Smoking cessation: commissioning

Commissioning of smoking cessation

Following the passage of the Health and Social Care Act in 2013 the responsibility and funding for commissioning smoking cessation services now sits within local authorities.

When commissioning smoking cessation services local authorities must be guided by the Public Health Outcomes Framework, local joint strategic needs assessments, and joint health and wellbeing strategies.

Clinical commissioning groups (CCGs) however continue to have a role in ensuring that the services they commission for their populations have an approach to smoking cessation that will reduce the harm caused by tobacco and yield better value services.

It is also important for CCGs to ensure that other smoking cessation activities, particularly the routine and systematic delivery of brief interventions, are included within all contracts with frontline provider services. These services and providers such as district nursing, maternity services, primary care and acute trusts are ideally placed to encourage and refer smokers to stop smoking services. Commissioners from both CCGs and public health also need to work collaboratively to raise awareness of evidence based services within their local area.

Health services should ensure:

- Staff are offered smoking cessation therapy
- People using the service have their smoking status checked
- Have a wide range of Nicotine Replacement Therapy (NRT) available to deal with withdrawal if admission is required.
- The service has a quit smoking lead
- Staff have information to refer people to local services
- Staff who see patients have VBA (Very Brief Advice) training (see document on smoking cessation training suppliers -)

Encouraging improvement

The National Institute for Health and Care Excellence (NICE) recommends that commissioners use the quality standard on smoking cessation to insert statements and measures in the service specification of a standard contract and establish key performance indicators as part of tendering. CCGs can also encourage improvements in provider performance by using quality standard measures in association with incentive payments such as the commissioning for quality and innovation (CQUIN) payment framework.

NICE quality standards provide a baseline against which improvements can be measured and rewarded, enabling commissioners to address gaps in service provision, support best practice and encourage evidence-based care.
The NICE quality standard, Smoking: harm reduction, published in July 2015, says services should be commissioned from providers that train health and public health practitioners to advise people who are unwilling or not ready to stop smoking that health problems associated with smoking are caused primarily by components in tobacco smoke other than nicotine. It also recommends that commissioners ensure that service specifications include a requirement that providers of 'stop smoking' services offer harm-reduction approaches to smoking to people who are unwilling or not ready to stop smoking.

Commissioners may need to specify smoking cessation arrangements for specific groups of people, for example, young people, people with mental illness, pregnant women, people in prison and people with asthma or chronic respiratory problems such as COPD.

Respiratory Services

For every 1% increase in prevalence of smoking in a practice there is a 1% increase in asthma and COPD admission rates.

The annual QOF smoking returns suggest that up to 1:4 people with common long-term conditions continue to smoke. Whilst there is currently no national data set of smoking prevalence in people with respiratory disease there is evidence to suggest that at least as many people with asthma smoke as in the UK general population.

COPD: COPD therapy trials over the last decade have shown that at least one third of subjects are consistently characterised as current smokers, with no apparent change over that time. In two boroughs of London, smoking prevalence in COPD has recently been recorded as 40% (Tower Hamlets - 2011) and 47% (Southwark -2013). 82% of people with COPD have another long-term condition that could also be improved by smoking cessation.

People with COPD find it harder to quit and they do relapse but there is convincing evidence that they want to quit and can quit with evidence-based interventions. Sometimes practice resources may not be sufficient to provide this intervention and referral to specialist services should be considered.

Asthma: It is known that smoking makes asthma worse, increases admissions and effectively neutralises the effect of standard dose inhaled steroids requiring people with asthma who smoke to take higher dose and potency inhaled steroids.

Hospital services

Any patient attending A&E or being admitted to hospital with asthma should have their smoking status checked and if admitted should be offered NRT to help manage withdrawal.

Any patient started on high dose (>1000bdp equivalent) inhaled steroids who smokes should be provided with a high dose steroid safety card and be offered stop smoking therapy as treatment for asthma and to encourage cessation and step down to standard levels of steroids.

A&E departments seeing children with asthma and respiratory problems should offer a brief intervention to parents and any other household members who smoke to support them with stopping smoking.

Stop before the op – Smoking and Surgery

There is strong evidence that smokers who undergo surgery have:

- A higher risk of lung and heart complications
- Higher risk of post-operative infection
- Impaired wound healing
- More admissions to an intensive care unit
- An increased risk of dying in hospital
- Higher risk of readmission
- Longer length of stay in hospital

Any patient attending a pre-assessment clinic should have a risk assessment based on smoking status and a treatment plan offered according to NICE guidance. Initial assessment at surgical outpatients should include a carbon monoxide level and record of smoking pack years.

During hospitalisation

This time is often a 'teachable moment' were patients are more receptive to intervention and more motivated to quit. Patients are ideally placed to be given information about treatment options, support through withdrawal and to be signposted to specialist services. The hospital smoke free environment supports abstinence. Abstaining from smoking at this time can lead to significant health benefits.

Smoking drives inequalities

A report called Smoking Still Kills by ASH, endorsed by PCRS-UK, says smoking is a key driver of health inequality. More than half of the difference in premature deaths between the highest and lowest socio-economic groups in England is attributable to differences in smoking rates between these groups. Although there are many factors that affect this inequality, the contribution of smoking is so great that someone in the least privileged socio-economic group who does not smoke has a better chance of survival than someone in the most privileged group who does smoke.

