

Health Inequalities National Support Team

Tobacco Control Strategies to Reduce Inequalities in Mortality

*Identifying strengths and effective practice and making tailored
recommendations on how to address gaps in service delivery*

Includes Potential Key Actions to Reduce Mortality (see Appendix 2)



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For Recipient's Use	

Tobacco Control Workbook

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Foreword

National Support Teams (NSTs) were established by the Department of Health from 2006 to support local areas – including Local Authorities, Primary Care Trusts (PCTs) and their partners – to tackle complex public health issues more effectively, using the best available evidence. By undertaking intensive, ‘diagnostic’ visits to local areas, spending time with key leaders (commissioners and providers) including clinicians and front-line staff, the ten NSTs provided intelligence, support and challenge to local areas to assist in their achieving better public health outcomes. The programme finished in March 2011.

The ten subject specific teams (Sexual Health, Tobacco Control, Health Inequalities, Teenage Pregnancy, Childhood Obesity, Alcohol Harm Reduction, Infant Mortality, Response to Sexual Violence, Vaccination and Immunisation and Children and Young People’s Emotional Wellbeing and Mental Health) were commissioned and established with a focus on improving health and reducing health inequalities.

The ten teams undertook more than 450 visits to local partnerships during the course of the programme and their findings and successes have been documented in Knowledge Management and Evaluation reports. Each team also produced reports setting out and consolidating the learning from their work. A further report that captures best practice identified by each team is planned to enable local areas to continue using the expertise and lessons learnt from the NST model.

The NST process involved a desk review of key documentation and data-based intelligence, and interviews with key informants, often in combination with a series of workshops or focus groups. Collation and analysis of findings was immediate, and the findings, including strengths and recommendations, were fed back straight away and on site to the key local players and leadership. Recommendations were accompanied by offers of support, either at the time of reporting, or as part of follow-up activity.

The Department is publishing a number of reports which distil the learning from the programme, and exemplify the methodology employed.

Executive Summary

This workbook is one of a series developed by the Health Inequalities National Support Team (HINST), in its work with the 70 local authorities covering populations in England with the highest levels disadvantage and poorest health. These workbooks are a summary of local views on good practice. The suggested approaches are not mandatory, and reflect learning from a snapshot in time. Where there is clear established evidence to support interventions, this has been signposted in the footnote. This is offered as useful resource for commissioners: use is NOT mandatory.

HINST is one of National Support Teams (NSTs) which were established by the Department of Health from 2006 to support local areas – including Local Authorities, Primary Care Trusts (PCTs) and their partners – to tackle complex public health issues more effectively, using the best available evidence.

The topic of this workbook – Tobacco Control Strategies to Reduce Inequalities in Mortality- was selected for its potential impact on health and wellbeing, and on mortality and life expectancy in the short, medium or long term.

Smoking remains the single largest cause of preventable mortality in England, and reducing smoking will continue to be a focus as reducing prevalence represents a huge opportunity for public health¹. In 2009 there were an estimated 81,400 smoking-related deaths in adults aged 35 and over, accounting for 18% of mortality within this age range². This is considerably more than other major causes of death, such as alcohol, drugs, road traffic accidents, other accidents/falls, diabetes, and suicide combined³. The health risks from smoking are well-established and tobacco will go on to kill half of its regular users.

In 2008-09 there were approximately 1.5 million hospital admissions with a primary diagnosis of a disease that can be caused by smoking⁴. It has been estimated that the cost of smoking to the NHS in England has risen in the 10 years to 2007, from £1.7 billion a year to £2.7 billion⁵.

Inequalities in health outcomes between the most affluent and disadvantaged members of society are longstanding, deep-seated and have proved difficult to change, and tobacco is the leading risk factor in terms of the causes of health inequalities⁶.

TC is an internationally recognised, evidence-based approach to tackling the harm caused by tobacco. The aim of TC is to reduce the disease, disability and death related to tobacco use. The evidence shows that a comprehensive approach that optimises synergy from applying a mix of educational, clinical, regulatory, economic and social strategies has been established as the guiding principle for eliminating the health and economic burden of tobacco use⁷.

To significantly reduce smoking prevalence and health inequalities and to make improvements sustainable in the medium and longer term, it is essential to deliver Tobacco Control (TC) in a comprehensive and consistent manner. TC needs to be recognised as core business for organisations, with strategic and crosscutting action. If local health economies are to effectively address health inequalities gaps they must aim for effective TC. *Excellence in tobacco control - an evidence-based resource for local Alliances* in May 2008 outlines effective practice based on the best available evidence and is the basis of this workbook. A summary of these potential key actions is included as Appendix 2.

This workbook – which is recommended for use in a facilitated workshop – provides advice on achieving best outcomes at **population level**, and for identifying and recommending changes that could be introduced locally. Recommended workshop invitees are provided.

¹ HM Government. Healthy Lives, Healthy People: our strategy for public health in England. 2010

² The Information Centre. Statistics on Smoking: England 2010

http://www.ic.nhs.uk/webfiles/publications/Health%20and%20Lifestyles/Statistics_on_Smoking_2010.pdf

³ Department of Health. Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control – An evidence-based resource for local Alliances, 2008

⁴ The Information Centre. Statistics on Smoking: England 2010

⁵ ASH. Beyond (2008) *Smoking Kills*

⁶ National Audit Office (2010). *Tackling inequalities in life expectancy in areas with the worst health and deprivation*

⁷ U.S. Department of Health and Human Services (2000) *Surgeon General Report: Reducing Tobacco Use*

Appendices 1, 2 and 3 of the workbook address issues that enable a broad understanding of the localities' approach to tobacco control (TC). A comprehensive approach to tobacco control is vital if the harm done by smoking is to be reduced. This section of the workbook enables a representative picture of the local TC work to be built up. The workbook sections (1-13) use the HINST diagnostic framework to examine the personal health interventions that make it easier to stop smoking.

This diagnostic framework – *Commissioning for Best Population Level Outcomes* (see pg 12), focuses on evidence-based interventions that produce the best possible outcomes at population level. Part of the framework addresses delivery of **service** outcomes in the most effective and cost effective manner. This is balanced by considerations of how the population uses services, and is supported to do so, to provide **optimal population level** outcomes that are fairly distributed.

The NHS also faces a challenging financial environment during the transition. Through the Spending Review, the government protected the NHS, with cash funding growth of £10.6bn (over 10%) by 2014/15. Nevertheless, by historical standards this remains extremely challenging and the NHS has been developing proposals to meet the Quality, Innovation, Productivity and Prevention (QIPP) challenge of efficiency savings of £20bn by 2014/15 for re-investment. This means that considerations of the affordability, and evidence on the cost-effectiveness and cost-benefit of the interventions presented should be of central consideration. Where possible priority should be given to interventions which are likely to lead to cash-releasing savings that can be re-invested in other services, based on a sound evidence base. Some of the relevant evidence has been referenced through the workbook.

The framework points to the following areas of consideration:

A CHALLENGE TO PROVIDERS

1. Known intervention efficacy
2. Local service effectiveness
3. Cost effectiveness
4. Accessibility
5. Engaging the public
11. Adequate service volumes
12. Balanced service portfolio
13. Networks, leadership and coordination

B POPULATION FOCUS

6. Known population health needs
7. Expressed demand
8. Equitable resourcing
9. Responsive services
10. Supported self management

The workbook is made up of sets of detailed questions in the above categories. They provide local groups of commissioners and providers with **a systematic approach to deciding what needs to be done in relation to tobacco control** to further improve population health and wellbeing, capitalising on evidence-based interventions. How these improvements will best be achieved in a given locality will be for local participants to decide. The workbook signposts good practice and guidance where this may be helpful.

Although this workbook is a stand alone document, its use is complemented by a number of other publications on the evidence base for, and commissioning and provision of, local tobacco control, including:

- NHS Stop Smoking Services: Service and monitoring guidance (2010/11) (www.dh.gov.uk);

- Stop Smoking Services – Needs Analysis: A Toolkit for Commissioners (www.ncsct.co.uk);
- Excellence in tobacco control– an evidence-based resource for local Alliances (see Appendix 2)
- Tackling Health Inequalities – Targeting Routine and Manual Smokers in Support of the Public Service Agreement Smoking Prevalence and Health Inequality Targets. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101224
- NICE Guidance PH1 – Brief interventions and referral for smoking cessation
- NICE Guidance PH5 – Workplace interventions to promote smoking cessation
- NICE Guidance PH14 – Guidance on preventing the uptake of smoking by children and young people
- NICE Guidance PH23 – School based interventions to prevent the uptake of among children

These publications provide detail on the local and national evidence-base for effective tobacco control, providing the basis against which the diagnostic framework in this workbook operates.

Introduction

This is one of a series of diagnostic workbooks developed by the Health Inequalities National Support Team (HINST), while working with the 70 local authorities covering populations in England with the highest levels of deprivation and poorest health. The programme finished work in March 2011, but the Department of Health is publishing its key outputs for local commissioners and providers to use if they so wish. Each workbook topic was selected for the importance of its potential impact on health and wellbeing, and also on mortality and life expectancy in the short, medium or long term.

