Public Health
England

Protecting and improving the nation's health

Models of delivery for stop smoking services

Options and evidence

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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List of abbreviations

Carbon Monoxide	CO
CleaR tobacco control self-assessment tool	CLeaR
Joint Strategic Needs Assessment	JSNA
National Centre for Smoking Cessation and Training	NCSCT
National Institute for Health and Care Excellence	NICE
Nicotine Replacement Therapy	NRT

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Foreword

Tobacco control in England is changing fast. Smoking rates are falling faster than at any time in the last decade yet the most deprived families, people with mental health problems and many pregnant women in deprived communities are being left behind. New but uncertain approaches are emerging and while supporting patients who smoke to quit is key to NHS sustainability, many local authorities are finding universal evidence-based services hard to sustain.

In preparing this tool we are responding to reports of local need and we are grateful to colleagues in local authorities who have provided feedback and helped us make important improvements. This is just one part of a family of tools that Public Health England offers to help local decision makers in relation to tobacco control: Local Tobacco Control Profiles offer an up-to-date picture of local prevalence and permit swift and reliable comparisons with other similar localities; JSNA support packs are produced annually for every local authority combining local data with commissioning prompts; and CLeaR self assessments offer a powerful diagnostic tool for system-wide improvement. Which tool fits best will depend on where a locality is on its journey to becoming smokefree.

Providing support for smokers to quit is highly cost effective[i] and the evidence is clear that smokers who receive a combination of pharmacotherapy and skilled behavioural support are up to four times as likely to quit successfully[ii]. It is clear that to reduce inequalities and improve public health, local systems need to identify their priority populations and provide them with this effective support to quit. These groups will be determined locally, but may include pregnant women, people with mental health problems, routine and manual workers and those with long term conditions.

Aim of this paper

This briefing is intended to support directors of public health and local healthcare commissioners in rapidly appraising the evidence, to enable informed decisions around the provision of local stop smoking support. In it we:

- describe interventions to support smokers to stop and evidence of effectiveness (service components)
- set out the different models for delivering these interventions currently being considered by local authorities (service models)

Martin Dockrell, Tobacco Control Programme Lead
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1. Stop smoking services and evidence-based interventions

Stop smoking services were rolled out nationally in 2000 and since that time have supported an estimated 1 million smokers to quit for good, typically heavy smokers at greatest risk from smoking-related diseases.

These services have been built around the principle of a universal offer of support available for all smokers, with a combination of behavioural support and pharmacotherapy. In 2017, whilst evidence for this model remains strongest, it is recognised that due to changes in commissioning and budgetary constraints local areas are now in some cases considering alternative modes of delivering stop smoking support.

A broad base of peer-reviewed evidence and official guidance is available on stop smoking interventions and how services to support smokers should be provided.

This includes information from the Cochrane Collaboration[iii], NICE (PH10[iv] & QS43[v]), and the NCSCT Service and Delivery Guidance[vi], which rates different interventions according to evidence of effectiveness.

Table 1 contains details of interventions that may be included in the package of support offered by a local stop smoking service. These are ranked in order, starting with interventions that have the strongest evidence base for effectiveness. A short summary of each component is provided, along with an indication of the likely effect size and a brief recommendation related to commissioning.

Table 1: Stop smoking interventions ranked for evidence of effectiveness and effect size

Rank	Component[1]	Summary	Evidence of effectiveness[vii]	When done properly, boosts quit rates by …[4]	Commissioning recommendation
1.	**Face–to-face group support with pharmacotherapy**	Weekly group sessions facilitated by one or more specialist stop smoking practitioners[2] with a number of smokers at a specified time and place, lasting approx. 1 hour for between 6 and 12 weeks. All smokers have access to their choice of pharmacotherapy and smoking status is verified by Carbon Monoxide (CO) monitoring at each session.	A	300%	This format has a very strong evidence base and will produce high success rates. It may be more applicable in an area or setting with a fairly large pool of smokers (a minimum of eight members is recommended to start a closed group). It is important that practitioners receive specialist training and continued supervision.
2.	**Face-to-face individual support with pharmaco-therapy**	Weekly sessions for an individual smoker with a specialist stop smoking practitioner, at a specified time and place, sessions averaging approx. 30 – 45 minutes over a 6 – 12 week period. All smokers have access to their choice of pharmacotherapy and smoking status is verified by Carbon Monoxide (CO) monitoring at each session.	A	200-300%	The majority of stop smoking interventions currently take place through one-to-one sessions[viii]. It is important that practitioners receive specialist training and continued supervision.
3.	**Supported use of pharmacotherapy**	This option involves providing smokers with stop smoking medication(s) (varenicline, NRT, bupropion) of their choice and giving appropriate information and support to use it in a way that will maximise effectiveness. It just needs one appointment to get started and one follow-up to check progress.	A[3]	50-100%	The easiest way to commission this is through GP prescriptions, but pharmacies may also be an option. It is essential to make varenicline and dual form NRT (eg transdermal patch plus a faster acting form) available as these offer the best chances of success.
4.	**Telephone support**	Multiple sessions of proactive telephone support provided by a trained advisor for 6 – 12 weeks[ix]. Sessions average 15 – 30 minutes and work best with multiple sessions in the first	A	50-100%	The boost in quitting rates depends on following optimal treatment protocols, with proactive telephone calls made by the specialist advisor to the individual

