Public Health England

Protecting and improving the nation's health

Tobacco control - commissioning support pack 2018-19: principles and indicators

Planning for comprehensive local tobacco control interventions

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Introduction

In July 2017, the Government published its Tobacco Control Plan for England[1] to pave the way for a smokefree generation. The comprehensive plan sets out the following national ambitions for achievement by the end of 2022:

- reduce smoking prevalence amongst adults in England from 15.5% to 12% or less.
- reduce the prevalence of 15 year olds who regularly smoke from 8% to 3% or less
- reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less
- reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population

The UK is a world leader in tobacco control but smoking remains our biggest preventable killer. In England alone, 79,000 people a year, or 200 per day, die from smoking. In addition to the human cost, smoking costs the economy £14.7 billion per year, £2.5 billion of which falls to the NHS.

Since publication of the last Tobacco Control Plan, smoking prevalence among adults in England has dropped from 20.2% to just 15.5% - the lowest level since records began.

The new plan sets out the ambition for a further reduction in smoking rates, down to 12% by the end of 2022, as the first step toward a generation of non-smokers - which will be achieved when smoking prevalence is at 5% or below.

The plan prioritises reducing the rates of smoking in pregnancy, as well as addressing the huge variation in harm across the country - which disproportionally falls on vulnerable communities. In 2015, there were almost three times as many smokers among the lowest earners in comparison to the highest earners.

The plan calls for targeting prevention and local action to address the variation in smoking rates in our society, educate people about the risks and support them to quit for good.

Comprehensive tobacco control interventions, implemented at local level and part of a strategic partnership approach, reduce smoking prevalence and have been proved effective in reducing social and health inequalities and improving NHS sustainability. Having a comprehensive approach to tobacco control can:

Cut costs to local business, healthcare and public services
In England each year it is estimated that smoking costs the public £14.7bn in terms of output lost from early deaths, smoking breaks, sick days, provision of NHS treatment, provision of social care, household fires, and smoking litter.[2,1]

Support the NHS sustainability and transformation agenda
Smoking is a leading cause of preventable illness and tackling it presents a major opportunity to make services across the entire health and care system more sustainable.

Protect children from harm
Two thirds of smokers say they began smoking before the age of 18 at which it is legal to purchase cigarettes and nine out of ten before the age of 19.[3] Children exposed to secondhand smoke are at much greater risk of cot death, meningitis, lung infections and ear disease.[4]

Boost the disposable income of the poorest people in your local area
Two adult smokers with a 20-a-day habit are likely to spend over £6,000 per year on cigarettes. Workers in routine and manual jobs are twice as likely to smoke as those in managerial and professional roles.[5] Poorer smokers spend five times as much of their weekly household budget on smoking as richer smokers.[6]

Drive improvement across key measures of population health
Reducing smoking rates will impact on core indicators included in three out of the four public health domains identified in 'Improving outcomes and supporting transparency: A public health outcomes framework for England'.[7]

Examples of indicators which would be positively affected include:

- sickness absence
- the number of children in poverty
- numbers of low birth-weight babies
- pregnant women smoking at time of delivery
- smoking prevalence rates in adults and children
- infant mortality and all cause preventable mortality
- mortality from cardiovascular disease
- mortality from cancer
- mortality from respiratory disease
- preventable sight loss

Joint strategic needs assessments

Joint strategic needs assessments (JSNAs) analyse the current and future health and social care needs of communities, to inform and guide the commissioning of health, wellbeing and social care services within local authority areas. The joint health and wellbeing strategy (JHWS) sets out the strategy for meeting the needs identified in the JSNA.

Aim of this support pack

Public Health England (PHE) supports local authorities in the delivery of locally appropriate interventions and services to improve the public's health, by providing data, interpretation and evidence. This pack supports the JSNA process and the commissioning of comprehensive tobacco control interventions. It also introduces a model from behaviour change theory, to support commissioners in a systematic and comprehensive analysis of their available commissioning options. Local authorities and their partners are also encouraged to adopt CLeaR, an evidence-based improvement model which can assist in evaluating the effectiveness of local action addressing harm from tobacco.[8]

Feedback

This is the fourth edition of PHE's JSNA support pack on tobacco control. It builds on feedback from commissioners and other local stakeholders regarding its value as a resource for reference, and as support for investment in comprehensive local tobacco control.

1. Commissioning principles for comprehensive local tobacco control

Statement of principle
Local authority public health commissioners work closely with all relevant partners to commission high quality, evidence-led comprehensive tobacco control interventions.

What is meant by 'evidence-led?'

Tobacco control is an area of public health that has a very strong and consistent evidence base. If recommended interventions are delivered, the evidence indicates clearly that they will save lives and reduce chronic ill-health and disability, providing net savings to the local and national economy within a few years.

The main drivers of reduction in smoking prevalence are decreasing uptake and increasing cessation. By far the largest impact on smoking prevalence in any one year comes from increasing cessation simply because the numbers affected are so much greater. It is therefore more cost effective to focus resources on cessation. An added advantage of this is that many interventions that promote cessation, such as raising the cost of smoking, also serve to reduce smoking uptake.

The evidence comes from large numbers of population-level and clinical studies. They demonstrate that, as with other types of behaviour change, for smoking cessation to occur it is essential to ensure that smokers have the capability, opportunity and motivation to change. All three of these need to be in place. This broad principle has been captured by the 'COM-B' model of behaviour.[9,10]

Figure 1 shows the COM-B model applied to smoking cessation in a given population or sub-population (for example, low income smokers, smokers with mental health problems or pregnant smokers).

Capability refers to smokers' ability to stop if they try. This depends on their level of addiction to cigarettes. Most smokers are addicted to some degree and so treating the addiction will improve their chances of success. Some smokers are much more heavily addicted than others and it is essential that these individuals have access to specialist support.

Motivation refers to smokers' desire to try to stop now rather than at some other time or never. Creating a sense of immediacy and hope are important in prompting quit attempts.