At the core of this workbook are two diagnostic frameworks:

- The triangle (pg 11) that looks at tobacco control as it is delivered through interventions with communities, with individuals and at a population level
- 'Commissioning Services to Achieve Best Population Level Outcomes' diagnostic (p7), which focuses on evidence-based interventions to motivate and support individuals to stop smoking in a way that produces the best possible outcomes at population level.

The frameworks are made up of a set of detailed, topic-based questions. Commissioning for Best Population Level Outcomes (p12) and appendices 1, 2 and 3 address issues that enable a broad understanding of the localities' approach to tobacco control (TC). A comprehensive approach to tobacco control is vital if the harm done by smoking is to be reduced. This section of the workbook enables a representative picture of the local TC work to be built up. The workbook sections (1-13) use the second diagnostic to examine the personal health interventions that make it easier to stop smoking.

The workbook provides local groups of commissioners and providers with **a systematic approach to deciding what needs to be done** to further improve population health and wellbeing, capitalising on evidence-based interventions. **How** these improvements will best be achieved in a given locality will be for local participants to decide. The workbook signposts good practice and guidance, where this may be helpful.

The resource represented by these workbooks can make a significant contribution during a period of transition for the NHS, as responsibility for commissioning of health and health related services transfers to the NHS Commissioning Board, GP Commissioning Groups and working towards delivery passes to the Health and Wellbeing Boards. Changes are also in progress within local government, social care and the voluntary sector. Current policy in relation to public services highlights the centrality of engaging people – as individual service users and patients, and as whole communities, in their own health and wellbeing and that of the wider community.⁸ The workbooks will support the newly emerging organisations and networks as an aid to understanding commissioning processes to aim for population level outcomes. Key processes that should significantly influence local Joint Strategic Needs Assessment and Health and Wellbeing Strategies, will be highlighted through the use of the workbooks. The skills and knowledge embedded within the realigned local Public Health teams will be critical in development and coordination of these key processes.

⁸ See for example NHS Constitution: <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx> and Localism Bill: <http://services.parliament.uk/bills/2010-11/localism.html> And NHS and Social Care Bill: <http://services.parliament.uk/bills/2010-11/healthandsocialcare.html>

The workbooks are designed, and tested to help areas identify which factors are important in the systematic and equitable delivery of health improvement. They should, therefore, provide a good framework for early identification of local solutions driven by the new perspectives being brought to bear.

Local facilitators and participants will be aware of changes that may be outside the scope of this workbook and of any detail in the workbook that may have been superseded. These should be taken into account. To facilitate this, a generic workbook, *A Generic Diagnostic Framework for Addressing Inequalities in Outcome from Evidence-based Interventions*, has been produced that could be used to guide the diagnostic questions and discussion during the workshop, with this detailed workbook being used alongside the generic one for reference.

How to Use this Workbook – a guide for facilitators

The objective of the workbook, used in a workshop setting, is to gain a picture of the local strengths and gaps in the delivery of stop smoking interventions in relation to the objective of achieving best outcomes at **population level**, and to identify and recommend changes that could be introduced. It is vital therefore that the wider tobacco control approach in the area is also examined.

The workbook is best used in a **facilitated** workshop setting for a **minimum of 8 and a maximum of 25 participants. Allow 4 hours for the workshop.** The participants in the workshop should include key individuals who are involved in planning, commissioning and delivering services and interventions in relation to the workbook topic through a partnership approach. The make-up of the group will vary according to local situations but the suggested minimal attendee list for this workbook is set out below:

<ul style="list-style-type: none"> • Director of Public Health • Director of Commissioning • Director Provider Services • Primary Care Lead • Partnership Communications Leads • Medical Director • PBC/GP Commissioning Lead • Acute Trust Medical Director • Head of Maternity Services • Mental Health Trust Director 	<ul style="list-style-type: none"> • Local Tobacco Control Lead • Local Authority Head of Environmental Health • Local Authority Head of Trading Standards • Stop Smoking Service Providers • Healthy Schools Lead • Voluntary Organisations • TC Partnership Chair • LSP representative • Health and Wellbeing Lead
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Provide a copy of this workbook to each participant at the workshop. It is suggested that the participants do not see the workbook in advance, but that they be informed that the workshop will be an opportunity to explore their knowledge of approaches to the issue with others who will bring differing perspectives. This will mitigate against any participants over-preparing, becoming defensive or being resistant to discussing – and finding solutions for – local issues

The facilitator should be familiar with the workbook questions and the models described below, which will encourage a population level perspective to be taken. It is suggested that facilitators introduce the participants to these models and approach. Following the introduction, it is important to look first at the questions on ‘Comprehensive Tobacco

Control' (page 21) as this gives an overview of the situation in the area. Depending on the time available and the depth of focus on wider tobacco control required in the workshop, it would be useful to also consider the questions listed in Appendix 3. The Christmas Tree sections 1 – 13 can then be addressed to examine the local approach to making it easier to stop smoking.

Group discussions about all of the questions in each section allow strengths, best practice and gaps to be identified, and the group to begin to think about where improvements could be made. A separate publication available on the website includes a facilitator's recording book, which can be used during the workshop to record this discussion. This need not be copied for workshop participants.

Key actions and lead stakeholders to take these actions forward can be identified during the workshop. The greatest impact is likely to result if summaries of these key actions and of the recognised strengths and recommendations from the workshop are produced and circulated to attendees and key accountable stakeholders within the partnership, following the workshop.

Background to Population Level Interventions

Challenging public health outcomes, such as achieving significant percentage change within a given population by a given date, will require systematic programmes of action to implement interventions that are known to be effective, and reaching as many people as possible who could benefit.

Programme characteristics will include being:

- **Evidence based** – concentrating on interventions where research findings and professional consensus are strongest
- **Outcomes orientated** – with measurements locally relevant and locally owned
- **Systematically applied** – not depending on exceptional circumstances and exceptional champions
- **Scaled up appropriately** – 'industrial scale' processes require different thinking to small scale projects or pilots ('bench experiments')
- **Appropriately resourced** – refocusing on core budgets and services rather than short bursts of project funding
- **Persistent** – continuing for the long haul, capitalising on, but not dependant on fads, fashion and changing policy priorities

Interventions can be delivered through three different approaches to drive change at population level, illustrated by the following diagram:

Community approaches

Individuals will only choose to use and benefit from certain behaviours and actions if they fit with the cultural and belief system of their own community. Communities can be based on place (neighbourhood, school, workplace), culture (ethnicity, faith) and others (disability, sexual orientation). Community development is one way of facilitating communities' awareness of the factors and forces that affect their wellbeing, health and quality of life. This was effectively demonstrated by the California Tobacco Control Programme, whose comprehensive approach started in 1988 and has enabled social norm change around tobacco, and been effective at reducing tobacco consumption.⁹

Community engagement is often patchy, favouring those communities that already have leadership, organisation and some resources. Instead, it needs to be systematic in bringing top-down and bottom-up priorities together into plans. This will strengthen community action to create more supportive environments and develop knowledge and skills of community members.

Service links into communities can be superficial, of poor quality, unsystematic, and based on low levels of understanding. Connectivity between services can be disorganised and confusing. Use of the voluntary community and faith sector as a bridge between services and community based structures needs to be more systematic and based on need rather than supply. Commissioning is key to this.

The different strands of tobacco control act at all three of the corners of the triangle of public health delivery. They work with communities to change perceptions and attitudes to smoking, and at a personal health level to provide a systematic approach to making it easier for individuals to stop smoking. Effective and systematic application of these local approaches leads to social norm change and population level health behaviour change.

Commissioning for Best Population Level Outcomes

Substantial progress can be achieved in making an impact in the short, medium and long term in relation to inequalities in mortality and life expectancy through a focus on existing services. Because of this, extra attention is given here to extracting maximum benefit from delivery of interventions for which there is strong evidence of effectiveness. In addition there is a deliberate emphasis wherever possible, on improving access to services of a scale that will impact on bringing about a population level improvement in mortality and life expectancy within a two to three year period.

The detail is illustrated in the diagram 'Commissioning for Best Population Level Outcomes' (p14), otherwise known as the 'Christmas Tree' diagnostic, with an accompanying description of its component principles. The framework balances two sets of factors that determine whether optimal outcome can be achieved at population level from a given set of personal health interventions.

In the case of tobacco control, this diagnostic is most relevant to Stop Smoking Service provision. It is important because smoking cessation will have a measurable short-term impact in terms of life expectancy. However, as discussed above, it is vital to remember

⁹ Roeseler, A and Burns, D. (2010) The quarter that changed the world. *Tobacco Control* 2010;19(Suppl 1):i3-i15.

that cessation is one strand of comprehensive tobacco control. It is vital that action on this broader front is taking place in parallel to cessation work aiming for short term gains that are not only sustainable, but that prevalence reduction strategies are in place for the medium and longer term.

It is therefore important that areas are in a position to work towards population level elements of the approach, such as policy measures, which are determined at a national level, are reflected at local level. This requires 'joining the dots' between both the different tiers and strands of tobacco control. If this is done and interventions are also carried out systematically at community and individual level, then social norms will change as the conditions are created where smoking becomes less desirable, less accessible and less acceptable. If the effort is greater in more disadvantaged communities, then health inequalities related to smoking will also be reduced.

