Tobacco control: joint strategic needs assessment (JSNA) support pack

Good practice prompts for planning comprehensive local tobacco control interventions in 2016-17
Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.
Introduction

Smoking is still the single largest cause of health inequalities and responsible for around half the difference in life expectancy between the richest and poorest.¹

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

Cut costs to local public services.
In England each year it is estimated that smoking costs the public £13.8bn in terms of the output lost from early deaths, smoking breaks, NHS care, sick days, the impact of passive smoking, household fires, and smoking litter.²

Protect children from harm.
Two thirds of smokers say they began smoking before the age of 18 at which it is legal to purchase cigarettes and nine out of ten before the age of 19. (General Lifestyle Survey 2011).³ Children exposed to tobacco smoke are at much greater risk of cot death, meningitis, lung infections and ear disease.⁴

Boost the disposable income of the poorest people in your local area.
Two adult smokers with 20-a-day habits are likely to spend over £5000 per year on cigarettes. Workers in routine and manual jobs are twice as likely to smoke as those in managerial and professional roles.⁵ Poorer smokers spend five times as much of their weekly household budget on smoking than richer smokers.⁶

Drive improvement across key measures of population health.
Reducing smoking rates will impact on core indicators included in three out of the four public health domains identified in “Improving outcomes and supporting transparency: A public health outcomes framework for England”.⁷ Examples of indicators which would be positively affected include:

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

**Joint strategic needs assessments**

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

**Aim of this support pack**

Public Health England (PHE) supports local authorities in the delivery of locally appropriate interventions and services to improve the public’s health, by providing data, interpretation and evidence. This pack supports the JSNA process and the commissioning of comprehensive tobacco control interventions. Local authorities, and their partners, are also encouraged to participate in CLeaR, an evidence based improvement model, that can assist in evaluating the effectiveness of local action addressing harm from tobacco.

**Feedback**

This is PHE’s second edition of the JSNA resource pack focused on tobacco control. It builds on the conversations and feedback from commissioners and other local stakeholders regarding the first version’s usefulness and value as a resource for reference, and to support for investment in comprehensive local tobacco control.
1. Commissioning principles for comprehensive local tobacco control

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

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

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

- having well-functioning partnerships between local authority-led public health, the NHS (clinical commissioning groups (CCGs) and NHS England local area teams (LATs)), acute health services, mental health services and adult social care, regulatory services, children’s services and criminal justice agencies
- operating transparently according to assessed need
- bringing partner agencies and services providers together into cost-effective delivery systems
- fully involving service users and local communities, including through Healthwatch

All people who smoke tobacco are offered a cessation intervention suited to their needs.

Tobacco control is a prominent action within strategies aimed at addressing health and social inequalities

What questions should you ask to check you are following the evidence and best practice that supports the principle?

1.1 Embedding in local systems

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

1.1.2. Do we have suitable mechanisms in place within the local public health structure to ensure the impact of tobacco is reported to the health and wellbeing board?
1.1.3. Do those responsible for commissioning tobacco control and stop smoking services have established partnership arrangements in place with CCGs, local clinical networks, NHS England LATs, regulatory services and criminal justice agencies?

1.1.4. Is there a formal strategic partnership in place for tobacco control involving key stakeholders and agencies (acute health, mental health, public health, regulatory services, employment, social care, children’s services, fire and rescue service and criminal justice)?

1.1.5. Are these partnerships set up within a fully integrated and comprehensive system that aims to prevent smoking uptake, support smokers to stop, reduce the harm and inequalities caused by smoking, and that advocates for a smokefree generation?

1.1.6. Have such strategic partnerships undertaken a self-assessment\(^9\) to enable you to:
- evaluate your local action on tobacco
- ensure that local activity follows the latest evidence-based practice
- identify priority areas for development?

1.1.7. Have strategic partner organisations acknowledged their responsibilities under Article 5.3 of the WHO Framework Convention on Tobacco Control (FCTC) by signing the Local Government Declaration on Tobacco Control?\(^10\)

1.1.8. Is information readily available to the general public, health care professionals and staff in partner agencies (including the voluntary sector) that promotes understanding of local stop smoking services, how they can be accessed and how people can be referred to them for support?