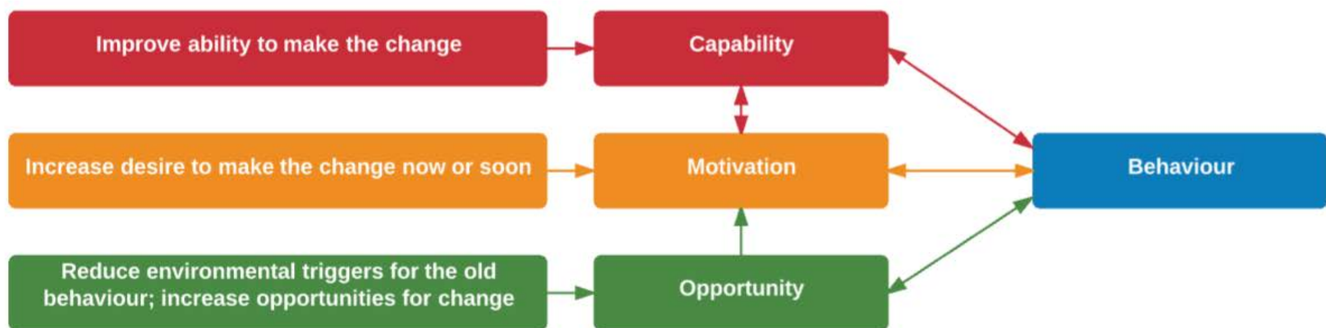
Examples include:

- social marketing via mass media, social media and other promotional platforms is a key driver of motivation to quit, working through; reminding smokers about quitting, the best ways to do it, and calls to action
- minimising access to cheap tobacco supports one of the key drivers of quitting: the financial cost
- brief advice from a healthcare professional is still one of the most important triggers to quitting, especially if it involves the offer of support

Opportunity refers to reducing triggers to smoke, making smoking seems less 'normal' and making quitting seem like the kind of thing everyone is doing. Setting up and enforcing smoking bans in key locations can play a role in this, as can ensuring compliance with bans on marketing and promotion.

Figure 1: The COM-B model of behaviour change applied to reducing smoking prevalence

The COM-B model of behaviour change



The COM-B model applied to reducing smoking prevalence

There is a high level of interaction between these elements, emphasising the need for comprehensive local tobacco control action plans. Improving smokers' ability to stop can increase the motivation to try, as can decreasing smoking triggers in their environment and increasing the public visibility of quitting.

The most effective tobacco control strategy is one in which all the elements are working together. This means, for example, linking up social marketing campaigns prompting quitting with brief advice from health professionals offering support. An integrated strategy requires multi-agency working with clear and coherent vision as to the local objectives and how the different elements of the strategy will combine to achieve these.

What will you see locally if you are meeting the principle?

Effective integrated commissioning of interventions that achieve positive outcomes for individuals, families and communities by:

- having well-functioning partnerships between:
    - local authority-led public health
    - NHS (clinical commissioning groups (CCGs) and NHS England regional teams)
    - acute health services
    - mental health services and adult social care
    - regulatory services
    - children's services
    - criminal justice agencies
- operating transparently according to assessed need
- bringing partner agencies and service providers together into cost-effective delivery systems
- involving service users and local communities, including through Healthwatch
- all smokers are offered cessation support suited to their needs and preferences
- tobacco control is a prominent action within strategies aimed at addressing health and social inequalities.

What questions should you ask to test whether you are following the evidence and best practice?

1.1 Embedding in local systems

1.1.1. Do tobacco control needs assessments, the local authority commissioning strategy, CCG commissioning strategy, and the joint health and wellbeing strategy (JHWS) and Sustainability and Transformation Plans (STPs) demonstrate an explicit link between evidence of need and service planning?

1.1.2. Are there suitable mechanisms in place within the local public health structure to ensure the impact of tobacco use is reported to the health and wellbeing board and STP delivery boards?

1.1.3. Do those responsible for commissioning tobacco control and stop smoking services have established partnership arrangements in place with CCGs, local clinical networks, NHS England regional teams, regulatory services and criminal justice agencies?

1.1.4. Has the role of tobacco control in supporting the NHS sustainability and transformation agenda been formally explored?

1.1.5. Have such strategic partnerships undertaken a self-assessment[11] to enable you to:

- evaluate your local action on tobacco
- ensure that local activity follows the latest evidence-based practice
- identify priority areas for development?

1.1.6. Have strategic partner organisations acknowledged their responsibilities to protect their tobacco control policies from the vested interests of the tobacco industry under Article 5.3 of the WHO Framework Convention on Tobacco Control (FCTC), by signing the Local Government Declaration on Tobacco Control?[12]

1.1.7. Is there a clearly accessible process for smokers to express their preferences for how they want to stop smoking and the type of support they are willing to engage with?

1.2. Needs assessment

Needs assessment involves not just assessing whether smokers in particular sub-groups would benefit from cessation support, but also what kind of support, if any, they are willing to engage with:

1.2.1. Does the local JSNA include a comprehensive section on tobacco control that addresses smoking-related harm and health inequalities, and readily acknowledges the impact of tobacco control activity across the public health outcomes framework (PHOF) and NHS outcomes framework (NHSOF)?

1.2.2. Is there a shared understanding of the local level of demand and need, based on a range of local and national data across a range of public services?

1.2.3 Is local data on tobacco control interventions provided within hospitals, primary health care and other settings collected and analysed to inform needs assessment?

1.2.4. Does analysis of tobacco-related hospital admissions inform the targeting of local interventions?

1.2.5. Do commissioners own and analyse local stop smoking service treatment data to assess quality, including specific breakdown by gender, age, postcode, condition, route of referral and treatment outcome, so that treatment provision can be aligned with need?

1.2.6. Does the needs assessment incorporate a methodology such as asset-based community development to take into account the availability and potential for development of existing community support networks and other local assets?

1.2.7. Are the following fully identified?

- gaps in the delivery of brief interventions across all partner agencies
- the equity of access to stop smoking services for key populations with a higher prevalence of smoking such as routine and manual workforce, teenage pregnant women, people with mental health problems, prison populations and lesbian, gay, bisexual and transgender (LGBT) communities
- the impact of tobacco control and stop smoking interventions on hospital admissions, length of stay and social care activity

1.3. Resources and investment

1.3.1. Is investment commensurate with the level of identified need and sufficient for a range of prevention, harm reduction and stop smoking service activities?

1.3.2. Can commissioners identify the total level of local investment by all partners who contribute to delivery?

1.3.3. Have the partners identified the potential return on investment for funding tobacco control interventions and does this include the economies to be achieved by commissioning supra-local activity?[13]

1.4. Effective commissioning

1.4.1. Do interventions commissioned for tobacco control and the tackling of smoking-related harm take an evidence-based approach based on NICE guidance and National Centre for Smoking Cessation and Training (NCSCT) commissioning recommendations?[14]

1.4.2. Are reliable cost-effectiveness data tools used to inform commissioning decisions and ensure that investment in tobacco control is based on an understanding of expenditure, performance and effectiveness?

1.4.3. Do contracts for commissioned services specify key performance indicators and are these regularly monitored and reviewed?

1.4.4. Are interventions and services geographically and socioculturally appropriate to those for whom they are designed?