The right hand side of the diagram (1 to 5) - a challenge to providers: links the factors that will influence health *service* outcomes, that is, how can we construct the most effective service.

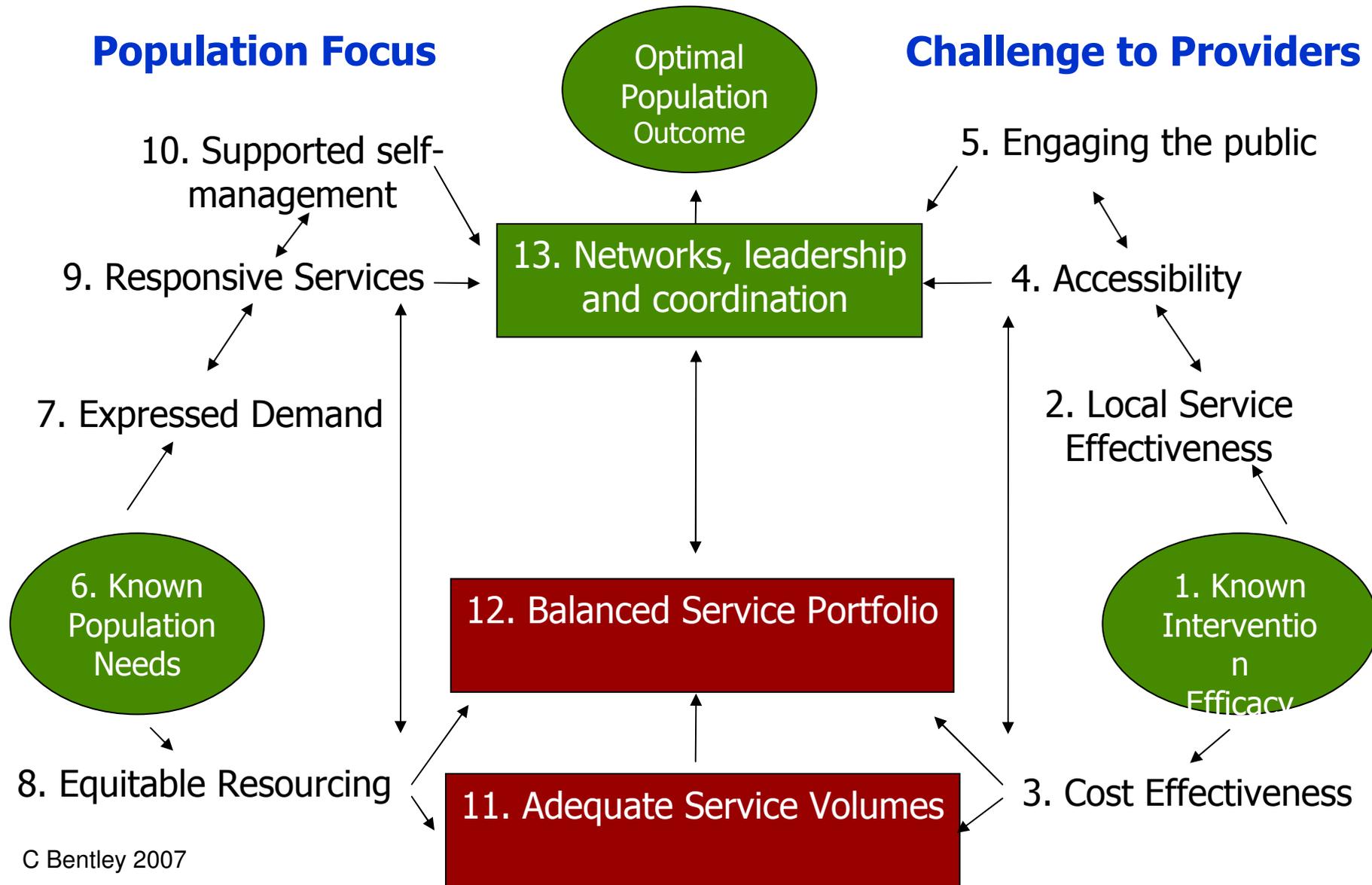
However, optimal outcomes *at population level* will not be obtained without the following:

The left hand side of the diagram (6 to 10) - a population focus: identifies those factors that determine whether a community makes best use of the service provided – for example, whether the benefits of personalised improvements to services are having a systematic impact on reducing health inequalities at the population level.

The balance between the two sides of the diagram - the commissioning challenge: Aiming for equality of outcome, not just equality of access to service provision and support, is a significant and crucial challenge for commissioners. The 'Christmas Tree' diagnostic, is a tool to help achieve this. The right side of the diagram enables commissioners to identify the best services available for their population. The left side allows commissioners to consider what is commissioned and delivered best meets the needs of all people in the local population. Attention to both sides of the diagram will help in aiming for all services to be effective **and** engaged with and used by all of the diverse communities in the area they serve.

The central elements of the diagram are concerned with aiming for that when the most effective services/interventions are identified that are fully acceptable, accessible and effective in terms of take-up and compliance, there is adequate capacity to meet the need.. Effective leadership and networks will enable all these elements to be kept under review to support continuous improvement and equality of morbidity and mortality outcomes.

Commissioning for Best Population Level Outcomes



Commissioning for Best Population Level Outcomes

A CHALLENGE TO PROVIDERS

1. **Known Intervention Efficacy:** Looks for life saving interventions, for which there is strong evidence, to be implemented equitably and made available to as many people who could benefit as possible.
2. **Local Service Effectiveness:** Aim for service providers maintaining high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit
3. **Cost Effectiveness:** Aim for programme elements that are as affordable as possible at population level
4. **Accessibility:** Aim for services to be designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of that service.
5. **Engaging the Public:** Working with service users and communities to aim for needs and requirements to be placed at the centre of service provision and for quality assurance systems in place that makes the services acceptable to service users
11. **Adequate Service Volumes:** Commissioning adequate service volumes to aim for acceptable access times.
12. **Balanced Service Portfolio:** Aim for balance of services within pathways to avoid bottlenecks and delays.
13. **Networks, Leadership and Co-ordination:** Designating leadership and co-ordination to aim for services that are commissioned and networked to meet population need and the population is supported to use services and interventions appropriately

B POPULATION FOCUS

6. **Known Population Needs:** Aim for a realistic assessment of the size of the problem locally, its distribution geographically and demographically and the level and type of service being based upon this assessment.
7. **Expressed Demand:** Aim for as many people as possible who are suffering from the problem or its precursors, to present to services in a timely and appropriate fashion, through informing, educating and supporting the population.
8. **Equitable Resourcing:** Aim for the distribution of finance and other resources to support equitable outcomes according to need.
9. **Responsive Services:** When people present to services, aim to make sure they are afforded equal access to timely beneficial interventions according to need.
10. **Supported Self Management:** Where appropriate, help service users to be empowered to make choices about their circumstances and service offer on the basis of good information, and to be supported to utilise the service offer to best effect

Equality

Equalities perspectives need to be built into all whole population approaches. The Equality Act 2010 set out the public sector equality duty:

(1) A public authority must, in the exercise of its functions, have due regard to the need to:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The Act identifies a number of 'protected' population groups/characteristics where specific elements of the legislation apply. These groups/characteristics are:

- *age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.*

Although socioeconomic inequalities are not specifically included in the Equality Act, there are a range of duties in relation to tackling inequalities included at different levels in new health and social care legislation, and for all key structures and partners involved in the commissioning and delivery of this legislation.

The Health and Social Care Bill 2010 proposes new legal duties on health inequalities for the Secretary of State and the NHS. Subject to Parliamentary approval:

- The Secretary of State for Health must have regard to the need to reduce health inequalities relating to the NHS and public health
- The NHS Commissioning Board and GP consortia must have regard to reducing inequalities in access to, and outcomes of, healthcare.'

In order to carry out these duties effectively an emphasis on socio economic disadvantage will be essential as it is recognised as a major driver in relation to inequalities of access to, and outcomes of, health and wellbeing services.¹⁰

Useful Materials¹¹

Why this topic has been chosen

Smoking and health inequalities

Smoking remains the single largest cause of preventable mortality in England, and reducing smoking will continue to be a focus as reducing prevalence represents a huge opportunity for public health¹². In 2009 there were an estimated 81,400 smoking-related deaths in adults aged 35 and over, accounting for 18% of mortality within this age

¹⁰ The Marmot Review (2010) *Fair Society, Healthy Lives - Strategic Review of Health Inequalities in England post 2010* <http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf>

¹¹ Department of Health (2008) *Making the difference – The Pacesetters beginner's guide to service improvement for equality and diversity in the NHS*

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086039

¹² HM Government. *Healthy Lives, Healthy People: our strategy for public health in England*. 2010

range¹³. This is considerably more than other major causes of death, such as alcohol, drugs, road traffic accidents, other accidents/falls, diabetes, and suicide combined¹⁴. The health risks from smoking are well-established and tobacco will go on to kill half of its regular users. In 2008-09 there were approximately 1.5 million hospital admissions with a primary diagnosis of a disease that can be caused by smoking¹⁵.