1.2 Needs assessment

1.2.1. Does the local JSNA include a comprehensive section on tobacco control that reflects need across the whole spectrum of reducing smoking-related harm and health inequalities, and readily acknowledges the impact of tobacco control activity across the public health outcomes framework (PHOF) and NHS outcomes framework (NHSOF) resulting in partnership, collaboration and support?

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

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

1.2.4. Does analysis of tobacco-related hospital admissions inform the targeting of interventions locally?
1.2.5. Do commissioners analyse and monitor local stop smoking service treatment data, including specific breakdown by gender, age, postcode, condition, route of referral and treatment outcome, so that treatment provision can be aligned with need?

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

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

1.3. Resources and investment

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

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

1.3.3. Have the partners identified the potential ‘return on investment’ for funding tobacco control interventions and does this include the economies to be achieved by commissioning supra-local activity?11

1.4. Effective commissioning

1.4.1. Do interventions commissioned for tobacco control and the tackling of smoking-related harm take an evidence-based approach such as outlined in NICE guidance?

1.4.2. Is there a tobacco control strategy that describes how best to meet local need and clearly identifies:
   - the level of local demand
   - existing strengths and ways in which services can be commissioned to maximise positive outcomes
   - finance and resources made available
   - how these can be utilised to meet local need?

1.4.3. Are reliable cost-effectiveness data tools used to inform commissioning decisions and ensure that investment in tobacco control is based on an understanding of expenditure, performance and effectiveness?
1.4.4. Do contracts for commissioned services specify key performance indicators and are these regularly monitored and reviewed?
1.4.5. Are interventions and services geographically and socioculturally appropriate to those for whom they are designed?
1.4.6. Have commissioning functions undergone a review of their fitness for purpose?
1.4.7. Is there sufficient tobacco control commissioning capacity and expertise?
1.4.8. Are arrangements in place to facilitate supra-local commissioning with regional partners?
1.4.9. Does formal evaluation of the range of tobacco control interventions feature within the commissioning strategy?
2. Supporting people to stop smoking successfully

Stop smoking services are a key component of highly cost-effective tobacco control strategies at local and national level. Targeted, high-quality stop smoking services are essential to the reduction of health inequalities in local populations. All health and social care services can play a key role in identifying smokers and referring people to stop smoking services. For those people who are not ready, willing or able to stop in one step, harm reduction interventions can support them in moving closer to becoming smokefree.

The role of electronic cigarettes in supporting people to stop smoking

A recent independent evidence review commissioned by PHE highlighted that smoking is increasingly concentrated in disadvantaged groups who tend to be more dependent and that e-cigarettes may offer a new opportunity to engage smokers, reduce smoking prevalence and improve health. Currently only one e-cigarette (or nicotine vapourising product) has been given marketing authorisation as a medicine, although it has not yet come onto the market. As soon as licensed e-cigarette products are made available the NHS will be able to prescribe them alongside other stop smoking medicines such as patches and gum. Stop smoking services can work with smokers who want to use their own e-cigarettes in a quit attempt, providing valuable behavioural support to increase their chance of success. Further guidance is available from the National Centre for Smoking Cessation and Training (NCSCT).

Statement of principle

Targeted stop smoking services, as an integral part of any comprehensive tobacco control strategy, provide high-quality evidence-based support to those people who require it the most.

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

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

Stop smoking services should achieve exhaled carbon monoxide (CO) validated success rates comparable to areas with similar smoker profiles and within the nationally prescribed range.

Lost to follow-up rates should be comparable with the national average.

Successful stop smoking interventions are delivered to vulnerable populations and those identified as at risk in the JSNA.
All licenced stop smoking medications are available as first line treatment options, including nicotine replacement treatment (NRT) in combination.

People who are using or want to use e-cigarettes to stop smoking can also receive support from their local stop smoking service.

Services receive a high satisfaction rating from clients/service users.

Services are independently audited and improvement plans are implemented where required.

There are clear and efficient referral pathways embedded throughout health and social care services and these are routinely used to engage smokers with stop smoking services.

Services are promoted locally to raise awarenss of the support available for people who want to stop smoking.

All required monitoring data is reported to the Health and Social Care Information Centre (HSCIC) through the quarterly reporting system.\[^{15}\]

What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?

2.1 Is service design and delivery informed by the latest evidence base, summarised in the local stop smoking service delivery and monitoring guidance 2014-15\[^{16}\] and in NICE guidance?

