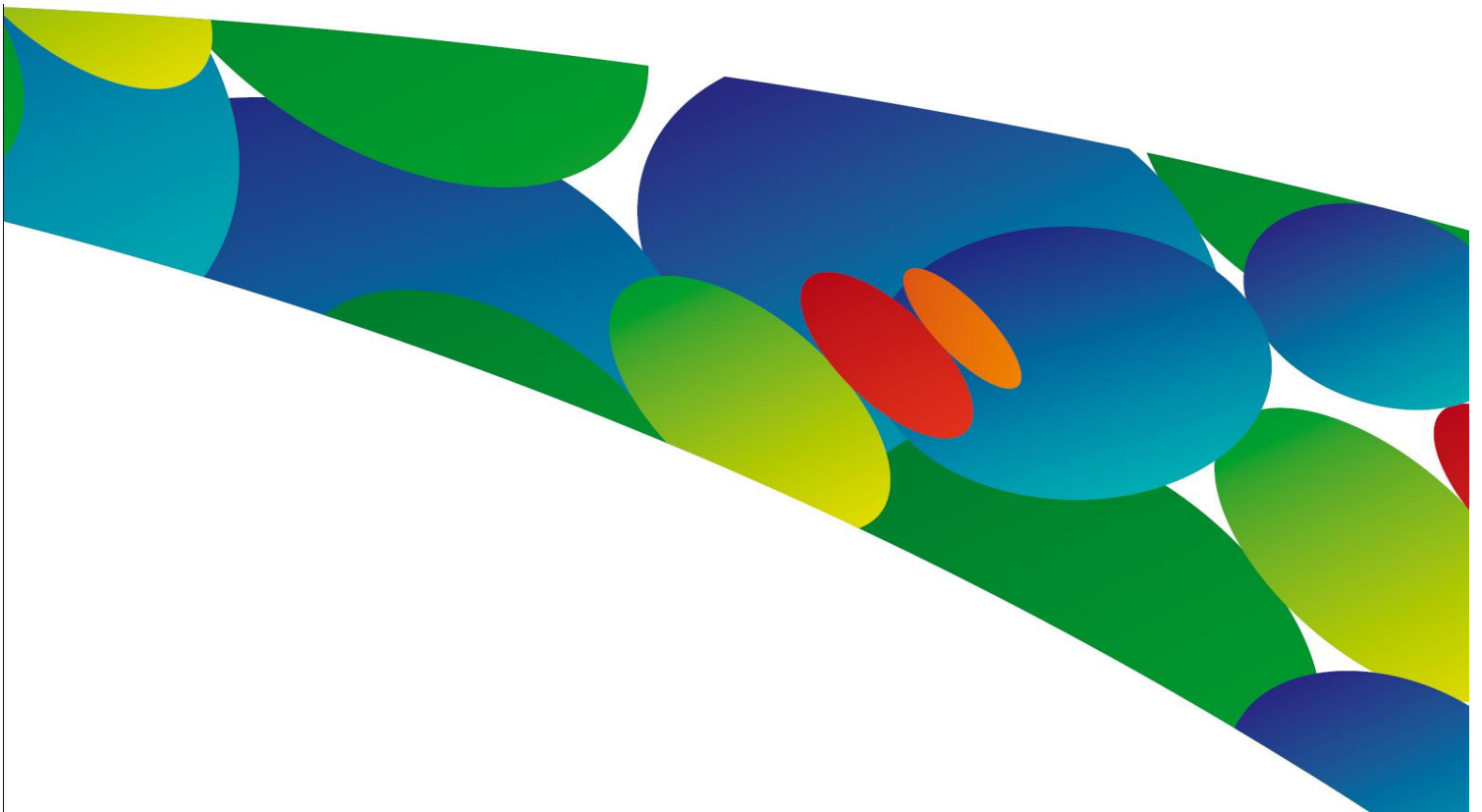




# **Tobacco Control National Support Team**

**Engage • Recommend • Facilitate**

*A Comprehensive Guide to Achieving Effective Local  
Tobacco Control: Evidence, Support & Publications  
Developed by the Tobacco Control National Support Team  
(2006 – 2011)*



**DH INFORMATION READER BOX**

Policy	Estates
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## EXECUTIVE SUMMARY

Smoking remains the largest preventable cause of premature death and illness in England, accounting for over 80,000 deaths each year. It is also the single largest cause of health inequalities, accounting for over half of the difference in premature death between the rich and poor in the UK.

To reduce the harm caused by tobacco use it is vital that local areas understand why this remains an important societal issue. With the shift towards the coalition Government's idea of 'Big Society', and the intended growth of local responsibility and accountability, it is essential that local decision-makers understand the important role they can play by enabling local communities to lead healthier, and more productive, smokefree lives.

Based on work carried out by the Department of Health's Tobacco Control National Support Team (NST), this guide aims to provide the reader with an introduction to local tobacco control, and guidance on how to identify and overcome some of the more significant barriers commonly found to undermine the impact of local tobacco control work.

This workbook is a diagnostic approach to analyse the approach to tobacco control in a local area. Through a series of questions and reference to evidence based interventions, it allows a group of local partners involved in delivering tobacco control, to determine what would need to be done to achieve a population level outcome through the delivery of these evidence based tobacco control interventions.

## **Tobacco control**

Tobacco control is an internationally recognised, evidence-based approach to addressing the harm caused by tobacco use. Key to its success is the need for a multi-stranded approach to tackling tobacco harm requiring a variety of educational, economic, clinical, regulatory and social strategies. Although some aspects of tobacco control can only be enacted at a national level (e.g. taxation on cigarettes), local areas have an important role to play in relation to all aspects of tobacco control. This has been effectively demonstrated by the California Tobacco Control Programme, whose comprehensive approach started in 1988 and has been effective at reducing tobacco consumption by 60% and lowering the adult smoking rate to a prevalence of 13.8% in 2007.

## **Tobacco Control National Support Team**

National Support Teams were established by the Department of Health in 2006 to support local areas – including Local authorities, Primary Care Trusts 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 NSTs provided intelligence, support and challenge to local areas to assist in their achieving better public health outcomes.

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.

An element of the NST process unique to the Tobacco Control NST was the integrated model of local tobacco control. This diagnostic model provides a useful tool through which to analyse the effectiveness of interventions across all the essential components needed to de-normalise tobacco use at a local level.

### **Learning from Tobacco Control NST visits**

During the course of the NST programme the Tobacco Control NST has undertaken 47 visits to local partnerships, and their findings and successes have been documented in Knowledge Management and Evaluation reports:

Retrospective analysis of visit recommendations (i.e. Knowledge Management) identified a number of key factors frequently found to undermine the effectiveness of local efforts to reduce smoking prevalence. Amongst others these included:

- Inadequate performance management;
- A lack of strategic accountability;
- Inappropriate use of data for planning and monitoring; and
- Weak multi-agency working.

An evaluation of the Tobacco Control NST diagnostic process and outcomes for the local area found that the diagnostic and support process:

- Raised the profile of tobacco control within the local health economy;
- Helped the local area to adopt a more evidence-based approach to tobacco control; and
- Improved local performance against key smoking-related targets.

Specific recommendations on the need to improve partnership working, communication and NHS Stop Smoking Services were identified by respondents as being of most use within the local context.

### **Tobacco Control NST publications**

In order to share the learning from the NST programme, the Tobacco Control NST has produced a number of products to help frontline staff more effectively deliver components of local tobacco control:

- Tackling Health Inequalities – targeting routine and manual smokers in support of the public service agreement smoking prevalence and health inequality targets;
- Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control. An evidence-based resource for local Alliances;
- Learning from National Support Team visits: Tobacco Control NST (parts 1 and 2).

Based on the learning from NST visits, an additional two products have been developed to help local areas develop a better understanding of (a) partnership working around tobacco control and (b) how to develop an integrated approach to local stop smoking service provision.

### ***Section 7 – Partnership Working for Tobacco Control***

The importance of partnership working is clearly recognised within the thinking of the coalition Government; in no other area of health improvement are partnerships more important than in tobacco control. To reduce the harm of tobacco use it is essential that local decision-makers understand that tobacco control cannot be achieved solely through the health system – tobacco use has ramifications (and opportunities) for society that fall within the remit of the criminal justice and regulatory system (e.g. illicit tobacco), environmental health (e.g. secondhand smoke) and local businesses (e.g. employee productivity) to name but a few. In order to reduce the prevalence of smoking within England it is necessary to adopt a multi-agency approach to de-normalising smoking behaviour, particularly within more deprived communities where smoking is seen as a ‘normal’ activity.

A needs assessment of local tobacco control Alliances revealed a number of partnership-related factors associated with an inability to deliver a reduction in local smoking rates. These included lack of breadth in Alliance representation (evidenced by an over-reliance on NHS membership), an absence of clearly defined roles and responsibilities (with the NHS seen as taking on a disproportionate amount of responsibility) and limited accountability within the Local Strategic Partnership. A comparison of areas scoring in the highest and lowest quartile in relation to partnership engagement showed considerable variation in terms of local performance:

- There were 23% more successful quitters in the top scoring Alliance areas than the low scoring Alliance areas in 2009/10 (per 100,000 16+ population);
- Around a third of those setting a quit date in the top scoring Alliance areas during 2009/10 were confirmed as having quit through CO validation, in line with the national average. In the lowest scoring Alliance areas the CO validated quit rate was just 22%, over a third lower at this time;
- The number of people setting a quit date with local stop smoking services was 14% higher amongst the top scoring Alliance areas than the lowest scoring Alliance areas during 2009/10 (per 100,000 16+ population).

***Section 8 – Integrated Service Framework for Stop Smoking Provision***

One of the most significant challenges to the NHS in recent years has been the separation of the commissioning process from the delivery function of local health services. To support this change in relation to the commissioning and provision of local NHS Stop Smoking Services, the Tobacco Control NST developed the integrated service framework (ISF), its primary aim being to: (a) illustrate and clarify the responsibilities of commissioners and providers and (b) provide a ‘steer’ to potential service configuration within a local health and social care economy. The ISF exemplifies a ‘whole system’ approach to the delivery of stop smoking advice and support, demonstrating where and how opportunities may be maximised to help smokers to quit.

Analysis of recent Tobacco Control NST visits identified a number of issues undermining the effectiveness of local NHS Stop Smoking Services, predominantly caused by an absence of clarity around responsibility (and consequently underlying systems) for monitoring and evaluating service effectiveness and supporting improvement in activity delivered by commissioned providers. In combination with other guidance (e.g. NHS Stop Smoking Services: Service and monitoring guidance 2010/11), the ISF is an example of how to develop and improve the management of a diverse network of NHS Stop Smoking Service providers.



## SECTION 1 – BACKGROUND TO NATIONAL SUPPORT TEAMS

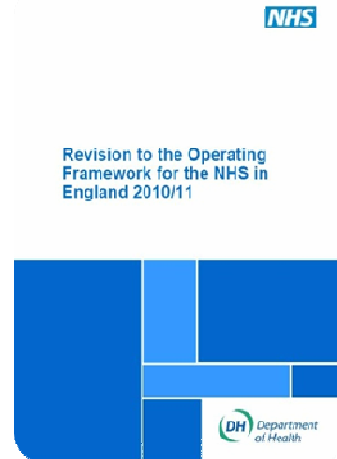
### Background

National Support Teams (NST) were initially established to provide tailored support to local NHS organisations facing the greatest challenge to achieve key deliverables such as orthopaedic and accident and emergency waiting times. Following their success, the Department of Health (DH) determined that such a process had benefit for wider public health and commissioned the provision of NST inputs along specific themes. Public Health NSTs worked on behalf of, and in partnership with, health improvement policy colleagues in DH, regional Government Offices and Strategic Health Authorities to identify and support health economies in England that faced the greatest challenge achieving their local priorities.

Ten NSTs provided tailored support. In order of establishment, they were:

- |                            |  |
|----------------------------|--|
| 1. Sexual Health.          | 7. Infant Mortality.   |
| 2. Tobacco Control.        | 8. Response to Sexual Violence.  |
| 3. Health Inequalities.    | 9. Vaccination and Immunisation.                                       |
| 4. Teenage Pregnancy.      | 10. Children and Young People's Emotional Wellbeing and Mental Health. |
| 5. Childhood Obesity.      |  |
| 6. Alcohol Harm Reduction. |  |

The NST programme offered support to Primary Care Trusts (PCT), local authorities and local health partnerships in their efforts to achieve the key deliverables for public health improvement as outlined in relevant documents including *Choosing Health*, DH national priorities, and the NHS Operating Framework.



The Tobacco Control NST was established to assist partners to reduce the prevalence of smoking through a wide range of tobacco control measures. The Tobacco Control NST used an intelligence-led approach to ensure its diagnostic and support activities were focused in those local areas with most need of support. Nationally recorded performance data for each PCT was gathered and interpreted within the context of 'soft' intelligence provided by local and regional colleagues. This 'dashboard' of data ensured that Tobacco Control NST resources were allocated where they would have the most impact in helping local areas reduce the harm of tobacco use.

## **The NST Process**

The Tobacco Control NST undertook diagnostic visits to PCT areas. Depending on the outcome of pre-visit meetings, the team arranged visits for between 2 – 5 days. During this time a number of discussions with individual stakeholders took place as well as engagement with local partnerships through two multi-agency plenary sessions. These helped the Tobacco Control NST to understand the local context and assess challenges to, and opportunities for, making progress. While a systematic process of enquiry was employed using a framework of key questions, these were designed to be free and frank discussions rather than formal interviews. All information given from these sessions was confidential.

The Tobacco Control NST formulated and presented a report, based on the findings from the interviews, on the final day of the visit. Each report outlined the key strengths of the local health partnerships and provided recommendations to improve delivery. The Tobacco Control NST also identified areas where on-going support was appropriate and returned soon after the visit to discuss the report with the relevant Chief Executive(s) and Director of Public Health to agree which offers of support would assist them most in achieving their local targets.

### *Guiding principles of the NST approach*

An NST visit was **not** an audit, nor was it part of performance management. The NST aims were to:

- Initiate good practice and process.
- Interpret current policy and research within the local context.
- Analyse whole systems approaches and support problem solving.
- Support public health behaviour change.
- Stimulate organisational change.

### *Stakeholder Interviews*

The Tobacco Control NST interviewed a range of local stakeholders during its visits. These took the form of one-to-one interviews, round table discussions, and focus groups depending on the time available and length of visit. Collectively, the team engaged with 20–30 people for the shorter 2-day visits through to around 100 people for the longer 5-day visits. These stakeholders represented a wide variety of local agencies and organisations. Stakeholders were typically Chief Officers, Directors,

senior managers, commissioners, and provider service managers. The NST's accumulation of knowledge through its programme of visits, the expertise it observed of local delivery and the opportunity to affect change is clearly demonstrated in **SECTION 6 – SUMMARY OF LEARNING FROM NST VISITS** starting on page 33 and **SECTION 9 – EVALUATION** starting on page 68.

### *Follow up Support*

The availability of support from the NST following one of its diagnostic visits was just as important as the diagnostic phase of the process. Follow-up support from the Tobacco Control NST was available to all areas that had received a full diagnostic visit. The report presented at the closing plenary included offers of support from both the Tobacco Control NST and the Regional Tobacco Policy Manager. Senior key stakeholders and the local tobacco lead would discuss and agree which offers of support to take forward at a meeting 6-8 weeks after the visit. An action plan was then developed to provide clarity about the support, who would deliver it and when. Typically, support from the NST would last for up to 12 months.

*"The interviewers were well informed and 'spoke my language!'. The team as a whole were professional, motivational, and approachable. Good to see offers of support were made"*

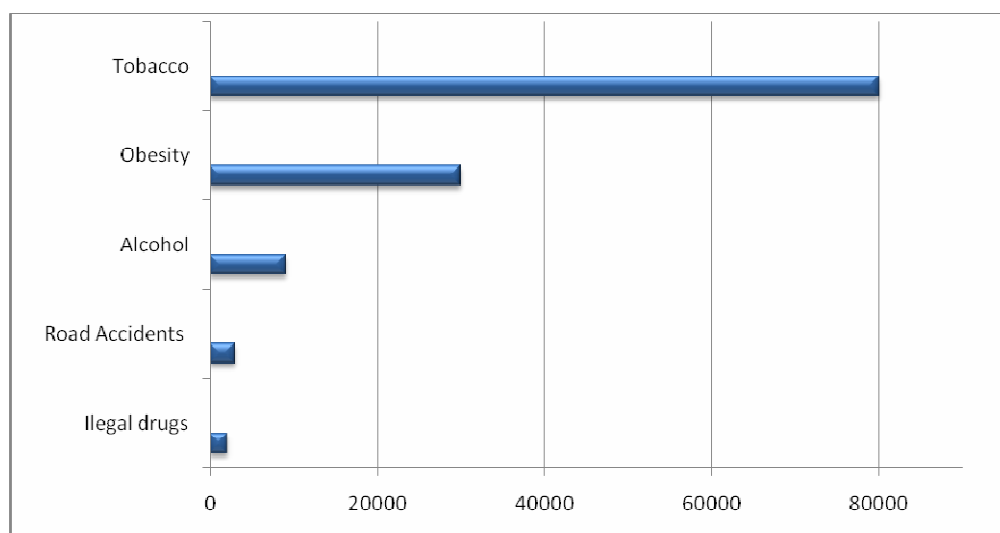
*- Local Authority, East of England*

## SECTION 2 – COMPREHENSIVE TOBACCO CONTROL ACTION

**T**obacco use has an enormous impact on society, not least in terms of ill health, but also economically, socially and environmentally. Smoking remains the single largest cause of preventable mortality in England, a fact recognised in the Government’s Public Health White Paper ‘Healthy lives, healthy people’, which states that ‘reducing smoking rates represents a huge opportunity for public health’<sup>1</sup>. The Government’s commitment to tobacco control is detailed further in ‘Healthy lives, healthy people: a tobacco control plan for England’<sup>2</sup>

The health risks from tobacco smoking are well established and in 2006-07 there were approximately 1.4 million hospital admissions with a primary diagnosis of a disease that can be attributable to smoking<sup>3</sup>. A large part of the population, often concentrated in the most deprived communities, remain exposed to these health risks.

Approximately 8.5 million people in England smoke and about half of all long-term smokers will die from smoking, half of those in middle age. 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 range<sup>4</sup>, and representing more deaths than obesity, alcohol, road traffic accidents, suicide and drug use combined.