A large part of our population, often concentrated in the most deprived communities, remains exposed to these health risks. In addition, there is a considerable economic toll associated with tobacco use. It has been estimated that the cost of smoking to the NHS in England has risen in the 10 years to 2007, from £1.7 billion a year to £2.7 billion¹⁶.

QIPP (Quality, Innovation, Productivity and Prevention): The health system is required to respond to the challenge for the NHS to make £20bn efficiency savings by 2014-15, with the focus firmly on improving quality and efficiency simultaneously. To support this challenge it will be useful to consider the costs and benefits of addressing prevention at a local level. A resource pack to support local analysis of cost effectiveness of interventions for lifestyle issues is described below¹⁷

Inequalities in health outcomes between the most affluent and disadvantaged members of society are longstanding, deep-seated and have proved difficult to change, and tobacco is the leading risk factor in terms of the causes of health inequalities¹⁸. Research clearly shows that never smokers have much better survival rates than smokers in all social positions, meaning that smoking itself may be a greater source of health inequalities than social position. This suggests the scope for reducing health inequalities related to social position is limited unless many smokers in lower social positions stop smoking¹⁹, and

¹³ The Information Centre. Statistics on Smoking: England 2010

http://www.ic.nhs.uk/webfiles/publications/Health%20and%20Lifestyles/Statistics_on_Smoking_2010.pdf

¹⁴ Department of Health. Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control – An evidence-based resource for local Alliances, 2008

¹⁵ The Information Centre. Statistics on Smoking: England 2010

¹⁶ ASH. Beyond (2008) *Smoking Kills*

¹⁷ Yorkshire and Humber Public Health Observatory have in partnership developed the NHS Yorkshire and the Humber QIPP resource pack: May 2010 (STAYING HEALTHY <http://www.yhpho.org.uk/resource/item.aspx?RID=79123>). The pack presents step-by-step analysis of lifestyle behaviours, cost implications and potential cost savings following intervention. The resource pack considers prevalence of lifestyle behaviours, cost to the NHS, attributable admissions, attributable deaths and evidence and cost of interventions.

Further modelling work has been conducted and trailed in a number of localities. The model was developed by Professor Malcolm Whitfield. Director of the Centre for Health and Social Care Research at Sheffield Hallam University and addresses on a locality basis the key questions:

- How much would we have to change the risk factors to reduce the burden of disease?
- What order of savings could we achieve on healthcare costs in the first five years?
- How much could we realistically invest in getting lifestyle change?

The decipher tool is available on the following website: <http://www.sportseng.org/sheftool/>

¹⁸ National Audit Office (2010). *Tackling inequalities in life expectancy in areas with the worst health and deprivation*

¹⁹ Gruer, L. et al. (2009) Effect of tobacco smoking on survival of men and women by social position: a 28 year cohort study *BMJ*338:b480

reinforces the need for comprehensive tobacco control, including NHS Stop Smoking Services, which can be successful in targeting disadvantaged communities.^{20, 21}

In addition, most of the substantial social inequalities in adult male mortality during the 1990s were due to the effects of smoking. Widespread cessation of smoking could eventually halve the absolute differences between these social strata in the risk of premature death²². Consequently, smoking levels are of central importance to the reduction of health inequalities because smoking kills tens of thousands each year, many of whom live in deprived areas²³.

In the White Paper 'Healthy Lives, Healthy People: Our strategy for public health in England', the Secretary of State for Health outlined his commitment to prevent ill health by empowering individuals to make healthy choices and giving local communities the tools to address their own health needs. An important component for the success of this strategy will be the continuing development of interventions to reduce the harm of tobacco use, which still remains the biggest cause of preventable death and ill health in England.

Tobacco control

Reducing smoking prevalence is crucial to delivering reductions in health and social inequalities, which means that tobacco control (TC) is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups²⁴. Tobacco use cannot be viewed as just a health issue – for smoking to be effectively tackled, a range of people need to take action and work together. It is everyone's priority not just because of the massive impact on mortality and morbidity, but also on poverty, the economy, productivity, the environment and crime.

TC is an internationally recognised, evidence-based approach to tackling the harm caused by tobacco. The aim of TC is to reduce the disease, disability and death related to tobacco use. The evidence shows that a comprehensive approach that optimises synergy from applying a mix of educational, clinical, regulatory, economic and social strategies has been established as the guiding principle for eliminating the health and economic burden of tobacco use²⁵.

The need for a comprehensive, multi-stranded and sustained programme of tobacco control is recognised in the World Health Organisation's (WHO) *Framework Convention on Tobacco Control*²⁶ (FCTC) – the world's first global public health treaty. The FCTC was unanimously adopted by the World Health Assembly in 2003 and has since proven to be one of the most rapidly embraced treaties in United Nations history with 168 signatory

²⁰ Chesterman, J. et al. (2005) How effective are the English smoking treatment services in reaching disadvantaged smokers?. *Addiction*, 100 (Suppl 2), 36 - 45

²¹ Bauld, L. et al (2007) Assessing the impact of smoking cessation services on reducing health inequalities in England: observational study. *Tobacco Control*, 16, p 400 - 404

²² Jha, P. et al. (2006) Social inequalities in male mortality, and in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland and North America. *Lancet* ; 368: 367-370.

²³ National Audit Office (2010) *Tackling inequalities in life expectancy in areas with the worst health and deprivation*

²⁴ Marmot, M. et al. (2010) *Strategic review of health inequalities in England post-2010. Fair Society, Health Lives: The Marmot Review*

²⁵ U.S. Department of Health and Human Services (2000) *Surgeon General Report: Reducing Tobacco Use*

²⁶ World Health Organisation (2003) *WHO Framework Convention on Tobacco Control*

nations. To provide technical assistance to member states, WHO has developed the MPOWER package of measures²⁷.

MPOWER package:

- **M**onitor tobacco use and prevention policies
- **P**rotect people from tobacco smoke
- **O**ffer help to quit tobacco use
- **W**arn about the dangers of tobacco
- **E**nforce bans on tobacco advertising promotion and sponsorship
- **R**aise taxes on tobacco and clamp down on illicit supplies

These main themes are reflected in the Department of Health's national six-strand approach and have been developed into a model of comprehensive TC for use at local level by the Tobacco Control National Support Team (TCNST). See Appendix 1. As mentioned previously, support for smokers to quit is an important element of this comprehensive approach, and one that has been very successful in England through the NHS Stop Smoking Services. This approach to support is not only effective, but extremely cost effective²⁸. The Department of Health has also investigated the feasibility of further 'routes to quit', with a view to providing wider and more flexible approaches that allow smokers to choose from the various evidence-based options for quitting, and to engage with the NHS.

To significantly reduce smoking prevalence and health inequalities and to make improvements sustainable in the medium and longer term, it is essential to deliver TC in a comprehensive and consistent manner. TC needs to be recognised as core business for organisations, with strategic and crosscutting action. If local health economies are to effectively address health inequalities gaps they must aim for effective TC.

In practice, this has been effectively demonstrated by the California Tobacco Control Programme, whose comprehensive approach started in 1988 and has enabled social norm change around tobacco. The programme has been effective at reducing tobacco consumption (by 60%), adult smoking (by 35% to 13.8% prevalence as of 2007) and youth uptake (second lowest 12-17 year old smoking rate in USA). This approach has resulted in declines in tobacco-related diseases (lung and bronchus cancer rates in California declined at nearly four times the rate of decline seen in the rest of the USA) and is associated with savings in healthcare expenditures (\$86 billion savings in healthcare costs)²⁹. In the UK, it has been estimated that a one percentage point reduction in smoking prevalence would lead to net revenue gains of £240 million per year, including NHS savings of £74 million³⁰.

The TCNST have visited a large number of local areas facing a challenge and building on this work, developed *Excellence in tobacco control. This highlights 10 potential key actions to achieve tobacco control – an evidence-based resource for local Alliances* in

²⁷ World Health Organisation. (2009) *WHO report on the Global Tobacco Epidemic 2009: Implementing smokefree environments*

²⁸ Godfrey, C. et al (2005) Cost effectiveness of English smoking cessation services. *Addiction* 100 (Suppl 2), 70-83

²⁹ Roeseler, A and Burns, D. (2010) The quarter that changed the world. *Tobacco Control* 2010; 19(Suppl 1):i3-i15.

³⁰ Landman Economics and ASH (2010) *The Effects of Increasing Tobacco Taxation: a Cost Benefit and Public Finances Analysis*

May 2008. This outlines effective practice based on the best available evidence and is the basis of this workbook. A summary of the potential key actions is included as Appendix 2.

Questions

The questions in this section reflect the need to gain a broad understanding of the localities' approach to TC work. This enables a representative picture of the local TC work to be built up. *Useful materials* ³¹

Comprehensive Tobacco Control

Multi-agency partnership working

- To what extent is there a shared understanding of the impact of tobacco on health inequalities within local partnerships?
- How does this understanding translate into a strategic approach to tackling the harm caused by tobacco?
- Is there a strategy to deal with this issue detailing interventions, responsibility and accountability?

Tackling illegal/underage availability

- What is the perceived situation with regard to illicit tobacco within the area? This includes smuggled, counterfeit, and underage sale issues.
- How does this knowledge translate into action to deal with the problem?