1.4.5. Is there sufficient tobacco control commissioning capacity and expertise?

1.4.6. Are arrangements in place to facilitate supra-local commissioning with regional partners?

1.4.7. Does formal evaluation of the range of tobacco control interventions feature within the commissioning strategy?

2. Supporting people to stop smoking

Statement of principle
Targeted stop smoking services, as an integral part of any comprehensive tobacco control strategy, provide evidence-based support tailored to the needs and preferences of smokers.

Stop smoking services are a key component of cost-effective tobacco control strategies at local and national level. Targeted, high quality stop smoking services are essential to the reduction of health inequalities in local populations. For many years, smokers in England have been offered a highly effective universal service. In recent years, some local authorities have been looking at new ways of providing this service, often in response to budgetary constraints.

It is important to ensure that resources are appropriately targeted, and that commissioning decisions are based on the evidence of what works and avoid selectively disadvantaging the local population.

All health and social care services play a key role in identifying smokers and referring them to stop smoking services. For those smokers who are not ready, willing or able to stop in one step, harm reduction interventions can support them in becoming smokefree over the longer term.

The need for tailored quitting support within a comprehensive strategy

The probability of success of an unaided quit attempt is typically less than 5%. That is a key reason why smoking prevalence is falling only very slowly despite the fact that a third of smokers try to stop every year.

Failure of quit attempts is also why prevalence is declining more slowly in people with greater social disadvantage. In the recent past there has been no difference in the rate at which more disadvantaged smokers try to stop. It is their chances of success that are lower.[15]

Smokers who get expert support from stop smoking services are up to four times as likely to quit successfully as those who try to quit unaided.[16] Therefore, support for smoking cessation is a crucial part of tobacco control at national and local level, and essential for reducing health inequalities caused by smoking.

As noted in Chapter 1, it is important to link stop-smoking support with other components of the local tobacco control strategy so that:

- smokers are motivated to try to stop and use effective methods to do so
- increasing ability to stop increases motivation to stop
- stopping smoking becomes more visible in the community (Figure 2).

Figure 2: The role of stop-smoking support in a comprehensive strategy

Note: Ensuring cessation support is available helps (1) tackle cigarette addiction, (2) which increases cessation rates and (3), can motivate others to quit, and (4), to use cessation support. Increased successful quitting in the community reshapes the social environment (5) making quitting normative and potentially helping to motivate others to quit (6).

Smoking cessation within integrated ‘lifestyle services’

With issues such as healthy weight and physical activity becoming more prominent, there is pressure to provide broader lifestyle advice and support. This has led some local authorities to commission ‘lifestyle services’ and to incorporate stop-smoking support into these. Broadly, two different models for integrating services have emerged and it is important to distinguish between them. One involves an umbrella organisation, which directs individuals to specific treatment programmes. For example, stop smoking support with evidence based behavioural support and pharmacotherapy. The other provides a more generic multi-behaviour change intervention, that may (or may not) include smoking.

It is essential that commissioning decisions take account of the large body of evidence on the effectiveness and cost-effectiveness of different approaches. The NCSCT has recently reviewed this literature and provided recommendations.[17] It concludes that smoking cessation is most effective and cost-effective when provided as a single intervention, rather than as part of broader integrated lifestyle interventions. The evidence associated with different componements and models for providing stop smoking interventions is summarised in a recent paper produced by PHE.[18]

Harm reduction and the role of electronic cigarettes (e-cigarettes) in supporting smokers to quit

The best thing a smoker can do is to stop smoking now, completely and for good.

However not all smokers are ready, willing or able to stop in one step and NICE tobacco harm reduction guidance PH45 sets out a series of approaches that support smokers to quit in the longer term:

- stopping smoking and using one or more licensed nicotine-containing products as long as needed to prevent relapse
- cutting down prior to stopping smoking with or without the help of licensed nicotine-containing products
- smoking reduction with or without the help of licensed nicotine-containing products.
- temporary abstinence from smoking with or without the help of licensed nicotine-containing products

There is growing evidence that harm reduction approaches may play a role in complementing conventional cessation-focused strategies. In the context of tobacco control in the UK, harm reduction involves:

- advising smokers who are not ready to quit that they should try to reduce their smoking with the aid of a nicotine substitute
- recognising that smokers who have stopped smoking with the aid of a nicotine substitute may need to continue to use that substitute for months or years to prevent relapse to smoking[19]

Stop smoking services provide highly cost-effective interventions to help people stop smoking and any investment in harm reduction should not detract from their provision. Rather, harm reduction interventions are intended to support and extend the reach and impact of existing services.

Although existing evidence is not clear regarding the health benefits of smoking reduction alone, those who reduce the amount they smoke are more likely to stop smoking eventually, particularly if they are using licensed nicotine-containing products.[20]

An estimated 2.9 million adults in Britain currently use e-cigarettes (vape). Over time, the proportion of vapers who smoke tobacco has fallen and the proportion who are ex-smokers has risen, while regular e-cigarette use among never smokers has remained negligible at 0.3%.[21]

The latest data shows that 1.5 million vapers, over half of the total, have managed to stop smoking completely[22] and 770,000 people have given up both smoking and vaping[23]. This indicates that for many smokers, dual use (vaping while continuing to smoke) may constitute a stage in their journey to becoming tobacco free and, ultimately, nicotine free.

Although current NICE guidance on tobacco harm reduction does not specifically mention the use of unlicensed nicotine containing products, the principle that smokers should have access to safer forms of nicotine holds. PHE's 2015 independent evidence review found that, based on the international peer-reviewed evidence, e-cigarettes are around 95% less harmful than smoking.[24]

The Royal College of Physicians (RCP) reached a similar conclusion in its report 'Nicotine without smoke: tobacco harm reduction' published in April 2016. The RCP recommends that, "in the interests of public health it is important to promote the use of e-cigarettes, NRT and other non-tobacco nicotine products as widely as possible as a substitute for smoking in the UK".[25] With effect from May 2017, in the UK all e-cigarette products are subject to comprehensive regulation for quality and safety under the Tobacco and Related Products Regulations 2016.

Based on the evidence of relative risk, public health advice to smokers in England is clear: all smokers should stop smoking. Smokers finding it hard to quit should switch to vaping, and vapers who continue to smoke should stop smoking as soon as possible.

E-cigarettes are now the most commonly used stop smoking aid.[26] Evidence for their effectiveness from research trials is currently limited but suggests that it is broadly similar to prescribed stop smoking medicines and more effective than licensed nicotine products if these are used without any professional support.[27] Smokers who combine e-cigarettes with support from stop smoking services in England have some of the highest quitting success rates – in 2016-17, around two thirds of smokers who took this route managed to quit smoking.[28]

E-cigarettes cannot be prescribed to smokers as part of specialist or brief support, as there are currently no medicinally licensed products available on the market. However clear advice on the benefits and risks should be included in optimal self-support, and specialist services should welcome smokers who want to use a self-purchased e-cigarette to help them quit. Further guidance is available from the National Centre for Smoking Cessation and Training (NCSCT).[29]

What will you see locally if you are meeting the principle?