2.2 Has an equity impact and gap analysis been carried out or is one planned, and do our commissioning priorities reflect this?

2.3 Have all stop smoking practitioners achieved certification through the NSCST?

2.4 Are all licensed stop smoking medicines offered as first-line interventions, including NRT in combination, varenicline, and bupropion?

2.5 Can services provide behavioural support to clients who want to use unlicensed nicotine containing products such as e-cigarettes?\[^{17}\]

2.6 Do those who have most to gain from the service (ie, smokers with mental health problems, pregnant smokers, those from routine and manual groups, etc) make up an appropriate proportion of total service users?

2.7 Are local stop smoking service providers monitored to ensure equitable success rates?

2.8 Are four-week quit outcomes collected, validated biometrically by measurement of exhaled carbon monoxide and is the full data set submitted quarterly to the HSCIC?

2.9 Do service specifications require providers to reduce the number of clients who are lost to follow-up?

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2.9 Do service specifications require providers to reduce the number of clients who are lost to follow-up?
2.10 Have harm reduction approaches been considered as part of the overall strategy to support smokers in addition to the provision of stop smoking interventions?

2.11 Are services required to promote the availability of stop smoking interventions, both to the public and to health professionals, including appropriate referral pathways?
3. Tobacco harm reduction

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

Although existing evidence is not clear regarding the health benefits of smoking reduction alone, those who reduce the amount they smoke are more likely to stop smoking eventually, particularly if they are using licensed nicotine-containing products.\textsuperscript{18}

NICE public health guidance (PH45) Tobacco: harm-reduction approaches to stopping smoking covers:

1. Stopping smoking and using one or more licensed nicotine-containing products as long as needed to prevent relapse.
2. Cutting down prior to stopping smoking with or without the help of licensed nicotine-containing products.
3. Smoking reduction with or without the help of licensed nicotine-containing products.
4. Temporary abstinence from smoking with or without the help of licensed nicotine-containing products.

Electronic cigarettes for harm reduction

E-cigarettes present an additional option for smokers to reduce the harm from smoking, particularly for those who may have tried other methods of quitting without success. Although current NICE guidance does not specifically mention the use of unlicensed products, the principle that smokers should have access to safer forms of nicotine holds. Use of e-cigarettes, or vaping, is estimated to be around 95% less harmful than smoking, therefore encouraging smokers who cannot or do not want to stop smoking to switch to e-cigarettes could be adopted as one of the key strategies to reduce smoking-related harm.\textsuperscript{12}

EU Tobacco Products Directive

From May 2016, new regulations under the revised EU Tobacco Products Directive (TPD, currently under consultation by the UK government) will bring in tighter standards of quality and safety for unlicensed e-cigarette products. Licensed e-cigarettes, when available, will be regulated under existing medicines legislation, for which the Medicines and Healthcare Products Regulatory Agency (MHRA) is responsible.
The TPD will also introduce restrictions on advertising of unlicensed e-cigarettes. Regulatory services should be aware of these changes and be prepared for appropriate local enforcement actions.

**Statement of principle**
The best thing a smoker can do is to stop immediately, completely and forever. For those people who are not ready, willing, or able to stop completely and in one step, harm reduction interventions can support them in moving closer to becoming smokefree.

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

Public awareness of the harm caused by smoking and secondhand smoke is linked to information on how people who smoke can reduce the risk of illness and death, to themselves and others, by using (licensed) nicotine-containing products.

Provision of harm reduction interventions do not detract from the provision of local stop smoking service interventions.

People who are not ready, willing, or able to stop in one step are offered a harm-reduction approach with use of licensed nicotine-containing products recommended.

People continue to use (licensed) nicotine-containing products in the long term rather than risk relapsing after they have stopped or reduced their smoking.

