since the first year of the CQUIN framework (2009/10), many areas have identified CQUIN schemes as an opportunity to include increased rates of referral to stop-smoking services.

Examples of smoking-related CQUIN schemes can be accessed at:
www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

NHS Health Check

The NHS Health Check programme is a preventative programme for eligible people in England aged 40 to 74, and is aimed at preventing heart disease, stroke, diabetes and kidney disease. The check itself involves a standard assessment based on straightforward questions and measurements including, amongst other things, smoking status as a key risk factor for vascular disease. Anyone who is a smoker and wants to quit

⁸ www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/ChangestoQOF2013.aspx

should be offered the support of a local NHS stop-smoking service as part of their NHS Health Check. The NHS Health Check risk assessment is one of the mandatory functions that local authorities will be expected to commission from 2013. With around 15 million people eligible for an NHS Health Check in England, the programme is helping to provide systematic smoking-cessation support for 40- to 74-year-olds.

In addition, it offers a real opportunity to make significant advances in tackling the socio-economic, ethnic and gender health inequalities that are caused by smoking. In order to ensure that the programme helps reduce health inequalities, the NHS Health Check programme has been designed so that the basic risk assessment and management components of the check are suitable to be undertaken in a variety of settings, including pharmacies, community centres and other sites, as well as GP practices. This means that people who are not in touch regularly with formal health care, particularly GP services, will be encouraged to access the checks at convenient locations and times.

Communications

NHS SMOKEFREE HELPLINE AND OTHER NATIONALLY PROVIDED SUPPORT FOR SMOKERS

The national NHS Smokefree Helpline and the Smokefree website (www.nhs.uk/smokefree) currently provide support and information for smokers, and are able to refer smokers to local stop-smoking services.

Other nationally provided support includes the Smokefree customer relationship management programme, the Smokefree Together programme, text support, the Quit Kit and the Smokefree Facebook page. For up-to-date information on the range of support available, please visit the Smokefree website.

Smokefree customer relationship management programme

The Smokefree customer relationship management programme enables ongoing communication with respondents who have opted to receive further support following marketing campaigns. For example, they may receive additional support emails and can be followed up to find out whether they have been successful in their quit attempt, or whether they require further support.

Some local stop-smoking services may already have similar programmes in place, but others should think about how they maintain contact with their service users. For example, a system could be set up to re-engage with unsuccessful quitters, attracting them back to the service at a later date or offering an alternative treatment. Guidance and tools for managing referrals effectively are available from the Smokefree Resource Centre (www.smokefree.nhs.uk/resources).

Smokefree Together

This is a free programme for smokers who would like additional support at home. They are supported through mail, phone, text and email communications throughout their quit attempt and beyond.

Text support

Smokefree also provides a text-only support programme for smokers. This has been developed following trials⁹ which showed that text support can improve quit rates – as much as doubling a smoker’s chances of success. The SMS-based support tool delivers a series of automated text messages direct to smokers’ mobile phones over a period of up to 12 weeks to help them through their quit attempt.

Quit Kit

The Quit Kit is a box of practical tools and advice developed with experts, smokers and ex-smokers, which has helped thousands of smokers quit successfully. It was designed to package up NHS support to appeal to those smokers who choose to quit smoking alone or ‘cold turkey’, to help improve their chances of quitting successfully. Smokers can visit www.smokefree.nhs.uk to find out how to get a Quit Kit.

NHS Smokefree Facebook page

Smokefree has a Facebook page providing online advice and information for smokers, and allowing smokers to support each other as they quit. The NHS Smokefree Facebook page can be found at www.facebook.com/nhssmokefree.

Advice and guidance for local services on setting up and managing their own Facebook pages can be found in the Smokefree Resource Centre.

GETTING THE MESSAGE ACROSS

There is worldwide evidence to show that effective mass-media campaigns prompt quit attempts and reduce smoking prevalence. Recent Smokefree marketing campaigns run by the Department of Health include: the ‘Smokefree Generation’ campaign (November 2011), which aimed to motivate smokers to quit; the ‘Right tools for the job’ campaign, which encouraged smokers to visit a pharmacy to order the new, improved Quit Kit; and a Smokefree homes and cars campaign (spring 2012), which dramatised the dangers of second-hand smoke. For further information on Smokefree marketing activity, please visit the Smokefree Resource Centre. You can also sign up for emails to get the latest information on national campaigns.

⁹ Free C, Knight R, Robertson S, Whittaker R, Edwards P, Zhou W, Rodgers A, Cairns J, Kenward MG and Roberts I (2011) Smoking cessation support delivered via mobile phone text messaging (txt2stop): a single-blind, randomised trial. *Lancet*, 378 (9785). pp. 49-55. ISSN 0140-6736 DOI: 10.1016/S0140-6736(11)60701-0

LOCAL MARKETING ACTIVITY

Strategies for promoting local services should be evidence based. Extensive research exists at a national level (e.g. on routine and manual groups and other audiences) and this can be shared with local services upon request to avoid duplication of resources. For further information and for creative templates and materials that can be used at a local level, please visit the Smokefree Resource Centre.

Where possible, any local communications activity should be integrated with national campaigns to enhance its effectiveness and avoid duplication.

Local marketing initiatives to promote services can add the most value by:

- Improving consumers' understanding of what their local service can offer and where help is available locally
- Generating local quit prospects for local services to help them deliver against performance outcomes.

Smokefree Resource Centre

To help support local marketing, a toolkit of creative resources, along with Smokefree literature, brand materials (including font, photographs and logo) and additional guidance, is now available from the Smokefree Resource Centre (www.smokefree.nhs.uk/resources). The toolkit includes a suite of branded artwork templates for leaflets, posters and other marketing materials, to help promote local services. The templates are editable PDFs, which can be tailored for local use simply by adapting the logo and contact details, or by replacing sections with relevant local information.