		week. Important to have a system for smokers to access stop smoking pharmacotherapy. While evidence of effectiveness is strong in the US, it is weaker for programmes tried in the UK.			who has sugned up for this support. If a way can be found for smokers easily to access medication, the boost should be greater.
5.	**Text message support**	Although evidence is a bit more limited on text messaging, it is clear that it can improve quit success rates compared with nothing. Because we have less evidence it is important to use a programme that has been tested directly.	B	40-80%	If considering this option, commissioners should look to existing programmes that have been fully tested. It is not recommended that new local programmes are developed without evaluation.
6.	**Online**	There is evidence that online information (websites) can be effective in supporting smokers to stop but none of the sites evaluated in randomised trials are available currently so websites should not be the only support offered to smokers[x].	B	Unknown	Websites can be a very cost-effective way of informing smokers about methods of stopping. If they are to be used as tailored support programmes it is important to understand that each website needs to be evaluated and these are not a substitute for the strongly evidence-based sources of support (behavioural support and pharmacotherapy)[xi].
7.	**Mobile digital applications**	There is limited evidence to date on the effectiveness of mobile applications and more good quality research is required before this option can be recommended.	C[3]	Unknown	There are a few mobile applications that appear to follow good practice but none has been proven effective, so these should not be used **instead** of the strongly evidence-based programmes (behavioural support and pharmacotherapy)[xii].

[1]Components: These interventions should adhere to the abrupt model that requires a smoker to set a quit date and commit to the 'not one puff' rule after that date.
[2] Stop smoking practitioners: Any practitioner delivering stop smoking interventions should be trained to the appropriate NCSCT standards.
[3]Graded by experts based on evidence published since the NCSCT Service and Delivery Guidance in 2014 (eg West et al 2015) from which other ratings are obtained.
[4]Assessment of improved success rates complied by Professor Robert West based on combined evidence from peer reviewed publications and NICE Guidance.

Box 1: Electronic Cigarettes

Background:

- Use of e-cigarettes has increased substantially in recent years and is currently the most ***popular*** quitting method in England.
- Behavioural support from a trained advisor, together with pharmacotherapy remains the most ***effective*** intervention
- Stop smoking services can provide what is known to effective, offering smokers using e-cigarettes in their quit attempt the best chance of **stopping smoking successfully**.

Evidence:

Research trials[a] and stop smoking service data returns[b] both indicate that e-cigarettes can help smokers to quit, may be at least as effective as licensed medications and that an increasing number of people are choosing this option.

Recommendation:

- Stop smoking services should offer an '**e-cigarette friendly' approach**. This involves being open to the use of e-cigarettes by those who wish to do so, providing behavioural support and offering stop smoking medications alongside an e-cigarette if chosen by the indvidual.

Further information is available in the **NCSCT briefing**[c] for stop smoking services.

[a] Cochrane review: Hartmann-Boyce, J., McRobbie, H., Bullen, C., Begh, R., Stead L.F & Hajek, P. (2016). Can electronic cigarettes help people stop smoking, and are they safe to use for this purpose? http://www.cochrane.org/CD010216/TOBACCO_can-electronic-cigarettes-help-people-stop-smoking-and-are-they-safe-use-purpose

[b] NHS Digital (2016). Statistics on NHS Stop Smoking Services: England, April 2015 to March 2016. http://content.digital.nhs.uk/catalogue/PUB21162

[c] NCSCT: Electronic cigarettes: A briefing for stop smoking services - http://www.ncsct.co.uk/publication_electronic_cigarette_briefing.php

2) Models of service delivery

A local stop smoking service may be commissioned to deliver all or a selection of the intervention components described in table 1. Key considerations in selecting the model to be commissioned include:

- the preferred approach should always be to ensure those in priority populations are offered, and can easily access, effective support (ie behavioural support and medication) to maximise reductions in smoking prevalence and health inequalities. Priority populations may include pregnant women, people with mental health problems, routine and manual workers and those with long term conditions
- the intensity of support offered is an important factor. This should be sufficient to address the needs of the population so as to have the required impact
- if commissioning intensive behavioural support is not possible, a minimum service offering smokers access to medication and support with appropriate use should be made available

Table 2 provides a description of the main models currently being considered by local authorities, with recommendations for commissioners regarding the implications of each.