In line with National Institute for Health and Care Excellence (NICE) guidance, service providers should treat at least 5% of their local smoking population:[30]

- stop smoking services achieve exhaled carbon monoxide (CO) validated success rates comparable to areas with similar smoker profiles and within the nationally prescribed range
- stop smoking support is routinely offered, and made easily accessible, to vulnerable populations and those identified as at risk in the JSNA
- all licensed stop smoking medications are available as first-line treatment options, especially dual form nicotine replacement therapy (NRT) (e.g. nicotine transdermal patch plus a faster acting product), and varenicline
- people who are using or want to use e-cigarettes to stop smoking can receive advice and behavioural support from their local stop smoking service.
- services are independently audited and improvement plans are implemented where required
- there are clear and efficient referral pathways embedded throughout health and social care services and these are routinely used to promote stop smoking services
- services are promoted locally through mass media channels to raise awareness of the support available for people who want to stop smoking
- there is a simple, easy-to-use online portal for smokers to gain information about the stop-smoking support available in their area, the benefits of using each of the options, the commitment required for each of the options and how to access each of the options
- the role of stop-smoking support in the local tobacco control strategy is clearly set out in terms of quantifying its expected contribution to prevalence reduction overall and in key sub-populations
- all required monitoring data is reported to NHS Digital through the quarterly reporting system[31]
- smokers who are not ready, willing, or able to stop in one step are advised and supported to use a licensed nicotine-containing product to help them reduce their smoking with a view to stopping in the future
- ex-smokers who feel they need to continue to use a nicotine substitute long term to avoid relapse to smoking are encouraged to do so

What questions should you ask to test whether you are following the evidence and best practice?

2.1 Is there a clear specification of how stop smoking support integrates with other parts of the local tobacco control strategy to increase the capability, motivation and opportunity of smokers to quit?

2.2 Is service design and delivery informed by the latest evidence, summarised in the NCSCT service delivery and monitoring guidance?[32]

2.3 Has an equity impact and gap analysis been carried out and do commissioning priorities reflect this?

2.4 Have all stop smoking practitioners been trained to NSCST standards? [33]

2.5 Are all licensed stop smoking medicines offered as first-line interventions, including dual form NRT and varenicline?

2.6 Is stop-smoking support offered to smokers who want to use e-cigarettes in their quit attempt?[34]

2.7 Have priority subpopulations been identified and do those in greatest need of specialist support (ie smokers with mental health problems, pregnant smokers, those from disadvantaged backgrounds, etc) have good access to it?

2.8 Are four-week quit outcomes collected as specified in the NCSCT serice and delivery guidance, validated biochemically by measurement of exhaled carbon monoxide, and is the full data set submitted quarterly to NHS Digital?

2.9 Does the commissioner own all the monitoring data and have the capacity to undertake independent audits and performance monitoring whenever desired?

2.10 Are stop smoking service providers subject to annual independent audit?

2.11 Are stop smoking services commissioned to promote the availability of stop smoking interventions, both to the public and to health professionals, including use of appropriate referral pathways?

2.12 Does the tobacco control strategy include a clear specification of how harm reduction approaches will be used to complement stop-smoking support?

2.13 Are smokers who are not ready to try to quit advised to use a licensed nicotine product to reduce their smoking with a view to quitting at a later date?

2.14 Are ex-smokers encouraged to use licensed nicotine products for as long as they feel they need them to prevent relapse to smoking?

2.15 Do services provide behavioural support to clients who want to use e-cigarettes, to help them quit smoking?

2.16 Can it be demonstrated that investment in harm reduction approaches will not or does not detract from existing stop smoking services?

3. Supporting pregnant smokers and those with infants to stop smoking

Statement of principle
All women who smoke and are pregnant, planning a pregnancy or have an infant should be referred for help to stop smoking.

Reducing smoking in pregnancy is an urgent priority

Smoking during pregnancy causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year in the UK. It also increases the risks of stillbirth and of the child developing respiratory disease; attention and hyperactivity difficulties; learning difficulties; problems of the ear, nose and throat; obesity; and diabetes.[35 36 37]

Addressing smoking in pregnancy should be a focus for all localities as this impacts on a range of issues related to health, inequalities and child development. NICE has produced guidance on how best to support women to stop smoking in pregnancy.[38]

Although rates have declined, 10.5% of women in England were recorded as smoking at the time of delivery in 2016/17, which translates into nearly 70,000 infants born to smoking mothers each year.[39]

There are significant demographic differences and factors associated with inequalities related to this issue. For instance, pregnant mothers under the age of 20 are six times as likely to smoke as mothers aged 35 or over. Those in routine and manual occupations are more than four times as likely as those in managerial and professional occupations to smoke throughout pregnancy (29% and 7% respectively). Infants born to smokers are much more likely to become smokers themselves, which further perpetuates health inequalities.[40]

Treating mothers and their babies (0-12 months) who have problems caused by smoking during pregnancy is estimated to cost the NHS between £20m and £87.5m each year.[41]

Support needed for pregnant smokers

Motivation to stop smoking is very high in pregnancy and by the time pregnant smokers come into contact with healthcare services, many of those who can stop by themselves will have done so. In application of the COM-B model, therefore, there needs to be a much greater emphasis on capability and opportunity. This may be expected to boost motivation to try to stop and to persist with quit attempts in the face of difficulties.

Pregnant women who continue to smoke should receive the highest quality stop-smoking support available based on evidence-based principles set out in NICE and NCSCT guidance. The healthcare system should support broader strategies to address this issue, creating a social environment in which smoking during pregnancy is not normative, but quitting is. This requires repeated and sustained offers of support for quitting, delivered in a way that inspires hope rather than fostering guilt.

Relapse to smoking soon after the baby is born is very common, but can be reduced by appropriate interventions from healthcare professionals working with new mothers. This kind of support should form part of a comprehensive programme commissioned by local authorities and embedded within the Local Maternity System.

What will you see locally if you are meeting the principle?

The issue of smoking is addressed by all healthcare professionals working with pregnant women throughout their pregnancy.

All pregnant women are screened for carbon monoxide (CO) at the booking appointment, and at subsequent antenatal appointments. If elevated levels are identified (indicating smoking) a referral is made to a specially trained pregnancy stop smoking advisor for support to stop.