**What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?**

3.1 Is advice on quitting completely and in one step offered to all smokers in the first instance?
3.2 Is referral to a stop smoking service made where support is required?
3.3 Are all types of licensed nicotine-containing products offered to people who smoke, as part of a harm reduction strategy and in combination where required?
3.4 Are licensed nicotine-containing products offered to help prevent relapse among people who have stopped smoking or reduced the amount they smoke?
3.5 Are people who want or need to abstain temporarily on a short, medium or longer term basis advised on how to do this?
3.6 Is behavioural support offered to people who want or need to abstain temporarily?
3.7 Are harm reduction interventions incorporated into the management of smoking in the care plan for people in closed institutions who smoke?
3.8 Can it be demonstrated that investment in harm reduction approaches will not or does not detract from existing stop smoking services?
3.9 Do providers of stop smoking and other behaviour change services offer people who smoke harm reduction approaches if they are not ready, willing or able to stop abruptly?
3.10 Are these harm reduction approaches available in the community, as part of primary and secondary healthcare, and on offer from local authorities?
3.11 Has the role of e-cigarettes in harm reduction been considered and included in local strategies and service specifications?
3.12 Can services provide behavioural support to clients who want to use unlicensed nicotine containing products, such as e-cigarettes, to help them quit smoking?\(^1^9\)
3.13 Have activity and outcome measures been developed to assess the performance of service providers involved in the provision of harm reduction approaches?
4. Supporting pregnant smokers and those with infants to stop smoking

Addressing smoking in pregnancy should be a focus for all localities as this impacts on a range of issues related to health, inequalities and child development. NICE has produced guidance on how best to support women to stop smoking in pregnancy.\textsuperscript{20}

Smoking during pregnancy causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year in the UK. It also increases the risk of developing a number of respiratory conditions; attention and hyperactivity difficulties; learning difficulties; problems of the ear, nose and throat; obesity; and diabetes.\textsuperscript{21 22 23}

Although rates are lower than in the past, 11.4\% of women in England are recorded as smoking at the time of delivery, which translates into around 70,000 infants born to smoking mothers each year.\textsuperscript{24}

There are significant demographic differences and factors associated with inequalities related to this issue. For instance, pregnant mothers under the age of 20 are more than three times as likely to smoke as mothers aged 35 or over. Those in routine and manual occupations are more than four times as likely as those in managerial and professional occupations to smoke throughout pregnancy (29\% and 7\% respectively). Infants born to smokers are much more likely to become smokers themselves, which further perpetuates health inequalities.\textsuperscript{25}

Treating mothers and their babies (0-12 months) who have problems caused by smoking during pregnancy is estimated to cost the NHS between £20m and £87.5m each year.\textsuperscript{26}

**Statement of principle**

All pregnant women who smoke, those who are planning a pregnancy or who have an infant aged less than 12 months, should be referred for help to stop smoking.

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

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

All pregnant women are screened for carbon monoxide (CO) at the booking appointment, and ideally at all subsequent antenatal appointments. If elevated levels are identified (indicating smoking) a referral is made to a specialist smoking cessation advisor for further discussion and/or support to stop.
Robust, opt-out referral pathways are in place between the healthcare professional who raises the issue of smoking with the pregnant women and the stop smoking service, or person trained to provide the intervention. This will include feedback mechanisms to ensure the referring HCP is aware of the outcome.

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

What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?

4.1 Is NICE Guidance (PH26) appropriately implemented across systems in your local area?
4.2 Do service specifications for local midwifery services include requirements for the issue of smoking to be addressed?
4.3 Do these specifications include routine CO screening at booking appointments and ideally other appointments?
4.4 Are there appropriate key performance indicators in place to monitor this activity, and are there systems in place to address poor performance?
4.5 Are individuals who smoke provided with appropriate and consistent messages around smoking, the risks of continuation and the importance of cessation, as well as the risks associated with second-hand smoke.
4.6 Are there appropriate opt-out referral pathways in place, ensuring women with elevated CO levels have swift access to the stop smoking service or specialist midwife?
4.7 Are there effective feedback mechanisms to the referrer that provide information and details of future follow-up?
4.8 Are all healthcare professionals who meet with pregnant women trained in Very Brief Advice for smoking in pregnancy enabling them to raise the issue of smoking and refer to specialist services?27
4.9 Are those providing stop smoking interventions appropriately trained and does the training meet NCSCT Standards?28
4.10 Are stop smoking interventions provided on an ongoing basis, in line with the evidence base, and is information on and access to stop smoking medications made available?
4.11 Is smoking status a mandatory data item collected at booking, including recording of the CO reading?
4.12 Is smoking status at time of delivery (SSATOD) monitored regularly within and across the locality?
4.13 Does the system for SSATOD data collection include the option of ‘not known’? If so are there plans to remove this to ensure more accurate and informative data collection?
4.14  Is there a local multi-agency partnership in place with appropriate local leadership to address the issue of smoking in pregnancy? Is there a strategy?