Table 2: Stop smoking service models and recommendations for commissioning

	Model description	Summary	Commissioning recommendation
1.	**Universal evidence-based service with specialist behavioural support and pharmacotherapy over (at least) a six week period[xiii], available for all smokers to access.**	This is the basis on which the stop smoking services in England were established and continues to be the recommended approach. Presented in the NCSCT Standard Treatment Programme[xiv]. Trained practitioners, for whom delivering stop smoking interventions forms all or most of their role, provide weekly sessions of around 30 minutes, ideally face to face although later sessions may be conducted over the phone, to smokers who set a quit date in the second or third week of the programme and receive their choice of medication (either on prescription or through a locally devised voucher system). People are supported for at least four weeks following the quit date and may be seen in groups or on a one-to-one basis. Outcomes are biochemically validated by carbon monoxide (CO) readings at the end of treatment. Telephone and text messaging may be incorporated into the service offer for additional support and/or contact between appointments. The provider may sub-commission the delivery of stop smoking interventions in certain settings, and is responsible for ensuring these are of equally high quality, delivered by appropriately trained practitioners with regular monitoring and mentoring.	Will provide the best quality outcomes. Should always be the first option considered for commissioning stop smoking interventions. If funds are not available for a full universal offer, then consider providing this level of quality service to priority groups.
2.	***Stop Smoking* +: a proposed new model for stop smoking services[xv]**	This is a three-tier approach proposed as a new way of organising local stop smoking support. This new framework has been developed based on existing evidence, but with the financial restrictions faced by local authory commissioners in mind. The aim is to maintain provision of cost-effective support for quitting, provided in a way that ensures priority groups are offered the most intensive and effective interventions. This model had three levels: a) Evidence-based specialist support for smokers who need it and are willing to make the necessary commitment to quit (as	This model has the potential to achieve efficiencies by providing specialist support to smokers who would most benefit based on their motivation and willingness to engage, although it will be vital to ensure disadvantaged and priority smokers are supported to receive the more intensive specialist option, otherwise there is a risk of inequity and inequality.[1]

		described in model 1) b) Brief support and a stop-smoking medicine for those who want help but are not willing to commit to a specialist course c) Self-support for those who want to stop but do not want professional support All options should be made easily accessible, ensuring smokers understand the difference between each and the commitment required – they can then make an informed choice as to which route to follow. Specialist support is still delivered by highly trained advisors, with brief support and medication offered by a variety of healthcare professionals and up-to-date self-support materials (written or online) provided in settings such as GP surgeries for those who do not wish to access professional support. An example is www.london.stopsmokingportal.com – see box 2 for an example.	
3.	**Integrated lifestyle/wellbeing services**	This term is often used to describe a situation where a range of services are organised collectively through an umbrella organisation or brand offering a range of wellbeing interventions. It is important to be aware of the distinction between the two main models of integrating services and the different type of support offered – see 3.1 and 3.2 below.	
3.1	**Providing dedicated specialist stop smoking support**	On making contact with the umbrella organisation, individuals are triaged into specific treatment programmes, eg stop smoking. Behavioural support and pharmacotherapy is available as described in model 1, with practitioners trained appropriately (NCSCT Standard) to deliver stop smoking interventions.	Setting the stop smoking service within a broader wellbeing collaboration has advantages, particularly in relation to savings associated with administration and promotion. Assuming quality of interventions is maintained, outcomes similar to model 1 can be expected. These services can also be targeted to specific groups if finances do not permit a universal offer.[1]
3.2	**Offering multi-behaviour change interventions**	The provision of lifestyle/wellbeing advice where smoking forms part of multi-behaviour change interventions. May be delivered by health trainers or those with generic training in addressing risky behaviours, promoting behaviour change and/or motivational interviewing.	Whilst there is some evidence for addressing risky behaviours such as poor diet and physical inactivity concurrently, multiple behaviour change interventions involving smoking