Robust, opt-out referral pathways are in place between the healthcare professional (HCP) who raises the issue of smoking with the pregnant woman and the stop smoking service or person trained to provide the intervention. This will include feedback mechanisms to ensure the referring HCP is aware of the outcome.

Partners and family members who smoke are also offered support to stop smoking and information is provided on the risks associated with secondhand smoke.

What questions should you ask to test whether you are following the evidence and best practice?

3.1 Is NICE Guidance (PH26) appropriately implemented across systems in your local area?

3.2 Do service specifications for local midwifery services include requirements for the issue of smoking to be addressed?

3.3 Do these specifications include routine CO screening at booking appointments and other appointments?

3.4 Are there appropriate key performance indicators in place to monitor this activity, and are there systems in place to address poor performance?

3.5 Are individuals who smoke provided with appropriate and consistent messages around smoking, the risks of continuation and the importance of cessation, as well as the risks associated with secondhand smoke?

3.6 Are there appropriate opt-out referral pathways in place, ensuring women with elevated CO levels have swift access to specialist support to stop smoking ?

3.7 Are there effective feedback mechanisms to the referrer that provide information and details for future follow-up?

3.8 Are all healthcare professionals who meet with pregnant women trained in Very Brief Advice for smoking in pregnancy enabling them to raise the issue of smoking and refer to specialist services?[42]

3.9 Are those providing stop smoking interventions appropriately trained and does the training meet NCSCT standards?[43]

3.10 Are stop smoking interventions provided on an ongoing basis and is information on and access to stop smoking medications made available?

3.11 Is smoking status a mandatory data item collected at booking, including recording of the CO reading?

3.12 Is smoking status at time of delivery (SATOD) monitored regularly within and across the locality?

3.13 Does the system for SATOD data collection include the option of 'not known?' If so are there plans to remove this to ensure more accurate and informative data collection?

3.14 Is there a local multi-agency partnership in place with appropriate local leadership to address the issue of smoking in pregnancy? Is there a strategy?

3.15 Is system-wide action to address smoking in pregnancy clearly specified within the Local Maternity System?

3.16 Are contract specifications reviewed regularly? Is there a process for monitoring delivery and outcomes?

4. Smokefree homes and cars

Statement of principle
Smokefree places/settings create an environment in which smoking is less normative and protect the health of non-smoking children and adults.

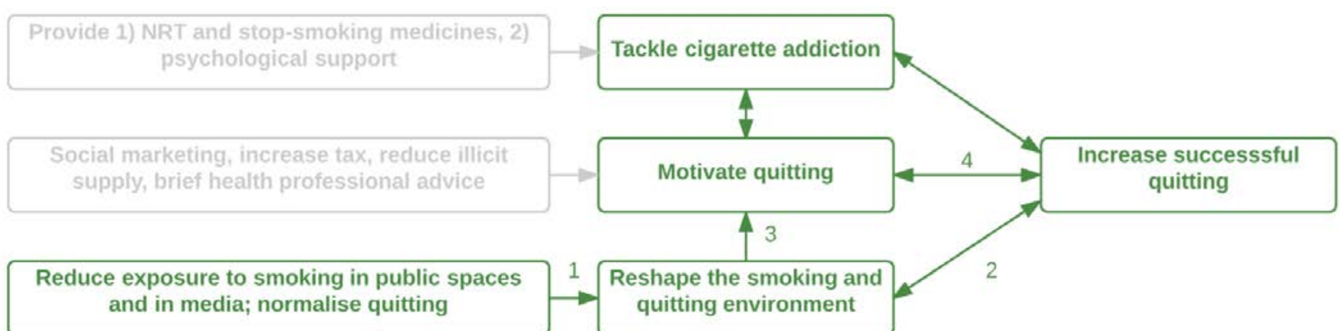
Smokefree environments protect non-smokers and promote quitting

Millions of children in the UK are still exposed to secondhand smoke that puts them at increased risk of respiratory problems, meningitis and sudden unexplained infant death. Each year this results in over 300,000 GP visits and around 9,500 hospital admissions in the UK and costs the NHS more than £23.6m.[44,45]

Exposure to secondhand smoke in confined spaces such as a car is particularly hazardous. Legislation introduced in October 2015 means it is now prohibited to smoke in a vehicle with someone under the age of 18 present. As there is no safe level of exposure to tobacco smoke, it is important that other vulnerable groups such as older adults are also protected.

Reducing the visibility of smoking can be expected to make smoking less normative (see Figure 4.1), helping to support smokers who are in the process of quitting and motivating other smokers to try to quit. This is an important contribution to a comprehensive local approach to tobacco control.

Figure 4.1: Promoting smokefree homes and cars to promote successful quitting



Note: Smokefree homes and cars reduces visibility of smoking for the family and promotes a wider non-smoking norm (1), which should trigger more quitting behaviour (2) and also provide greater motivation to quit (3) which should also promote more quitting behaviour (4).

What will you see locally if you are meeting the principle?

Frontline health and social care workers routinely ask service users if they are ever exposed to tobacco smoke in an enclosed environment.

Frontline health and social care workers provide expert advice on how to make homes and cars smokefree.

Local policies and plans are in place to increase smokefree spaces, especially enclosed environments, supporting smokers to create and maintain smokefree homes and cars.

Partners are in a position to educate the public on compliance with smokefree legislation, including the prohibition of smoking in a vehicle with someone under the age of 18 present.[46]

What should you ask to test whether you are following the evidence and best practice

4.1 Have early years partners undertaken an assessment of their capacity to deliver brief interventions, advice about smoking cessation, and secondhand smoke interventions?

4.2 Do frontline health and social care workers monitor and record smoking status?

4.3 Are there measures of exposure to secondhand smoke for vulnerable groups, especially children?

4.4 Is there access to a freely available and evidence-based stop smoking service? [Further prompts are provided in Section 2: Supporting people to stop smoking]

4.5 Have smoking cessation advisors and frontline health and social care workers completed the NCSCT module for very brief advice on secondhand smoke?[47]

4.6 Does advice on secondhand smoke extend to cars, with and without under-18s present, and other enclosed environments?

4.7 Do you have evidence that brief interventions on secondhand smoke are being delivered?

4.8 Do you have evidence that commitments to smokefree homes and cars are being adopted and maintained?

5. Preventing young people from taking up smoking

Statement of principle
Positive influences in the school, home and local community prevent young people from taking up smoking.