The Smokefree Resource Centre also has the latest news about the national campaign and the resources available, case studies and a range of guides to carrying out local marketing activity. You can also order/download materials to help support local marketing and engagement with partners and sign up for campaign updates.

Intervention quality principles

The quality principles that follow are based on previous guidance, changes in the evidence base and the latest understanding of 'best practice'. There have been no specific amendments to the quality principles published in the 2011/12 guidance, but these are repeated here for reference:

- Interventions should be based on the current evidence base and follow NICE guidance (see Annex D)
- Prior to treatment, clients should be informed of all available (evidence-based) treatment options both locally and nationally

- Stop-smoking service provision should be guided by a treatment protocol clearly indicating the elements of behavioural support programmes and when and how they should be applied. This manual should follow recommended practice from evidence-based national guidelines
- All staff involved in the delivery of stop-smoking interventions should be trained to a level appropriate to the level of service that they are delivering. Examples of training standards have been published by the NCSCT, which also offers certification to those who successfully complete their Stage 1 and Stage 2 online training assessments. These can be accessed free of charge at www.ncsct.co.uk
- To have the greatest effect, all interventions should be multi-session, offering weekly support for at least the first four weeks following the quit date, with a total potential client contact time of at least 1.5 hours (from pre-quit preparation to four weeks after quitting). This will ensure effective monitoring, client compliance and ongoing access to medication
- Smoking status at four weeks from the quit date should be biochemically verified (by carbon monoxide (CO) or cotinine testing) in a minimum of 85% of cases
- Interventions should be managed efficiently, with sufficient administrative support for general organisation, client contact processes and data handling. There should be sufficient administrative support to ensure clients are contacted within a week of being made known to the stop-smoking service provider and seen within two weeks
- New, non-evidence-based delivery models should initially be piloted on a small scale and should be evaluated carefully before being adopted as a significant part of local delivery
- Service delivery in all settings should be independently audited at regular intervals to ensure that the intervention being provided is of acceptable quality and duration.

See Annex C for an example checklist to support commissioning.

MEASURING SUCCESS

Four-week quit data will continue to be collected in 2012/13 as part of the 2012/13 NHS Operating Framework (see 'monitoring local stop-smoking services', on page 25).

In 2010/11, 787,527 treated smoker episodes were recorded by local stop-smoking services, resulting in 383,548 self-reported quitters at four weeks.¹⁰

The average self-reported quit rate recorded in 2010/11 was 49%, but this varied between PCTs, ranging from 29% to 69%. Given that smokers attempting to stop without additional support would be expected to have a success rate of 25% (for CO-validated quits) or about 35% (for self-reported quits) at four weeks, services must achieve

¹⁰ www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-england-april-2010-march-2011

success rates in excess of these figures to show an effect,¹¹ i.e. an added benefit. According to 2010/11 data, 4% of services did not achieve a self-reported quit rate above 35%.

CO validation rates have gradually increased over the past four years. In 2010/11, CO validation averaged 70%, an increase of 1 percentage point on 2009/10, although still lower than the 85% recommendation. However, CO validation rates varied between PCTs, ranging from 7% to 99%. It is important to note that, if local four-week quit data is accurate and robust, it is possible to calculate the expected number of longer-term (12-month) quitters.¹² Biochemical validation of quit outcomes should therefore remain a priority if local areas want to assure the quality of their quit data in order to reliably demonstrate their contribution to longer-term quit rates and quality of service provision.

Developments within the evidence base

Developments and changes within the evidence base are reported on pages 18 – 20.

See Annex A for a summary of the key evidence ratings.

Return on investment

The National Institute for Health and Clinical Excellence (NICE) has been asked by the Department of Health to develop a prototype model for local-authority commissioners, showing the potential return on investment (ROI) for health-improvement interventions. This work will initially focus on tobacco control.

The model will build on the cost-impact project that was set up by NICE to explore the feasibility and usefulness of producing a range of cost-effectiveness and cost-impact/ROI data and tools to support local decision-making. The project showed that a wide range of metrics and tools are needed to support effective decision-making at a local level. The full report is available at www.nice.org.uk/media/664/AC/cost_impact_proof_of_concept.pdf.

The starting point for the ROI prototype will be a model funded by and developed for Tobacco Free Futures, Fresh (Smoke Free North East) and Smokefree South West to show the costs of smoking and estimate the cost savings that could be achieved by having local tobacco-control services and/or sub-national strategies in their geographical areas

11 The best estimate of the 30-day abstinence figure in untreated smokers is 18% to 28%. NRT with minimal behavioural support has been found to increase success rates by about a half, giving a range of 27% to 42%. Taking the lower estimate of 27% and rounding down to 25% gives an approximate minimal level of success that would be expected for smokers receiving medication and minimal behavioural support. Given the evidence that self-reported success overestimates true success by about 10 percentage points, the self-report baseline figure needs to be some 10 percentage points higher (25% + 10% = 35%). These figures do not take account of the fact that the 4-week success rates of the services allow for smoking during the first two weeks. It is not known what effect this might have but, if anything, it would raise the true baseline figure even further. Further, specific research is required to inform baselines for specific smoking population groups

12 Hughes JR, Keely J and Naud S (2004) Shape of the relapse curve and long-term abstinence among untreated smokers. *Addiction* 99(1): 29-38

(e.g. region, county or local authority). The model currently allows users to explore the short-, medium- and long-term impacts of various combinations of tobacco-control interventions (i.e. to explore the impact of different scenarios).

By definition, an ROI model compares the monetary benefits of an intervention with the cost of that intervention. Thus, in order to explore the ROI and cost-effectiveness of a range of different scenarios in the short, medium and long term, it is necessary to develop the current model further and include a range of economic metrics informed by the cost-impact project. It is anticipated that the model should be available by September 2012.