**Figure 1 – Major Causes of preventable and premature deaths in the United Kingdom (Department of Health analysis of Office for National Statistics death registrations, 2007.)**

<sup>1</sup> HM Government. Healthy lives, healthy people: our strategy for public health in England. 2010

<sup>2</sup> HM Government. Healthy lives, healthy people: a tobacco control plan for England. 2011.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_124917](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917)

<sup>3</sup> NHS Information Centre, Statistics on Smoking in England, 2009

<sup>4</sup> [http://www.ic.nhs.uk/webfiles/publications/Health%20and%20Lifestyles/Statistics\\_on\\_Smoking\\_2010.pdf](http://www.ic.nhs.uk/webfiles/publications/Health%20and%20Lifestyles/Statistics_on_Smoking_2010.pdf)

Tobacco use is a risk factor for six of the eight leading causes of death in the world. Over a quarter of cancers are attributable to tobacco use; 90% of all lung cancer is caused by smoking. The three most common causes of death from smoking are lung cancer, chronic obstructive pulmonary disease and cardiovascular disease (CVD)<sup>5</sup>

***Cost to Society***

Recorded smoking rates are now lower than they have ever been with 2.4 million fewer smokers than in 1998. This has saved the NHS £385million<sup>6</sup>. Sadly, the individual, social, and human cost of smoking remains high, and the cost of tobacco use to society in England is calculated to be £13.74 billion<sup>7</sup>

**Table 1 – Cost of Tobacco Use in England 2008**

Descriptor	Cost
Health Care Bill	£2.7 billion
Smoking Breaks	£2.9 billion
Increased Absenteeism	£2.5 billion
Productive Loss from Premature Death: Smoker	£4.1 billion
Passive Smoker	£713 million
Smoking Related House Fires	£507 million
Cleaning up Cigarette Butts	£342 million
<b>TOTAL COST</b>	<b>£13.74 BILLION</b>

A smoker will lose an average of 10-years of life. The financial toll of the illicit market results in a loss of £2 billion of lost revenue to the treasury each year.<sup>8</sup> 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 million<sup>9</sup>.

***Smoking and Health Inequalities***

Inequalities in health outcomes between the most affluent and disadvantaged members of society are long standing, deep seated and have proved difficult to change. Tobacco has been called the leading risk factor in terms of the causes of

<sup>5</sup> Source: The NHS information centre of Health and Social Care (2009),Statistic on smoking: England,2009. Available for download from [www.ic.nhs.uk/webfiles/publications/smoking09/statistics\\_on\\_smoking\\_england\\_2009.pdf](http://www.ic.nhs.uk/webfiles/publications/smoking09/statistics_on_smoking_england_2009.pdf)

<sup>6</sup> Source: ASH Beyond Smoking Kills 2008

<sup>7</sup> Source: Henry Featherstone Policy Exchange 2010

<sup>8</sup> Sources: ASH Beyond Smoking Kills 2008; Allender et al, Burden of smoking related ill-health in the UK, 2009

<sup>9</sup> Landman Economics and ASH, The Effects of Increasing Tobacco Taxation: a Cost Benefit and Public Finances Analysis. 2010

health inequalities<sup>10</sup>. In 2003, Wanless highlighted that half the difference in survival to 70 years of age between professional classes and unskilled classes can be attributed to higher rates of smoking in the unskilled groups<sup>11</sup>. This was later echoed by Jarvis and Wardle, who noted that smoking was the biggest single cause of inequalities in death rates between rich and poor in the UK. Smoking accounts for over half of the difference in risk of premature death between social classes<sup>12</sup>.

Smoking levels are therefore of central importance to the reduction of health inequalities because smoking kills tens of thousands each year, many of whom live in deprived areas<sup>13</sup>. This is highlighted by the Marmot review, which points out that tobacco control is central to any strategy to tackle health inequalities because smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups<sup>14</sup>.

A large part of our population remains exposed to these health risks and because smoking follows a social gradient, the impact is disproportionately concentrated in the most deprived communities. People on low income spend proportionally more of their income on tobacco than wealthier people. The cost of maintaining regular smoking, which is currently over £2,000 per year when buying 20 cigarettes each day at typical UK retail prices, is substantial, and this further exacerbates poverty<sup>15</sup>. In 2008, households in the lowest income bracket spent £3.40 per week on cigarettes whilst those in the highest group spent £3.70 per week. This equates to 1.6 percent and 0.4 percent respectively of total weekly household expenditure<sup>16</sup>.

Efforts to address smoking across the social gradient have led to a better understanding of the effectiveness of different interventions. These interventions involve measures at population level to prevent people from starting smoking and helping them to quit, such as smoke free legislation, reducing smuggling, restricting advertising and placement, workplace interventions (for example group therapy), individual counselling, self-help materials, nicotine replacement therapy and social support, and abolishing prescription charges for nicotine replacement therapy<sup>17</sup>. This illustrates that tobacco use, and control, 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.

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<sup>10</sup> National Audit Office. Tackling inequalities in life expectancy in areas with the worst health and deprivation, 2010

<sup>11</sup> Wanless - Securing good health for the whole population (2003)

<sup>12</sup> Jarvis, M. J. and Wardle, J (2005) in Marmot and Wilkinson (eds) Social Determinants of Health.

<sup>13</sup> National Audit Office. Tackling inequalities in life expectancy in areas with the worst health and deprivation, 2010

<sup>14</sup> Marmot, M. et al. Strategic review of health inequalities in England post-2010. Fair Society, Health Lives: The Marmot Review. 2010

<sup>15</sup> Passive Smoking and Children – A report by the Tobacco Advisory Group of the Royal College of Physicians. 2010

<sup>16</sup> ASH. Economics of smoking. 2010

<sup>17</sup> Cahill K, Moher M and Lancaster T (2008) Workplace interventions for smoking cessation. Cochrane Database of Systematic Reviews, Issue 4

### ***Tobacco Control***

The term tobacco control refers to an internationally recognised, evidence-based approach to tackling the harm caused by tobacco. National and International evidence has demonstrated that in order to eliminate the health and economic burden of tobacco use there is a need for a comprehensive mix of educational, clinical, regulatory, economic and social strategies<sup>18</sup>. The ultimate aim of these combined strategies will be the de-normalisation of tobacco use amongst those populations most at risk of tobacco-related harm.

The need for a comprehensive, multi-stranded and sustained programme of tobacco control is recognised in the World Health Organisation's (WHO) Framework Convention for Tobacco Control<sup>19</sup> (FCTC). This is the world's first global public health treaty and was unanimously adopted by the World Health Assembly in 2003. It has since proven to be one of the most rapidly embraced treaties in United Nations history which to date has 168 signatory nations. To provide technical assistance to member states WHO has developed the MPOWER package of measures<sup>20</sup>

#### ***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 use
- E**nforce bans on tobacco advertising, promotion, and sponsorship
- R**aise taxes on tobacco and clamp down on illicit supplies

The UK has signed up to the FCTC, and the MPOWER themes are reflected in the DH's six stranded approach to tobacco:

1. Support smokers to quit.
2. Reduce exposure to second-hand smoke.
3. Run effective communication and education campaigns.
4. Reduce tobacco advertising, marketing and promotion.
5. Regulate tobacco products.
6. Reduce the availability and supply of tobacco products.

'Smoking Kills', the first ever White Paper on smoking<sup>21</sup>, was published in 1998. It laid a clear agenda for tobacco control. Since its publication, significant progress has been made to reduce the harm from tobacco use. Notwithstanding these achievements, the impact of tobacco use is still too great a burden. If local health economies, along with their partners, are to address the health inequalities gap effectively, it is important to implement effective tobacco control. In practice, this has

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<sup>18</sup> US Department of Health and Human Services, Surgeon General Report: Reducing Tobacco Use, 2000

<sup>19</sup> World Health Organisation, WHO Framework Convention on Tobacco Control, 2003

<sup>20</sup> World Health Organisation, WHO report on the Global Tobacco Epidemic 2009: Implementing smoke-free environments, 2009

<sup>21</sup> Smoking Kills: A White Paper on Tobacco. Department of Health. 1998



been 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 (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)<sup>22</sup>.

It is noteworthy that the importance of tobacco control continues to be recognised and that reducing smoking will continue to be a focus for public health. The Government remains committed to creating environments that further discourage smoking and help bring about cultural change to make it less attractive. In March 2011, the Government published 'Healthy lives, healthy people: a tobacco control plan for England.' It sets out how tobacco control will be delivered in the context of the new public health system, focusing in particular on the action that the Government will take nationally over the next five years to drive down the prevalence of smoking and to support comprehensive tobacco control in local areas.<sup>23</sup>

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<sup>22</sup> Roeseler, A and Burns, D. The quarter that changed the world. *Tobacco Control* 2010; 19(Suppl 1):i3-i15.

<sup>23</sup> HM Government. Healthy lives, healthy people: a tobacco control plan for England. 2011. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_124917](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917)



## SECTION 3 – THE TOBACCO CONTROL NST

### *How the NST operated*

The style and nature of an NST input was essentially that of an organisational development approach, with elements of a more technical consultancy skills set where required (often as part of the follow-up support rather than the main visit itself).

The NST approach always aimed to act strategically, and recognised that behaviour change requires attention to whole systems, not just system components. The NST approach is therefore primarily an organisational development approach.

The approach sought to engage, inform, inspire and assist by using the knowledge and experience of experts in the public health and tobacco control field. This was channelled within a systematic technique that:

- Mirrored back to the clients what they had said, with emphasis and understanding of the technicalities of the delivery environment.
- Offered local solutions.
- Secured (and utilised) Director-level 'buy-in'.
- Supported leadership to enact change where appropriate.
- Suggested solutions with potential for wide practical use.
- Provided a whole-system diagnosis.

The NST methodology recognised that only those local areas visited can own and deliver the recommended change(s). The NST acted only as a catalyst for change. However, within this role, the NST provided valuable support to help identify:

- Where to direct effort.
- Where the driving forces were not sufficient to enable change.
- Actions to maximise the likelihood that change will have a sustainable impact on the area's identified outcomes.

The NST offered:

- The listening skills of the NST interviewers.
- Detailed knowledge of applied change models and accredited expertise in management consultancy.
- Emphasis upon systematising and scaling-up to make a real impact.
- Attention to structure and process.

## ***A Comprehensive Guide To Achieving Effective Local Tobacco Control: Evidence, Support & Publications***

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- Engagement at Chief Executive and Director level, to direct their focus on a specific public health topic at greater length and in more depth than would normally be possible.
- Attention to leadership issues.
- Attention to, and expertise in, developing partnership working on public health delivery.
- Specialist expertise in accessing and interpreting both national and international evidence and guidance.
- The ability to accurately ‘mirror back’ the understanding, context and analysis of local stakeholders and provide practical recommendations to resolve these locally identified deficiencies.
- Intensity and clarity of focus.
- Provider service redesign and development.
- Inspirational, energising delivery of input, particularly recommendations.
- Supportive tone, acknowledging strengths but ready to identify/challenge weaknesses and gaps fairly and appropriately.
- Rapid, thorough, interesting feedback that moves the agenda further forward.

### ***Benefits of an NST Visit***

There were a number of benefits to local partnerships and stakeholders from participation in the NST visits. These included:

- Access to expert external support to help diagnose any local obstacles and the opportunities for moving forward.
- Potential access to further support and resources to help with action planning and implementation.
- Help for the PCT and local partnerships in improving and developing their tobacco control strategies, including those relating to stop smoking services and tobacco control alliances.
- Influence in relation to national public health policy in general and development of the NST process across the country.
- Bringing national attention to local examples of good practice, and learning about examples of good practice elsewhere, that can be applied locally.
- Support and engagement with a wide range of partners to help the achievement of shared objectives.

## **Methodology**

### ***The Tobacco Control Diagnostic Model***

The diagnostic and assessment methodology employed by the NST identified potential to improve multi-agency partnership working, commissioning, service

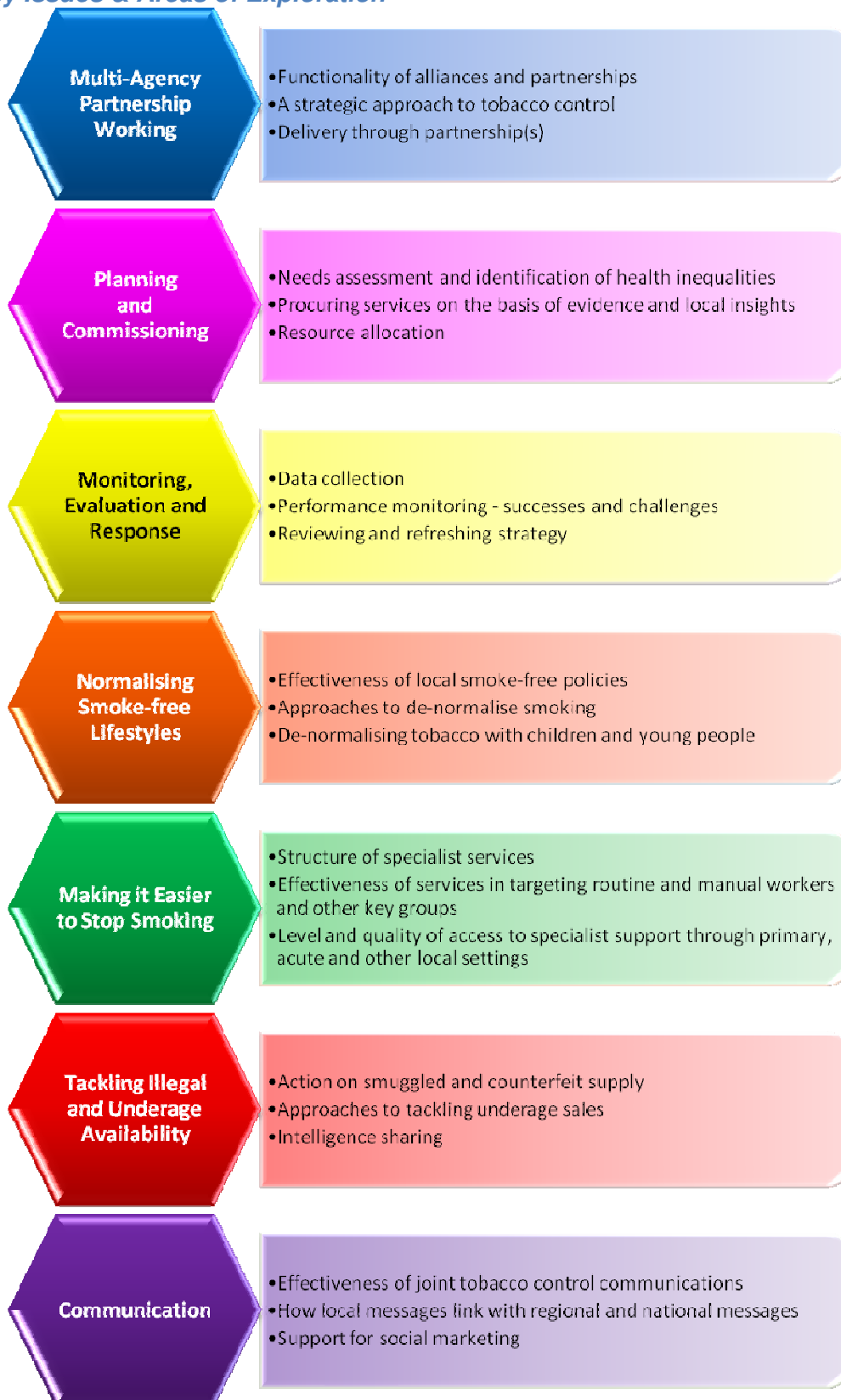
modernisation, and provision to meet local needs. The NST employed a systematic process of enquiry, using a framework of key questions for assessment of local barriers and opportunities for making progress.

A key element of the Tobacco Control NST diagnostic model involved analysing approaches and effectiveness across all of the essential elements of tobacco control at a local level, using an NST Tobacco Control Diagnostic Model based on the DH's 'six strands' model:



**Figure 2 - The Tobacco Control NST Diagnostic Model**

***Key Issues & Areas of Exploration***



### ***Deciding Priorities***

The Tobacco Control NST attempted to effectively target tobacco control interventions on wider health inequalities, ensuring a more consistent cross-NST approach was adopted (e.g. by working in partnership with the Infant Mortality NST). This benefited localities through the service on offer, as well as providing a clear focus for targeting areas of need. As a result, the decision was taken to build on the analytical approach used by the Health Inequalities NST to more clearly identify those local areas facing a clear tobacco control challenge, and that may benefit from Tobacco Control NST input.

Working with the NST analyst team, all Tobacco Control NST and Health Inequalities NST tobacco inputs to date were reviewed and augmented with soft intelligence. In addition, key data were reviewed. This included:

#### Smoking data

- Number of four-week quits per 100,000 population.
- Carbon monoxide validated four-week quit rates.
- Percentage of pregnant women smoking at the time of delivery.

#### Wider Health Issues

- Rate of infant mortality.
- Male life expectancy at birth.
- Female life expectancy at birth.
- Rate of mortality from lung cancer.
- Rate of mortality from all cancers (aged under 75).
- Rate of all cause mortality.

#### Risk Estimates

- Estimated smoking prevalence.
- Proportion of local population that are routine and manual workers.
- Estimated prevalence of stroke.
- Estimated prevalence of hypertension.
- Estimated prevalence of coronary heart disease.
- Estimated prevalence of chronic obstructive pulmonary disease.

This was then developed into a 'dashboard' covering a range of localities which was regularly updated to reflect new data and progress. By conducting this work a list of local areas emerged, with baseline information, that were considered a priority for Tobacco Control NST input.

## **Tobacco Control NST Visit Process**



**Figure 4 – The Tobacco Control NST Visit Process**

## Stakeholder Engagement

The Tobacco Control NST undertook a total of 47 visits to local areas. The table below summarises the number of stakeholders the team met during these visits, along with their organisations.

Table 2 – N° Stakeholders & Organisations with whom the Tobacco Control NST met

Chief Officers	NHS	Local Authority	Other	Police / Fire	Voluntary	Total
87	903	318	36	9	14	1367

These statistics are represented below in percentile format to emphasise the point that effective local tobacco control is a partnership of multiple organisations working together and not solely an issue for the NHS.