Pregnant women

Every time a heathcare professional has contact with a pregnant woman who smokes (including through children's centres, teenage pregnancy and youth services) they should use that opportunity to give brief advice and refer them to stop smoking services.

Women in the lowest socio-economic group are most likely to smoke during pregnancy, according to Smoking Still Kills.

Mental health services

Up to 33% of people with mental health problems and more than two-thirds (70%) of patients in psychiatric units, smoke cigarettes. 42% of all the tobacco smoked in the UK is by people with a mental health problem. People in prison and the homeless have higher rates of both mental illness and smoking. People with severe mental illness are more likely to die prematurely and predominantly from physical diseases caused or made worse by tobacco smoking.

Smoking Still Kills says people with longstanding anxiety, depression or another mental health condition are twice as likely to be smokers as those who do not have any mental health problems. Rates of smoking increase with the severity of the disorder, ranging from 25% among people with eating disorders to 56% among those with probable psychosis. Over the last 20 years, smoking prevalence has changed little in those with severe illness.

Recent studies show that people with mental health problems are just as likely to want to stop smoking as the general population and are able to stop when offered evidence-based support.

Royal College of Physicians/Royal College of Psychiatrists 2013 guidance recommends that all professionals working with or caring for people with mental disorders should be trained to deliver brief cessation advice, to provide or arrange further support for those who want help to quit and to provide positive (i.e. non-smoking) role models.

Cancer services

Quitting smoking enhances cancer therapy. Smoking cessation before the initiation of radiation therapy in lung cancer is associated with an increased rate of complete response to treatment compared to those who continue to smoke through treatment.

Impact of smoking cessation on people with HIV

People who are HIV positive tend to smoke more than the general population. Patients with HIV who smoke shave a dozen years from their life expectancy and may have a four-fold risk of death compared with non-smoking patients with HIV, even when they receive antiretroviral therapy.

People with HIV who smoke are more likely to get HIV-related infections and develop other serious illnesses including COPD, heart disease and stroke and a cancer.

What makes an effective stop-smoking service?

Research into intervention characteristics and success rates, adjusting for key smoker characteristics, finds that:

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

In Summary

Smoking Still Kills recommends that commissioners:

- Ensure that good quality evidence-based Stop Smoking Services are accessible to all smokers, particularly those from lower socio-economic groups and disadvantaged populations.
- Ensure that smokers with mental health problems and smokers with long term conditions receive stop smoking interventions as a routine part of their care.
- Promote universal adherence to NICE guidance on tobacco, especially: brief interventions and referral for smoking cessation; smoking cessation in secondary care: acute, maternity and mental health services; quitting smoking in pregnancy and following childbirth (ensure that midwives have the training, equipment and time to undertake carbon monoxide screening with every pregnant woman).
- Ensure that Stop Smoking Services and all health professionals are equipped to provide accurate, high quality information and advice to smokers about the relative risks of nicotine and all nicotine containing products.
- Increase the support and information available to smokers who are unable to quit to switch to less harmful sources of nicotine, in line with the principles set out in the NICE guidance on tobacco harm reduction.

Resources for commissioners

- PCRS-UK EQUIP Module 1 Prevention and Treatment – smoking cessation. https://www.pcrs-uk.org/resource/Improvement-tools/equip-module-1-prevention
- Support for commissioning smoking cessation. NICE. August 2013 http://www.nice.org.uk/guidance/qs43/resources/qs43-smoking-cessation-supporting-people-to-stop-smoking-support-for-commissioning2
- Quality Standard for Smoking Cessation. Smoking cessation: supporting people to stop smoking. NICE. August 2013. http://www.nice.org.uk/guidance/QS43
- NICE Quality Standard. Smoking: harm reduction. July 2015. http://www.nice.org.uk/guidance/qs92
- Smoking Still Kills. ASH 2015. http://www.ash.org.uk/current-policy-issues/smoking-still-kills

- Behaviour change: individual approaches NICE. January 2014 http://www.nice.org.uk/guidance/PH49
- Smoking Services – Needs Analysis: A Toolkit for Commissioners. National Centre for Smoking Cessation Training 2012. http://www.ncsct.co.uk/usr/pub/NCSCT%20needs%20analysis.pdf
- CLeaR Local tobacco control assessment. Public Health England July 2014. https://www.gov.uk/government/publications/clear-local-tobacco-control-assessment
- ASH The case for local action on tobacco http://www.ash.org.uk/localtoolkit Local costs of smoking ready reckoner.
- Local Tobacco Control Profiles for England. Public Health England http://www.tobaccoprofiles.info
- Stop Smoking Service: monitoring and guidance update. Department of Health September 2012 https://www.gov.uk/government/publications/stop-smoking-service-monitoring-and-guidance-update-published
- PCRS-UK Smoking cessation resources - https://www.pcrs-uk.org/smoking-cessation

Date of Production: November 2014

Resource Number: 2014SC006.1

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Updated October 2015

The PCRS-UK smoking cessation resources have been sponsored by an educational grant from Pfizer Ltd. The views expressed in this publication are not necessarily those of either the sponsor or the Primary Care Respiratory Society UK

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