4.15  Are contract specifications reviewed regularly? Is there a process for monitoring delivery and outcomes?
5. Smokefree homes and cars

Millions of children in the UK are exposed to second-hand smoke that puts them at increased risk of respiratory problems, meningitis and sudden unexplained infant death. Each year this results in over 300,000 GP visits and around 9,500 hospital admissions in the UK and costs the NHS more than £23.6m.²⁹,³⁰

A survey of 1,000 young people aged 8-13, undertaken on behalf of the Department of Health in October 2011, demonstrated that children want smokefree lives. It found that:

- 98% of children wish their parents would stop smoking
- 82% of children wish their parents wouldn’t smoke in front of them at home
- 78% of the children wished their parents wouldn’t smoke in front of them in the car
- 41% of children said cigarette smoke made them feel ill
- 42% of children said cigarette smoke made them cough

Exposure to second-hand smoke in confined spaces such as a car is particularly hazardous. As there is no safe level of exposure to tobacco smoke, it is important that other vulnerable groups such as older adults are also protected.

As well as the health risk, normalisation of smoking behaviour is an important consideration given that exposure to adult smoking is the main influencing factor for uptake by children. As non-smoking adult role models become increasingly the norm, rates of children and young people taking up smoking will decline.

**Statement of principle**

Smokefree environments are healthier places for infants, children and young people to grow and older adults to live.

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

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

Frontline health and social care workers advise about the benefits of a smokefree home or car.

Local policies and plans are in place to increase smokefree spaces, including enclosed environments, supporting smokers to create and maintain smokefree homes and cars.
Partners are in a position to educate the public on compliance with new smokefree legislation banning smoking in vehicles when someone under the age of 18 is present.31

What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?

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

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

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

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

5.5 Have smoking cessation advisors and frontline health and social care workers completed the NCSCT module for very brief advice on secondhand smoke?32

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

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

5.8 Do you have evidence that commitments to smokefree homes and cars are being adopted and maintained?
6. Preventing young people from taking up smoking

Smoking has been shown to be a childhood addiction, not an adult choice.\(^{33}\) The majority of smokers start while in their teenage years with very few new smokers beginning after the age of 20. It is estimated that approximately 207,000 children aged 11-15 start smoking each year in the UK,\(^ {34}\) with 13% of 15-year olds classified as regular or occasional* smokers.\(^ {35}\)

Many factors contribute to an increased likelihood of young people starting to smoke. These include whether a parent, carer or sibling smokes, the level of exposure to tobacco industry marketing, tobacco imagery in the media and the availability of cheap tobacco. Lower socio economic status, higher levels of truancy and substance misuse are also associated with higher rates of youth smoking.

Young people who smoke can be particularly susceptible to negative health effects, in the short and the long-term, including respiratory illness and poorer lung function. Smoking can also impair lung growth in children and young people.

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

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

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

There are tobacco policies in learning environments that are widely understood and aim to prevent smoking uptake and increase cessation in young people.

Education content implemented in learning environments informs young people about short and long-term health, and the economic and societal consequences of tobacco use.

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

* Regular smokers are defined as usually smoking at least one cigarette per week and occasional smokers as usually smoking less than one cigarette per week
A reduction in the number of young people exposed to smoking role models and instances of smoking.

A reduction in the availability and affordability of tobacco for young people.

What should you ask to test whether interventions are based on accurate local evidence and best practice and will help you to meet the principle?