PART 2: DELIVERING SERVICES

This section focuses on key updates relating to the delivery of stop-smoking interventions and the provision of stop-smoking services. Changes within the evidence base, new pharmacological products and the regulation of novel nicotine devices are summarised. Updates from centrally commissioned projects such as those carried out by the UK Centre for Tobacco Control Studies (UKCTCS) and NCSCCT are also provided.

Developments within the evidence base

A summary of the latest evidence ratings is provided in Annex A.

EVIDENCE RATING KEY:

A	The recommendation is supported by good (strong) evidence
B	The recommendation is supported by fair (reasonable) evidence, but there may be minimal inconsistency or uncertainty
C	The recommendation is supported by expert (published) only
I	There is insufficient evidence to make a recommendation
	Good-practice point

WHAT MAKES AN EFFECTIVE STOP-SMOKING SERVICE?

A recent study¹³ using PCT monitoring data to examine intervention characteristics and success rates, adjusting for key smoker characteristics, reaffirmed the following:

- Single NRT provided by a healthcare professional is associated with higher success rates than no medication, whilst varenicline and combination NRT are more successful than single NRT
- Group support is linked to higher success rates than one-to-one support
- Support provided within primary care settings is less successful than support provided by specialist services. The reasons for this could include the fact that delivering stop-smoking support is commonly only one part of a primary care practitioner's role, rather than a full-time focus as it is for dedicated stop-smoking advisers. Generally, therefore, full-time advisers have a greater opportunity to develop and refine the core competencies and skills associated with the delivery of effective stop-smoking support.

INTERVENTION TYPES

In 2010/11 most treated smokers received one-to-one support (636,036), followed by drop-in support (84,743), open (rolling) group support (26,142), closed group support (13,899), telephone support (11,576) and couple/family support (7,822).¹⁴ Telephone support and closed group support resulted in the greatest self-reported quit rates (64% and 60% respectively). One-to-one support had the lowest self-reported quit rate of 48%. The reasons for this could include the fact that one-to-one support is often the preferred intervention type in primary care settings, where lower quit rates are generally seen.

Drop-in support

A study¹⁵ of routine monitoring data from a sample of PCTs found drop-in support to be less effective than some other forms of behavioural support – particularly closed groups. However, further research is needed before the evidence rating for this type of intervention can be changed from I.

Text-based telephone support

The evidence rating for this intervention type has changed from B to A.

13 Brose L, West R, McDermott M, Fidler J, Croghan E and McEwen A (2011) What makes an effective stop smoking service? *Thorax* doi:10.1136/thoraxjnl-2011-200251

14 www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-england-april-2010-march-2011

15 Brose L, West R, McDermott M, Fidler J, Croghan E and McEwen A (2011) What makes an effective stop smoking service? *Thorax* doi:10.1136/thoraxjnl-2011-200251

In 2011 a trial with six-month biochemically validated outcomes was published, providing greater confidence about the efficacy of text-based support. The txt2stop trial¹⁶ randomised smokers who were willing to make a quit attempt to a mobile-phone text-messaging smoking-cessation programme that sent motivational messages and behavioural-change support, or to a control group that received text messages unrelated to quitting. Abstinence at six months increased significantly in the txt2stop group compared with the control group, suggesting that text-messaging support to stop smoking is effective in the UK.

Smokefree Together Plus trial

As previously reported, the Proactive or Reactive Telephone Smoking Cessation Support (PORTSCS) trial¹⁷ began in early 2009. The trial looked to compare the effects of free nicotine replacement therapy or proactive telephone counselling in addition to standard smoking-cessation support offered through a telephone quitline.

Overall, the trial found that, at six months, 17.7% (n=229) of those who were offered nicotine replacement therapy reported smoking cessation, compared with 20.1% (n=260) of those who were not offered such therapy. Similarly, 18.2% (n=236) of those who were offered proactive counselling reported smoking cessation, compared with 19.6% (n=254) of those who were offered standard support.

The author concluded that offering free nicotine replacement therapy or proactive counselling on top of standard helpline support had no additional effect on smoking cessation.

Novel nicotine delivery devices (including e-cigarettes)

Following consultation in 2010, the Medicines and Healthcare products Regulatory Agency (MHRA) is currently considering how novel nicotine delivery devices such as e-cigarettes should be regulated. A decision is due by May 2013. During the same period, NICE is developing public-health guidance on tobacco harm reduction; further details can be found at guidance.nice.org.uk/PHG/Wave23/23.

HEATH INEQUALITY PILOTS

In 2010, UKCTCS was awarded funding to carry out six heath inequality pilot projects in the following areas:

16 Free C, Knight R, Robertson S, Whittaker R, Edwards P, Zhou W, Rogers A, Cairns J, Kenward M and Roberts I (2011) Smoking cessation support delivered via mobile phone text messaging (txt2stop): a single-blind, randomised trial *The Lancet*, Volume 378, Issue 9785, pages 49–55

17 Ferguson J, Docherty G, Linda Bauld L, Lewis S, Lorgelly P, Boyd KA, McEwen A and Coleman T (2012) Effect of offering different levels of support and free nicotine replacement therapy via an English national telephone quitline: randomised controlled trial. *BMJ* 2012;344:e1696

□ **Pregnancy cessation services**

This project involved testing an opt-out referral system to local NHS stop-smoking services from maternity services and comparing three methods (self-report, carbon-monoxide testing and urinary cotinine testing) of identifying smoking in pregnancy.

□ **Mental health and cessation of tobacco use**

This project involved the development and piloting of a comprehensive tobacco-dependence support service, tailored to the needs of patients with mental illness treated in the community and on inpatient wards.