Normalising smoke free lifestyles

- What is the understanding of promoting smokefree lifestyles above and beyond Smokefree Legislation?
- What initiatives have been considered within the area to help denormalise the use of tobacco?

Communication

- How does the area's strategic approach to TC address the issue of communicating key messages both internally to the partnership, and externally to the general public?

Note³²

Personal health interventions

Making it easier to stop smoking

- Brief history of service provision
- Commissioner or provider - position
- Make-up of the core team and network of 'associates' delivering both intensive and brief interventions
- Membership on TC Alliance and activities to support wider TC agenda

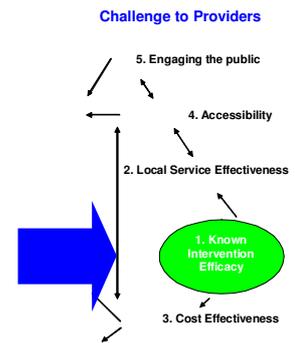
³¹ More detailed checklists on the different strands of TC are included as Appendix 3 in this workbook.

³² To tackle the issue of tobacco as a determinant of health inequalities is complex in that it requires a comprehensive approach at population, community, and personal levels. In addition, impact is dependent on time and intensity. As such, comprehensive TC must be sustainable in the longer term to achieve maximum impact, as demonstrated internationally by TC programmes in the USA and Australia, where some areas have reduced prevalence to between 13-14%.

The actions explored in the workbook are specifically about smoking cessation, on the basis that this will have a measurable short-term impact in terms of life expectancy. However, it is vital to remember that smoking cessation is one strand of the comprehensive approach and will not significantly reduce prevalence in isolation. As an illustration, Department of Health Guidance indicates that NHS Stop Smoking Services should aim to target approximately 5% of the local smoking population. While some services achieve more than this, approximately 90% of smokers are likely to quit without the support of NHS SSS. Wider tobacco control efforts are vital in prompting and maintaining these quit attempts, through a whole range of interventions designed to change social norms. In addition, social norm change is the most effective approach in tackling the issue of children and young people yet to start, protection from second hand smoke, and illicit tobacco.

The Workbook

Tobacco Control Strategies to Reduce Inequalities in Mortality



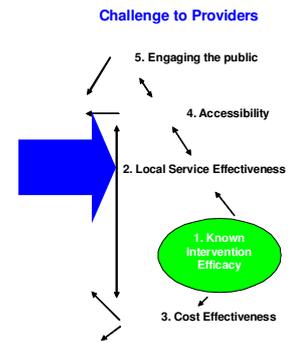
1. **Known intervention efficacy**

Looks for life saving interventions, for which there is strong evidence, to be implemented equitably and made available to as many people who could benefit as possible.

1. Is the DH Service and Monitoring Guidance adhered to in delivery of Stop Smoking Services (SSS)?
 - Is lost-to-follow-up rate low and carbon monoxide monitoring high?
 - Regular monitoring & improvement activity?
 - Is there a variety of best evidence interventions – group, one to one, etc?

2. Is there a clearly explicit and systematically applied smoking care pathway based on guidance/evidence for:
 - secondary care
 - primary care
 - routine and manual
 - smoking in pregnancy
 - mental health

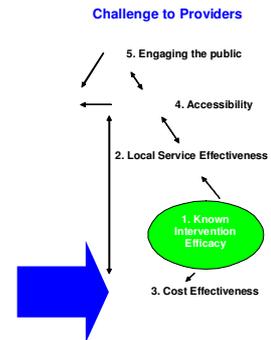
3. Is very brief advice (Ask, Advise, Act - AAA) systematically built into all disease care pathways?



2. Local service effectiveness

Aim for service providers maintaining high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit

1. Is the monitoring data systematically collated, analysed and interpreted to measure the quality SSS as delivered in different localities and in different ways?
To whom is it reported?
2. How is information on individual advisors and groups fed back?
Are comparisons made between peer groups?
Is it presented in a user friendly way so that comparisons can be made?
What support is available to identify potential consequential action?
3. Is data to reflect the impact of brief advice also collated and analysed? How is this data used to improve this impact and make it more systematic?
4. Is the data used by:
 - Commissioners
 - SSS provider organisation
 - Multi-disciplinary team
 - Individual practitioners
5. Who is responsible for responding and supporting the implementation of action?
6. Is the SSS using an Integrated Service Framework approach to pursue consistent delivery and quality across the entire health economy?
7. Is there regular National Centre for Smoking Cessation Training standard training, and update training, for associate advisors and bank staff?
Are these advisors given clinical support?
8. Discuss primary care/community support arrangements: Service level agreement (SLA)/ Local Enhanced Services (LES), monitoring and payment, pharmacy involvement and clinical governance.
9. What management barriers are currently perceived to be holding back service effectiveness?
 - Resources
 - Facilities
 - Processes



3. Cost effectiveness³³

Aim for programme elements that are as affordable as possible at population level.

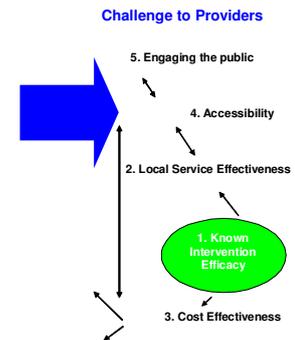
1. What is the current financial provision for stop smoking interventions?
2. Has the cost effectiveness of the service been analysed and benchmarked against comparable services?
Are resources then allocated according to priority/need?
3. Has the impact of smoking cessation on costs and outcomes of other services (e.g. elective surgery) been modelled and used to inform a) commissioning? and b) providers themselves? Is the emphasis on cost benefits to service used to promote commissioning by GP consortia, as opposed to this being a separate 'public health' initiative only?
Does the PCT have a pre-operative smoking cessation policy in place with all providers?
4. Is there a policy in place to 'raise the bar' of existing standards. This could be, for example, by negotiating with GPs to put a QOF+ system in place and reduce exception reporting within the QOF system across all smoking-related diseases with a chronic disease register
5. Is smoking cessation activity included in CQUIN components of contracts, being used to optimise quality return on investment?

³³ Yorkshire and Humber Public Health Observatory have in partnership developed the NHS Yorkshire and the Humber QIPP resource pack: May 2010 (STAYING HEALTHY <http://www.yhpho.org.uk/resource/item.aspx?RID=79123>). The pack presents step-by-step analysis of lifestyle behaviours, cost implications and potential cost savings following intervention. The resource pack considers prevalence of lifestyle behaviours, cost to the NHS, attributable admissions, attributable deaths and evidence and cost of interventions.

Further modelling work has been conducted and trailed in a number of localities. The model was developed by Professor Malcolm Whitfield. Director of the Centre for Health and Social Care Research at Sheffield Hallam University and addresses on a locality basis the key questions:

- How much would we have to change the risk factors to reduce the burden of disease?
- What order of savings could we achieve on healthcare costs in the first five years?
- How much could we realistically invest in getting lifestyle change?

The decipher tool is available on the following website: <http://www.sportseng.org/sheftool/>



4. Accessibility

Aim for services to be designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of that service.

1. To what extent have a) cultural, and b) socio-demographic segment preferences, been considered in the way services are offered?
Is there a Customer Access Strategy offering a menu of options for accessing services (rather than a 'one-size-fits-all' approach)?
2. Are group and drop-in stop-smoking sessions, facilitated by appropriately trained staff, offered in a variety of accessible locations (e.g. not just 'clinical settings') at times when demand is greatest (including weekends and evenings)?
3. How is provision more equitably targeted at areas of high prevalence (i.e. Routine and Manual) in order to close the gap?
Do at least 50% of all smokers treated by SSS come from Routine & Manual occupational groups?
If not what is being done to increase the percentage?
4. Has analysis of appropriate and proportionate provision according to need been carried out in relation to groups of equity and interest, including the following:
 - ethnicity
 - faith
 - age
 - sex
 - sexuality
 - disability:
 - physical disability
 - learning disability
 - enduring mental health problems
 What action has been taken as a result?

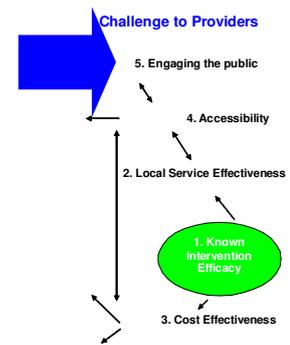
Secondary care

5. Is there access to intensive stop smoking support in coronary care unit, chest pain clinics, cardiac rehabilitation, acute respiratory assessment and in cancer and diabetes services?

6. Is the local acute trust signed up to the Department of Health implementation programme for smoking in secondary care?
7. Do all directorates provide mandatory brief advice training, implement AAA (Ask, Advise, Act) and is this activity regularly monitored?
8. Are referral pathways in place to enable prompt referral to intensive stop smoking support from SSS for those who wish to quit?
Do these pathways link across primary and secondary care?
9. Is NRT easily available (for both withdrawal management and quitting) in the acute trust?