6.1 Is tobacco prevention work in schools evidence-based?  
6.2 Do schools have a tobacco policy that is understood and implemented?  
6.3 Do schools include tobacco education as part of the curriculum?  
6.4 Are adult-led and peer-led interventions adopted and maintained?  
6.5 If peer-led interventions are rationed, do you prioritise in areas of greatest need?  
6.6 If you commission tobacco prevention work for young people that is not evidence-based, is it evaluated and are the results published?  
6.7 Are frontline workers in schools and youth settings trained to discuss smoking with young people?  
6.8 Are young people who smoke offered very brief advice by frontline workers in school and youth settings?  
6.9 Is there access to a freely available and evidence-based stop smoking service for everyone who smokes or uses tobacco in any other form?  
6.10 Is the stop smoking service accessible to young people?  
6.11 Are harm-reduction approaches offered for those who smoke but do not want to quit?  
6.12 Are there evidence-based programmes in place to protect young people from the harms of second-hand smoke. [Further prompts are provided in section 5: Smokefree homes and cars.]  
6.13 Do you monitor compliance with point-of-sale legislation for tobacco?  
6.14 Is training and information offered to retailers to maintain or strengthen compliance with point of sales legislation?  
6.15 Is your monitoring and enforcement of point of sale legislation intelligence-led?  
6.16 Are systems in place to identify and report sales of illicit tobacco locally? [Further prompts are provided in section 11: Tackling cheap and illicit tobacco.]
7. Workplace interventions

Reducing levels of smoking among employees will help reduce illnesses and conditions such as cardiovascular disease and respiratory problems, which are important causes of sickness absence. This will result in improved productivity and a reduced burden on employers and employees.

The workplace has several advantages as a setting for smoking cessation interventions: large numbers of people can be reached (including groups who may not normally consult health professionals, such as young men), there is the potential to provide peer group support and a non-smoking working environment encourages people who smoke to quit. (NICE PH5)\(^\text{41}\)

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

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

A widely accessible stop smoking service available to all employees.

Employers supporting employees through quit attempts by enabling access to stop smoking services.

Where demand is identified, stop smoking clinics delivered on site in workplaces.

Smokefree working environments and comprehensive smokefree policies are consistently enforced.

**What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?**

7.1 Is support for smoking cessation established in local workplace wellbeing initiatives?\(^\text{42}\)

7.2 Are there established channels of communication between the stop smoking service and local employers?

7.3 Have barriers to accessing stop smoking support from the workplace been identified?

7.4 Are employees routinely provided with information on local stop smoking support services. Are staff allowed time off to attend stop smoking services?

7.5 Do larger employers in the area allow the local stop smoking services to attend events to offer very brief advice?
7.6 Are public sector smoking policies an exemplar to other local employers?
7.7 Does your policy facilitate the use of licensed nicotine replacement therapy in the workplace?
7.8 Does your policy make a clear distinction between smoking and use of e-cigarettes in the workplace and, where possible, provide for a more facilitative approach to the latter?
7.9 Are all employees protected from secondhand smoke in their workplace, including those who provide home visits, or visit other workplaces?
7.10 Is our smokefree policy regularly reviewed and updated if necessary?
8. Mental health

Smoking is around twice as common among people with mental health problems and even higher in those with more severe disease. With up to three million smokers in the UK, 30% of them have evidence of mental disorder and up to one million have long-standing disease. A third of all cigarettes smoked in England are smoked by people with a mental disorder. In contrast to the marked decline in smoking prevalence in the general population, smoking among those with mental disorders has changed little, if at all, over the past 20 years. Smokers with mental disorders are just as likely to want to stop as those without, but are more likely to be heavily addicted to smoking, more likely to anticipate difficulty stopping smoking, and historically much less likely to succeed in any attempt.

Statement of principle
Comprehensive tobacco control strategy provides high quality evidence based interventions to those people who require it the most.

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

NICE guidance specifically related to smoking cessation and tobacco control is implemented fully in all aspects of care for individuals with mental health problems.

People with poor mental health are provided with the same, or better, opportunities to access support services as the general population.

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

Effective links between primary and secondary care provision, resulting in seamless care that is fundamentally linked to other health outcomes.

Providers of mental health services have an excellent understanding of what they are required to deliver in relation to smoking cessation and smokefree environments.

Smokefree signage and application of policy is clear and consistent throughout the estate, with high levels of compliance.

Those people who do not want, or are unable to stop smoking in one step, are offered other strategies to reduce the harm of tobacco, as outlined in NICE public health guidance PH45: tobacco harm reduction.
What questions should you ask to check you are following the evidence and best practice that supports the principle?

8.1 Has NICE public health guidance (PH48), which supports mental health trusts’ implementation of smokefree policies, been followed and have staff and patients had an opportunity to voice and overcome their concerns?†

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

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

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

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

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

8.7 Do specialist cessation services for those with mental illness achieve results comparable with the best services nationally?