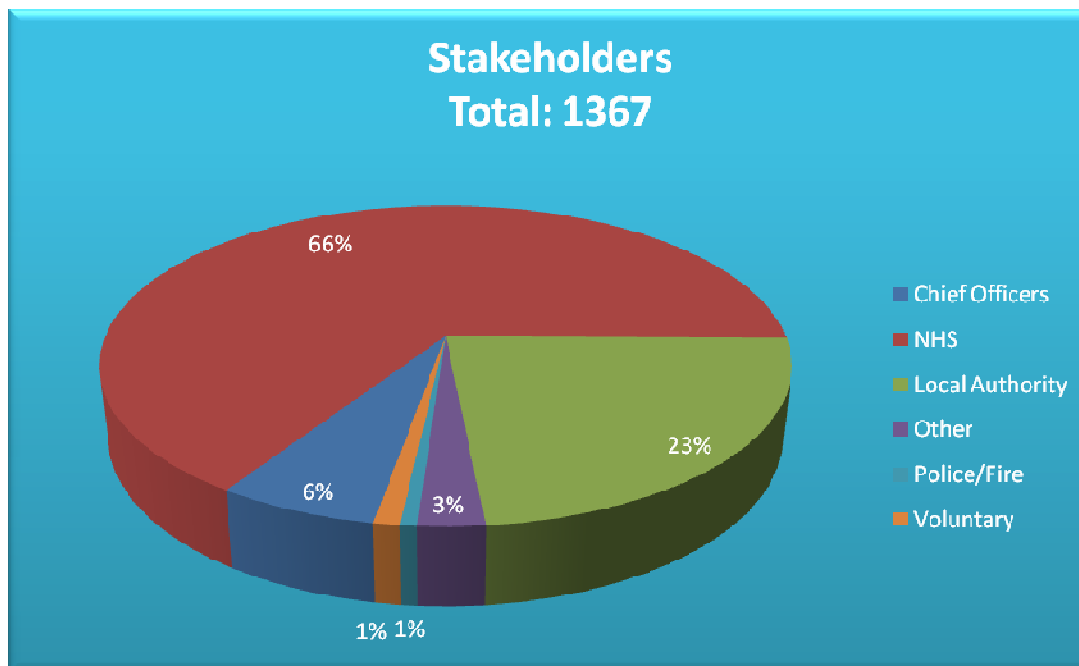


Figure 5 – Stakeholders & Organisations the Tobacco Control NST met

## Typical Examples of Follow-up Support Offers

The Tobacco Control NST provided a range of support offers following a diagnostic visit. The type of support required and subsequently developed was tailored to individual need and agreed at the 6-week follow-up meeting.

An illustrative list of the typical or frequently employed support products is given below.

- Tobacco Control Visioning workshops:

- To enable high level strategic tobacco control stakeholders to develop and own a clear vision for an integrated tobacco control programme, feeding in to action on tackling health inequalities to deliver healthier and more prosperous communities
- To develop a local strategic approach to tobacco control with accountability to a local strategic partnership.
- Tobacco Control Alliance toolkit – in partnership with Regional Tobacco Control Team – to reactivate or develop a Tobacco Control Alliance or revise its functionality and fitness for purpose.
- Action planning workshops:
  - Helping Tobacco Control Alliances and Stop Smoking Services to develop strategic implementation plans.
  - Reconfiguration of local Stop Smoking Services to prepare for modernised delivery at the provider level.
- Commissioning workshop, enabling commissioners to explore different stop smoking service commissioning issues looking at quality, cost effectiveness service and clinical pathways.
- Integrated Services Framework (ISF), designed to enable stakeholders to develop an integrated approach to stop smoking service and tobacco control delivery.
- Critical friend role:
  - Interpret national guidance documents and applying to local challenges.
  - Support strategy formulation and inclusion of tobacco control in high level / long term planning documents.
  - Review training standards and signposting to training provision to redress skills gaps.
  - Review financial commitment to tobacco control.
  - Review and advise on service level agreements and contracts
  - Advice on service evaluation and data analysis.
  - Signposting to areas of good practice and procurement of recommended external expertise.
- Use of external consultants:



- Interim support to turn around stop smoking services or get them back on track where they are not performing as effectively as possible.
- Provide in-house training and help services to develop their own in-house training.
- Source data collection software.
- Support 'face-to-face' initiatives in short term to help services reach targets.
- Facilitate access to support from national social marketing centre.

*"Working as a consultant to the NST is quite demanding - there is a great deal of background information to read, planning for the visit and of course the process of meeting with people on the ground at all levels to help them to clarify what will really make a difference for them and their organization. I bring to the table a detailed understanding of how local authorities can contribute to tobacco control and reducing smoking prevalence based on my own experience as well as the evidence of what makes a difference."*

*A Tobacco Control consultant.*

*"The TCNST was a very positive experience for us, in that the visiting team soon got to grips with the issues we were facing. For example, members of the team facilitated a workshop that introduced the LSSS to the advantages of switching to an integrated service framework model of delivery - by adopting this approach the LSSS have improved both their reach to smokers across the area and the quality of the service. The TCNST also made a series of recommendations which we have put into action. Indeed, as I write this testimonial, [this local] NHS is a top performer in the East of England region in terms of supporting smokers to quit to four weeks. I would like to take this opportunity to thank the TCNST for both their sound advice and active support, it has been a pleasure working in partnership with them."*

*- A Public Health Consultant, East of England*

## SECTION 4 – PARTNERSHIP WORKING ACROSS NSTS

The Tobacco Control NST worked closely with colleagues in other NSTs to provide expert input into complex cross cutting issues. Most notably this was with the Health Inequalities NST and the Infant Mortality NST. The team has also undertaken a joint visit with the Alcohol Harm Reduction NST.

### **Tobacco Control and Health Inequalities NSTs**

In its work with the NHS and wider stakeholders in the local health economy, it was essential to have close collaboration between the NST work streams. The links between the Health Inequalities NST and the Tobacco Control NST, are particularly important as reducing smoking prevalence is crucial to delivering reductions in health inequalities and tackling health problems in poorer communities.

The need to ensure consistency of approach and messaging when working to tackle health inequalities led to the Health Inequalities NST and Tobacco Control NST developing a formal collaborative working agreement in January 2009. This led to a Tobacco Control Associate Delivery Manager joining the Health Inequalities NST full time to co-ordinate activity between the teams, and an identified lead for health inequalities within the Tobacco Control NST. This approach reflected NST values of supportive and joint working, and was of benefit to a range of stakeholders by increasing capacity to work with:

- Local areas to encourage partnership working and performance improvement to achieve local priorities.
- Performance delivery team in assessing progress in performance and in selecting local areas.
- The regions to support their performance improvement role by providing specialist expertise.
- The DH policy teams to ensure support and messaging reflect policy direction.

Tobacco control workshops had always been carried out as part of Health Inequalities NST visits, but the new arrangement ensured that a Tobacco Control NST specialist would always be in a position to facilitate them. This meant that tailored recommendations within the Health Inequalities NST report would more readily reflect current practice and developments within the tobacco control field, and allow more structured follow up to be provided to local areas.

In 2009, seventeen tobacco control workshops were delivered as a part of the Health Inequalities NST diagnostic process. In a piece of work mapping trends and common themes that emerged from these workshops, (*see SECTION 6 – SUMMARY OF LEARNING FROM NST VISITS starting on Page 33*). recommendations from Health Inequalities NST workshops were compared to ‘priority’ take home messages made during Tobacco Control NST visits.

The similarity between workshop recommendations and the 'priority' take home messages, with five of the top six most frequent themes appearing in both NST reports suggests that Health Inequalities NST tobacco control workshops had a high degree of reliability relative to Tobacco Control NST visits when identifying the support needs of local areas.

One of the main aims of the collaborative working agreement was to ensure a consistent service offer which follows the evidence base and is tailored to local need. That both NST inputs were addressing the challenges in local areas with broadly similar proposals for solutions demonstrates that over a period of time consistency steadily improved and aims were achieved.

### **Tobacco Control and Infant Mortality NSTs**

Smoking in pregnancy is a major risk factor for both mother and baby. Babies born to mothers who smoke during pregnancy are more likely to die during the first weeks of life than babies of mothers who do not smoke. Smoking during pregnancy contributes to 6% of all infant deaths.<sup>24</sup>

The impact of reducing smoking in pregnancy and exposure to tobacco smoke may make one the biggest short term contributions to reducing infant mortality. The development of comprehensive tobacco control strategies that de-normalise smoking and focus on the development of innovative and targeted services in the antenatal and postnatal period are both essential to help reduce inequalities in infant mortality.

The Infant Mortality NST was launched in April 2009 and immediately established collaborative working arrangements with the Tobacco Control NST, in order to maximise impact and consistency of message and support to local areas and make best use of organisational expertise and resources.

The working approach included a combination of facilitation of small group discussion workshops during infant mortality visits and appropriate support provided through follow up arrangements. The Tobacco Control NST has been involved in 18 of the infant mortality team visits to local areas.

### **Joint Tobacco Control and Alcohol Harm Reduction NST visit to Tameside**

In June 2009, the Alcohol Harm Reduction and Tobacco Control NSTs conducted a joint visit to Tameside and Glossop. Both teams identified Tameside and Glossop as an area that may benefit from a visit in both topic areas. A pre-visit

*"I found the work of the NST immensely valuable and the input from the individuals in the team quite inspiring. Thank you for your input to Tameside and Glossop on tobacco control which had a huge impact on taking forward our local strategy."*

*A Director of Public Health, North West*

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<sup>24</sup> Our Health and Wellbeing Today. HM Government, 2010. DH analysis of infant mortality statistics and data on prevalence of risk factors – percentages relate to population attributable fractions.

telephone meeting with the Chief Executive of NHS Tameside and Glossop confirmed that a joint approach would be both beneficial and timely in terms of supporting local improvement in both topic areas.

The teams developed a joint diagnostic model, using the central spine to assess partnership and strategy, commissioning and data; and 4 sub-themes which adequately reflected the tobacco control and alcohol harm reduction agendas. The visit was conducted over 4½ days and proved to be a highly valuable and positive experience for both the local area and the two teams involved

## **Joint Tobacco Control NST and Regional Support Team visit**

In July 2010, the Tobacco Control NST and the East Midlands Regional Health Inequality Support Team conducted a joint visit to Leicestershire and Rutland. Prior to the visit the teams met together to develop a joint diagnostic model and decided to utilise the Health Inequalities NST's model but with a heavy emphasis on tobacco control throughout and the addition of a tobacco control workshop.

The visit took place over 4 days and evaluation from the delegates at the closing plenary proved that it had been a positive experience for the local area.

*"I found the whole process both supportive and constructive. In particular, the Tobacco Control workshop was extremely well facilitated by Gail Addison, with colleagues feeling she really captured the detail of what was and wasn't happening. I also felt very comfortable in my one to one interview and found this a very positive experience. The feedback and recommendations made by your team will be extremely helpful in taking things forward."*

*A Stop Smoking Service Manager, East Midlands*

Following the visit, the Regional Health Inequality Support Team conducted a separate analysis of the joint visit experience, identifying a number of key lessons and themes.

### *Regional Health Inequality Support Team Evaluation*

*"Overall, this was a successful visit, with positive feedback from the evaluation forms, and directly from the PCT. The hybrid visit format was complex, and brought together different styles of working, combined with a relatively new regional team – and while this created challenges, it also provided a productive learning and working environment."*

## SECTION 5 –TOBACCO CONTROL NST PUBLICATIONS & PRODUCTS

### Publications & Products

The Tobacco Control NST has published and contributed to several products to assist workers in the field:

- 10 High Impact Changes
- Integrated Services Framework
- Partnership working for Tobacco Control
- Targeting Routine & Manual Smokers
- Learning from National Support Team visits: Tobacco Control NST (Parts 1 & 2).
- NST Commended Public Health Practice.

A summary of each along with details of where a full copy can be downloaded in portable document format (PDF) follows:



#### ***Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control. An evidence-based resource for local Alliances***

Whilst there is robust evidence about the effectiveness of tobacco control, at a local level there are still questions about translating this into practice and help to implement their tobacco control work.



This led to the decision to produce a High Impact Changes (HIC) document for tobacco control. The document was produced as a practical guide aimed at local tobacco control leads and other interested organisations that have direct or indirect responsibility in relation to tobacco control and the impact of tobacco use. It is essential that tobacco control is not perceived as being solely the responsibility of the health sector; it is a multi-sectoral concern and needs to be everyone's business. It represents a 'how to' manual, designed to assist, guide, inspire and ultimately lead to public health gains across communities by strengthening the ability and capacity

for local tobacco control to make change happen. It was developed in collaboration with frontline staff for frontline staff and was subject to widespread and rigorous consultation with those working in tobacco control.

A specific message was included to convey to senior decision makers, such as Local Authority Chief Executives, Directors of Public Health, and Elected members, that they have an essential role to play. They, and indeed anyone who has a leadership role within local communities, can ensure that a strategic approach to tobacco control is achieved by recognizing the impact of this issue on local communities and providing effective leadership. Effective tobacco control needs to be driven by local priorities, local action and local leadership.

***Cumbria Case Study  
Tobacco Control & NHS Stop Smoking Service***

*The original visit to Cumbria took place in September 2007 with main take home messages around the need to address comprehensive Tobacco Control through a strategic approach, and to ensure turnaround of NHS SSS.*

*Follow up support took place over a number of months, initially beginning with attendance at the meeting of the Tobacco Control Alliance, followed by advice on membership, High Impact Changes and subsequent support and presentation at Alliance meeting.*

*In addition, admin support was funded for the SSS for a period of 2 months from Tobacco Control NST budget to aid turnaround activity, and a consultant was commissioned to support the service short term. A hub and spoke workshop for the service was facilitated by the ADM, and while sign off came in July 2008, communication remained open between ADM and Associate DPH. Further support was provided on short term recovery activities for SSS was provided more recently.*

*The Associate DPH recently contacted Tobacco Control NST to confirm that Cumbria had met not only its Vital Signs and NI 123 targets, but also the 3 Year LAA stretch target, a process she felt started with the Tobacco Control NST visit. The support from Tobacco Control NST was described as timely, thorough and extremely helpful, with the supportive, but challenging approach ensuring honest dialogue. This in turn secured senior support for increased resource, strong performance management of the SSS, and provided a mandate for strengthened cross-sector working at senior level on wider tobacco control.*

**The 10 High Impact Changes in summary:**

**1. Work In Partnership**

**Case Study**

*NHS Cambridgeshire was visited by the TCNST in March 2009 – at the time of the visit Cambridgeshire was in the process of splitting from a joint Peterborough/Cambridgeshire Tobacco Control (TC) Alliance and a Cambridgeshire specific alliance was beginning to form.*

*The TCNST made several recommendations in its report in relation to wider TC and the emerging Alliance. The recommendations called for a strategic approach to TC with high-level board support and the development of a TC Alliance plan, which was both prioritised and evidence based.*

*To support these recommendations, members of the TCNST facilitated 2 TC Alliance workshops. The first workshop in the summer of 2009 looked at the alliance membership and which TC themes we could as an area be concentrating on. The result of this workshop was the development of a TC action plan, which identified 4 key themes; normalising SF, communication, strengthening the role and function of the alliance and tackling illicit tobacco.*

*At our 6-month post visit review meeting with the TCNST, we discussed the possibility of another TC workshop that would aim to refine the action plan and ensure it was in line with the East of England TC Strategy. This workshop took place in March of 2010 and resulted in the development of a locally owned TC Strategy and refined action plan. Again, this was facilitated by the TCNST who ensured that the Regional Tobacco Policy Manager was present so that our strategy reinforced the priorities in the East of England TC Strategy.*

**2. Gather and Use the Full Range of Data to Inform Tobacco Control.**

**3. Use Tobacco Control to Tackle Health Inequalities.**

*“Working with the NST has been a very useful stimulus to get Inequalities mainstreamed into the PCT agenda. The combination of external scrutiny and practical support has been a powerful twin approach to engineer organisational change. Handling the relationships with key leaders and decision makers is core to this, alongside the work with clinicians and public health. The how-to guides and master classes have helped provide concrete examples of what can be done.”*

*- A Director of Public Health, North East*

**4. Deliver Consistent, Coherent and Co-ordinated Communications.**



## **5. An Integrated Stop Smoking Approach.**

*"In addition to supporting NHS Sheffield to commission a 'fit for purpose' Stop Smoking Service, the NST was invited to facilitate the Alliance self assessment.*

*NHS Sheffield exceeded its 2009/10 stop smoking quitters target and in July 2010 the new service was successfully awarded to a external NHS provider in the Yorkshire and Humber region.*

*In addition, the NST was invited to facilitate the Alliance annual self-assessment in November 2009. This meeting enabled the partnership to re-examine its governance framework, including membership of key players, priorities and accountability to the Local Strategic Partnership, Sheffield First. This in turn enabled a more systematic and comprehensive update of the action plan for tobacco control.*

*The Consultant in Public Health responsible for commissioning tobacco control remarked that the flexible and expert advice and support from the NST had been an invaluable resource, particularly with regard to achievement of quit targets whilst undergoing service transition."*

*- A Consultant in Public Health Medicine, Yorkshire and the Humber*

## **6. Build and Sustain Capacity in Tobacco Control.**

### **7. Tackle Cheap and Illicit Tobacco.**

### **8. Influence Change Through Advocacy.**

### **9. Helping Young People to be Tobacco Free.**

### **10. Maintain and Promote Smokefree Environments.**

This document is available for download in PDF from the following location:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_084847](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084847)

### ***Partnership Working for Tobacco Control***

High Impact Change 1 focused on the importance of multi-agency partnership working in order to tackle the tobacco problem. It was noted that this requires strong strategic leadership, positioning within the locality accountability framework, resource for co-ordination, and a clear mandate for partners to act on tobacco. In the time since the publication of 'Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control', this particular issue has been highlighted frequently during Tobacco Control NST input with local areas. One of the most common key recommendations following a visit has been in relation to the development of a comprehensive approach to tobacco control through multi-agency partnership working.

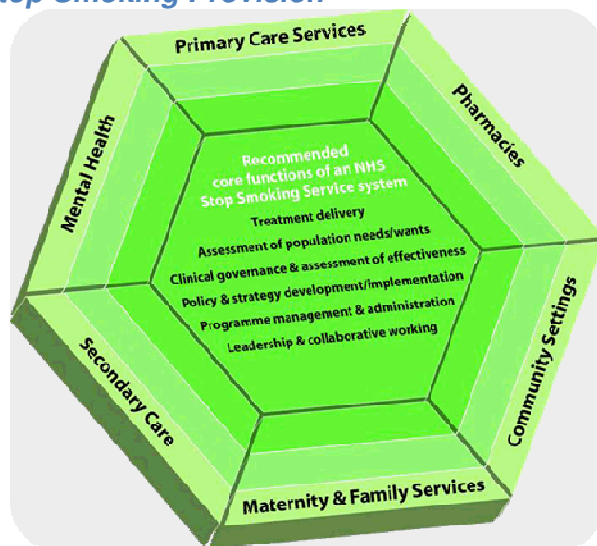
This trend in local need was corroborated by a systematic analysis of the recommendations made in visit and workshop reports. These reports highlighted a need for local stakeholders to develop a better understanding of the rationale for



prioritising tobacco control, alongside the need to adopt a strategic, multi-agency approach to deliver this priority. Specific sub-themes underlying these broader recommendations emphasised a need for improved: ‘vision’; partnership structures (e.g. Alliances); strategy; and high level ownership and accountability. In addition, a recent stakeholder evaluation reported that the NST process helped to raise the profile of tobacco control within partner organisations (96% of respondents) as well as improve multi-agency working (88% of respondents) . This led to the decision to revisit HIC 1 with a view to building further on this and examining some examples of functioning tobacco control partnerships. Partnership working for Tobacco Control is included within this document in **SECTION 7– PARTNERSHIP WORKING FOR TOBACCO CONTROL** starting on page 38.