Pregnancy

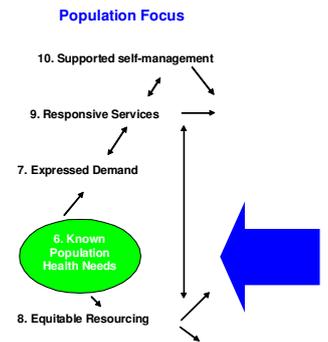
10. To increase the number of quit attempts overall, is AAA with referral routinely and systematically offered and monitored in:
 - all maternity units (all pregnant women)
 - community midwifery services (all pregnant women and their partners)
 - children's centres (all women of childbearing age and their partners)
 - in fertility clinics, hospitals, pharmacies, women's voluntary agencies and teenage pregnancy programmes
11. Is there specialist provision for pregnant women, and their families, to support quit attempts?
Are the most vulnerable pregnant smokers supported in their own home?
Do pregnant women have a range of service options from which to choose?
12. Is regular CO testing of all pregnant women in place as a part of routine testing at booking/ 1st trimester screening?
13. Is there an opt-out, rather than opt-in policy of referral to SSS in place for pregnant women who smoke, seen initially by midwives?



5. Engaging the public

Working with service users and communities to aim for needs and requirements to be placed at the centre of service provision and for quality assurance systems in place that makes the services acceptable to service users

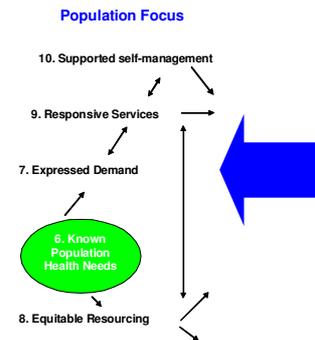
1. Are regular consultations/ market research carried out with smokers to determine needs and preferences, and the information used to determine development of the service (taking account of both clients and those smokers who are less likely to engage)?
Have the following mechanisms been used?
 - patient/user satisfaction surveys
 - systematic involvement of user and carer representatives in the networks
 - audit of 'did not attend' episodes in (by ethnicity, sex, age, social segment, etc.)
 - discovery interviews
 - focus and reference groups
 - local support and interest groups
2. Have the priorities in the service been developed through the involvement of the community?
Is this involvement part of a wider community engagement programme?
Are population segmentation tools used to define and engage appropriately with the communities of interest?
3. Are LINKs (Local Improvement Networks) utilised to identify the barriers to accessing the SSS?
4. How systematic is engagement with, and empowerment of, frontline staff in the local partnership, to draw in intelligence and ideas to improve the accessibility and appropriateness of service provision?



6. Known population needs

Aim for a realistic assessment of the size of the problem locally, its distribution geographically and demographically and the level and type of service being based upon this assessment.

1. Has a needs assessment been carried out using local prevalence data?
Is it based on national surveys, commercial databases (e.g. MOSAIC), local strategic lifestyle survey?
2. Does this take account of:
 - age
 - sex
 - sexuality
 - ethnicity
 - patients in residential and nursing homes and housebound
 - geography
 - segmentation group
 - people with physical or learning difficulties or mental health problems
 - other relevant vulnerable groups (e.g. prisons, Gypsies and Travellers)
3. What are the main conclusions?
What are the important trends?
4. As a result, has there been any prioritisation or stratification of the extent of need?
Have particular outcome 'black-spots' been identified?
5. Is there an analysis of smoking QOF returns by GP and practice, and an intervention/ support policy where recorded smoking status is low?
6. Have data and information from all partners involved in TC:
 - been jointly analysed
 - formed part of a joint strategic needs assessment?
 - been used to develop profiles by – for example - locality, neighbourhood, GP practice
7. Has this information been collated, analysed and interpreted for a range of audiences?
How has the intelligence been disseminated/communicated, and to whom?
Has it been received by all relevant parties who might use it to support decision making?

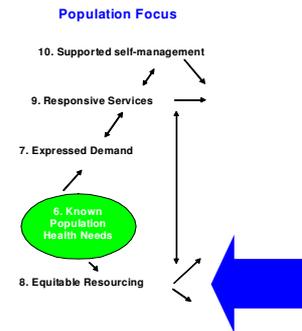


7. Expressed demand

Aim for as many people as possible who are suffering from the problem or its precursors, to present to services in a timely and appropriate fashion, through informing, educating and supporting the population.

1. Have Health Equity Audits been carried out to enable equal access to Stop Smoking provision across different population groups?
2. Have any forms of survey or Insight work been carried out to establish what barriers may be holding back segments or sub-groups of the population from using Stop Smoking support?
Have these explored:
 - perceived practical problems with delivery of the service
 - cultural issues of community knowledge and expectation
 - problems of individuals (e.g. self esteem, knowledge, low expectations of life, low expectations of service)
3. How has this knowledge been translated into actions to address barriers:
 - in access and the way services are delivered
 - in engaging with communities to work on cultural barriers
 - reaching out to individuals/families to appropriately engage in services
4. Do frontline staff from all sectors (health visitors, social workers, care workers, youth workers, etc) stimulate demand and maximise every opportunity to promote health gains by providing routine brief interventions and referral to SSS?
Are:
 - staff given regular training
 - key screening questions provided
 - Is this activity systematised by incorporating into contracts (Health Gain Schedules or similar in place)
 - Is data on referrals from different parts of the system collected, analysed and reacted to in a systematic way
5. To increase number of quit attempts overall, is AAA (Ask, Advise, Act) routinely and systematically offered in:
 - local authority social care
 - mental health trust
 - all community/charity/voluntary organisations, including minority and faith groups
 - niche settings (e.g. prisons, military bases, etc)

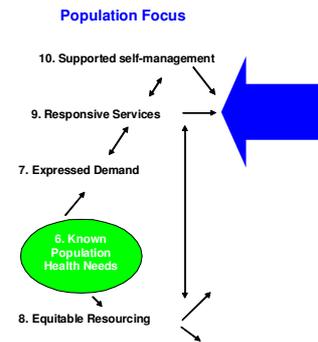
6. Are patients on primary care disease registers regularly (at least once a year) and systematically (e.g. by direct mailing or other method) offered stop smoking support? Does this involve a range of approaches, and a menu of options for support, preferably tailored to knowledge of likely preferences?



8. Equitable resourcing

Aim for the distribution of finance and other resources to support equitable outcomes according to need.

1. Are SSS resources targeted according to need rather than service providers' 'interest'?
2. Are Local Enhanced Services or Service Level Agreements in place to support and extend smoking cessation/TC?
 - How detailed are the specifications?
 - Do they take groupings of equity concern (e.g. deprivation/ethnicity etc) into account to incentivise work with these groups?
 - How are they performance managed?
3. Do GP practices or pharmacies have sufficient trained associate advisors in place to meet need according to smoking prevalence estimates?
4. Has market testing been carried out and all willing providers been considered when looking for potential providers of stop smoking or TC work

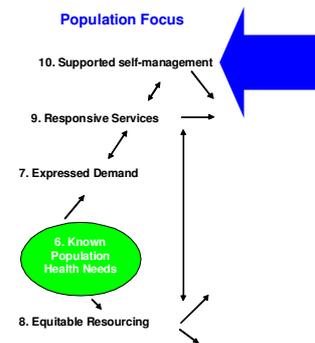


9. Responsive services

When people present to services, aim to make sure they are afforded equal access to timely beneficial interventions according to need.

1. Are robust referral pathways in place to enable prompt support for those high risk groups (CVD, COPD, cancer, diabetes) who wish to quit?
Do care pathways link seamlessly across primary and secondary care?
Is there an opt-out, rather than opt-in, referral system in place?
2. How are DNAs and 'lost to follow up' handled?
Is there a 'failsafe' strategy to enable all possible contact opportunities to be explored to reengage clients/service users before closing file?
3. Are heavily addicted smokers who have may have accessed the service several times, catered for?
4. Are there mechanisms for people trying to quit to get emergency help/support (e.g. urgent appointments, telephone helpline or online support)?
Are these well promoted to service users?
5. Are all NICE-approved pharmacotherapies available as first line treatments?
6. Has there been consideration of the full range of interventions and appropriate routes to quit to enable support to be tailored to client preference, recognising that one size does not fit all (including Together Programme³⁴, telephone support, over the counter and prescription Nicotine Replacement Therapy [NRT])?
7. Is this range of interventions adequately promoted for those who do not wish to access intensive support, using insight analysis and social marketing techniques?
8. What proportion of pharmacies are offering support or referring to the SSS when NRT is purchased?
9. Are the full range of services offered to pregnant women and their partners (groups, 1:1, telephone, web and home visits where appropriate)?

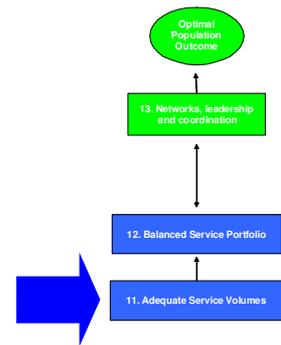
³⁴ <http://smokefree.nhs.uk/ways-to-quit/motivational-messages-at-home/?&gclid=CLL25Nijg6kCFQoY4QodelcKTg>



10. Supported self-management

Where appropriate, help service users to be empowered to make choices about their circumstances and service offer on the basis of good information, and to be supported to utilise the service offer to best effect.