8.8 Are mental health service users able to access stop smoking medications?

8.9 Are polices in place to monitor levels of other relevant medication as a result of smoking cessation?

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

8.11 Do services achieve the desired outcomes?

8.12 Has demand for services increased?

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

8.14 Are policies in place regarding use of unlicensed nicotine-containing products within the mental health estate?

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

Nationally around 80% of prisoners smoke compared with just under 20% in the general population, with similar levels recorded across the offender journey in police custody and community supervision where data are available.\textsuperscript{48,49}

This high rate of smoking causes health problems to the smokers themselves and to non-smokers who are exposed to their tobacco smoke. The offender population has a high prevalence of poor mental health and other substance misuse, and offenders are predominantly from disadvantaged backgrounds,\textsuperscript{50,51} all of which are associated with elevated smoking prevalence. Offenders who smoke and those exposed to this smoke experience a marked increase in health inequalities.

A strong case for addressing smoking among offenders is endorsed in ‘Improving health, supporting justice,\textsuperscript{52} which recognised high levels of health needs among offenders, whether in police custody or under community supervision and included key objectives such as working in partnership, equity of access to services, improving pathways and continuity of care.

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

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

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

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

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

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

There are links throughout the offender pathway, resulting in seamless care that is fundamentally linked to other health outcomes.
Licenced nicotine-containing products are available and offered to those entering a custodial situation for the first time.

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

Those people who do not want or are unable to stop smoking in one step should be offered other strategies to reduce the harm of tobacco, as outlined in NICE public health guidance PH45: tobacco harm reduction\textsuperscript{53}

What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?

9.1 Has NICE public health guidance been followed and have staff and offenders had an opportunity to voice and overcome their concerns?
9.2 Has consultation with appropriate stakeholders, including groups who represent offenders, influenced the design of services?
9.3 Are the needs of people in custody or in community supervision sufficiently well understood to ensure that services are appropriately commissioned?
9.4 Do governors, senior management and senior clinicians support and champion the process?
9.5 Do all staff in custodial and community settings receive training on brief interventions for smoking cessation, with medical and nursing staff receiving more extensive training? This should also include training staff in prison settings, in particular health providers, listeners and peer supporters. Such training would advise on best practice for assisting those with mental health problems to successfully give up smoking.
9.6 Is smokefree accommodation an integral part of a more health-promoting culture within custodial settings, providing alternative, meaningful activity during the day?
9.7 Do specialist cessation services for those in custody or community supervision achieve results comparable with the best services nationally?
9.8 Are outcomes monitored in such a way as to ensure that they reduce health inequalities?
9.9 Do services achieve the desired outcomes?
9.10 Has demand for services increased?
9.11 Are those people who do not want or are unable to stop smoking in one step offered other strategies to reduce the harm of tobacco, as outlined in NICE public health guidance PH45: tobacco harm reduction?
9.12 Are stop smoking services in the community linked to prison-based services in order to provide post release support?
10. Secondary care

Stopping smoking at any time has considerable health benefits for people who smoke and those around them. For people using secondary care services, there are additional advantages, including shorter hospital stays, lower drug doses, fewer complications, higher survival rates, better wound healing, decreased infections, and fewer re-admissions after surgery.\textsuperscript{54}

Secondary care providers have a duty of care to protect the health of people who use or work in their services and to promote healthy behaviour among them. This duty of care includes providing effective support to stop or abstain from smoking while using or working in secondary care services. (NICE PH 48)\textsuperscript{55}

**Statement of principle**
Secondary care settings present an excellent opportunity to engage with people who smoke and this engagement will have positive outcomes for the recipient and the provider.

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

People who attend secondary care settings and who smoke are offered advice and support to stop.

All hospitals have an on-site stop smoking service that provides intensive behavioural support and pharmacotherapy as an integral component of secondary care.

Integrated care pathways exist that allow for a seamless transition of care between primary and secondary settings.

Stop smoking medications are available on hospital formularies and available to support people experiencing nicotine withdrawal when in hospital.

There are no designated smoking areas or staff-facilitated smoking breaks for anyone using secondary care services.

Strong leadership and management that ensure premises remain smokefree.