			are **not** found to be effective in successfully supporting smokers to stop[xvi]. This approach is not found to be effective or cost effective.
4.	**Pharmacy only services** **(delivered by pharmacist or pharmacy assistant)**	Pharmacy teams have an important role in promoting and encouraging attempts to stop smoking and can be trained to provide effective stop smoking interventions. This often occurs in the community, but hospital and GP based pharmacists are also well placed to offer this support. Pharmacy practitioners are also well placed to offer stop smoking interventions with behavioural support and medication, as described in section 1, and there is evidence that this can be effective[xvii]. However, relying on this setting for service provision will limit the scale and quality of interventions available and requires individual pharmacies to sign up to provide the service (including engaging with the relevant training and returning required data).	Stop smoking interventions provided in the pharmacy setting can be delivered successfully when staff are appropriately trained, monitored and mentored – arrangements need to be made to ensure this is in place. Commissioners should be mindful that the number of smokers accessing support in any single pharmacy is likely to be small. Consideration should be given as to how the availability of this support is promoted and the way in which this is accessed from other points of identification eg pregnant women from maternity services and those with mental health conditions, to ensure priority groups are being reached effectively.
5.	**Hospital 'in-house' stop smoking services**	Targeting services at smokers in the healthcare system, including hospital inpatients, can make an important contribution to the sustainability of local health and social care services and reduce inequalities.	Local authorities and the local NHS may consider joint commissioning of services, particularly for priority populations such as pregnant smokers, smokers with mental health conditions and smokers with long term conditions such as asthma and diabetes.

[1] Note: These models have not yet been evaluated - any implementation should be evaluated for efficacy and cost implications.

Box 2: Taking care with *definitions*

Digital: The term digital has two different meanings in the context of stop smoking services:

a) The provision of stop smoking interventions through a digital channel eg web-based prorammes or mobile apps. There is limited evidence for this approach and not recommended in place of other more established options (see rows 6 and 7 in Table 1).

b) The presentation of information relating to the different types of stop smoking support available, allowing the smoker to choose which option suits them best. This approach is being trialed in London with the Stop Smoking+ model (see row 2 in Table 2 and Box 3).

Integrated services: This format for arranging treatment options has been used to describe different types of service, most commonly:

a) One organisation responsible for delivering a range of different services, including stop smoking, where after initial contact with a central ‘hub’ individuals are directed to specialst support where they receive an evidence-based intervention with a trained stop smoking advisor (see row 3.1 in Table 2).

b) Multi-behaviour change interventions, where smoking is addressed in conjunction with a number of other risky behaviours, eg poor nutrition, physical inactivity, high alcohol consumption. This type of intervention is not found to be effective in helping smokers to stop (see row 3.2 in Table 2).

Box 3: A new model for framing stop smoking support?

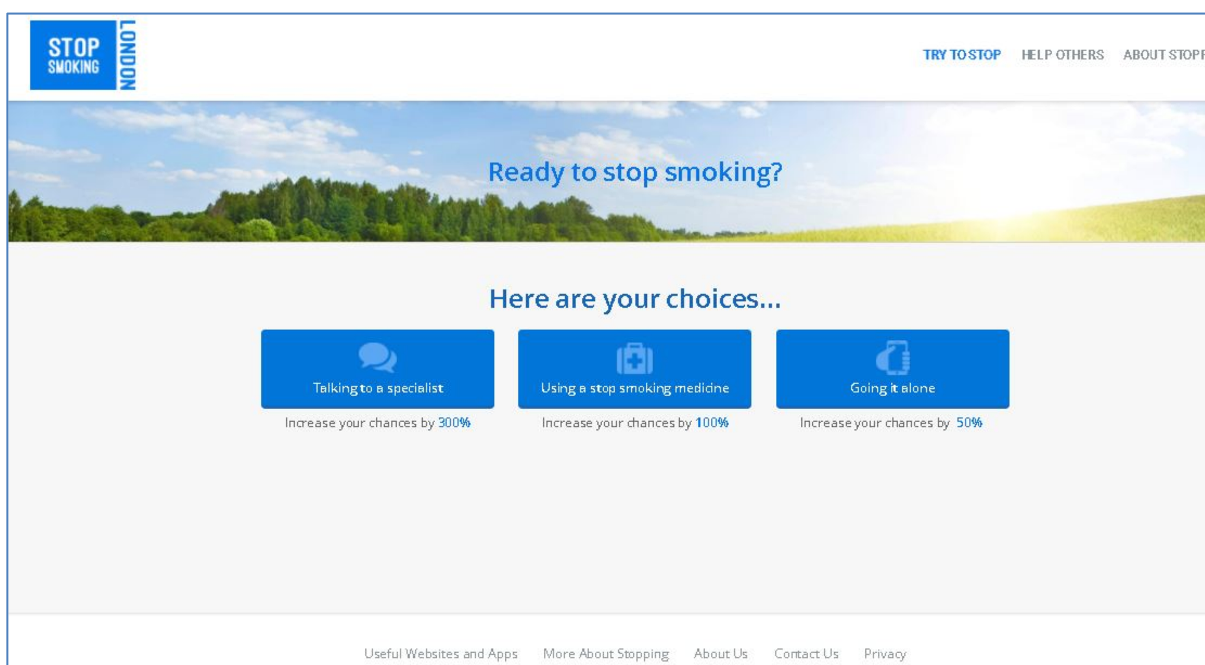
Stop Smoking+ (as described in row 2 Table 2) and the Stop Smoking London web portal[a] https://london.stopsmokingportal.com/