### *Integrated Services Framework for Stop Smoking Provision*

The Integrated Services Framework (ISF) was launched at the 2009 United Kingdom National Smoking Cessation Conference (UKNSCC). The ISF is a tool designed to help commissioners and providers think through the configuration of their local stop smoking provision across a range of potential settings. The ISF model builds upon an earlier iteration of stop smoking service delivery (i.e. ‘hub and spoke’). This revised version of the ‘hub and spoke’ model emphasises the different layers of support that can be made available to smokers. They range from brief advice through to intensive support and incorporate the different functions that need to be carried out within a ‘whole system’ approach to stop smoking support. The model also captures the different roles and responsibilities that both commissioners and providers are recommended to adopt so that the system operates most effectively in order to provide quality evidence based support for smokers who wish to quit. The ISF is included within this document as **SECTION 8 – INTEGRATED SERVICES FRAMEWORK (ISF) FOR STOP SMOKING PROVISION** starting on page 52.

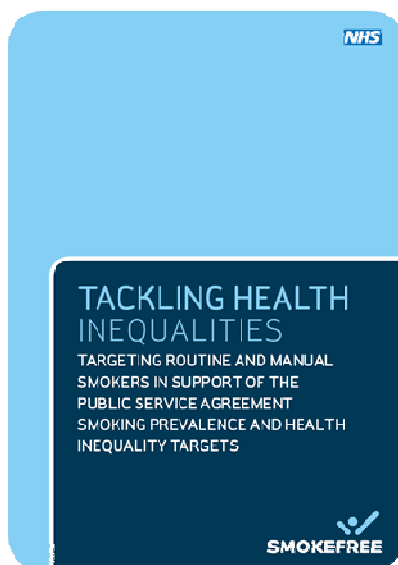


### **Case Study**

*Great Yarmouth and Waveney was visited by the TCNST in November 2009 – at that time the LSSS had been through some difficult reorganisations and was about to adopt the ‘Hub and Spoke’ approach to target and support smokers to quit.*

*During the visit process the TCNST introduced us to the latest iteration of the Hub and Spoke model and explained that due to the current commissioner / provider split the Integrated Service Framework (ISF) approach would enable the LSSS to function more effectively in terms of extending their reach and improving the quality of the service they offered. In addition, it would also allow the commissioners to concentrate on their role and functions to ensure the service was properly commissioned and supported to achieve target.*

*After the visit, members of the TCNST facilitated an ISF workshop, which was represented by both the commissioners and members of the LSSS. This resulted in the development of a specific Great Yarmouth and Waveney ISF product, which is now implemented and has had a really positive impact. NHS Great Yarmouth and Waveney successfully exceeded its 4-week quit target in 2009/10 by 130% and currently this trend (in 2010/11) looks likely to continue.*



### **Tackling Health Inequalities – Targeting Routine and Manual Smokers in Support of the Public Service Agreement Smoking Prevalence and Health Inequality Targets’**

Designed to complement the NHS Stop Smoking Service and Monitoring Guidance 2009/10, this document provides the rationale for reducing local health inequalities by targeting stop smoking service interventions within routine and manual (R&M) communities.

The document was intended to be used at a locality level and provides practical recommendations for PCT commissioners and providers, local authorities and the third sector in order to enable them to translate government policy into effective action.

Prior to it being published, insight from local areas suggested that there was confusion as to which smokers belonged to the R&M group – therefore it was crucial to provide a clear definition about who

was included and who was not.

The document also provided local areas with a clear explanation of why targeting R&M smokers would ultimately help other harder to reach smokers to quit, highlighting that:

- R&M smokers account for approx 50% of all smokers.
- They will engage with NHS services.

- Because a third of smokers in the R&M group live in the most deprived 20% of areas, helping them to quit will also help de-normalise smoking in these areas and make it easier for harder to reach groups to quit in the future.

Finally, the document reminded local stakeholders that NHS Stop Smoking Services cannot operate in isolation when targeting smokers in the R&M group and encouraged local areas to develop a comprehensive approach to tobacco control.

This guidance was launched at the UKNSCC and at ASH Wales in 2009, and has been extensively utilised by local authorities participating in the IDeA funded tobacco control programme and NHS Stop Smoking Services.

This 15-page document is available for download in PDF from the following location:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_101224](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101224)



***Learning for National Support Team visits: Tobacco Control NST (Parts 1 & 2).***

Since the inception of the Public Health NST programme, 480 diagnostic visits have been conducted in local areas across England. During this time the NSTs have accumulated an array of knowledge around ‘what works’ and ‘what could be improved’ in relation to local delivery of health improvement initiatives.

Published in 2010, these documents were developed to provide an overview of the most common tobacco control recommendations made by the Tobacco Control NST and Health Inequalities and Infant Mortality NST tobacco control workshops. By systematically analysing and coding visit and workshop reports it was possible to identify specific aspects of local tobacco control working in which there is an obvious gap between what is needed and what is being achieved locally. These documents are a useful tool for enabling commissioners to recognize and pre-empt potential risks to the key strategic and

organisational components essential to the delivery of any local tobacco control strategy.

A summary of the finding from these reports is provided in **SECTION 6 – SUMMARY OF LEARNING FROM NST VISITS** starting on page 33 and both reports are available for download in PDFs from the following location: <http://www.dh.gov.uk/nst>

***Commendable Practice Identified by National Support Teams***

England has some of the most innovative and effective local tobacco control initiatives in the world. Unfortunately, there is often neither the time, resources or systems in place to effectively share local 'best practice' with other commissioners and practitioners throughout the country. The creation of Public Health England will hopefully go some way towards remedying this by providing a centralised repository for health improvement evidence and practice.

As part of the NST diagnostic and support process, 'commendable' public health practices are identified, catalogued and shared with local areas. This document provides a number of case studies of innovative and effective practices identified by the Tobacco Control NST. Utilising the NST model of integrated tobacco control as a framework, this guide is intended to complement '*Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control*' and provide local commissioners and providers with practical suggestions on how to best implement their own local tobacco control initiatives.

This document is available for download in PDF from the following location:

<http://www.dh.gov.uk/nst>

## SECTION 6 – SUMMARY OF LEARNING FROM NST VISITS

Over the course of the Public Health NST programme, the Tobacco Control NST acquired a significant amount of insight into the reality of delivering tobacco control at a local level.

In an effort to utilise this knowledge, a project was undertaken to catalogue and evaluate information acquired through the NST diagnostic process by coding visit recommendations to identify common barriers to the successful implementation of local tobacco control.

### **Method**

Recommendations produced by NSTs are presented under a small number of main ‘theme’ headings (e.g. Communications; Data). The complete range of generic themes utilised by all NSTs can be seen in Table 3 below. A ‘grounded theory’ approach was then adopted, whereby NST staff analysed visit reports to identify sub-themes within the main themes. The number of sub-themes was found to vary for each main theme. In order to account for Tobacco Control NST topic-specificity, two unique tobacco-related main themes (and sub-themes) were also identified: stop smoking services and tobacco control.

**Table 3 – Main themes developed to code NST recommendations**

Vision	Local leadership
Strategy and Performance	Commissioning
Data	Evaluation
Organisational & partnership arrangements	Communications and social marketing
Training	Access
Targets	Resources
High Impact Changes	Guidelines
Community Engagement	Determinants of Health

Following the creation of sub-themes, recommendations were systematically coded for a sample of Tobacco Control NST visits and tobacco control workshops, conducted as part of Health Inequalities and Infant Mortality NST diagnostic visits.

### **Tobacco Control NST: ‘Top 5 Take Home Messages’**

Twenty-four visit reports were examined, covering all visits undertaken by the Tobacco Control NST between January 2008 and December 2009. Every Tobacco Control NST report includes a section titled ‘top five take home messages’ – these

***A Comprehensive Guide To Achieving Effective Local Tobacco Control: Evidence, Support & Publications***

are five priority recommendations that reflect the areas of most need, highlighting ‘must do’ actions if the local area is to progress the tobacco control agenda. Table 4 below illustrates the relative frequency of the six most common themes identified as a priority recommendation.

**Table 4 – Summary of key themes to emerge from Tobacco Control NST priority recommendations**

<b>Main themes</b>	<b>Frequency (%)</b>	<b>Sub-themes (n)</b>
<b>Strategy and performance</b>	23 (96%)	46
<b>Commissioning</b>	21 (88%)	39
<b>Organisational/Partnership</b>	19 (79%)	26
<b>Stop Smoking Services</b>	18 (75%)	21
<b>Social Marketing and Communications</b>	13 (54%)	21
<b>Vision</b>	12 (50%)	14

1. Strategy and Performance: Main recommendation types related to the development of strategies and action plans for tobacco control, and improved accountability and performance management arrangements within the Local Strategic Partnership.
2. Commissioning: The main sub-themes to emerge were the improvement of commissioning arrangements, the development of commissioning frameworks, and the integration of commissioned services.
3. Organisational and Partnership Arrangements: Key issues that emerged were the need to improve tobacco control partnerships, and to broaden the range of partners within local Tobacco Control Alliances.
4. Stop Smoking Services: The majority of recommendations related to a general need to develop or consolidate the provider(s) of NHS Stop Smoking Services, or to undertake a review of the existing provider services.
5. Social marketing and Communications: Particularly the development of communications strategies and the improved application of the principles of social marketing,
6. Vision: Principally the need to win ‘hearts and minds’ to tobacco control, with the overall aim of making tobacco control ‘everybody’s business’.

## Health Inequalities NST tobacco control workshops

Between January 2009 and December 2009, the Health Inequalities NST visited 23 local areas. In 17 visits, a tobacco control workshop was requested and delivered as part of the diagnostic process, incorporating 275 recommendations (mean = 16). After comparing the frequency with which the 'main themes' appeared in Health Inequalities Tobacco Control recommendations, six principle themes emerged (see Table 5 below).

Table 5 – Summary of key themes emerging from Health Inequalities tobacco control workshops

Main Themes	Frequency (%)	Sub-themes (N°)
<b>Strategy and Performance</b>	17 (100%)	47
<b>Stop Smoking Services</b>	17 (100%)	44
<b>Organisational / Partnership Arrangements</b>	17 (100%)	31
<b>Social Marketing and Communications</b>	16 (94%)	49
<b>Tobacco Control</b>	15 (88%)	29
<b>Vision</b>	14 (82%)	22

1. Strategy and performance: Main recommendation types related to the need to develop a more strategic approach and improve accountability and performance management arrangements.
2. Stop Smoking Services: In relation to clinical services, the most common recommendation type related to better targeting resources at populations with most need.
3. Organisational and partnership arrangements: Key issues to emerge within the heading related to the need for a broader range of partners and a more appropriate organisational structure for delivering the tobacco control agenda.
4. Social marketing and communications: A common finding was a lack of an adequate communications strategy and poor internal communication between partners.
5. Tobacco control: In a majority of reports at least one recommendation was made regarding the need for a more comprehensive approach to tackling the impact of illicit tobacco or exposure to second hand smoke.

6. Vision: The least common theme, recommendations generally related to the need to 'win hearts and minds' towards the issue of tobacco control.

### **Infant Mortality NST 'Smoking in Pregnancy' workshops**

Between January 2009 and December 2009, the Infant Mortality NST visited 13 local areas and delivered 13 Smoking in Pregnancy (SiP) workshops resulting in a total of 91 distinct recommendations (mean = 7). Table 6 below shows the relative frequency of the six most common themes and also indicates the total number of unique sub-themes found within the workshop reports.

**Table 6 – Summary of key themes emerging from Infant Mortality SiP workshops**

<b>Main Themes</b>	<b>Frequency (%)</b>	<b>Sub-themes (n)</b>
<b>Data</b>	10 (77%)	14
<b>Training</b>	9 (69%)	14
<b>Stop Smoking Service</b>	9 (69%)	14
<b>Commissioning</b>	8 (62%)	12
<b>Strategy and Performance</b>	7 (54%)	10
<b>Resources</b>	6 (46%)	8

1. Data: In terms of Data, the main recommendation types often related to a need for local areas to undertake more robust data analyses to inform programme development, as well as better linking and sharing of data between partners.
2. Training: Smoking in Pregnancy workshops often identified an inadequate strategic approach to the delivery of training relevant to smoking in pregnancy.
3. Stop Smoking Services: A common theme within these workshops was a need to review the existing service model and also to explore opportunities for improving access to smoking cessation medication.
4. Commissioning: In terms of commissioning, the main sub-themes to emerge were the need to improve commissioning arrangements and to better performance manage providers.
5. Strategy and Performance: Unlike the Health Inequalities workshop, the main recommendation around strategy and performance related to a need to 'scale up' the amount of smoking in pregnancy activity.



6. Resources: A review of existing service capacity was a common recommendation, alongside a review of funding to establish if resources are commensurate with need.

## **Conclusion**

This retrospective analysis of NST recommendations has helped identify a number of barriers common to local areas struggling to successfully implement an integrated approach to tobacco control. Of particular note is the high level of consistency observed between recommendations made by the Tobacco Control NST and the Health Inequalities NST. Despite using different diagnostic techniques (e.g. full visit vs. workshop), both teams identified very similar issues across a diverse range of local areas.

Interpretation of these findings suggest that for many local areas there remains a degree of unmet need, particularly in relation to 'Strategy and Performance', 'Organisation and Partnerships' and 'Commissioning/Stop Smoking Services'. Based on this learning, the Tobacco Control NST developed the following sections to explore Partnership Working for Tobacco Control and Integrated Services Framework for Stop Smoking Provision.

## SECTION 7 – PARTNERSHIP WORKING FOR TOBACCO CONTROL

### **Rationale**

In *Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control*, the Tobacco Control NST identified High Impact Change number 1 as Working in Partnership. This reflected the need to see the reduction of tobacco-related harm as not ‘just’ being the domain of the health sector, but a multi-sectoral concern that needs to be everyone’s business. For example, Local Authorities, NHS trusts, PCTs, the Fire Service, and Voluntary Organisations.

The Tobacco Control NST diagnostic process regularly identified issues associated with the effectiveness of local partnership working. This often resulted in offers of further NST support such as workshops and events, their aim being to assist local areas to set up Tobacco Control Alliances, review existing partnerships or develop a shared vision.

This trend in local need was further corroborated by a systematic analysis of the recommendations made in visit and workshop reports (see **SECTION 6 – SUMMARY OF LEARNING FROM NST VISITS**, Table 4 & Table 5 starting on page 34). These reports highlighted a need for local stakeholders to develop a better understanding of the rationale for prioritising tobacco control, alongside the need to adopt a strategic, multi-agency approach to deliver this priority. Specific sub-themes underlying these broader recommendations emphasised a need for improved: ‘vision’; partnership structures (e.g. Alliances); strategy; and high level ownership and accountability.

Given the importance of developing a strategic multi-agency approach to the delivery of tobacco control, the NST prioritised the development of resources aimed at helping local areas to adopt such an approach (e.g. Tobacco Control Alliance workshops). Indeed, a recent stakeholder evaluation reported that the NST process helped to raise the profile of tobacco control within partner organisations (96% of respondents) as well as improve multi-agency working (88% of respondents)<sup>25</sup>

Using insight and intelligence gathered by the Tobacco Control NST, this section aims to help local areas strengthen their strategic and multi-agency approach to the delivery of tobacco control.

### **Aim**

While there are many resources available in relation to partnership working, the Tobacco Control NST often found that local areas continue to highlight tobacco control as a top priority, but found maintaining this focus through a time of change and system reform is difficult. Since the publication of *Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control*, the Tobacco Control NST gained further insight into the importance of partnership working for achieving effective local tobacco control. The overall aim of this document is to engage key

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<sup>25</sup> ‘Evaluation of National Support Teams: Summary of Overall Findings

decision makers and to guide them in developing a strategic approach to tobacco control through partnership working. From this fall four objectives:

- To build upon *'Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control'* and specifically High Impact Change 1 (HIC 1) – *Work in Partnership*. The intention here is to demonstrate the rationale for and benefits of tobacco control, while also offering some practical advice on how to achieve this.
- To raise the level of priority given to comprehensive tobacco control and the role of partnership working to achieve this end. To acknowledge that while this may be challenging, the benefits it brings far out weigh any difficulties individuals or organisations anticipate.
- To utilise the checklist originally written for HIC 1, a number of existing tobacco control partnerships will be examined to identify the traits that successful partnerships demonstrate.
- While the target audience is anyone interested or working in tobacco control, this section is presented using sector neutral terminology in the hope this will ease the transition of the majority of current tobacco control partnerships (mainly led by public health within Primary Care Trusts) into local authority settings.

## Working in Partnership

Even though there has been a decline in prevalence, smoking remains at epidemic proportions in this country. There is robust evidence about the effectiveness of comprehensive tobacco control, but at local level there are still questions about translating this into practice. This is what led the Tobacco Control NST to publish *'Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control'*, to help guide the development of evidence based action for maximum impact on smoking prevalence within local communities through effective multi-agency Tobacco Control Alliances and partnerships. The need for collaborative working to achieve comprehensive tobacco control is clearly articulated within the FCTC, which highlights the need for capacity building to carry out effective and sustainable tobacco control programmes, and that effective implementation will require the involvement of many sectors of government and civil society<sup>26</sup>.

This approach was endorsed by the working group of experts who gathered to consider which high impact changes should be included in the 2008 document. It is no coincidence that working in partnership became HIC 1, because without this, the other HICs cannot be effectively implemented, due to the cross-cutting nature of the impact of tobacco, and the need for a cross-cutting response. As illustrated by the different strands of tobacco control, many different agencies must work in partnership to provide a coherent response. The need for partnership working as part of the social norm change approach to tobacco control is also recognised within the exemplar California Tobacco Control Programme, which highlights the

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<sup>26</sup> World Health Organisation. WHO Framework Convention on Tobacco Control. 2003

importance of building local coalitions, and notes that working in partnership lowers the cost and effort for others to opt in to social norm change strategies.<sup>27</sup>

This view has been strongly reinforced through the practical experience of the Tobacco Control NST in visiting many localities. The importance of working in partnership continues to be clearly recognised in important publications and is within the thinking of the current Government. This is perhaps most clearly articulated by the desire to expand the role of local authorities to promote local wellbeing, to empower local leadership and encourage wide responsibility across society to improve everyone's health and wellbeing, and tackle the wider factors that influence it<sup>28</sup>. This recognises the scope for stronger institutional arrangements, led by elected members, to support partnership working across health and social care, and public health<sup>29</sup>.