Reducing smoking uptake involves creating non-smoking communities

Evidence suggests that a strong anti-smoking ethos in schools, the family and the wider community is important in preventing smoking uptake. The majority of smokers start while in their teenage years with very few new smokers beginning after the age of 20.[48]

Many factors contribute to an increased likelihood of young people starting to smoke. School-based programmes have been found to have some effect in reducing smoking uptake but may be limited if they are based on educational approaches alone. Promoting a non-smoking community and reducing access to tobacco in those under the age of 18 are key to youth prevention.

"One of the most effective ways to reduce the number of young people smoking is to reduce the number of adults who smoke. Continuing to encourage adult smokers to quit must therefore remain an important part of reducing prevalence amongst the young, and achieving a smokefree generation."

Towards a Smokefree Generation – A Tobacco Control Plan for England, (2017)

Note: there is a separate JSNA support pack for young people's drug, alcohol and tobacco use that should be read alongside the following prompts.

What will you see locally if you are meeting the principle?

Every learning institution has a clear anti-smoking ethos that applies to everyone who comes into contact with the institution.

Educational content implemented in learning environments ensures that young people understand the short- and long-term health, and the economic and societal consequences of tobacco use. This can be achieved within the school curriculum.

Targeted peer mentoring programmes are implemented in areas of greater need.

A reduction in the availability and affordability of tobacco for young people (see section 11: Tackling cheap and illicit tobacco).

What should you ask to test whether interventions follow the evidence and best practice?

5.1 Does tobacco prevention work in schools follow the evidence base by promoting a non-smoking community?[49]
5.2 Do schools have a clear anti-smoking ethos that is backed by a clear policy on tobacco?
5.3 Do schools include tobacco education as part of the curriculum?
5.4 Has consideration been given to using peer-led smoking prevention programmes?
5.5 Are frontline workers in schools and youth settings trained to discuss smoking with young people?
5.6 Do you monitor compliance with retail legislation for tobacco?[50]
5.7 Is training and information offered to retailers to maintain or strengthen compliance with point of sales legislation?
5.8 Is your monitoring and enforcement of point of sale legislation intelligence-led?
5.9 Are systems in place to identify and report sales of illicit tobacco locally? [Further prompts are provided in Section 11: Tackling cheap and illicit tobacco].

6. Primary care

Statement of principle
Primary care remains a key source of evidence-based advice and support about smoking and action must be properly integrated with other tobacco control activities.

The continuing role for primary care

Approximately 90% of patient interaction with the healthcare system in England is with primary care services.[49] Smoking is responsible for many fatalities from cancer, respiratory and circulatory disease but there are also many non-fatal diseases which are intensified as a result of smoking. It is therefore likely that a higher proportion of smokers will present to primary care services, many of whom will have illness caused or aggravated by smoking.[50]

The majority of smokers want to quit and around a third make a quit attempt each year. However success rates are low, as most use the quitting methods with the least evidence of effectiveness. There is a significant opportunity to direct smokers motivated to quit to more effective methods of cessation, both for their individual benefit and to support the sustainability of services.

What will you see locally if you are meeting the principle?

- GPs identifying smokers, delivering Very Brief Advice (VBA) and following up, where appropriate, with a referral into stop smoking services, in accordance with NICE guidance PH1
- all evidence-based support options are available to smokers through primary care and smokers are clear about what they involve and the benefits of each
- there are effective referral routes into specialist stop-smoking support
- as part of the NHS Health Check for adults aged 40 to 74, all smokers are given advice and offered a referral to their local stop smoking service
- patients who decline support are advised to reduce their smoking with the aid of a licensed nicotine product or, if they prefer, an e-cigarette
- all GPs have completed the NCSCT 'Very Brief Advice on Smoking' online training module[51]

What should you ask to test whether interventions follow the evidence and best practice?

6.1 Is smoking status of all patients known?
6.2 Are records routinely updated to ensure smoking status of all patients is accurate?

6.3 Is there access to a freely available and evidence-based stop smoking service for everyone who smokes or uses tobacco in any other form? [Further prompts are provided in Section 2: Supporting people to stop smoking]

6.4 Have any barriers to accessing stop smoking support been identified?

6.5 Is referral to a stop smoking service made where support is required?

6.6 Is referral recorded on the patient's records and is the outcome of the intervention recorded?

6.7 Have all in-house stop smoking practitioners been trained to NCSCT standards?

7. Secondary care

Statement of principle
Smokers attending secondary care are usually in most urgent need of encouragement and support to stop and should routinely be offered support. Inpatients should be offered support that continues after discharge.

Smoking cessation support should be integral to secondary care

Stopping smoking at any time has considerable health benefits for people who smoke and those around them. For people using secondary care services, there are additional advantages, including shorter hospital stays, lower drug doses, fewer complications, higher survival rates, better wound healing, decreased infections, and fewer re-admissions after surgery.[52]

Secondary care providers have a duty of care to protect the health of people who use or work in their services and to promote healthy behaviour among them. This duty of care includes providing effective support to stop or abstain from smoking while using or working in secondary care services (NICE PH48).[53]

What will you see locally if you are meeting the principle?

- smokers who attend secondary care settings are offered advice and support to stop
- all hospitals have an onsite stop smoking service that provides intensive behavioural support and pharmacotherapy as an integral component of secondary care
- integrated care pathways exist that allow for a seamless transition of care between primary and secondary settings
- stop smoking medicines are available on hospital formularies and available to support people experiencing nicotine withdrawal when in hospital
- there are no designated smoking areas or staff-facilitated smoking breaks for anyone using secondary care services
- all secondary care estates are designated completely smokefree and the policy is clearly communicated to all patients, staff and visitors
- policies on e-cigarette use make a clear distinction between smoking and vaping, and support smokers to quit smoking and stay smokefree while managing identified risks
- local tobacco control strategies include secondary care as a main point of contact for smokers

What should you ask to test whether interventions follow the evidence and best practice?

7.1 Do local tobacco control strategies include secondary care? Do these strategies employ contractual levers such as the 'Preventing ill health by risky behaviours – alcohol and tobacco' CQUIN?

7.2 Is information on the smoking policies and available stop smoking support provided to people in advance of planned or anticipated use of secondary care?

7.3 Is there a mandatory training programme for all frontline healthcare staff to know and use very brief stop smoking advice and, where possible, train in motivational interviewing for behavioural change, in order to 'make every contact count' (MECC)?

7.4 Do health and social care practitioners in all acute, maternity, public health and mental health services – including community services, drug and alcohol services, outpatient and pre-admission clinics – identify people who smoke and offer help to stop?

7.5 Is anyone who is not willing or able to stop completely provided access to harm reduction strategies and pharmacotherapies to support them?

7.6 Do hospital staff routinely provide information and advice for carers, family and other household members and hospital visitors on the services available to help them stop smoking?