□ **Smokeless tobacco use**

This project aimed to develop and evaluate a smokeless-tobacco cessation service for members of the Indian, Pakistani and Bangladeshi communities. It assessed how effective the service was at helping people to quit and how happy people were with the service.

□ **Relapse prevention of return to smoking (among routine and manual workers)**

This project describes the development, implementation and subsequent evaluation, in terms of practicability and client response, of a text-based relapse prevention service delivered within a routine NHS stop-smoking service.

□ **Children's services workforces and smoking-cessation services**

This project involved testing the feasibility of an integrated system of referrals to local NHS stop-smoking services and to 'smokefree homes' schemes, targeted at parents and carers registered with Children's Centres.

□ **Smoking-cessation services in prisons**

This project examined the innovative role of a Regional Tobacco Coordinator (Criminal Justice System) and aimed to develop stop-smoking support for offenders by working across criminal justice and relevant public health settings based on a systems approach.

Further information is available from the UKCTCS website.¹⁸ Publication of the full reports, as well as key-point summaries, is expected in 2012.

Update from the National Centre for Smoking Cessation and Training

In 2009, the NCSCT¹⁹ was funded for three years by the Department of Health to help local stop-smoking services in England to deliver high-quality behavioural support by providing assessment, certification, training and continuing professional development for stop-smoking practitioners.

¹⁸ www.ukctcs.org/ukctcs/research/featuredprojects/dhinequalitiespilots/index.aspx

¹⁹ www.ncsct.co.uk

The NCSCT Training and Assessment Programme was launched in September 2010 and to date has been accessed by over 9,000 stop-smoking practitioners, more than 4,700 of whom have gone on to pass the NCSCT Stage 1 assessment. Evaluation has shown that knowledge scores improved from 64% before use of the online training programme to 78% after successful completion of the programme. The more time that practitioners spent engaging with the online training programme, the more their scores increased.

The online NCSCT Stage 2 assessment of smoking-cessation skills is now available and can be accessed through the NCSCT website (<http://www.ncsct.co.uk/>). Stop-smoking practitioners who pass this assessment, in addition to the NCSCT Stage 1 assessment (which they must have passed first), will be eligible for full NCSCT certification.

Additional developments expected from NCSCT in 2012/13 include:

- Second-hand-smoke training module
- Speciality modules for smoking in pregnancy and mental health
- Train the trainers course
- Update and supervision courses
- Medications module.

NCSCT BRIEFINGS

The NCSCT publishes briefings in response to questions from the field or from identified gaps in the evidence base or clinical knowledge. The following are a selection of the available NCSCT briefings that have been published to date and can be downloaded from the NCSCT website:²⁰

- Smoking and bone health
- Smoking reduction
- Combination nicotine replacement therapy
- Cardiovascular disease and varenicline
- Smoking cessation interventions involving significant others: the role of social support
- Varenicline: effectiveness and safety
- Cost-effectiveness of pharmacotherapy for smoking cessation.

NCSCT CIC DEPARTMENT OF HEALTH COMMISSIONED PROJECTS

In 2010, the NCSCT CIC was commissioned by the Department of Health to continue the development and implementation of a number of projects during the transitional year.

²⁰ www.ncsct.co.uk/resources/briefings

An overview of these projects, including the latest updates, can be found on the NCSCCT website.²¹ Full reports on each project will be made available as each is published.

In summary, the commissioned projects included:

- **Testing the new ‘routes to quit’ model** – aiming to broaden the support options provided by stop-smoking services to include reduction and medication-only approaches in addition to the more traditional abrupt-quit service.
- **Developing, piloting, implementing and evaluating a streamlined system for stop-smoking interventions in secondary care** – including embedding the systematic identification and referral of smokers within hospital settings using an electronic referral system. A three-month pilot in the Queen Alexandra Hospital in Portsmouth was completed in February 2012.
- **Testing a systematic service model for the identification and referral of pregnant women who smoke** – based on NICE guidance and utilising an electronic referral system which can be used by midwives as well as by a broad range of healthcare professionals engaged in care during pregnancy and post-partum.
- **Designing and developing an online training module to protect families and children from second-hand smoke in the home and car** – to improve awareness and knowledge of the risks and improve skills to raise the issue and support behaviour change for all healthcare professionals who work with these groups – launched in March 2012.
- **Designing and developing a VBA on smoking online training package** – designed for GPs and other healthcare professionals to increase the frequency and quality of VBA given to patients who smoke, based around short film clips providing examples and including key facts, figures and messages.
- **Developing an audit tool to permit quality-assurance assessment of local stop-smoking services** – an independent audit service model focusing on procedures and key delivery standards, consisting of provider-level self-assessment and patient-level assessment to evaluate the validity of data and client satisfaction.

Update from NICE

The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance and quality standards related to improving health and treating ill health. As part of this core remit, NICE produces public health guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector. Information on previously published smoking- and tobacco-related NICE guidance can be found at Annex D and is available at www.nice.org.uk/guidance/phg/index.jsp.

²¹ www.ncsct.co.uk/delivery/projects

The following public health guidance is being developed by NICE:

- Smokeless tobacco cessation – South Asians, expected to be published in autumn 2012. This guidance aims to help people of South Asian origin to stop using smokeless tobacco. The recommendations cover: assessing local need; working with local South Asian communities; planning and providing services; providing brief advice and referral: dentists, GPs, pharmacists and other health professionals; and training for practitioners and specialist cessation services.
- Tobacco – harm reduction, expected to be published in May 2013. This guidance will provide recommendations for good practice based on the best available evidence of effectiveness, including cost-effectiveness. It is aimed at professionals, commissioners and managers with public health as part of their remit. It is especially aimed at those involved in smoking-cessation services within the NHS, local authorities and the wider public, private, voluntary and community sectors. It will also be of interest to members of the public, especially people who want to stop smoking or reduce the amount they smoke.
- Smoking cessation – acute and maternity services, expected to be published in November 2013. This guidance will address smoke-free policies and smoking cessation in hospitals and other acute or maternity care settings. It will cover emergency care, planned specialist medical care or surgery, and maternity care provided in hospitals, maternity units, outpatient clinics and the community. It will also cover secondary care services provided in the community.
- Smoking cessation – mental health services, expected to be published in November 2013. This guidance will address smoke-free policies and smoking cessation in mental healthcare settings. It will cover assessment, care and treatment for people with severe mental illness in hospitals, outpatient clinics and the community, as well as intensive services in psychiatric units and secure hospitals.