Bearing in mind the important impact of tobacco on health inequalities, it is also worth noting that the Marmot report on tackling health inequalities, Fair society, Healthy Lives,<sup>30</sup> suggests there is good evidence that partnership working between primary care, local authorities and the third sector to deliver effective universal and targeted preventive interventions can bring important benefits. As previously highlighted by the Tobacco Control NST, Marmot also acknowledges that local level progress in delivering has been inconsistent, partly as a result of some significant limitations in local delivery organisations, funding and difficulties with partnership working. Interestingly, Fair Society, Healthy Lives also states:

*'There are lessons to be learnt from the failure of some key stakeholders to give partnership working the priority it needs to be successful. These include significant variation in engaging the senior personnel necessary to deliver effective partnership and strategic change and a corresponding lack of commitment to drive forward and tackle the very challenging issue of health inequalities'.*

*"The challenge is to move beyond simple co-operation and co-ordination to create a spirit of collaboration and partnership to address tobacco as a community issue. Several factors support successful collaborations, including mutual trust, shared decision making, open communication, and having a skilled convener."*

*Winer, M.B and Ray, K.L  
(1994) Collaboration Handbook - creating, sustaining and enjoying the journey, St. Paul, MN:  
Amherst.H Wilder Foundation*

The phrase *'no one can do everything but everyone can do something'* is entirely relevant to the discipline of tobacco control, where the full benefits of a

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<sup>27</sup> The quarter that changed the world. Roeseler, A and Burns, D. Tobacco Control 2010 19: i3-i15

<sup>28</sup> HM Government. Healthy Lives, Healthy People: our strategy for public health in England. 2010

<sup>29</sup> Consultation on democratic legitimacy 2010

<sup>30</sup> Fair Society, Healthy Lives 2010

comprehensive programme are only realised through partnership working across all levels. Effective tobacco control is built on teamwork and a diverse range of skills. At a local level it requires a strategic approach with board level support from PCTs, local authorities and others on Local Strategic Partnerships. Multi-sectoral working of this kind requires input from statutory, voluntary and business sector partners. In other words, a comprehensive tobacco control programme will involve multiple agencies and a clear commitment from senior officers at each partner organisation. This will be made easier with the transfer of local health improvement functions to local government, and the establishment of local statutory health and wellbeing boards, bringing together the key NHS, public health and social care leaders in each local authority area to work in partnership<sup>31</sup>.

### *The role of senior leaders*

Tobacco Control NST experience has shown that the potential to reduce the harmful effects of smoking and reduce prevalence within local communities is limited without the energy, vitality and backing of senior level personnel who have the ability to:

- Put in place a sound local infrastructure and dedicated resources.
- Drive capacity building where required.
- Identify the overlap between national targets and local aspirations, translating tobacco control evidence into prioritised local action.
- Promote interagency collaboration by sponsoring activity at organisational level.
- Provide the political will, strategic thinking and high level recognition that tackling smoking is a priority.
- Show a willingness to help overcome issues that arise as part of local tobacco control work.
- Demonstrate unquestionable commitment to a comprehensive tobacco control programme.

This need for senior level strategic leadership is reflected in the Government's approach to public health with the expanded role of Directors of Public Health who will be seen as 'the strategic leaders for public health and health inequalities in local communities, working in partnership with the local NHS, and across the public, private and voluntary sectors'<sup>32</sup>.

Effective tobacco control should to be driven by local priorities, local action and local leadership. Given the senior level mandate to act, the modest action of partnerships following the advice in '*Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control*', can do much to reduce smoking prevalence, health inequalities, avert unnecessary disease, improve wellbeing and quality of life, and ultimately save lives. However, the frontline staff referred to above need the strategic direction and senior level mandate to act.

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<sup>31</sup> HM Government. Healthy Lives, Healthy People: our strategy for public health in England. 2010

<sup>32</sup> HM Government. Healthy Lives, Healthy People: our strategy for public health in England. 2010

Partnership working is an evolving process and needs renewing, revitalising and refocusing from time to time. There are several useful resources to help Alliances assess their functionality as partnerships, to plan for the challenges and priorities ahead, and to reflect on achievements to date. These include toolkits developed by Fresh<sup>33</sup> in the North East, and also a London based resource<sup>34</sup>

Evidence from the North East<sup>35, 36, 37</sup> shows there are three key factors underlying an effective partnership:

- Co-ordination by a 'neutral' officer not seen as entirely within the structure and procedures of any one member organisation (e.g. NHS trust or local authority). In reality, it is highly unlikely the co-ordinator will come from outside these two structures but the way he or she approaches the work and partnership relations can be based on this requirement for neutrality.
- A clear but detailed purpose that enables each of the partners to identify the importance of their and their organisations' contribution.
- Dedication of managerial time and attention to developing effective working relationships and a shared sense of mission.

By its very nature a partnership must:

- Be equitable.
- Be diverse and multi-agency.
- Allow for informal networking between meetings.
- Have accountability.
- Have a shared goal.

PCTs have been primarily responsible for the way tobacco control is managed by the health services in their respective areas, but they cannot serve their populations in isolation. Indeed, planned structural changes in NHS commissioning and in provision of public health introduced by the Government will mean partnership working and local community involvement is essential. Crucial to this will be the new role for local authorities to promote local wellbeing, with statutory arrangements to take on the responsibility for promoting integration and partnership working between the NHS, social care, public health and other local services and strategies<sup>38</sup>.

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<sup>33</sup> Fresh Toolkit ref

<sup>34</sup> London Toolkit ref

<sup>35</sup> Russell A, Heckler S, Sengupta S, White M, Chappel D, Hunter DJ, Mason J, Milne E, Lewis S. The evolution of a regional tobacco control office in its early years: social contexts and policy dynamics. *Health Promotion International*, 24(3): 262-268, 2009.

<sup>36</sup> Heckler, S. and Russell, A. J. (2008a) 'Emotional engagement in strategic partnerships: grassroots organising in a tobacco control partnership in the North East of England', *Evidence and Policy*, 4(4): 331-354.

<sup>37</sup> Heckler, S. and Russell, A. J. (2008b) 'Confronting collaboration: dilemmas in an ethnographic study of health policy makers'. *Anthropology in Action*, 15(1): 14-21.

<sup>38</sup> Department of Health (2010) *Equity and Excellence: Liberating the NHS*.

The importance of partnerships for tobacco control was previously highlighted by the Health Commission in its 2007 report *'No ifs, no buts: Improving services for tobacco control'*, which revealed that a characteristic of high performing PCTs was their engagement in partnerships with local agencies such as councils, hospitals and prisons. Those PCTs with the highest proportion of smoking quitters achieved a score of 'excellent' in the key review area of partnership working. Fully engaged partnership working is essential for successful local tobacco control action<sup>39</sup> and areas intending to develop truly effective partnership working around tobacco control recognise the importance of developing productive relationships, as well as an adequate infrastructure<sup>40</sup>.

## Effectiveness of tobacco control partnerships

HIC 1 described the importance of working in partnership to deliver local tobacco control effectively. Traditionally, the delivery of tobacco-related partnership working has been reliant upon adequate resourcing and an appropriate co-ordination structure. At a local level this structure has commonly taken the form of a Tobacco Control Alliance (from here on in referred to as the 'Alliance').

In an effort to identify the reality of what characterises an effective tobacco control partnership, the Tobacco Control NST undertook a needs assessment of local Alliances. Key personnel (e.g. Alliance Co-ordinators) from a sub-sample of the highest scoring Alliances were asked to provide additional insight into what they perceived to be the essential components of effective partnership working. In order to provide a framework within which to structure interviewee responses (as well as assess the continuing relevance of HIC 1), answers were (where possible) interpreted according to the ten HIC 1 action points.

## Findings

### Tobacco Control Alliance Needs Assessment

A total of 19 Alliances returned a completed needs assessment form, providing data on a small number of key structural and strategic partnership requirements. Alliances scored an average of 12 out of 17, ranging from 6 to 16 points.

Position of Tobacco Alliance Co-ordinator	46	2.4 (3)
Defined role and responsibilities for Alliance membership	32	1.7 (3)
Senior Alliance Chair/Champion (e.g. Councillor; DPH)	52	2.7 (3)
Strategy and accountability to Local Strategic	56	2.9 (5)

<sup>39</sup> Strategy Planning for Tobacco Control Movement Building American Cancer Society, 2003

<sup>40</sup> Best Practices for Comprehensive Tobacco Control Programs Centers for Disease Control and Prevention, 2007



Partnership etc.		
Appropriate breadth of local representation in Alliance	40	2.1 (3)
<b>Total</b>	<b>241</b>	<b>12.1 (17)</b>

These data revealed a lack of breadth in Alliance representation (evidenced by an over-reliance on NHS membership) and an absence of clearly defined roles and responsibilities (with the NHS seen as taking on a disproportionate amount of responsibility). Neither of these findings is surprising given the low score recorded for accountability within the Local Strategic Partnership.

The Alliance areas included in the sample all faced substantial challenges with relatively low life expectancy, high mortality rates and high levels of chronic disease. Despite this, the areas that had the highest scores in this assessment (the top quartile) and the areas that had the lowest scores (the bottom quartile) varied considerably in terms of performance:

- There were 23% more successful quitters in the top scoring alliance areas than the low scoring alliance areas in 2009/10 (per 100,000 16+ population).
- Around a third of those setting a quit date in the top scoring alliance areas during 2009/10 were confirmed as having quit through CO validation, in line with the national average. In the lowest scoring alliance areas however, the CO validated quit rate was just 22%, 35% lower than the national average during this time.
- The number of people setting a quit date with local stop smoking services was 14% higher amongst the top scoring alliance areas than the lowest scoring alliance areas during 2009/10 (per 100,000 16+ population).

Source: The Information Centre for Health and Social Care

Using these data, a sub-sample of co-ordinators from Alliances with scores indicative of a higher level of structural integrity and strategic accountability (i.e. scoring within the top quartile) were invited to participate in a follow-up interview in order to identify how useful (and relevant) the action checklist from HIC 1 is in terms of helping to develop effective local partnership working around tobacco control.

### ***Tobacco Control Alliance Interviews***

Telephone interviews with Alliance leads took place in November and December 2010. In total 7 Co-ordinators were interviewed, 2 of whom worked at a sub-regional level. The length of each interview was approximately 30 minutes. A grounded theory approach was used to identify common themes.

***Action point 1*** *Seek advice, guidance and support from the Regional Tobacco Policy Manager as required*



All respondents indicated that they utilised a variety of external networks and resources to support the work carried out by their own local Alliance. A regional tobacco control office and Tobacco Policy Manager (where available), Action on Smoking and Health (ASH), Globalink and the Department of Health were all cited as commonly utilised sources of advice, evidence and support.

Use of these networks and resources was consistent across local Alliances. For example, regional tobacco control offices offered a variety of benefits, including:

- access to other topic related networks (illicit tobacco, advocacy, commissioning, smoking in pregnancy);
- strategic direction that could be adopted locally;
- resources and toolkits; and
- communication networks - ensuring that key messages were communicated across a wide network and geographical area.

Networks such as ASH and Globalink were often utilised as and when specific issues arose, primarily for gathering information and evidence. ASH was also seen to provide a beneficial advocacy support function.

***Action point 2 Undertake a functionality review to assess existing partnership arrangements***

Respondents indicated that the introduction of smokefree legislation in 2007 reduced the perceived need for local tobacco control amongst Alliance members. In a response to this the majority of respondents undertook a functionality review. Use of functionality reviews was a common feature amongst the Alliances examined, with many undertaking this process in order to:

- Review membership;
- Review achievements;
- Evaluate action plans;
- Reinforce need for continued partnership working.

All participants described this process as being of particular use during a time of change (e.g. following smokefree legislation). As new commissioning and delivery arrangements emerge following the publication of the Government's Public Health White Paper, *Healthy lives, healthy people*, the ability of Alliances to remain 'fit for purpose' will become even more important.

***Action point 3 Successful partnership working around tobacco control requires a dedicated co-ordinator who has high level support alongside the ability to plan strategically and inspire confidence***

Unsurprisingly, all respondents indicated that successful partnership working is dependent upon having a dedicated co-ordinating resource. This resource was most

often described in terms of a facilitative and organisational role. Respondents described a number of essential functions for this role, including:

- agenda setting;
- strategy development and action planning;
- dissemination of key messages through local communication channels;
- lobbying and responding to requests;
- preparing briefing papers and Board reports; and
- supporting the alliance chair/champion.

Respondents commonly described the risk associated with Alliance partners operating independently of each other, with little understanding of the ‘added value’ of partnership working. A dedicated co-ordinating resource was seen as crucial to ensuring that opportunities are maximised both within and across Alliance partner organisations.

***Action point 4*** *Effective partnerships need high profile leadership via an influential champion with management buy-in.*

Two respondents reported that they had been unable to engage an appropriate champion to chair their Alliance. The absence of an influential champion was felt to have restricted the ability of the Alliance to overcome some local strategic challenges (e.g. getting better tobacco control outcomes linked to the children’s agenda).

In Alliances with a senior level Chair/champion, this role was viewed as being hugely beneficial. For example, one respondent had secured a local councillor who was well positioned to prompt action from both NHS and local authority partners.

Another respondent had secured a Director of Public Health as the chair, the benefits of which included having an important figurehead (illustrating the importance of the Alliance) as well as someone with an understanding of tobacco control in a position to influence the local strategic agenda in relation to both the life expectancy and health inequalities agenda.

On the whole, Alliance champions were not expected to become involved in the administration of the partnership, but were seen more as a source of political and strategic advice as well as the Alliance’s primary spokesperson.

***Action point 5*** *Demonstrate why it is important for people, communities and organisations to engage with the Alliance. To emphasise the benefits of partnership working it is important to have links with the local strategic partnership.*

***Action point 6*** *Be realistic – different partners will have different agendas so it will take time and persistence to develop a broad and effective partnership.*

When discussing Alliance membership several themes emerged, including:

- how Alliance co-ordinators approached potential new partners;
- how co-ordinators 'sold' the concept of partnership working and the benefits it brings in relation to tobacco control; and
- barriers co-ordinators faced and how they overcome them.

Many respondents discussed the importance of developing relationships with potential members by engaging with them face-to-face. One respondent noted that, 'you need to let them know that the issue is important and their effort critical to it'.

The importance of partnership working was commonly highlighted by emphasising the role of the Alliance in bringing disparate pieces of tobacco-related activity together, ensuring its effect was maximised and not duplicated or off-track.

It was noted that although different organisations would often have different goals for the work they were delivering around the tobacco control agenda, Alliances provided the infrastructure to develop a shared common goal between organisations. In order to achieve this, the goal had to be broad, strategic, understood and valued. Respondents emphasised the importance of continually communicating the aims of the Alliance, with a particular focus on what had been achieved due to the combined efforts of the partnership. In relation to this, one respondent noted that, '...each partner understands their world better than I do, understands the hooks, barriers, what works and what doesn't – they are the expert and that's what we need.'

Partnerships worked best when there was a positive value placed on them, regardless of the topic or issue. Respondents in areas without a culture of partnership working perceived this as an important barrier requiring urgent attention.

In addition to placing a high value on partnership working, respondents recognised that all strands of comprehensive tobacco control had to be addressed. Some respondents suggested that there was still a lack of understanding of how tobacco control relates to the health inequalities agenda and this could lead to resources not being allocated appropriately. Furthermore, it appeared doubtful that tobacco control would remain a priority by local authorities adopting a neighbourhood model approach to commissioning.

Common barriers to success included resistance to tobacco control by some organisations, most commonly acute and mental health trusts. Although the notion of helping smokers to stop was understood, a significant problem was communicating the purpose of broader tobacco control interventions. Another common barrier was ensuring senior representation on the Alliance. In the words of one respondent, 'You think you have cracked it, but people move on or they send somebody else instead with no mandate to act, it's hard to find the right hook sometimes'.

**Action point 7** *Target potential partners beyond public health, including the media, council leaders, non-Government organisations, health professionals, lawyers, economists, schools, unions and business leaders*

A number of respondents highlighted an increasing need to engage with new partners outside of the usual statutory organisations. Utilising the voluntary and community sector to develop links within local communities was seen as particularly important in terms of engaging with and enabling local people to make more informed choices about their own health.

Respondents also acknowledged an increasingly important role for local business within an Alliance, particularly given the Government's intention to encourage responsibility for public health beyond the statutory sector (e.g. the Public Health Responsibility Deal, though the tobacco industry is excluded from this initiative). An effective partnership structure can act as a conduit between disparate partners resulting in benefits at both an individual and organisational level. For example, one respondent described how the Alliance fostered a relationship between employers of routine and manual workers and the local NHS Stop Smoking Service. Not only did this help enable smokers to get support to quit, it contributed to the local four-week quit target and helped local businesses to consider the short and long term benefits of a healthy workforce.

All respondents recognised the importance of periodically reviewing Alliance membership, especially with an eye to recruiting organisations or individuals in a position to help deliver the local vision for a future free from the harm caused by tobacco.

***Action point 8*** *Consistent communication with all stakeholders is needed to ensure ongoing commitment to implement all ten High Impact Changes*

***Action point 9*** *Consider using sub-groups for specific topic areas to help develop and implement the tobacco control strategy*

As mentioned in relation to the co-ordinating resource, sound organisation and clear communication to all partners is integral to the long term effectiveness of a Tobacco Control Alliance. Respondents commonly referred to the need to adopt a flexible approach to Alliance membership – an overly prescriptive approach to Alliance business was reported as one of the main reasons for partner disengagement

A typical schedule described by respondents tended to involved quarterly strategic meetings into which updates are fed from a variety of operational sub-groups. Feedback from respondents suggested that this approach worked well as Alliance members were not inundated with meeting requests and business issues were resolved quickly as sub-group leads updated the membership on progress against the strategy and action plan.

All respondents noted that an integral part of the Alliance co-ordination role is to make it as easy as possible for members to engage and have their say. On those occasions when representation from particular organisations flagged, respondents ensured that representatives were kept up to date using various communication methods. Similar to engaging new members, participants preferred face-to-face communication as issues could be addressed immediately and normal representation resumed.

Effective Alliance co-ordinators adopt a pragmatic approach when maintaining existing partnerships or encouraging short-term expert involvement. This approach, as recommended in the HIC 1 checklist, appears to work well in that core partners are not inundated with meeting requests and the expertise of short-term partners is not lost to the detriment of the Alliance.