7.7 Are all stop smoking medicines available as first-line treatment for people who are in hospital?

7.8 Are robust referral systems in place that provide a prompt for action (including the referral of people to stop smoking support) and that ensure smoking status is consistent in all patient records? Are these records stored in a way that facilitates easy access and audit?

7.9 Do directors, senior managers and clinical leads provide leadership on stop smoking support?

7.10 Do all secondary care sites have smokefree grounds or do they have a plan to achieve this status within the next six months?

7.11 Are policies on e-cigarette use consistent with PHE advice?[54]

7.12 Do secondary care providers act as exemplars of best practice as is befitting of their position as the flagships of healthcare?

7.13 Are staff provided with support to stop smoking?

8. Mental health

Statement of principle
A comprehensive tobacco control strategy provides high quality evidence-based interventions to people who need it most.

People with a mental health condition die on average 10 to 20 years earlier than the general population. It is estimated that a third of all cigarettes smoked in England are smoked by people with a mental health condition.[55] [56] Smoking among this population has changed little, if at all, over the past 20 years and in 2014/15, smoking prevalence among people with a serious mental illness was 40.5%.

People with a mental health condition are just as likely to want to stop smoking as those without, but are more likely to be heavily addicted to smoking and more likely to anticipate difficulty stopping smoking.[57] There is an urgent need to address the widening inequalities which remain from stubbornly high smoking rates among this population. Routine identification of smokers in mental health services with systematic offers of evidence-based support, reflective of NICE guidance PH48, is essential to reducing this gap.

What will you see locally if you are meeting the principle?

- NICE guidance relating to smoking cessation and tobacco control is implemented fully in all aspects of care for individuals with a mental health condition[58]
- people with a mental health condition are provided with the same, or better, opportunities to access smoking cessation support services as the general population
- these services provide outcomes that are comparable to those experienced by the general population
- effective links between primary and secondary care provision, resulting in integrated tobacco dependence treatment pathways
- providers of mental health services have an excellent understanding of what they are required to deliver in relation to smoking cessation and smokefree environments[59]
- smokefree signage and application of policy is clear and consistent throughout the estate, with high levels of compliance
- policies on e-cigarette use make a clear distinction between smoking and vaping, and support smokers to quit smoking and stay smokefree while managing identified risks
- those people who do not want or are unable to stop smoking in one step are offered other strategies to reduce the harm of tobacco, as outlined in NICE guidance PH45[60]

What should you ask to test whether interventions follow the evidence and best practice?

8.1 Has NICE guidance PH48, which supports mental health trusts' implementation of smokefree policies, been followed and have staff and patients had an opportunity to voice and overcome their concerns?[*]

8.2 Has consultation with appropriate stakeholders, including service user groups, influenced the design of services?

8.3 Are the needs of people with a mental health condition who smoke sufficiently well understood to ensure that services are appropriately commissioned?

8.4 Do senior clinicians support and champion the process of identification, referral, intervention and follow-up?

8.5 Do all staff in mental health settings receive training on brief interventions for smoking cessation, with medical and nursing staff receiving more extensive training in smoking cessation?

8.6 Are smokefree mental health units an integral part of a more health promoting culture, providing alternative, meaningful activity during the day?

8.7 Are policies on e-cigarette use consistent with PHE advice?[54]

8.8 Do specialist cessation services for those with a mental health condition achieve results comparable with the best services nationally?

8.9 Are users of mental health services able to access stop smoking medications?

8.10 Are outcomes monitored in such a way as to ensure that they reduce health inequalities?

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[*] NICE has endorsed the PHE resource, NICE guidance smoking cessation in secondary care in mental health settings: self-assessment tool. This provides an easy to use audit tool for understanding delivery in line with NICE PH48.

9. Offender health

Statement of principle
Comprehensive tobacco control strategy provides high quality evidence-based support to those people who need it most.

Offenders tend to have poorer physical and mental health and high smoking rates

Nationally around 80% of prisoners smoke compared with 15.5% in the general population, with similar levels recorded across the offender journey in police custody and community supervision where data are available.[61,62]

This high rate of smoking causes health problems to the smokers themselves and to non-smokers who are exposed to their tobacco smoke. The offender population has a high prevalence of poor mental health and other substance misuse, and offenders are predominantly from disadvantaged backgrounds, [63,64] all of which are associated with elevated smoking prevalence. Offenders who smoke and those exposed to this smoke experience a marked increase in health inequalities.

A strong case for addressing smoking among offenders is endorsed in 'Improving health, supporting justice'[65] which recognised high levels of health needs among offenders, whether in police custody or under community supervision and included key objectives such as working in partnership, equity of access to services, improving pathways and continuity of care.

The delivery of an entirely smokefree prisons estate will provide the opportunity for around 200,000 people each year to experience life free of smoke. For many of these, this will be their first ever opportunity to do so.

NHS England has now published the healthcare minimum offer for stop smoking services and support in custody.[66] All prisons are expected to meet this minimum service offer. It supports the work programme to reduce levels of smoking in prisons and is aimed at standardising the approach and quality of smoking cessation services delivered in prisons. This document defines standards for training, interventions and pharmacological support for smoking cessation to be adhered to by stop smoking services in all prisons.

What will you see locally if you are meeting the principle?

NICE guidance relating to smoking cessation and tobacco control is implemented fully in all aspects of care for those within the justice system.

People in prison, custody or under community supervision are provided with the same, or better, opportunities to access stop smoking support services as the general population.

These services provide outcomes that are comparable to those experienced by the general population.

People in prison, custody or under community supervision report that the services provided are accessible, suitable and address their specific needs.

There are links throughout the offender pathway, resulting in seamless care that is fundamentally linked to other health outcomes.

Nicotine-containing products including e-cigarettes are available and offered to smokers entering a custodial situation for the first time and their availability is maintained through the offender pathway.

Staff working within the criminal justice system have a full understanding of what they are required to deliver.

Those people who do not want or are unable to stop smoking in one step should be offered other strategies to reduce the harm of tobacco, as outlined in NICE guidance PH45.[67]

What should you ask to test whether interventions follow the evidence and best practice?

9.1 Do NHS England Health and Justice and local authority commissioners work together to ensure that there are robust arrangements in place to support those in need of smoking cessation services as they move between custody and the community?

9.2 Has NICE public health guidance been followed?

9.3 Has consultation with appropriate stakeholders, including groups representingoffenders, influenced the design of services?

9.4 Are the needs of people in prison, custody or under community supervision sufficiently well understood to ensure that services are appropriately commissioned?

9.5 Do governors, senior management and senior clinicians support and champion the process?

9.6 Do all staff in prison, custodial and community settings receive training on brief interventions for smoking cessation, with medical and nursing staff receiving more extensive training? This should also include training staff in prison settings, in particular health providers, listeners and peer supporters.