All secondary care estates are designated completely smokefree and it is clear to all patients, staff and visitors that this is the case.
Local tobacco control strategies include secondary care as a main point of contact for smokers.

What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?

10.1 Do all secondary care settings have a policy on smoking cessation and smokefree compliance for staff and patients?

10.2 Do local tobacco control strategies include secondary care?

10.3 Is information on the stop smoking policies and services available provided for planned or anticipated use of secondary care?

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

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

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

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

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

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

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

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

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

10.13 Are staff provided with support to stop smoking?
11. Tackling cheap and illicit tobacco

The illicit tobacco market is in long-term decline but remains a problem in some communities. It undermines tobacco-control measures, including taxation and age of sale regulations, enabling children to start a lethal addiction and encouraging smokers to smoke more than if they were paying full price. Criminal activity in the illicit trade tends to target smokers in deprived areas, increasing health inequalities further.\(^{56}\)

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

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

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

Full engagement between public health, police regional intelligence units, trading standards and HMRC and other regulators to improve the intelligence base.

Active intelligence-led enforcement in the locality, followed by PR to increase the intelligence flow.

A greater awareness and understanding of the impact of illicit tobacco among partner organisations and the general public.

Clear data and intelligence on the levels of demand for illicit tobacco enabling priority communities to be targeted.

Increased reporting of illicit tobacco from the general public.

**What should you ask to test whether you are doing what the available evidence and best practice suggests will help you meet the principle?**
11.1 Have local measures been established to measure the impact of activity, including levels of information received from the public, seizures and enforcement activity, and increased partnership working between agencies?\textsuperscript{57}

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

11.3 Is there a safe, anonymous intelligence-sharing resource available for the public and partner agencies to use?

11.4 Is there a dedicated budget for illicit tobacco enforcement activity/social marketing activity?

11.5 Is there collaboration on illicit tobacco between local areas within the region?

11.6 Has a public opinion and stakeholder survey been carried out on illicit tobacco?

11.7 Do the local Trading Standards Authorities and Police Forces recognise tackling illicit tobacco as a strategic priority within broader tobacco control work?\textsuperscript{58}

11.8 Is there a regional policy in place on WHO Framework Convention on Tobacco Control Article 5.3: protecting policies from the interests of the tobacco industry?
Next steps

It is hoped that this JSNA resource will prove valuable in supporting local tobacco control commissioning programmes. Comments on its content and examples of its use in supporting the JSNA process are welcome.

Supporting strategic partnerships

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

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

Self-assessment: CLeaR model

CLeaR is an evidence-based improvement model that helps you to develop local action to reduce smoking prevalence and the use of tobacco. The model is designed for use by local authorities, tobacco alliances and health and wellbeing boards. The CLeaR model offers:

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

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


Commissioning principles for comprehensive local tobacco control


10. Local Government Declaration on Tobacco Control www.smokefreeaction.org.uk/declaration/index.html


Supporting people to stop smoking successfully


Tobacco harm reduction


Supporting pregnant smokers and those with infants to stop smoking


28 National Centre for Smoking Cessation & Training (NCSCT). Training, resources, midwifery briefing – London: National Centre for Smoking Cessation and Training www.NCSCT.co.uk

Smokefree homes and cars


Preventing young people from taking up smoking

33 Two thirds of smokers become addicted before the age of 18 and 39% under 16. See data from the General Lifestyle Survey

34 Hopkinson NS, Lester-George A, Ormiston-Smith N, Cox A, Arnott D. Child uptake of smoking by area across the UK. Thorax. 2013 Dec 4

www.hscic.gov.uk/catalogue/PUB17879


Workplace interventions


42 The Workplace Wellbeing Charter
www.wellbeingcharter.org.uk/CubeCore/m/providers?provider=Health%40Work

Mental health

www.rcplondon.ac.uk/sites/default/files/smoking_and_mental_health_-_key_recommendations.pdf


Offender health


Secondary care


Tackling cheap and illicit tobacco

Tackling Illicit Tobacco for Better Health Partnership www.illegal-tobacco.co.uk


Guidance for Trading Standards on engaging with the tobacco industry, prepared by Trading Standards officers in the Tackling Illicit Tobacco for Better Health Partnership in consultation with Trading Standards colleagues [in print] www.illegal-tobacco.co.uk

Next Steps