For further information about any of the above guidance, see: www.nice.org.uk/guidance/index.jsp?action=bypublichealth&PUBLICHEALTH=Smoking+and+tobacco#/search/?reload

PART 3: MONITORING LOCAL STOP SMOKING SERVICES

The collection of PCT four-week quit data remains a requirement within the 2012/13 NHS Operating Framework and will continue to be collected on a quarterly basis [ROCR/OR/0028/006MAND – 212-001].

The monitoring and reporting process, including the key definitions, remains predominantly the same as detailed in the 2011/12 guidance. This information is provided in Annex B.

Table 1: 2012/13 returns timetable

Quarter	End of 6-week follow-up period	PCT deadline to submit data to IC and elapsed weeks	Date of publication by IC website
April 2012 to June 2012 (Q1)	13/08/2012	10/09/2012	25/10/2012
July 2012 to September 2012 (Q2)	14/11/2012	10/12/2012	16/01/2013
October 2012 to December 2012 (Q3)	14/02/2013	14/03/2013	17/04/2013
January 2013 to March 2013 (Q4)	14/05/2013	17/06/2013	15/08/2013

The latest version of the 'gold standard' monitoring form is provided in Annex I of *Local stop smoking services: service delivery and monitoring guidance 2011/12*.²² Services are encouraged to either use this form or adapt existing forms to include the same content (as a minimum). A more comprehensive monitoring form is available on the NCSCCT website.²³

It should be noted that the expenditure figure provided on these forms should exclude expenditure on nicotine replacement therapy (NRT), bupropion (Zyban), and Varenicline (Zyban) on prescription.


22 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125389

23 www.ncsct.co.uk/resources/resources-for-practitioners/clinical-tools/stop-smoking-service-client-record

ANNEX A: EVIDENCE RATINGS

Every recommendation in the delivery section (Part 2) of the 2011/12 guidance has a rating to show the extent to which it is based on evidence. This is based upon the Scottish Intercollegiate Guidelines Network (SIGN) rating system,²⁴ an internationally recognised scale to rate research evidence. The SIGN rating system was recently adapted for smoking-cessation guidance by the New Zealand Guidelines Group,²⁵ and the same evidence ratings are used here. These are as follows:

EVIDENCE RATING KEY:

A	The recommendation is supported by good (strong) evidence
B	The recommendation is supported by fair (reasonable) evidence, but there may be minimal inconsistency or uncertainty
C	The recommendation is supported by expert (published) only
I	There is insufficient evidence to make a recommendation
	Good-practice point

In order to grade the evidence in this guidance, reviews of published research were conducted by members of the guidance development group. The process included identifying relevant systematic reviews and primary studies of smoking-cessation interventions. Particular attention was paid to reviews conducted to inform NICE guidance and primary studies conducted in the UK, due to their relevance for English stop-smoking services. Evidence gradings are updated annually in line with the guidance to take into account the findings of any new studies.

Only one change has been made for 2012/13, altering text-based support from a B to an A rating.

24 Scottish Intercollegiate Guidelines Network (2010) SIGN 50: A guideline developer's handbook www.sign.ac.uk/guidelines/fulltext/50/annexb.html

25 New Zealand Ministry of Health (2007) New Zealand Smoking Cessation Guidelines. Ministry of Health. www.moh.govt.nz

Section	Evidence rating
Very brief advice	A
Behavioural support	A
Intervention types	
One-to-one support	A
Couple/family support	I
Closed group support	A
Open (rolling) group support	B
Drop-in support	I
Telephone support	
<input type="checkbox"/> Proactive	A
<input type="checkbox"/> Reactive	B
<input type="checkbox"/> Text-based	A
Online support	B
Assessing nicotine dependency and smoking status	
Quantitative approach to assessing nicotine dependency	A
Carbon Monoxide testing	A
Increasing quit rates through lung function/spirometry	I
Cotinine testing	A
Pharmacotherapy	
Nicotine replacement therapy	A
Combination therapy	A
Preloading/nicotine-assisted reduction to stop (NARS)	B
Bupropion (Zyban)	A
Varenicline (Champix)	A

Section	Evidence rating
Smoking populations	
Routine and manual smokers	B
Pregnant smokers	B
<input type="checkbox"/> use of nicotine replacement therapy in pregnancy	C
<input type="checkbox"/> teenage pregnancy	✓
Smoking and mental health problems	B
Secondary care	A
Prisoners	C
Substance mis-users	C
Black and minority ethnic groups	B
Children and young people	
<input type="checkbox"/> stop-smoking interventions	I
<input type="checkbox"/> prevention and tobacco control	B
Relapse prevention	I
Repeat service users	✓

Other interventions and products that are either not recommended or are currently not evidence based are also included in the delivery section and are again summarised below.

Intervention/product
Some evidence of effectiveness but not recommended
Rapid smoking Cytisine
Insufficient evidence – currently not recommended
Allen Carr Nicobrevin NicoBloc St John’s Wort Glucose Lobeline Exercise
Evidence of no effectiveness – not recommended
Hypnosis Acupuncture Acupressure Laser therapy Electro-stimulation Anxiolytics Incentives/competitions

ANNEX B: DEFINITIONS

Bank staff

Staff involved in the delivery of stop-smoking interventions who have been trained to appropriate local standards and who are paid to provide these services outside their normal working hours.