9.7 Are the stop smoking services delivered in line with the Minimum Offer for Stop Smoking Services and Support in Custody?

9.8 Is voluntary smokefree accommodation an integral part of a more health-promoting culture within custodial settings, providing alternative, meaningful activity during the day?

9.9 Do specialist cessation services for those in prison, custody or under community supervision achieve results comparable with the best services nationally?

9.10 Are outcomes monitored in such a way as to ensure that they reduce health inequalities?

9.11 Do services achieve the desired outcomes?

9.12 Are those people who do not want or are unable to stop smoking in one step offered other strategies to reduce the harm of tobacco, as outlined in NICE guidance PH45?

9.13 Are stop smoking services in the community linked to prison-based services in order to provide post-release support?

10. Workplace interventions

Statement of principle
Interventions delivered in the workplace will encourage more people to access support to stop smoking, reduce absenteeism and increase productivity.

Workplaces can be important settings for promoting smoking cessation

Smoking has a significant impact on local business productivity. It is estimated that smoking breaks and smoking-related sick days cost businesses in England around £6.8bn a year.[3] Reducing levels of smoking among employees will help reduce illnesses and conditions such as cardiovascular and respiratory disease, which are important causes of sickness absence. This will result in improved productivity and a reduced burden on employers and employees.

The workplace has several advantages as a setting for smoking cessation interventions: large numbers of people can be reached (including groups which may not normally consult health professionals, such as young men). There is the potential to provide peer group support; and a non-smoking working environment encourages people who smoke to quit (NICE PH5 and NICE QS82).[68, 69]

What will you see locally if you are meeting the principle?

- a widely accessible stop smoking service available to all employees
- employers supporting employees through quit attempts allowing them time off to attend stop smoking services
- where demand is identified, stop smoking clinics delivered on site in workplaces
- smokefree working environments and comprehensive smokefree policies are consistently enforced
- policies on e-cigarette use make a clear distinction between smoking and vaping, and support smokers to quit and stay smokefree while managing identified risks

What should you ask to test whether interventions follow the evidence and best practice?

10.1 Is support for smoking cessation established in local workplace wellbeing initiatives?[70]
10.2 Are there established channels of communication between the stop smoking service and local employers?
10.3 Have barriers to accessing stop smoking support from the workplace been identified?
10.4 Are employees routinely provided with information on local stop smoking support services? Are staff allowed time off to attend stop smoking services?

10.5 Do larger employers in the area allow the local stop smoking services to attend events to offer very brief advice?
10.6 Are public sector smoking policies an exemplar to other local employers?
10.7 Does your policy facilitate the use of licensed nicotine replacement therapy in the workplace?
10.8 Is your policy on e-cigarette use consistent with PHE advice?[54]
10.9 Are all employees protected from secondhand smoke in their workplace, including those who provide home visits, or visit other workplaces?
10.10 Is your smokefree policy regularly reviewed and updated if necessary?

11. Tackling cheap and illicit tobacco

Statement of principle
There are established supra-local partnership arrangements in place focused on reducing the demand for and the supply of illicit tobacco.

Illicit tobacco costs lives and local action is needed to combat it

The illicit tobacco market is in long-term decline but remains a problem in some communities. It undermines tobacco control measures, including taxation and age of sale regulations, enabling children to start a lethal addiction and encouraging smokers to smoke more than if they were paying full price. Criminal activity in the illicit trade tends to target smokers in deprived areas, further increasing health inequalities.[71]

Effective approaches are co-ordinated across large geographical areas where health and enforcement partners collaborate to reduce the demand for and the supply of illicit tobacco. Evidence-based social marketing and PR campaigns have raised awareness of the issue, helped to generate intelligence and have provided the facts on illicit tobacco by countering the misinformation circulated by the tobacco industry.

What will you see locally if you are meeting the principle?

- full engagement between public health, police regional intelligence units, trading standards, licensing and HMRC to improve the intelligence base
- active intelligence-led enforcement in the locality, accompanied by communications to build support in the local community and encourage people to report perpetrators of illicit tobacco crime
- a greater awareness and understanding of the impact of illicit tobacco among partner organisations and the general public
- clear data and intelligence on the levels of demand for illicit tobacco enabling priority communities to be targeted
- increased reporting of illicit tobacco by the general public

What should you ask to test whether interventions follow the evidence and best practice?

11.1 Have local measures been established to assess the impact of activity, including quantity of information received from the public, seizures and enforcement activity, and increased partnership working between agencies?[72]

11.2 Have regional evaluation surveys been conducted to measure the impact of activity? Do these include the establishment of a baseline?

11.3 Is there a safe, anonymous intelligence-sharing resource available for the public and partner agencies to use?
11.4 Is there a dedicated budget for illicit tobacco enforcement activity/social marketing activity?
11.5 Is there collaboration on illicit tobacco between local areas within the region?
11.6 Has a public opinion and stakeholder survey been carried out on illicit tobacco?
11.7 Do the local trading standards authorities and police forces recognise tackling illicit tobacco as a strategic priority within broader tobacco control work?[73]
11.8 Is there a regional policy in place on the WHO Framework Convention on Tobacco Control Article 5.3: protecting policies from the vested interests of the tobacco industry?

Next steps

Supporting strategic partnerships

Effective partnerships are central to moving the tobacco control agenda forward. It is therefore vital to ensure that partner agencies involved in local tobacco control activity have an opportunity to contribute to the process of assessing need and assessing further additional action that can be undertaken.

Formal strategic partnerships for tobacco control should involve key stakeholders and agencies (acute health, mental health, public health, regulatory services, employment, social care, children's services, fire and rescue service and criminal justice), the aim of which is to develop a fully integrated and comprehensive system for preventing smoking uptake, supporting smokers to stop, reducing the harm and inequalities caused by smoking and advocating for a tobacco-free generation.

Self-assessment: CLeaR model

CLeaR is an evidence-based improvement model that supports the development of local action to reduce the use of tobacco.[74] The model is designed for use by local authorities, tobacco alliances and health and wellbeing boards. The CLeaR model offers:

- free-to-access self-assessment tool that can assist in evaluating the effectiveness of local action addressing harm from tobacco - a major aspect of any health and wellbeing strategy
- a voluntary peer assessment process, which provides independent challenge to self-assessments and access to a recognised quality mark
- a chance to benchmark work on tobacco over time and against others
- membership of the Smoke Free Action Coalition and a growing professional network

A guide to the CLeaR process can be found at:
www.gov.uk/government/publications/clear-local-tobacco-control-assessment

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