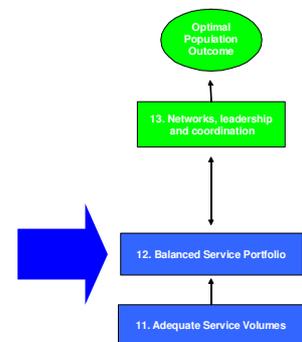
1. Are the most vulnerable smokers (in deprived areas, routine and manual groups, black and ethnic minority groups, etc) targeted, with systems in place to provide suitable locations and more intensive support, and with the local population needs taken into account?
2. Are advisors in a position to address the particular needs that these smokers have (e.g. language differences, support materials, etc)?
3. Are materials and support available for disability groups (e.g. poor literacy, low IQ, poor vision and hearing)?
4. Are systems to access pharmacotherapy simple and effective?
5. Is direct marketing, informed by segmentation analysis, used to follow up those who have used the service in order to deter relapse and encourage re-use of the service?
6. Is there a robust administrative system in operation whereby all identified pregnant women are tracked and regularly followed up from booking through to birth and three months postnatal?
 - How is this used to improve long term quitting among pregnant women?



11. Adequate service volumes

Commissioning adequate service volumes to aim for acceptable access times.

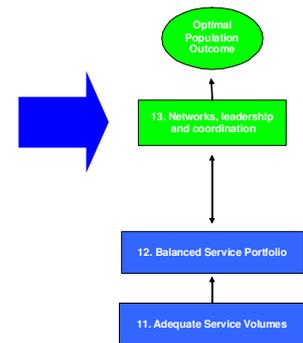
1. Are there sufficient trained associate advisors to provide quality support in all locations according to demand?
Does the core SSS have sufficient capacity to support these advisors and provide specialist support to heavily addicted smokers?
2. Is there evidence of waiting lists or significant delay in clients being able to access services when they need them?
3. Is there awareness of any emerging pressures on the service in terms of either increased demand or savings targets?
Are seasonal demands on services (e.g. New Year and No Smoking Day) taken into account in planning service provision?



12. Balanced service portfolio

Aim for balance of services within pathways to avoid bottlenecks and delays.

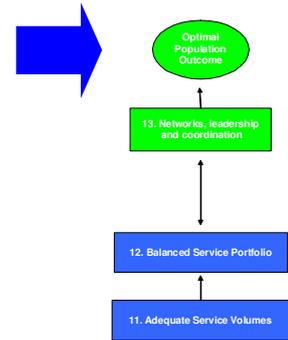
1. Have patient pathways been mapped to improve design and enable all smokers wishing to quit get fast and efficient access to support?
In particular are all sources of brief intervention linked to direct booking for support?
2. Are pathways audited to help drive improvements in efficiency and effectiveness?



13. Networks, leadership and coordination

Designating leadership and co-ordination to aim for services that are commissioned and networked to meet population need and the population is supported to use services and interventions appropriately

1. Is there evidence that there is a commissioning plan for stop smoking services that is:
 - comprehensive
 - needs based (informed by analysis discussed in **section 6**)
 - geared to population need rather than service outcomes
 - actually addresses differential need/ health inequalities?
2. Has this model of provision then been commissioned?
3. Is there a multi-agency Tobacco Control Alliance in the area?
Are the following in place:
 - overview of structure – membership, roles and function
 - key aims and objectives
 - governance arrangements and accountability – LSP, Regional links
4. Is there consistent high level chairing of this group and a dedicated coordinator to check progress on actions and secure their implementation?
5. Is there public health specialist input to the alliance?
6. Does the Alliance work with multi-agency partners (LA, etc), including commissioned services (e.g. acute trust, mental health trust), in such a way that all partners are equal and not 'health' dominated?
7. Is the Alliance in a position to:
 - set a strategic approach to tobacco control and inform commissioning of tobacco control interventions
 - monitor and evaluate the overall approach and respond to new evidence or evolving circumstances?
8. Has tobacco control and smoking been subject to the scrutiny process/ external or peer review? What was the outcome?



Optimal Population Outcome

Aim for service outcomes that are meaningful locally, and drive the programme.

1. Are national and local outcome measures used to reduce life expectancy gaps?
2. Is the partnership on trajectory for any local All Age All Cause Mortality outcomes goals?
3. Has the impact of changes to smoking prevalence/numbers of smoking quitters on the local mortality/life expectancy gap been modelled, and what are the intentions for the next commissioning cycle?
4. Is there any measure or estimate of smokers quitting without using NHS SSS? Does this reflect the effectiveness of the wider tobacco control approaches?

Appendix 1 Comprehensive local tobacco control

The seven strand Tobacco Control (TC) model below was developed by the TC NST as a basic framework for assessing and building a local strategic approach to tobacco control.



- **Multi-agency partnership working:** This is the central, crucial, factor on which an effective local tobacco control programme depends. The crosscutting nature of tobacco control has already been highlighted, and it is vital to have strategic partnerships and functional alliances at a local level to deliver evidence based interventions. These need to be closely linked to regional and national action on tobacco control.
- **Planning and commissioning:** The partnership should be in a position to set a strategic approach to tobacco control and develop clear delivery plans for this. All local tobacco control action has potential to be strengthened through joint commissioning, and the planning and commissioning of stop-smoking provision is often a useful starting point to explore opportunities to deploy effective commissioning approaches to behaviour change ends and to make full use of social marketing principles
- **Monitoring, evaluation and response:** Four week quit targets and their monitoring have played an important role in enabling the cessation elements of tobacco control work in particular to maintain importance locally. However, it is vital that the full range of local tobacco control action is monitored and evaluated. The relevant

partnerships need to be in a position to evaluate their overall approach and respond to new evidence or evolving circumstances.

Together, the three elements described in the last 3 bullets, form the central spine to the tobacco control model. (Note: in the workbook questions, these three elements are represented by 'multi-agency partnership working' – see appendix 3).

The four other strands of this model form the basis of the operational interventions needed for effective tobacco control action.

- **Tackling illegal/underage supply:** Price is still the leading trigger for smokers to quit, and supply of illicit tobacco supply threatens to undermine other effective tobacco control interventions if not minimised by appropriate controls.
- **Normalising smokefree lifestyles:** Having delivered smokefree workplaces the next step is to move on to a focus on lifestyle (rather than just environment). This may require attention to support compliance with smokefree workplace and further voluntary measures are adopted where appropriate, as well as support available to tackle activities or behaviour that promote or present tobacco use as a normal adult activity.
- **Communication.** There are three foci here:
 - the means for partners to communicate between agencies to maintain an adequate and up-to-date shared strategic approach to tobacco control
 - the ability of the partnership(s) to communicate messages and opportunities about tobacco control to local communities effectively and using national campaigns material to the full
 - the preparedness of partnerships and key members to advocate for continued and enhance comprehensive tobacco control action.

Making it easier to stop smoking. This is not just about NHS SSS. It is also about the context in which they operate, how local partners promote the benefits of going smokefree and the means to do so, how specialist services are linked to community-based and secondary care evidence-based assistance to quit, and how the PCT commissions integrated interventions (backed with access to appropriate pharmacological aids) to this end. The entire partnership should be involved.

Appendix 2: 10 Potential key actions to achieve tobacco control ³⁵

1. Work in partnership

Effective partnerships are central to moving the tobacco control agenda forward. Partnerships need to be strategic and create a joined-up approach to tackling the public health issue of tobacco as a shared priority. This requires senior leadership, developed Tobacco Control Alliances, and positioning of these within the framework of strategic local partnerships.

2. Gather and use the full range of data to inform tobacco control

Collecting robust data to determine the scale of the challenge in a given area will inform local tobacco control goals, supporting efforts that are focused in the right places. The available knowledge can then be translated into informed planning and commissioning. This will hopefully be aided by the introduction of the Integrated Household Survey from the Office for National Statistics, which will seek to provide statistical estimates with greater precision and to a lower geographical level. In addition, the Local tobacco control profiles for England, developed by the London Health Observatory, will also be useful at local level.

3. Use tobacco control to tackle health inequalities

A locality committed to addressing health inequalities will need to intelligently commission tobacco control if more significant reductions in smoking-related inequalities are to be achieved. Interventions targeted at the substantially untapped group of smokers in the routine and manual group must be a priority, as this is the main means of tackling health inequalities.

4. Deliver consistent, coherent and co-ordinated communication

Bringing communications into the local strategic approach to tobacco control increases the effectiveness of national and local smokefree campaigns, is central to social marketing and is fundamental to tobacco control advocacy.

5. An integrated stop smoking approach

The local NHS Stop Smoking Service should be viewed as just one element of an overall strategic and comprehensive programme rather than the sole agency delivering tobacco control at a local level, albeit acknowledged as a function that underpins many other parts of a comprehensive programme.

6. Build and sustain capacity in tobacco control

Capacity building is a long-term process; in order to maintain progress and momentum in tobacco control it is essential that local capacity is strengthened and sustained. Successful tobacco control will require infrastructure, resources and political will.

7. Tackle cheap and illicit tobacco

Tobacco smuggling seriously undermines the impact of other tobacco control measures. There needs to be greater effort to reduce both the demand and supply of cheap illicit

³⁵ Department of Health (2008) *Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control – An evidence-based resource for local Alliances*

tobacco. This is a crosscutting issue that requires engagement from all partners in a local Alliance.