CO-verified four-week quitter

A treated smoker whose CO reading is assessed 28 days from their quit date (-3 or +14 days) and whose CO reading is less than 10ppm. The -3 or +14 day rule allows for cases where it is impossible to carry out a face-to-face follow-up at the normal four-week point (although in most cases it is expected that follow-up will be carried out at four weeks from the quit date). This means that follow-up must occur 25 to 42 days from the quit date (Russell standard).

Clients whose follow-up date falls outside this time span may not be counted for the purposes of quarterly data submissions to the NHS Information Centre (IC).

CO verification should be conducted face-to-face and carried out in at least 85% of self-reported four-week quitters. Cotinine levels can be assessed using postal sample collections if necessary.

The percentage of self-reported four-week quitters who have been CO verified should be calculated as shown below:

$$\frac{\text{Number of treated smokers who self-report continuous abstinence from smoking from day 14 to the four-week follow-up point, and who have a CO reading of less than 10ppm}}{\text{All self-reported quitters}}$$

All self-reported quitters

Exception reporting system

A data verification and checking system designed to improve data quality and identify the reasons for outlying data (i.e. data that falls outside the expected success-rate range derived from the evidence base on smoking cessation).

Local stop-smoking services

A local stop-smoking service is defined as a locally managed, co-ordinated and provided service, funded by the Department of Health nationally and commissioned locally, to provide accessible, evidence-based, cost-effective clinical services to support smokers who want to quit. Service delivery should be in accordance with the quality principles for clinical and financial management contained within this guidance.

Lost to follow-up (LTFU)

A treated smoker who cannot be contacted either face-to-face, via telephone, email, letter or text following three attempts to contact at different times of day, at four weeks from their quit date (or within 25 to 42 days of the quit date). The four-week outcome for this client is unknown and should therefore be recorded as LTFU on the monitoring form.

Monthly monitoring

Voluntary monthly collection and reporting system for which local stop-smoking services collect and report data on the number of smokers entering treatment and setting a quit date and the number recorded as quit. **This return is now optional** (as of November 2008).

Non-treated smoker

A smoker who receives no support or is given very brief advice and/or supplied with leaflets, helpline cards or pharmacotherapy only, and does not set a quit date or consent to treatment. Examples may include smokers seen at a health fair or community event, during a GP consultation and during a hospital stay where a quit date is not set and a quit attempt is not made.

Quarterly data set

Stop-smoking service data that is submitted to the IC on a quarterly basis.

Quit date

The date on which a smoker plans to stop smoking altogether with support from a stop-smoking adviser as part of an NHS-assisted quit attempt.

Renewed quit attempts

A quit attempt that takes place immediately following the end of one treatment episode. A new treatment episode should be commenced in the database/service records.

Routine and manual smoker

A smoker whose self-reported occupational grouping is of a routine and manual (R/M) worker, as defined by the National Statistics Socio-Economic Classification.²⁶

26 Office for National Statistics (2005) *The National Statistics Socio-economic Classification User Manual*. ONS

Self-reported four-week quitter

A treated smoker whose quit status at four weeks from their quit date (or within 25 to 42 days of the quit date) has been assessed (either face-to-face or by telephone, text, email or postal questionnaire). The percentage of self-reported four-week quitters should be calculated as shown below:

$$\frac{\text{Number of treated smokers who self-report continuous abstinence from smoking from day 14 post-quit date to the four-week follow-up point}}{\text{All treated smokers}}$$

Smoked product

Any product that contains tobacco and produces smoke is a smoked product, including cigarettes (hand-rolled or tailor-made), cigars and pipes. Pipes include shisha, hookah, narghile and hubble-bubble pipes.

Smokeless product

There is evidence to show the use of smokeless tobacco products (e.g. chewing tobacco, paan and khat) can have negative health effects, including oral cancers. There is some evidence to suggest that behavioural support can be effective.

Note for commissioners:

Commissioners who identify communities within their localities with high rates of smokeless tobacco use may also consider these priority groups and look to commission services to help them to stop. There is currently a limited evidence base to suggest the most effective type of service for smokeless-tobacco users and consideration needs to be given to how clients who self-report cessation will be clinically validated. It is also important to note that clients who attend such services are not to be included in data-monitoring returns, as the outcomes relate specifically to smoking.

Smoker

A person who smokes a smoked product. In adulthood this is defined in terms of daily use, whereas in adolescence (i.e. for those aged 16 or under) it is defined in terms of weekly use.

Smoking cessation

In clinical terminology, used to denote activities relating to supporting smokers to stop.

Spontaneous quitters

Smokers who have already stopped smoking when they first come to the attention of the service may be counted as having been 'treated' only if they have quit within the 48 hours prior to coming to the attention of the service and have attended the first session of a structured multi-session treatment plan within two days of their spontaneous quit date (which should be recorded as the quit date).

Examples of such quitters include clients who experience unplanned admission to hospital and stop smoking before receiving support or pregnant smokers who have already stopped smoking before approaching their local stop-smoking service provider or one of the service's trained agents. While it is recognised that it is desirable to offer as many smokers as possible support to quit and maintain abstinence, local commissioners will need to balance the needs of their smoking population against available service resources.

Smokers who have already stopped smoking when they first come to the attention of the service and have been quit for more than 48 hours may be counted as having been 'treated' for local accounting purposes only and not included in the national quarterly data return. It is recommended that such clients are only recorded if they have quit within the 14 days prior to coming to the attention of the service and have attended the first session of a structured multi-session treatment plan within 14 days of their spontaneous quit date (which should be recorded as the quit date).

Stop smoking

Preferred term to denote patient-facing communications relating to smoking-cessation activity.