**Action point 10** *Tobacco Control Alliances are not just about NHS Stop Smoking Services and should encompass the broader tobacco control agenda*

All respondents highlighted the value of the local NHS Stop Smoking Service (SSS) having representation within the Alliance. Respondents described their local SSS as often isolated and unaware of the benefits of partnership working prior to Alliance membership. Membership helped raise awareness of how the work of local SSSs related to the broader tobacco control agenda, as well as the benefits from working with other Alliance partners. Benefits often realised by local SSS, included:

- partners helping the service achieve their 4-week quit objectives by increasing throughput to the service following brief intervention training and referral;
- working through the challenges faced by local SSSs (and commissioners) as a consequence of the separation of the commissioner and provider functions;
- Resolution of issues associated with the development of the SSS provider market and its impact on the existing service and staff.

A point commonly made by respondents was that the benefits of local SSS membership within the Alliance are primarily realised by the SSS and their clients.

## **Conclusion and recommendations**

Using the interview data above the Tobacco Control NST are able to recommend specific actions to aid localities develop and maintain effective partnerships, based on the action checklist listed under HIC 1.

It is recommended that:

Alliances utilise a wide range of appropriate networks so that local tobacco control interventions are well informed, evidence based and responsive to local need in all its diversity.

Whenever possible local alliances align themselves to regional smoke free offices as this represents partnership working at its most effective. Based on the feedback from the participants, this recommendation from the checklist has stood the test of time.

Alliances utilise the alliance toolkits that are available in order to reflect on past achievements and review current membership, strategies and action plans. Time could be set aside to do this annually. However, as the participants described a review as useful during a time of change completing one could be advantageous during times of rapid change. For example, as new partnerships/networks/issues

emerge following the publication of the Government's tobacco control action plan and the movement of the public health improvement agenda to local authorities.

In addition, Alliances require a resourceful lead that can pull together the efforts of the partners, motivate existing members, negotiate with strategic leads and feedback the achievements of the collective membership. In the current economic climate, the Tobacco Control NST recommend that organisations represented on an Alliance explore joint funding a designated lead in order that the partnership functions efficiently and effectively and realise their full potential.

The Tobacco Control NST recommends that leads work hard to identify an influential chairperson/champion who is fully briefed about the issues and barriers the partnership is facing. When the two roles work together in this way, it appears Alliances are able to progress more quickly and with more conviction, than when a partnership is left to function alone.

Tobacco is a complicated issue, impacting local communities on many different levels of which health is just one part. It is recommended that Alliances engage a wide representation of interested and influential partners, so that issues stand a better chance of being addressed, building in greater diversity. In addition, Alliances should exploit the proven impact tobacco use has on increasing health inequalities across a locality, educating those in strategic roles of the value of comprehensive tobacco control in reducing them.

The Tobacco Control NST note that effective Alliance leads adopt a pragmatic approach when maintaining existing partnerships or encouraging short-term issue based expert participation. This approach, as recommended in the HIC 1 checklist, appears to work well; core partners are not inundated with meeting requests and the expertise of short-term partners is not lost to the detriment of the alliance.

Finally, there are benefits to local SSS when they are represented on an Alliance. Therefore, the Tobacco Control NST recommend that local SSS align themselves to a local Alliance whenever possible, acknowledging the value that it will bring.

The Tobacco Control NST note that local SSS are the treatment arm for smokers wanting to quit and as such are not responsible for an overall reduction in smoking prevalence across a locality. However, participation with a local Alliance will increase the overall chances of smokers in their locality during the process of quitting and staying quit, and this in turn could help reduce the health inequalities smokers experience due to their tobacco use.

In considering these recommendations, it is no surprise that HIC 1 concentrated on the importance of effective partnership working, encouraging alliances/partnerships to work together and utilise the strengths, expertise and knowledge of the partners involved, while acknowledging the challenges that collaborative partnership working often brings. It is clear that these challenges can be considerable as an area seeks to tackle cross cutting problems like tobacco within complex communities by utilising complex organisations and the systems they operate within.

To maximise chances of effectiveness, partnerships need to be truly strategic with members able to work together to create a joined up approach to tackling public health issues like tobacco as a shared priority. Good partnerships facilitate a crosscutting approach which tackles a problem in as seamless a way as possible. A piecemeal approach will fail to have maximum effect on smoking prevalence and, therefore, health inequalities. By working in partnership with other organisations the harmful effects of tobacco and the benefits of quitting can be better effectively. In short, partnerships are vital in moving the tobacco control agenda forward.

The Tobacco control NST would like to acknowledge the contribution of the following people in the development of Section 7 of this document:

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## SECTION 8 – INTEGRATED SERVICES FRAMEWORK (ISF) FOR STOP SMOKING PROVISION

### **Rationale**

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 evidence-based interventions (and systems) to improve the chance of smokers staying quit once they make the decision to stop smoking.

### **NHS Stop Smoking Services**

As previously discussed, evidence-based tobacco control utilises a multi-component approach to help accelerate a reduction in smoking prevalence. One component which local areas commonly have responsibility for is ensuring that smokers have access to services to support them during a quit attempt. Unfortunately, competing priorities in health care mean that treatment has often taken precedence over the prevention of diseases such as those caused by smoking. To meet the challenge of delivering more and better population prevention, there is a need to adopt a more integrated and innovative way of supporting people to make healthier choices through interventions such as those delivered by NHS Stop Smoking Services.

Over the last 10 years England has developed the world's most comprehensive network of evidence-based smoking cessation treatment services. During this time the NHS Stop Smoking Services have proven themselves to be clinically effective, increasing four-fold the chance of a smoker quitting compared to using willpower alone<sup>41</sup>. The services are also highly cost-effective, with the average cost per life year gained for smokers treated by these type of services calculated as £1,000 per QALY (quality adjusted life year) compared to NICE guidelines of £20,000 per QALY.

In *Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control*, the Tobacco Control NST identified HIC number 5 as adopting an Integrated Stop Smoking Approach. The Tobacco Control NST diagnostic process regularly identified issues associated with the effectiveness, reach and accessibility of stop smoking provision. Offers of support made by the Tobacco Control NST were intended to reflect local need, and during the last four years there have been numerous requests for the NST to facilitate workshops to help improve the performance of local NHS Stop Smoking Services. Indeed, a recent stakeholder evaluation reported that 69% of respondents were of the opinion that the Tobacco Control NST improved local performance against their key 4-week quit target. Delivery of these workshops informed the development of the Tobacco Control NST's *Integrated Service Framework* (ISF) for local stop smoking services. Developed in partnership with local areas, the ISF is a tool to enable commissioners

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<sup>41</sup> Chersternan et al. (2005) 'How effective are the English smoking treatment services in reaching disadvantaged smokers?' *Addiction* 100 (Suppl.2): 36-45



and providers to improve their understanding of how a local systems approach can be adopted in relation to the provision of NHS Stop Smoking Services.

A systematic analysis of recommendations made by the NST also identified a number of specific barriers commonly found to undermine the effectiveness of locally commissioned NHS Stop Smoking Services (see **SECTION 6 – SUMMARY OF LEARNING FROM NST VISITS**, Table 4 & Table 5 starting on page 35).

These reports identified a particular need for local areas to improve their commissioning arrangements and structures, alongside the development of a more ‘integrated’ approach to the delivery of these services. Sub-themes underlying these broader recommendations emphasised a need for commissioners to: implement clearer and more robust performance monitoring systems; develop more transparent service specifications, and provide more support (e.g. training) for existing, and potential, service providers (see Table 7 below).

## *A Comprehensive Guide To Achieving Effective Local Tobacco Control: Evidence, Support & Publications*

Table 7 – Specific themes and recommendations: Commissioning of NHS Stop Smoking Services

Sub-theme	Example Recommendation from NST Report	No of Reports
<b>Improve commissioning arrangements and structures</b>	“...the NST recommends further action to develop commissioner and provider roles: A commissioning process for the integrated stop smoking system jointly developed by public health and commissioning Directorates; a shared understanding of the current commissioning arrangements and how these could develop in the future; developed contractual and performance arrangements for all service providers; active support for individual providers to develop and extend their capacity to act as system components.”	13
<b>Commissioned services are integrated</b>	The NST recommends that you, “...Commission an integrated model of support for local stop smoking services, which includes the recommended settings and that the relevant groups are appropriately prioritised (e.g. pregnant women, routine and manual, prison).”	9
<b>Develop commissioning frameworks</b>	The NST recommends that, “...This model and its resulting contractual and specification framework should then form the basis of performance management by commissioners and performance reporting by providers.”	7
<b>Improve performance management and clinical governance of providers</b>	The NST recommends that you, “... support provider activity and performance management functions (objectives and Key Performance Indicators) are worked up into an integrated framework.”	4
<b>More effective joint commissioning</b>	The NST suggests that, “...This would appear to be an appropriate juncture to consider joint NHS and local government commissioning to reduce health inequalities.”	3
<b>Develop and support existing and potential markets</b>	The NST recommends that you, “...Support development of current Stop Smoking Service so that they are market aware to allow them to compete on a level footing for future tenders.”	3

### **Aim**

This section aims to help NHS and local authority commissioners and providers understand how they can best meet the challenge of effectively (and efficiently) supporting smokers to quit by adopting a more integrated and needs-based approach to the provision of local NHS Stop Smoking Services.

Using insight and experience accumulated by the Tobacco Control NST over the last four years, this document intends to:

- Describe the ISF within the context of the commissioning cycle to enable providers and commissioners to develop a more integrated approach to the delivery of their local NHS Stop Smoking Services.

- Demonstrate how some of the key barriers commonly found to reduce the effectiveness of local NHS Stop Smoking Services may be avoided or overcome using case studies from local areas.

Whilst this guide may be read as a standalone document, it can also be viewed as a companion piece to existing publications on the commissioning and provision of stop smoking services, particularly 'NHS Stop Smoking Services: Service and monitoring guidance (2010/11)<sup>42</sup>' and 'Stop Smoking Services - Needs Analysis: A Toolkit for Commissioners'<sup>43</sup>.

## **An Integrated Service Framework for NHS Stop Smoking Services**

One of the biggest challenges to the internal landscape of the NHS has been the separation of the commissioning process from the delivery function of local health services. Commissioners have a responsibility to ensure that the type of interventions and the configuration of provider(s) they procure are accessible, clinically effective and provide value for money. To do this, it is important that commissioners identify the needs of their local population, understand and apply the smoking cessation evidence-base and introduce systems for service monitoring and evaluation. Providers have a responsibility to deliver a range of interventions in accordance with the service specification and protocols approved by their commissioner.

Launched in 2009 at the United Kingdom National Smoking Cessation Conference, the ISF expanded upon the 'hub and spoke' model of NHS Stop Smoking Service delivery. The 'hub and spoke' model developed independently in a number of different local areas, and was identified through the NST visit process as a highly effective and robust model of service delivery. The 'hub' referred to a small team of dedicated (i.e. often full-time) stop smoking professionals responsible for:

- Delivering targeted smoking cessation interventions;
- Commissioning and supporting other service providers;
- Developing partnership working; and
- Assessing need and service equity.

The 'spokes' referred to a variety of health, community and local authority staff responsible for delivering a range of less intensive interventions to motivate (brief intervention) and support (e.g. 1-2-1 intervention) smokers in their efforts to quit. Some 'spokes' would be contracted to deliver interventions (e.g. under a GP local enhanced service contract) whilst other 'spokes' would deliver brief advice as part of their substantive role (e.g. Health visitors).

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<sup>42</sup> Department of Health (2009) NHS Stop Smoking Service: Service and monitoring guidance 2010/11.DH

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_109696](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109696)

<sup>43</sup> NHS Centre for Smoking Cessation and Training (2010) Needs Analysis: A Toolkit for Commissioners. NCST [www.ncst.co.uk/resources/downloads/NCST\\_needs\\_analysis\\_final.pdf](http://www.ncst.co.uk/resources/downloads/NCST_needs_analysis_final.pdf)

Over time the 'hub and spoke' model was identified as being more resilient and adaptable than more 'specialised' (i.e. all treatment activity delivered by one team) models of delivery. A key to the success of this model was the manner in which the support and development of the non-specialist 'spoke' providers was an integral part of the 'hub' team's role and responsibilities. In light of the changing commissioner and provider landscape it became apparent that many of these responsibilities would no longer be appropriate for a service provider to undertake. In order to address these challenges, without compromising the essence of what made this model so effective, the Tobacco Control NST developed the ISF. The primary aim of the framework is to:

- Illustrate and clarify the respective responsibilities of commissioners and providers
- Provide a 'steer' as to the potential configuration of stop smoking provision within a local health and social care economy

The ISF exemplifies a 'whole system' approach to the delivery of stop smoking advice and support, demonstrating where and how opportunities may be maximised to help smokers to quit<sup>44</sup>. The external component of the ISF (see Diagram 1) outlines a combination of providers or stakeholders (e.g. pharmacists), venues / locations (e.g. acute sector) and levels of intervention (i.e. brief advice, brief intervention and intensive support). The central component represents the core functions of an NHS Stop Smoking Service system, some of which would have been carried out by the 'hub' team in the earlier iteration of the ISF (see Diagram 2).

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<sup>44</sup> NHS Employers 2009 Pharmacy stop smoking services: optimising commissioning: [www.nhsemployers.org/Aboutus/Publications/Documents/Smoking\\_Cessation\\_Guidance\\_fb230709.pdf](http://www.nhsemployers.org/Aboutus/Publications/Documents/Smoking_Cessation_Guidance_fb230709.pdf)

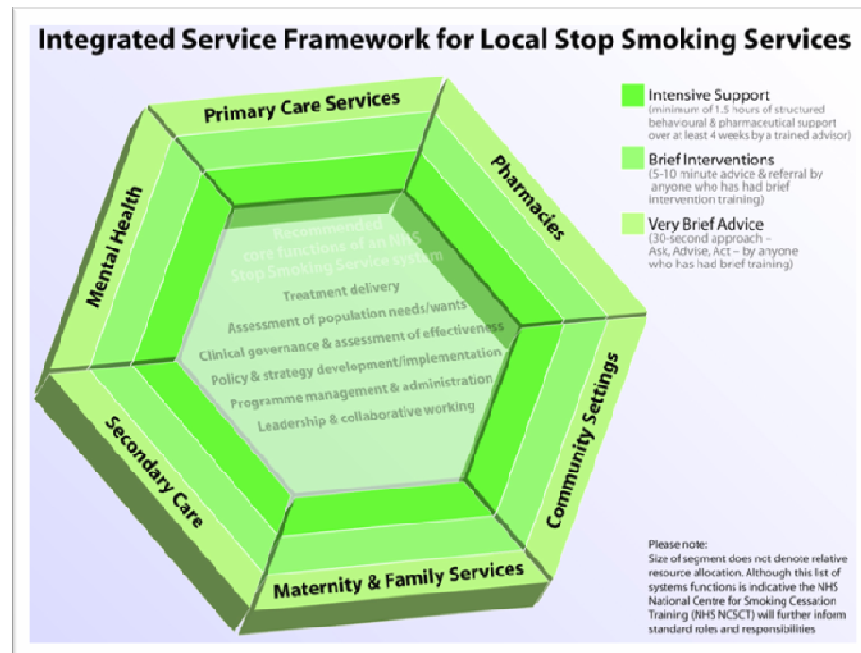


Diagram 1. Service provision component of ISF

### Service provision component of ISF

The exact configuration of this component of an ISF is dependent upon the outcome of the local strategic planning and procurement process. In order to establish this, commissioners need to gather and analyse a range of data to help develop a picture of ‘population need’. Key questions that a commissioner should try to answer include:

- What is the prevalence of smoking within your local community?
- What are the smoking rates within particular communities?
- What is the need for behavioural support within these communities?
- What do smokers want to enable them to quit smoking?

Once this ‘picture’ of the local population has been created, it is necessary to develop a quantitative understanding of the work being carried out by existing providers of NHS Stop Smoking Services:

- What type of behavioural and pharmacological support is being delivered?
- Is the service delivering appropriate clinical outcomes?
- Who is accessing the service?

Combining the qualitative and quantitative data gathered to answer the above questions will allow commissioners to identify gaps in current service provision, relative to the need of the smoking population.

In order to address the priorities identified through the strategic planning process, commissioners can draw upon an evolving range of evidence-based smoking cessation interventions. Intensive behavioural support for smokers combines specialist advice (delivered in a variety of forms, including 1-2-1 and groups) with smoking cessation pharmacotherapy (e.g. nicotine replacement therapy).

Where possible, intensive behaviour change programmes should be integrated within the broader local health and social care system. Because need and expressed demand for smoking cessation outstrip uptake of NHS Stop Smoking Services, commissioners should consider all available opportunities for maximising the identification, motivation and referral of smokers for support. As a starting point it may be helpful to map smokers likely to use the various providers and settings identified in the ISF and match to an appropriate series of interventions. Adding to this are workforce based strategies such as Health Gain Schedules<sup>45</sup>, which provides an industrialised approach to embed brief intervention and referral systems, across the workforce frontline.

**‘Core’ function of an integrated NHS Stop Smoking Service system**

The central component of the ISF represents the ‘core’ functions of a local NHS Stop Smoking Service system. These functions can be carried out by a range of individuals working collaboratively across the provider and commissioner landscape and represent the processes and systems needed so that both commissioners and providers are capable of identifying and responding to the needs of their population in an efficient and effective manner.

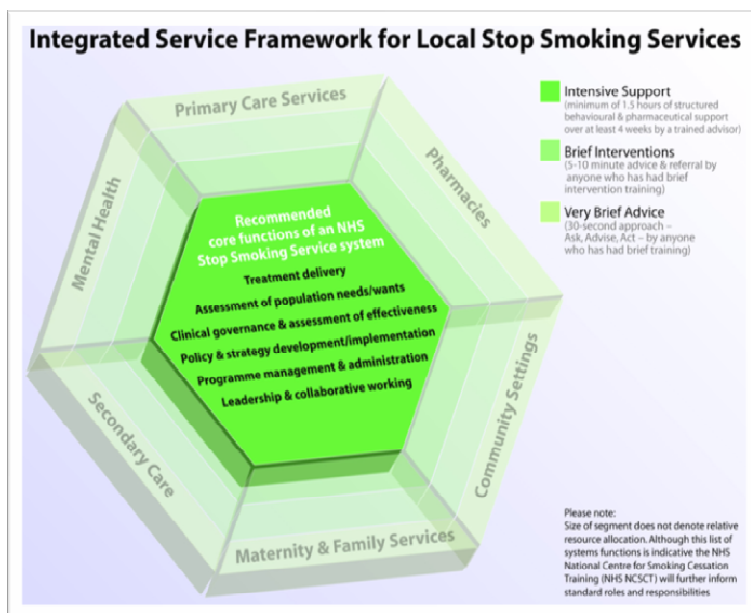


Diagram 2. ‘Core’ functions of local stop smoking service system

In order for local NHS Stop Smoking Services to perform effectively, it is essential that there is clarity between the commissioner and provider(s) around their

<sup>45</sup> Health Inequalities National Support Team 2010, Health Gain Schedule 2010

respective roles as they relate to these functions. For some aspects of the ISF 'core' this is relatively straightforward. For example, responsibility for assessing population need clearly lies with the commissioner responsible for reducing the harm of tobacco use, although this would be carried out in conjunction with key partners such as service providers and public health information leads. For other aspects of the ISF (and the commissioning process itself) responsibility and accountability is not as well delineated. As revealed by the analysis of recommendations shown in Table 7 on page 54, a feature common to many of the areas visited by the NST was an absence of commissioning systems, underscored by a lack of clarity around responsibility for monitoring, evaluating and responding to the needs of clients and service providers. Taken as a whole, the experience of the NST and the findings reported in Table 4 & Table 5 starting on page 34 indicate that for a proportion of NHS Stop Smoking Services reviewed by the Tobacco Control NST, effectiveness and population reach was undermined by a lack of programme governance and performance management systems.