8. Influence change through advocacy

Tobacco control advocacy is about changing the political, economic and social conditions that encourage tobacco use and gaining public, political and media support for tobacco related issues.

9. Helping young people to be tobacco free

Smoking prevalence among 11–15 year olds has remained at 6% since 2007, but this increases dramatically with age. Regular smoking in 11 year olds is less than 0.5%, while at age 15, 15% are regular smokers³⁶. Smoking prevention among young people should be part of a comprehensive tobacco control programme based on denormalising smoking across the wider population.

10. Maintain and promote smokefree environments

A concerted effort is required to sustain the profile of tobacco control and maintain the momentum built up over the past decade, most notably by the Smokefree legislation of July 2007, if the significant benefits to be had from denormalising smoking are not to be lost.

³⁶ Smoking, drinking and drug use among young people in England 2009
http://www.ic.nhs.uk/webfiles/publications/Health%20and%20Lifestyles/sdd2009/SDD_2009_Report.pdf

Appendix 3: Multi-agency Partnership Working Checklist

1. Is there an evidence of a strategic approach to tobacco control that addresses the main strands, and applies an action plan, timelines, monitoring processes and roles?
2. Is there a multi-agency tobacco control alliance in the area?
3. Are the following in place:
 - a. overview of structure – membership, roles and function
 - b. key aims and objectives
 - c. governance arrangements and accountability – partnership, Regional links
4. Is there consistent high level chairing of this group and a dedicated coordinator to check progress and secure implementation of actions?
5. Is there planned investment for tobacco control interventions - human and financial resource - and is the funding for tobacco control protected by an SLA?
6. Does the Alliance work with multi-agency partners (LA, etc), including commissioned services (e.g. acute trust, mental health trust, local authority), , in such a way that all partners are equal and not 'health' dominated?
7. Is the Alliance in a position to:
 - a. set a strategic approach to tobacco control and inform commissioning of tobacco control interventions
 - b. monitor and evaluate the overall approach and respond to new evidence or evolving circumstances
8. Is tobacco control and smoking subject to the scrutiny process?
9. Status of tobacco control in strategic plans: is this included in Health and Wellbeing documents (or plans to include it as strategies develop)?
10. Is the importance of tobacco control in reducing health inequalities recognised in health inequalities strategies and plans?
11. How closely do HMRC/police get involved in developing strategic approaches to top priorities around safer communities, crime prevention, reducing health inequalities, etc?
12. Are there interventions delivered by CVS or other relevant community organisations, to target population segments (e.g. BME groups, older people, mental health service users)?
13. Does the local Tobacco Alliance have a strong communications network or good links to an active generic one?
14. Is there local authority potential to become market aware, especially in relation to Routine and Manual (R & M) workers?

Tackling illegal/underage availability checklist

1. How involved are the LA regulatory service in tobacco control work/the alliance?
2. What action is underway to reduce illicit sales of illicit/smuggled tobacco (including underage sales), and what plans are in place to address the issue of tobacco smuggling?
3. Is there a local strategy for the reduction of the rate of growth in tobacco smuggling and corresponding tax evasion? Does it respond to links between illicit tobacco sales and deprived populations?
4. Is enforcement action undertaken in relation to counterfeit or smuggled product?
5. Is the area aware of the North of England Cheap and Illicit Tobacco Plan and the key strands?
 - developing partnerships
 - engaging health and community workers
 - generating and sharing intelligence
 - identifying informal markets and preventive action
 - enforcement
 - marketing and communications
 - working with business
6. Does the local area:
 - Have action plans to monitor and reduce illegal sales of tobacco to children in accordance with the Children and Young Person's (sale of tobacco, etc.) Order 2007
 - Carry test purchase operations, including any test purchasing from Vending Machines
 - permit test purchasers to lie about their age (as outlined in the LACORS guidance)
 - plan any additional work in support of the increased retailer sanctions (for those who persistently sell to under 18s), which came into force on 1st April 2009
7. To what extent is the Alliance/LA proactive in seeking improvement in product regulation, legislation around sales to young people and the labelling of tobacco products?
8. Do Environmental health and Trading Standards officers exploit opportunities to combine enforcement activities with promoting the smokefree message?
If so, to what extent do they systematically appraise compliance with smokefree workplace regulations and advise on illicit tobacco when out on visits, and effectively manage communication between different services.
9. Is there active monitoring and enforcement of the Tobacco Advertising and Promotion Act 2002 and Tobacco Advertising and Promotion (Brandsharing) Regulations 2004?
10. If appropriate to local population, is there publicising of the dangers relating to paan, sheesha and other forms of chewing tobacco and enforcement of regulations relating to these?

Normalising smoke free lifestyles checklist

1. Are there local smoking prevalence estimates?
What are these based on? (e.g. national surveys, commercial databases [MOSAIC], local strategic lifestyle survey)?
2. Is there experience of implementing smokefree workplace regulations and are there future intentions to maintain compliance?
3. Does work continue on monitoring and enforcing the legislation as regards smoking in enclosed public places?
4. How are the general public encouraged to report breaches of the smokefree workplace regulations?
5. How was DH funding allocated – employment of a specialist SF compliance officer?
Has this post been mainstreamed?
6. Regarding compliance: are there any particular sectors that are proving more difficult to work with than others (possibly vehicles/ taxis)?
7. Are all local government and NHS premises used to publicise and educate about the risks of smoking?
Role modelling/ are staff smokefree ambassadors?
8. Is there a consistent no smoking policy for partnership organisations
Does the policy extend to grounds/car-parks?
How the policy is disseminated?
Who has responsibility for it?
9. What is being done to support places where the legislation is difficult to enforce (e.g. outside A&E, in mental health facilities and residential care)?
10. Are there policies to avoid staff and contractors being exposed to second hand smoke, particularly in clients' homes?
How well are these policies implemented?
11. What work has the Alliance done to promote non-smoking as the norm (e.g. advocating against incidents where smoking is glamorised, work with events promoters to encourage smoke free events and workplaces)?
12. Do strategies exist and are programmes in place to reduce exposure to second hand smoke in the home and in cars?
Is there a particular focus on areas where smoking prevalence is highest?
13. Are all the opportunities for whole school approaches to smoking work (working with parents, families, staff to normalise smokefree lifestyles) being taken? Do these include the Extended schools programme?
14. What involvement does the Healthy Schools Programme have in tobacco control (e.g. communicating risks of second hand smoke in the home, sharing intelligence with Regulatory Services about where young people purchase tobacco products)?

Communication checklist

1. Is there a strong Communications Network and is this linked to the Tobacco Control Alliance?
2. Is there a communications strategy for? What are its key components and how is its impact monitored and evaluated?
3. How are key tobacco control messages communicated internally to stakeholders (e.g. within the Health and Wellbeing Board):
 - methods of effective internal communication
 - communication with multi-agency partners (LA, etc), including commissioned services (e.g. acute trust, mental health trust)
 - barriers to effectiveness
4. How are key tobacco control messages externally communicated to the public (e.g. denormalising smoking, public consultation):
 - communication of appropriate and tested healthy lifestyle messages across different market segments (in particular, R&M workers, BME groups)
 - support of use of alternative communication channels to reach service users or potential service users
5. What is the role the tobacco control partnership plays in local advocacy of tobacco control and awareness raising of key issues such as cheap and illicit tobacco, availability of tobacco to children and young people (e.g. working with elected members, media, etc)
6. What is the balance of locally initiated to nationally initiated publicity and communications?
How does the communications function enable the SSS to make best use of national campaigns?
7. What is the extent to which a social marketing approach is understood, and is there any use of social marketing techniques to promote non-smoking?
How and to what extent?
8. Have particular communities been identified as priorities for targeted action around smoke free? If so:
 - Has consumer research been carried out to gain insight into audience characteristics and needs? Is this reflected in subsequent approaches?
 - Are different interventions and types of stop smoking support directly tailored to particular audience segments/client need?
9. Has use been made of MOSAIC or other software to segment the population?

Appendix 4: Acronyms and abbreviations

AAA	Ask, Advise, Act – ‘very brief advice’
AAACM	All age all cause mortality
CO	Carbon monoxide
COPD	Chronic obstructive pulmonary disease
CQUIN	Commissioning for Quality and Innovation
CVD	Cardiovascular disease
FCTC	<i>Framework Convention on Tobacco Control</i>
HMRC	Her Majesty’s Revenue and Customs
LESSs	Local Enhanced Services
LINK	Local Involvement Networks
MOSAIC	Segmentation tool
MPOWER	<ul style="list-style-type: none"> • Monitor tobacco use and prevention policies • Protect people from tobacco smoke • Offer help to quit tobacco use • Warn about the dangers of tobacco • Enforce bans on tobacco advertising promotion and sponsorship • Raise taxes on tobacco and clamp down on illicit supplies
NRT	Nicotine replacement therapy
PALS	Patient Advice and Liaison Services
QOF	Quality and Outcomes Framework
SLA	Service level agreement
SSS	Stop smoking services
TC	Tobacco control
TCNST	Tobacco Control National Support Team
WHO	World Health Organisation’s