Stop-smoking adviser

An individual who is NCSCT certified, has received stop-smoking service training that meets the NCSCT published standards and is employed by a commissioned stop-smoking service provider.

Stop-smoking service provider

A stop-smoking service provider is defined as a locally managed and co-ordinated service commissioned to provide accessible, evidence-based, cost-effective clinical services to support smokers who want to quit. Service delivery should be in accordance with the quality principles for clinical and financial management contained within this guidance.

Time between treatment episodes

(see also 'treatment episode')

When a client has not managed to stop smoking, there is no definitive period of time required between the end of a treatment episode and the start of another. The stop-smoking adviser should use discretion and professional judgement when considering whether a client is ready to receive support to immediately attempt to stop again. If this is the case, the client must start a new treatment episode, i.e. attend one session of a structured multi-session intervention, consent to treatment and set a quit date with a stop-smoking adviser in order to be counted as a new data entry on the quarterly return.

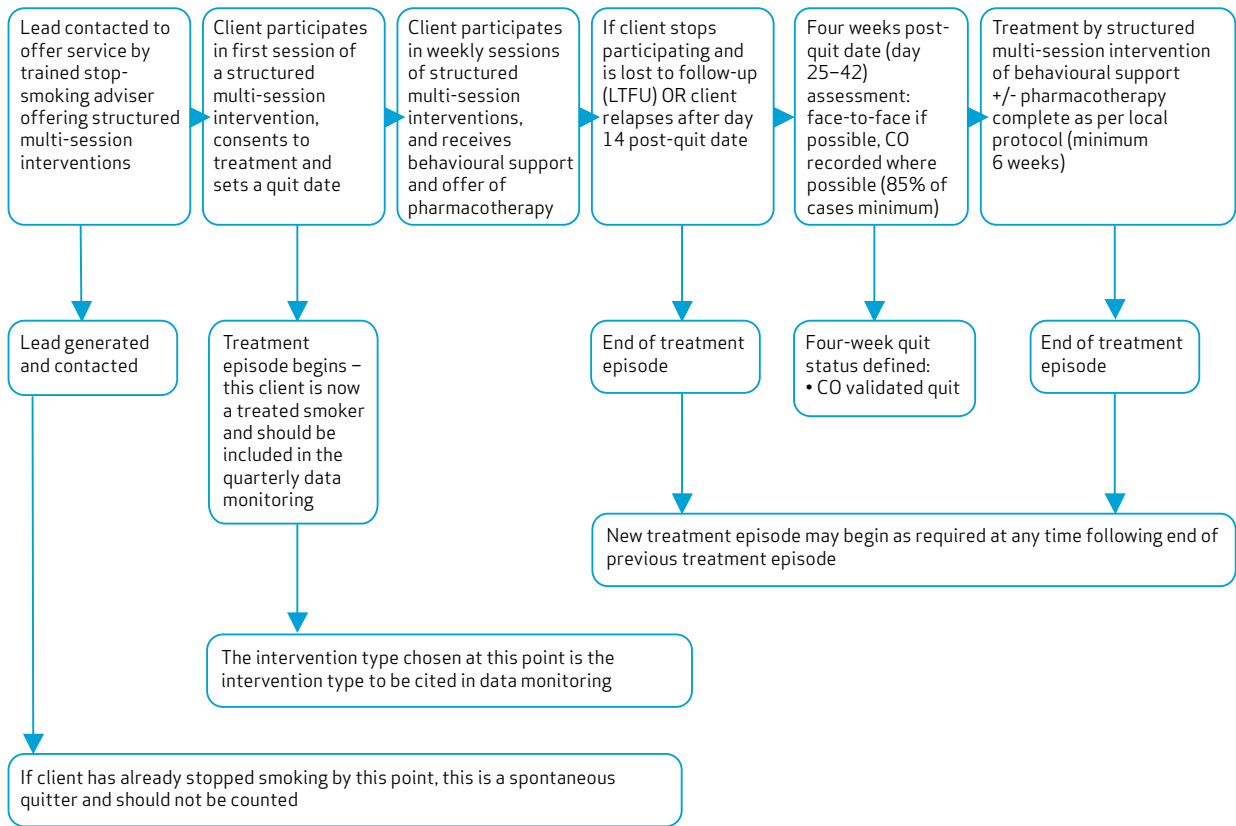
Treated smoker

A smoker who has received at least one session of a structured multi-session intervention (delivered by a stop-smoking adviser) on or prior to the quit date, who consents to treatment and sets a quit date with a stop-smoking adviser. Smokers who attend a first session but do not consent to treatment or set a quit date should not be counted.

Treatment episode

At the point of attending one session of a structured multi-session intervention, consenting to treatment and setting a quit date with a stop-smoking adviser, a client becomes a treated smoker and the treatment episode begins. The treatment episode ends when a client has either been completely abstinent for at least the two weeks prior to the four-week follow-up (see flow chart below) or is lost to follow-up at the four-week point, or when a four-week follow-up reveals that a client has lapsed during the two weeks immediately prior to the follow-up and is therefore recorded as a non-quitter.

Figure 2: Treatment episode flow chart



ANNEX C: COMMISSIONING CHECKLIST

STRATEGIC PLANNING

Assessing needs, reviewing service provision and deciding priorities.

Recommendation	Completed? Yes/No	Action required (If no)	Expected date of completion
Is service take-up by routine and manual (R/M) smokers, pregnant smokers and smokers with mental health diagnoses proportional to your local smoking population?			
Have you established the composition of your local smoking population and its service needs, and is provider development informed by local intelligence, community engagement and customer evaluation involving different populations?			
Have you obtained local prevalence and current activity data on smoking populations? Have services been weighted in terms of deprivation and does this include high-risk groups such as pregnant women, prisoners or smokers with mental health diagnoses?			