### ***Ensuring better governance and management of risk***

Commissioning any health improvement programme relies upon a systematic approach to reviewing activity and responding to the needs of the local population. Within the context of both the commissioning process and the ISF, a robust data collection and performance management framework is essential. Without this, realistic service improvement goals and parameters cannot be agreed and there is the potential to undermine the relationship between the commissioner and provider.

Robust commissioning of these services requires clarity around what data is captured (e.g. DH minimum data set), how these data are captured (e.g. via electronic systems; paper-based) and by whom (e.g. the commissioner or a particular provider), all of which should be incorporated into a commissioning and provider governance structure developed so that service activity is delivered to an appropriate standard. It is down to the commissioner to decide on the overall governance of the stop smoking system and gain agreement with providers on the specific arrangements to meet it.

The following provides a shortlist of issues that commissioners need to consider in relation to this:

- The minimum data set to be collected by providers to guarantee adequate performance management (including user evaluations);
- That these data requirements are part of service specification and that these data can be collected efficiently by providers;
- That these data are returned to the commissioner and evaluated within the context of both population outcomes and provider performance;
- That there are mechanisms/structures in place to allow constructive performance management and support of providers;



- That there are systems in place for providers to utilise service monitoring data in order to help inform their service improvement.

In order to make certain that smokers receive the quality of service stipulated within a provider contract, commissioners need to regularly analyse outcome and performance data. Importantly, the commissioner needs to be capable of interpreting these data to identify, diagnose and resolve issues that may pose a risk to the quality, quantity and timing of work being carried out within the local area.

Ideally, tobacco control commissioners would be able to procure interventions from a market of experienced, self-governing NHS Stop Smoking Service providers. Unfortunately, the market for preventative services is far less developed than primary and secondary care services. Commissioners therefore have a responsibility for 'stimulating' the provider market and taking action so that the provider(s) they select have the right knowledge and skills and are able to self-monitor their activity. This action may involve supporting the provider with relevant training to deliver the programme to the standards set out by the commissioner<sup>46</sup>. Reflecting the diverse nature of the smoking population, the needs of service providers will vary according to a range of factors, including:

- The location of the service (Is it convenient? Will it generate client engagement?)
- The type of intervention being provided (Is it appropriate for population?)
- The basis for payment (Is it performance related? Will it inhibit or incentivise activity?)
- The proportion of time dedicated to service delivery (Is the provider likely to treat enough smokers to maintain clinical skills?)
- The source of referrals (Are there robust systems in place? Are providers contracted to recruit clients into the service?)

These variables can interact in a number of ways that may affect the quality and quantity of service delivery. In order to ensure that the commissioner can manage these performance issues, it is essential that the correct data is collected and analysed in a timely fashion and that these data are fed into a system that allows concerns to be raised with providers in a constructive and solution-focused manner.

### *Case Studies*

As described in Table 4 & Table 5 starting on page 34, a review of NST recommendations revealed a number of common challenges to the commissioning and delivery of local NHS Stop Smoking Services, particularly in relation to the following components:

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<sup>46</sup> Shircore, R. (2009) Guide for World Class Commissioners – Promoting Health and Well-being: Reducing Inequalities. RSPH. <http://www.rsph.org.uk/download.cfm?docid=36B243B7-B455-4893-8AB7157AB86353B9>



- Clinical governance & assessment of effectiveness
  - Monitoring and evaluation of provider effectiveness
  - Patient satisfaction
- Programme management & administration
  - Performance improvement
  - Data collection and analysis
  - Equipment maintenance

The following three case studies illustrate how different NHS Stop Smoking Services initiated a mix of different commissioning processes and service improvement responses through an ISF approach. Although Great Yarmouth and Waveney achieved high success with the biggest number of quitters in the East of England region during 2009/10 following implementation of the ISF model, the examples have been chosen primarily to illustrate some of the key issues and solutions that three areas worked through.

## **Case Study 1: NHS Great Yarmouth and Waveney**

Great Yarmouth and Waveney PCT has a resident population of 212,000, the health needs of which are driven by high levels of deprivation concentrated largely in the urban areas of Great Yarmouth and Lowestoft. NHS Great Yarmouth and Waveney is the most deprived PCT in the East of England and has the highest overall smoking prevalence the region at 21.5%, rising to 28% in the most deprived quintile<sup>47</sup>.

The specialist NHS Stop Smoking Service is commissioned by the PCT's public health Directorate and the specialist team was employed directly by the PCT as part of the health improvement function. In preparation for the commissioner provider separation in 2010/11 a team leader was appointed and the specialist team were identified as a community provider function, although initially during the transition some managerial functions were retained by the commissioner, who had been a stop smoking advisor for a number of years. All of the provider and commissioning functions are now fully separated, ready for transfer from the PCT in April 2011.

An NST visit in November 2009, recommended that the area exploit the potential to increase access to R&M and pregnant smokers through an ISF approach. In addition, the visit highlighted that work needed to be done to revise systems for data collection, principally to aid a better understanding of the source of referrals to the service in order to enable more effective targeting of provision.

Shortly after the NST visit, the local commissioner-provider split began to progress, clarifying commissioning responsibilities for all services. As part of this process, a dedicated 'commissioning advisor' role was established. Although the commissioners managed the service level agreements (SLA) and local enhanced services (LES) with local pharmacies and primary care, arrangements for the support of existing level 2 (i.e. non-specialist interventions) services were revised, with the provision of training, mentoring and network support delivered via the specialist core team. A range of relevant settings were identified to increase service reach in alignment with the areas of high health inequality across Great Yarmouth and Waveney. The specialist advisors adopted and 'owned' specific work areas in which to maximise reach and deliver targeted stop smoking support. The primary focus was on workplaces, pharmacies, secondary and maternity care services, mental health and extended support in the community to Gypsies and Travellers.

Following NST recommendations, the commissioning advisor created a tobacco control action plan, and having secured a budget for tobacco control, began utilising the breadth of mature partnerships that exist between the PCT and the four local authorities in the area to develop a local Tobacco Control Alliance with working groups for each work stream.

Overall, the service exceeded its 4 week quit target in 2009/10 by 130.5% and for the first time became the highest performing service in the East of England region. The Team was also recognised by Great Yarmouth and Waveney PCT as the "Team

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<sup>47</sup> East of England Lifestyle Survey, MORI/IPSOS 2008

of the Year”, and at the time of writing, continues to flourish and retain its positive status in the region.

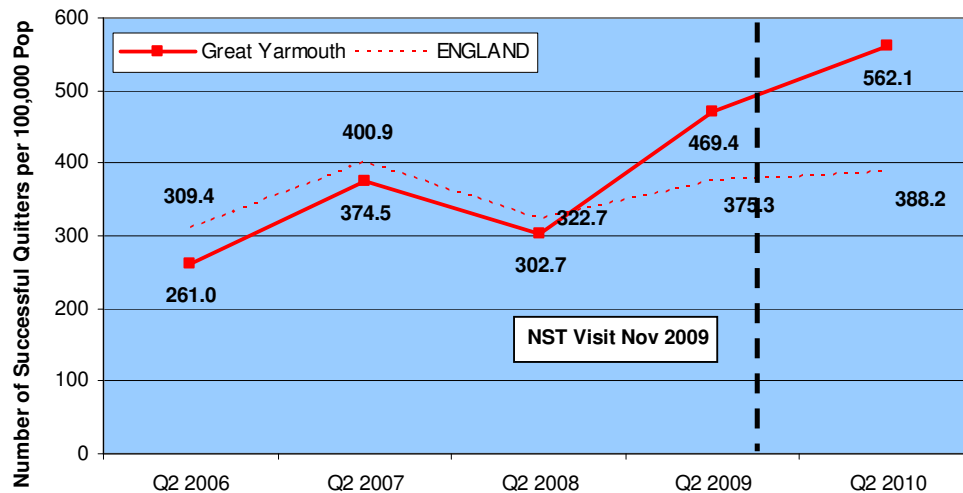


Figure 6 - N° of Successful Quitters per 100,000 Population: April 2006 - September 2010

## Case Study 2: NHS Warrington Case Study

Overall, 20.4% of Warrington residents responded to a local health and lifestyle survey in 2006 stating that they currently smoke; this suggests that there are approximately 30,700 adult smokers in the borough<sup>48</sup>. There is wide variation within Warrington and amongst age groups, with males aged 18 - 39 years living in the more deprived central and inner wards of Warrington having the highest prevalence, at between 37.1% and 40.7%. This is markedly higher than Hatton, Stretton and Walton which had the lowest estimated smoking rates at 3.1%.

In 2009, NHS Warrington’s specialist NHS Stop Smoking Service consisted of a team of 8 stop smoking advisors and a team manager. The team was part of a group of ‘lifestyle behaviour’ teams which included health trainers and weight management staff, commissioned from the PCT’s public health Directorate. The service has a long history of achieving high quit rates through intensive support interventions delivered by the core team in a number of standing clinics within the borough. The majority of smokers were referred to the service from GPs and primary care.

During 2009, a management restructure in the provider arm, along with some staff absence, had influenced the capacity of the specialist team in implementing a community focussed approach to the development of the services. Appointed to lead the service was a Clinical Services Team Manager, who was to take overall operational charge of the stop smoking team in October 2010. A pharmacy LES was in operation but only 8 of the 39 pharmacies were providing level 2 advice and support and there was limited capacity from the specialist team to provide the necessary support to enhance the network. A tobacco control co-ordinator, part

<sup>48</sup> Warrington Health and Lifestyle Survey 2006

funded by Warrington PCT, hosted by Warrington Borough Council, was in post and developing a number of pieces of wider community based activity, including an excellent Smoke Free Homes programme, and the provision of brief intervention training to council employees. This work was part of a tobacco control action plan for Warrington, where work was underway to take a systematic approach to referral and support for the local stop smoking service.

The Tobacco Control NST undertook a rapid visit in Warrington in December 2009. At 65%, the quit rate for the service was, and at the time of writing, remains above the regional and national average. Despite this, the PCT was not achieving its agreed target number of 4 week quitters and by the end of 2009/10, the service had achieved only 74% of its final target.

The Tobacco Control NST visit identified a number of strengths, challenges and opportunities for Warrington and developed a set of recommendations that primarily focused on the need for both commissioner and provider leads to work together to adopt an ISF approach. It was suggested that the commissioners identify the opportunities across the wider landscape of health improvement commissioning, particularly optimising the excellent links that already existed between Warrington Borough Council and its partners, to ensure that relevant and robust training systems were put in place for all existing and potential staff involved with the stop smoking service. Underpinning this was the need to develop a clearer commissioning framework for the service going beyond the core service specification set by the commissioner. A highly developed performance framework was devised, which included milestones for many of the NST's recommendations. This was used to track progress with the service, and also submitted to the PCT Executive Commissioning Board for reporting and feedback. These efforts helped to raise the ongoing profile with corporate leadership, increasing the breadth of support for stop smoking provision and wider tobacco control activity.

The NST visit uncovered the potential to further develop and embed stop smoking support in Warrington's key settings, including workplaces, secondary care and prisons. Although some effort had previously been made to establish support in these settings, there had been a tendency to view these pieces of work as 'projects' which had not been genuinely informed by an understanding of population need and lacked synthesis of referral, data collection and targeting as part of an overall system. There was evidence of work that had begun to develop in the settings, but had not fully progressed as part of an agreed overall outcome based plan.

The visit also identified some barriers to effective service provision and follow up concerning the effective use of data and monitoring. The existing 'hybrid' system of paper and electronic monitoring meant the service was unable to fully use client service data in a pro-active way to inform service marketing, client access and address follow up in a comprehensive manner.

In order to move the work of the service forward and address the key issues identified through the NST visit, a series of action planning and review events were held with the team, led by the Clinical Service Team manager. The commissioner

was involved in an initial event to ensure that overall objectives were understood and agreed.

Some detailed changes to the data collection tools (including the service database) were made, which gave the service a fresh opportunity to look at its activity data for targeting clients in local areas and settings more systematically begin to address clients' needs. A major benefit from this process is that the service emphasis has begun to change in achieving a better balance of improved reach over clinical efficacy. A number of high impact actions in order to achieve this are now committed to in the service action plan 2010/11 and continue to be implemented:

- A focus on working in the 20% most deprived areas of the borough to provide stop smoking support and neighbourhood level working, aligned to the NHS Warrington Inequalities agenda/programme focus;
- Improved targeted workplace provision building on the work with 'Greencors' a large employer in the Borough;
- Utilising the 'social marketing insight' work the PCT commissioned to understand needs and engage with smokers in different ways;
- Improved uptake of pharmacist level 2 stop smoking support and additional wave of training for participating pharmacies during 2010/11;
- Linking more robustly with health care professional staff in community provider services, out of hours provision and contact in libraries to extend community reach, through brief intervention and referral;
- Linked referral and pathway support to clients identified through the Warrington Cardio Vascular Disease programme;
- Linking through the 'healthy prisons' team to improve provision and embed the support in HMP Warrington and Risley.

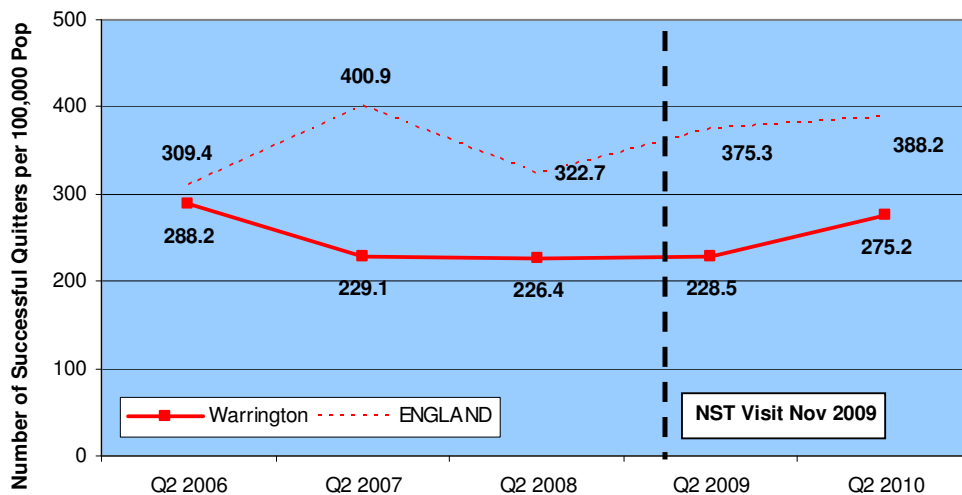


Figure 7 – Number of Successful Quitters per 100,000 Population: April 2006 - September 2010

### **Case Study 3: NHS South Birmingham**

NHS South Birmingham currently commissions services for a population of 383,000 people. Smoking prevalence is estimated at 23%, placing the number of adult smokers at approximately 71,000<sup>49</sup>. In 2009/10, the four-week quitter vital signs target for NHS South Birmingham increased from 1,896 to 2,844 (an increase of 33%).

To achieve this target it was decided that the number of smokers supported to quit by pharmacy and GP providers would need to increase, without any additional investment in marketing and communication.

In light of an imminent move to the local NHS provider function, it was agreed with the commissioner that the role of the core stop smoking service team would be redefined, moving from a pre-dominantly service delivery role to a performance management function.

Moving to a 'locality' model, specialist cessation staff were given responsibility for performance monitoring (and where necessary improving) 'sub-contracted' stop smoking providers (i.e. pharmacists and GPs delivering interventions under a local enhanced service contract). Targets were assigned to providers based on previous performance (for pharmacies) and list sizes (for GP providers). Performance and client data (e.g. quit rates; number of clients accessed; CO-verified quits; socio-economic status) collected from providers to unlock activity payments were input into the web-based client management system. Using these data, it was possible for the core stop smoking team to:

- Identify which providers were having difficulty delivering against their target;
- Identify what these issues might be (e.g. quality of service/inability to engage clients);
- Gather qualitative feedback on provider performance from service users using the client management system;
- Use this information to inform strategies to engage and support providers;
- Work with the providers to support improvement, leading to better outcomes for the population of South Birmingham

This change in staff role and the more efficient use of data for monitoring and evaluation purposes led to a significant increase in service uptake and is a good example of 'scaling up' an existing service model. Once it was clarified that the specialist Stop Smoking Service provider would be commissioned to deliver monitoring and support to locally enhanced service providers, activity carried out by GP and pharmacy-providers increased by 38% and 39% respectively.

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<sup>49</sup> South Birmingham PCT Annual Public Health Report (2007/08)

	2008/09		2009/10		Difference
	4-week quits	Quit rate	4-week quits	Quit rate	
Pharmacy	872	47%	1210	46%	+338
General Practice	578	44%	795	45%	+217

In addition, the use of the electronic client management system reduced the number of clients lost to follow-up from 3% (167 clients) in 2008/09 to only 1% (70 clients) in 2009/10.

## **Conclusion**

The last 10 years has seen a huge expansion in the accessibility and effectiveness of evidence-based interventions to help smokers quit. Although by themselves NHS Stop Smoking Services are limited in reducing overall prevalence of smoking within local communities, they are an important component of any tobacco control strategy.

Despite the outstanding place England has internationally, in terms of an ever improving understanding of the needs of smokers, and the constant improvement of smoking cessation technologies, NHS Stop Smoking Services are not as effective as they could be. Commissioning these interventions truly effectively involves a comprehensive and detailed set of activities, which consistently support the goals of more effective services, based on clear population needs provided by the most capable and cost effective provider(s) that meet the defined quality standards.