PROCURING SERVICES

Designing services, shaping structure of supply, planning capacity and managing demand.

Recommendation	Completed? Yes/No	Action required (If no)	Expected date of completion
Have you sought advice and guidance from internal and local networks, and is the commissioner(s) in regular communication with external sources of support?			
Are stop-smoking service providers fully aware of all commissioning arrangements and how they should be working with other local providers of stop-smoking support? (For example, are locally commissioned stop-smoking services fully integrated?) Are clear communication channels in place to ensure all providers are updated on local and national developments?			
Does the provider(s) have a clear treatment protocol?			
Does the provider(s) have a dedicated lead?			
Does the provider(s) offer the optimum balance of high-efficacy treatment, reach and accessibility?			
Does the provider(s) currently deliver a range of evidence-based interventions that consistently achieve auditable success rates of between 35% and 70% and which comply with the quality principles?			
Are all stop-smoking advisers NCSCT certified and supported to attend relevant training events? Do they all have continuing professional development plans?			

Recommendation	Completed? Yes/No	Action required (If no)	Expected date of completion
Are all NICE-approved stop-smoking medicines available as first-line treatments for smokers wanting to quit?			
Does the provider(s) achieve CO validation rates at the recommended minimum of 85% of all self-reported four-week quitters?			
<p>Does the provider(s) benefit from a robust, integrated IT system that provides:</p> <ul style="list-style-type: none"> <input type="checkbox"/> systems for prompt and accurate return of quarterly service data? <input type="checkbox"/> concordance with mandatory data requirements and the flexibility to update data fields when necessary? <input type="checkbox"/> the facility to manage client appointments efficiently and conduct detailed analyses of local performance? <input type="checkbox"/> the ability to analyse service performance and identify gaps in support provision 			
Does the provider's(s') budget include adequate provision for the supply and maintenance of the required equipment (e.g. CO monitors, tubes, calibration kits etc.)?			
Have you budgeted sufficiently for local marketing and service promotion? Do local promotions use national Smokefree branding and campaign messaging and are they integrated with regional and national marketing plans?			

Recommendation	Completed? Yes/No	Action required (If no)	Expected date of completion
Do you have plans for consistent follow-up of referrals throughout the quitting journey? Do you have plans to re-engage smokers who have stopped using the service?			
Does the provider(s) have a contingency plan to deal with potential service disruption?			
Is the delivery of very brief advice (VBA) and referral of smokers to commissioned stop-smoking services contracted as part of all other commissioned services?			
Is VBA training available to staff working in potential referral services?			

MONITORING AND EVALUATION

Seeking public and patient views, managing performance and supporting patient choice.

Recommendation	Completed? Yes/No	Action required (If no)	Expected date of completion
Do you have access to the full range of data required and is there effective data sharing across all providers to provide quality assurance?			
Do you have robust and routine performance-management and clinical governance systems to monitor service quality and facilitate independent audits?			
Do you have systems in place to measure service user satisfaction?			

ANNEX D: NICE GUIDANCE

The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance and quality standards related to improving health and treating ill health. As part of this core remit, NICE produces public health guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector. More information is available at www.nice.org.uk/guidance/phg/index.jsp.

All of the following NICE guidance is related to smoking or tobacco and can be accessed from the NICE website.²⁷ Each piece of guidance is informed by reviews of evidence of effectiveness and cost-effectiveness. The evidence reviews can also be found on the NICE website, under the relevant piece of guidance.

PUBLIC HEALTH GUIDANCE

- Brief interventions and referral for smoking cessation (PH1)
- Workplace interventions to promote smoking cessation (PH5)
- Smoking cessation services (PH10)
- Preventing the uptake of smoking by children and young people (PH14)
- Identifying and supporting people most at risk of dying prematurely (PH15)
- School-based interventions to prevent smoking (PH23)
- Quitting smoking in pregnancy and following childbirth (PH26)

IN DEVELOPMENT

- Smokeless tobacco cessation – South Asians
- Smoking cessation – acute and maternity services
- Tobacco – harm reduction
- Smoking cessation – mental health services

TECHNICAL APPRAISALS

- Smoking cessation – varenicline (TA123)
- Smoking cessation – bupropion and nicotine replacement therapy (TA39, replaced by PH10)

QUALITY STANDARD

- Chronic obstructive pulmonary disease (COPD) quality standard (QS10)

²⁷ www.nice.org.uk/guidance/index.jsp?action=bypublichealth&PUBLICHEALTH=Smoking+and+tobacco#/search/?reload, and <http://publications.nice.org.uk/school-based-interventions-to-prevent-smoking-ph23>

ANNEX E: USEFUL CONTACTS

Department of Health

www.dh.gov.uk/health/category/policy-areas/public-health/tobacco/

The Information Centre

Statistics on NHS stop-smoking services

www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services

Statistics on smoking in England

www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/smoking

National Centre for Smoking Cessation and Training (NCSCT)

enquiries@ncsct.co.uk

www.ncsct.co.uk/

National Institute for Health and Clinical Excellence

www.nice.org.uk/

Regional Tobacco Alliance Leads

North East

Ailsa Rutter ailsa.rutter@freshne.com

North West

Andrea Crossfield andrea.crossfield@tobaccofreefutures.org

South West

Fiona Andrews fiona.andrews@smokefreesouthwest.org.uk

Smokefree Resource Centre

www.smokefree.nhs.uk/resources

Other useful contacts

NHS Stop Smoking Helpline 0800 169 0 169

NHS Pregnancy Smoking Helpline 0800 169 9 169

NHS Asian Tobacco Helplines

Urdu 0800 169 0 881

Punjabi 0800 169 0 882

Hindi 0800 169 0 883

Gujarati 0800 169 0 884

Bengali 0800 169 0 885

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