Based on findings from the Tobacco Control NST, the effectiveness of local services can be dramatically undermined if the challenges to assess, monitor, evaluate and respond to the needs of both local smokers and local service providers are not robustly responded to. In light of 'Healthy lives, healthy people: our strategy for Public Health in England' and the involvement expected from General Practitioners and local authorities within this new system, it is hoped that this guide will be of use and lead to a better understanding of the importance of robust commissioning and programme governance.



## SECTION 9 – EVALUATION

### Executive Summary of key findings

- 96% of respondents feel a visit from the Tobacco Control NST raised the profile of tobacco control work within their own and partner organisations;
- 91% of respondents said they would recommend the Tobacco Control NST diagnostic and support process to other local areas;
- 91% of stakeholders feel that the visit helped their local area adopt a more evidence-based approach to the delivery of tobacco control;
- A majority of respondents (69%) believe that the Tobacco Control NST visit improved local performance against key smoking-related targets.

### What stakeholders said about the Tobacco Control NST

*“(The visit was) very helpful and constructive. The members of the team were very knowledgeable, insightful but also diplomatic and sensitive to local challenges.”*

*An Assistant Director of Primary Care, South Central*

*“The Tobacco Control NST visit was very helpful and I would recommend to other areas. I would want to see the NST programmes continue, particularly the opportunity it provides to highlight best practice from around the country.”*

*A Director of Public Health North East*

*“The Tobacco Control NST visit was a positive experience which ensured that key stakeholders were able to get together. It helped multi-agency partnership working, raised the profile of tobacco control, not just smoking cessation; and a business case for tobacco control has since been developed.”*

*A PCT Chief Executive East of England*

*“After the visit, members of the TCNST facilitated an ISF workshop, which was represented by both the commissioners and members of the LSSS. This resulted in the development of a specific PCT ISF product, which is now implemented and has had a really positive impact. We successfully exceeded our 4-week quit target in 2009/10 by 130% and currently this trend (in 2010/11) looks likely to continue.”*

*A Tobacco Control Commissioner East of England*

*“A very helpful and positive experience that re-invigorated the tobacco control agenda and added to the good work that was ongoing.”*

*A PCT Chief Executive North West*



## Methodology

As part of a wider evaluation encompassing the Health Improvement NST programme,<sup>50</sup> senior stakeholders (e.g. Directors of Public Health) were asked to comment on the local impact of the Tobacco Control NST. To ensure robust engagement from local areas, PCT Chief Executives were contacted via telephone by a senior member of the NST. If the Chief Executive agreed to participate in the evaluation, they were then asked to identify approximately four other local stakeholders (including local authority staff) who would be asked to complete an online questionnaire. This questionnaire comprised a series of closed questions regarding the perceived impact of the Tobacco Control NST's visit to the local area. Stakeholders were also given an opportunity to provide additional comments at the end of the questionnaire.

## Main Findings

### *Response Rates*

All seven local areas in the Tobacco Control NST sample agreed to participate in the evaluation. Of the 32 individual stakeholders identified to participate in the process, 24 (75%) completed at least part of the questionnaire. These included five PCT Chief Executives, five Directors of Public Health, and two deputy Directors of Public Health.

Twenty-three out of twenty-four respondents (96%) felt that the Tobacco Control NST visit had successfully '*raised the profile of tobacco control*' in their own and partner organisations. Stakeholders also felt that the visit had '*improved multi-agency working*' (88%) and '*helped to change thinking*' (84%) within their organisation in relation to tobacco control (see Table 8 below).

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<sup>50</sup> See 'Evaluation of National Support Teams: Summary of Overall findings'

***A Comprehensive Guide To Achieving Effective Local Tobacco Control: Evidence, Support & Publications***

Table 8 – Broad impact of Tobacco Control NST visit for local area

The Tobacco Control NST process helped...	Yes	No	Don't know
<b>Raise the profile of tobacco control with local stakeholders</b>	96% (23)	4% (1)	0% (0)
<b>Change thinking around tackling smoking-related health inequalities</b>	84% (20)	8% (2)	8% (2)
<b>Improve multi-agency working around tobacco control</b>	88% (21)	8% (2)	4% (1)
<b>Improve performance against local smoking targets</b>	69% (16)	9% (2)	22% (5)
<b>Adopt a more evidence-based approach to tobacco control</b>	91% (21)	0% (0)	9% (2)

***Evidence-based practice***

Twenty-one out of twenty-three respondents (91%) reported that the Tobacco Control NST helped the local area adopt a more '*evidence-based*' approach to delivering tobacco control. When asked to indicate which guidance had been used to support this process, the majority of respondents indicated the DH's High Impact Changes document (N<sup>o</sup> = 16) followed closely by the DH's NHS Stop Smoking Service guidance (N<sup>o</sup> = 14) (see Table 9 below).

Table 9 – Guidance used by local areas to inform a more evidence-based approach to tobacco control

<b><i>Guidance used by local areas to inform a more evidence-based approach to tobacco control</i></b>	<b><i>% (N<sup>o</sup>)</i></b>
<b>Excellence in Tobacco Control: 10 High Impact Changes to Achieve Tobacco Control (DH)</b>	70% (16)
<b>NHS Stop Smoking Services: Service and Monitoring Guidance (DH)</b>	61% (14)
<b>Brief interventions and referrals for smoking cessation (NICE)</b>	48% (11)
<b>Smoking cessation – Varenicline (NICE)</b>	48% (11)
<b>Smoking cessation services (NICE)</b>	43% (10)
<b>Preventing the uptake of smoking by children and young people (NICE)</b>	39% (9)

<b>Workplace interventions to promote smoking cessation (NICE)</b>	39% (9)
<b>School based interventions to prevent smoking (NICE)</b>	35% (8)

### **Recommendations made to local areas**

At the close of a diagnostic visit, stakeholders are presented with a report providing recommendations on how the local situation might be improved. Respondents were asked to rate the usefulness of these recommendations on a scale of '0' ('Not Useful at All') to '5' ('Extremely Useful'). As can be seen in Table 10 below, recommendations on '*Multi-Agency Partnership Working*' and '*Communications*' were rated as the most helpful. Although 88% (N<sup>o</sup> = 14) of respondents scored '*Planning and Commissioning*' between 3 ('useful') and 5 ('extremely useful'), these recommendations were perceived as being of lesser significance than the other diagnostic areas.

Table 10 – Usefulness of recommendations made by the Tobacco Control NST \*

<b>Recommendations to Help Improve...</b>	<b>Total score</b>	<b>Mean Score</b>	<b>% rated 4 or 5<sup>†</sup></b>
<b>Multi-agency partnership working</b>	78.00	4.10	79%
<b>Communications</b>	66.00	3.70	67%
<b>Making it easier to stop smoking</b>	64.00	3.60	56%
<b>Normalising smoke-free lifestyles</b>	63.00	3.50	56%
<b>Monitoring, evaluation and response</b>	51.00	3.40	53%
<b>Tackling illegal and underage availability of tobacco</b>	62.00	3.40	50%
<b>Planning and commissioning</b>	53.00	3.30	31%

\* The number of respondents who scored each section varies depending on their individual areas of expertise.

† This is the proportion of respondents who rated the recommendation type as either 4 ('very useful') or 5 ('extremely useful').

### **Progress against local smoking targets**

Following input from the Tobacco Control NST, stakeholders were asked whether any progress has been made in delivering against their key smoking-related performance measures (see Table 11 below). The majority of respondents (69%) reported improved performance against their four-week quit targets, with 43% reporting 'significant' progress. As highlighted in Table 8 above, 69% of stakeholders

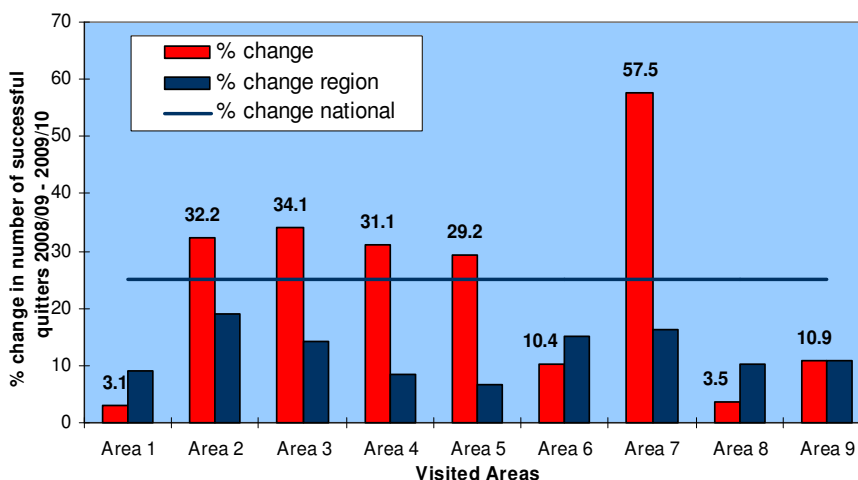
feel that the Tobacco Control NST were instrumental in helping them to achieve these improvements.

**Table 11 – Progress with smoking-related targets post Tobacco Control NST visit and support**

Progress with smoking related targets post Tobacco Control NST visit and Support	Significant progress	Some progress	No progress	Not applicable
<b>Four-week quitters</b>	43% (10)	26% (6)	0% (0)	30% (7)
<b>Smoking in pregnancy</b>	4% (1)	52% (12)	4% (1)	39% (9)

The number of individuals quitting smoking using NHS Stop Smoking Services in England has increased by 75% over the last seven years, reaching a high of 895 successful quitters per 100,000 adults. Many of the areas visited by the Tobacco Control NST have shown an improvement in performance in the period following the diagnostic visit:

- The majority (83%) of the visited areas currently have a Tobacco Control Alliance in place;
- Almost two thirds of the visited areas (61%) saw a decrease in their smoking in pregnancy rates in the period following the NST visit and just 15% experienced an increase. This finding mirrors the progress reported in Table 11 above;
- Visited areas<sup>51</sup> saw an increase of 25% in the number of successful four-week quitters between 2008/09 and 2009/10 compared to an increase of 10% nationally (see Figure 8 below).



**Figure 8 – Change in the number of 4-week quitters (2008/09 – 2009/10)**

<sup>51</sup> This is based on an analysis of areas that were visited by the Tobacco Control NST between October 2008 and June 2009.

## What stakeholders said about the Tobacco Control NST

Stakeholders were asked to provide additional comments about their experience of participating in a Tobacco Control NST visit, the majority of which were resoundingly positive. Key themes to emerge included:

- Reinforcement of the importance of multi-agency working between the PCT and local authority, with the Tobacco Control NST serving to 're-invigorate' the wider tobacco control agenda;
- Praise for the sensitivity of the approach taken and the enthusiasm of the team;
- The effectiveness of the visit process acting as a 'catalyst' for change;
- Appreciation of the knowledge and good practice shared by the team;
- Generally positive comments about the visit and how helpful it had been.

One DPH wrote, "They are the best National Support Team that I have been involved with," whilst a PCT Chief Executive described the visit as, "Really helpful, very constructive and approached in a very sensitive manner. It enabled us to drive through the necessary changes."

*"They are the best National Support Team that I have been involved with."*

*Director of Public Health  
East of England*

When responses were less than completely positive, stakeholders tended to qualify their observations. Three stakeholders placed their evaluation scores within the context of their local area already being a 'high achiever', therefore limiting the impact the visit could make. Another respondent raised the need for less intensive visits: "Although I would recommend a visit to other areas, the Tobacco Control NST visit was more resource intensive than Sexual Health and was more difficult to sell to partner agencies." There was also a comment suggesting more follow up support should be provided: "The visit was a great success, however, I felt there needed to be more detailed follow-up at three and six months then one year to maintain momentum."

## Summary

It is encouraging that over 90% of respondents would recommend a visit from the Tobacco Control NST to other local areas, highlighting the perceived benefit of this process to both stakeholders and their local populations. As the public sector undergoes significant change, it is vital that the NST reflect on how it can continue to influence the tobacco control agenda in a manner that resonates with local commissioners. The findings from this evaluation, alongside the analysis of tobacco control recommendations, will help to inform this process.

***“Overall I believe the input of the Tobacco Control NST was very helpful and constructive.***

*The members of the team were very knowledgeable, insightful but also diplomatic and sensitive to local challenges.*

*They... certainly acted as a significant catalyst for change within what was our own provider at the time. For instance, clearly recognising and stating that the stop smoking service was too closely aligned to the substance misuse team.*

*I believe the input from the NST was instrumental in the provider transferring the service to another Directorate and subsequently transforming itself.*

*The NST provided considerable support to the provider arm in terms of interim management, worked with staff to identify the changes they needed to make and helped them to recruit a new team leader*

*I personally found the opportunity to talk through the concerns with someone ‘independent’ helpful as I had recently assumed responsibility for this area of public health*

*They very correctly highlighted the importance of the wider tobacco control agenda – not just stop smoking services.*

*I fully agree that the NST was an excellent catalyst for helping us to change the way that Solent Health Care worked and we would not have moved the NHS SSS out of their previous Directorate without your help. You were an excellent source of support and advice to staff and helped her enormously. I am very clear that we would not have achieved our very challenging smoking target last year without the support from the NST.”*

*– A Director of Public Health, South East*

## SECTION 10 – RECOMMENDATIONS AND CONCLUSION

Tobacco Control NST visits resulted in a bespoke report for the visit area, which highlighted the scale of the challenge, the particular strengths that the area has, and a detailed set of recommendations to improve performance. Drawing on this approach and in collating experience from the field, from the subsequent systematic analysis of learning, and specific evaluation, the Tobacco Control NST would highlight the need for a strategic approach to comprehensive tobacco control through the set of recommendations below:

### **Key recommendations for successful local tobacco control:**

#### *Multi-agency Partnership working*

- Develop a strategic approach to tobacco control, which is co-ordinated across the partner agencies. Senior buy-in is essential so that those implementing a locally owned tobacco control strategy/plan have the mandate to carry out the work, are budgeted for and are supported.
- Understand how tobacco affects the local population at all levels and in all groups and communities:
  - Health impact
  - Prevalence across all ages, groups and communities
  - Economic impact
  - Contribution to health inequalities
- Use this information to win hearts and minds of politicians, elected members, medical consultants, commissioners, consortia etc. to enlist influential advocates and champions.
- Set aspirations and outcome measures, which are written into high level documentation, and provide governance and accountability through the newly emerging Health and Well-being Boards.
- Document all tobacco control activity in an implementation plan for consistency of approach and avoid duplication of work.

#### *Commissioning*

- It is important that commissioners fully understand tobacco control and are armed with the evidence, needs assessment, local insights and economic argument for action.
- It is recommended that financial resources are used appropriately and according to the evidence base.
- All tobacco control interventions, including all training needs, should be transparent, monitored and supported in contractual arrangements.
- Commission tobacco control pathways which are transparent in contractual arrangements such as maternity care, secondary care, long term conditions and chronic disease, cancer screening etc.

### *Data*

- Develop robust recording systems across all partners to fully understand the impact of tobacco locally and to be able to monitor and evaluate progress.

### *Communications and marketing*

- Develop a co-ordinated approach to communications so that all partners are giving a consistent message.
- Use social marketing and community development insight work to understand the population at a micro level so that messages are heard and understood by everyone.
- Cooperate together in national and local campaigns to reach all members of the community.
- Develop a consistent approach to branding and identity across all partners
- Identify local champions to act as spokespeople for media work, and enable them to be fully briefed on the local tobacco control approach.

### *Normalising smokefree and preventing uptake*

- Through social marketing and community development approaches help communities to understand the scale of the challenge within their community to take action and to encourage large scale behaviour change.
- Incorporate the tobacco control strategy into wider health and well being plans that tackle the wider determinants of ill health and health inequalities.
- It is vital to actively monitor and uphold all tobacco regulations.
- Consider local measures in problem areas e.g. smokefree grounds, play areas, outdoor venues especially where children and young people congregate etc.
- Share local intelligence across all partners to understand the scale of illicit activity and make the workforce aware of counterfeit and niche products such as Shisha, chewing tobacco and tobacco confectionery.
- It is important that all retailers are tackling underage sales and ensuring that 'as and when' workforce understand the importance of checking age of customer.
- Consider a proof of age scheme to make it easier for retailers to raise the issue.
- Encourage smokefree homes and cars by raising awareness of the harm of secondhand smoke in enclosed places.
- Encourage all partner organisations to be exemplars for healthy lifestyles by promoting themselves as a healthy workplace, offering staff support to stop



smoking, having smokefree sites/ grounds and by acting as positive role models themselves.

- It is vital that all those who work with young people understand their influence as role models and are trained to give appropriate advice.
- Be guided by NICE and DH regarding evidence-based school interventions.

### *Making it easier to stop smoking*

- Develop an ISF approach so that there are a full range of easily accessible, flexible services available to meet the needs of a diverse population, led by local intelligence and insight of population needs and wants.
- Anyone wanting to give up smoking should have access to all medications as a first line allowing choice, compliance and greater success.
- All those who are delivering support to stop should be appropriately trained, monitored, updated and supported.
- It is recommended that all partners are aware of the availability of services and can offer brief advice and signposting to services.

## **Conclusion**

Over the past 5 years the Tobacco Control NST has been in the unique and privileged position to work at a local level with a range of partners in tobacco control, at a regional level with tobacco policy and delivery managers and at a national level with the Tobacco Policy Team. This has enabled valuable cross team insights and the Tobacco Control NST has aimed to be a conduit for the dissemination of guidance and best practice, feeding back learning from the local level to help shape future guidance and strategy. The focus has been on the delivery of tobacco control at a local level and the difficulties organisations face in prioritising activity, particularly the whole range of tobacco control activities where there have been no specific performance indicators, have been experienced firsthand.

The Tobacco Control NST experience strengthens the view that to significantly reduce smoking prevalence and health inequalities, and make improvements sustainable in the medium and longer term, it is essential to deliver tobacco control in a comprehensive and consistent manner. Tobacco control needs to be recognised as core business for organisations, as does the need for strategic and cross-cutting action.

The Tobacco Control NST is delighted that tobacco control remains a priority within 'Healthy lives, healthy people: our strategy for public health in England'. The aim to create environments that further discourage smoking and help bring about cultural change to make it less attractive is a worthy one and will be enhanced by the publication of 'Healthy lives, healthy people: a tobacco control plan for England', to the development of which the Tobacco Control NST has contributed.

The hope is that this legacy document, as well as previous publications such as 'Excellence in tobacco control: 10 High Impact Changes to Achieve Tobacco

Control', will be useful in helping the public health workforce, their partner organisations and local communities to further develop tobacco control in the future. This will be important in changing social norms and attitudes towards smoking, with the ultimate aim of reducing the disease, disability, inequalities and death related to tobacco use.

*This document was produced by the Tobacco Control NST, March 2011:*

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