Aim: Every smoker in London knows **what options are available** to them locally and is assisted in finding the one that suits them and their level of commitment best.

The portal (website) **signposts** London smokers to: local stop smoking services, telephone support, stop smoking medication with brief advice, or digital solutions such as apps and other self-help materials for those who wish to quit without professional help.

An additional enhanced offer of **proactive telephone advice** is also being piloted. This service will provide callers to the national smokefree number from London[b] the opportunity to receive a telephone intervention from NCSCT trained advisors.

This approach is being **evaluated** to assess reach (borough-specific info), access (clicks and calls), user experience (through follow up emails) and quit rates (via the telephone helpline).



[a]This work is funded by the London Association of Directors of Public Health, with Support from Professor Robert West (UCL) and CRUK.

[b] Three Boroughs not participating

3) Additional good practice for commissioning

- Appropriate measures are in place to ensure the service is run efficiently and effectively. Monitoring, mentoring and governance frameworks should be set out clearly. For more detail see section 3 of Service & Delivery Guidance, along with Annex A for a checklist for commissioners[xviii].

- NICE guidance recommends that local services should aim to treat around 5% of their smoking population each year with a success rate of at least 35%, any less instigating exception reporting and investigation into the quality of interventions provided.

- Biochemical (CO) verification is important to validate smoking status and as a marker of quality service provision.

- To maximise outcomes, behavioural support should be provided by those trained to the appropriate NCSCT standards[xix], with the full range of products to assist smokers in dealing with withdrawal symptoms made available (eg NRT, Varenicline) or signposted (eg e-cigarettes).

- Stop smoking services remain an important component of a comprehensive approach to tobacco control, including enforcement/regulation, communications and action on illicit tobacco, which when implemented collectively and sustainably have been shown to reduce smoking prevalence.

- Mobile applications may have some value as an adjunct to evidence based interventions, but there is no evidence for their use as a replacement. Where mobile applications are incorporated into a local offer of support, these should be carefully evaluated.

4) Key guidance

NICE public health guidance

Supporting smokers to stop (PH10) https://www.nice.org.uk/guidance/ph10
Smoking: brief interventions and referral (PH1) https://www.nice.org.uk/guidance/ph1

Public Health England

Joint strategic needs assessment (JSNA) support pack:
Good practice prompts for planning comprehensive local tobacco control interventions in 2017-18
http://www.nta.nhs.uk/uploads/jsna-support-pack-prompts-tobacco-control-201718.pdf
Key data sources for planning effective tobacco control in 2017-18
http://www.nta.nhs.uk/uploads/t-jsna1516example.pdf

National Centre for Smoking Cessation & Training

Service and Delivery Guidance
http://www.ncsct.co.uk/usr/pub/LSSS_service_delivery_guidance.pdf
Standard Treatment Programme
http://www.ncsct.co.uk/usr/pub/standard_treatment_programme.pdf
Training Standard
http://www.ncsct.co.uk/usr/pub/NCSCT_training_standard.pdf

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[iii] Cochrane Tobacco Addiction Group - http://tobacco.cochrane.org/evidence

[iv] NICE Public Health Guidance: Supporting smokers to stop - https://www.nice.org.uk/guidance/ph10

[v] NICE Quality Standard: Smoking: Supporting smokers to stop - https://www.nice.org.uk/guidance/qs43

[vi] NCSCT Service and Delivery Guidance - http://www.ncsct.co.uk/usr/pub/LSSS_service_delivery_guidance.pdf

[vii] NCSCT Service and Delivery Guidance - http://www.ncsct.co.uk/usr/pub/LSSS_service_delivery_guidance.pdf

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[xii] West et al (2015). Health-care interventions to promote and assist tobacco cessation: a review of efficacy, effectiveness and affordability for use in national guideline development. Addiction, 110, 1388–1403

[xiii] NICE PH10 - https://www.nice.org.uk/guidance/ph10/chapter/4-Recommendations

[xiv] NCSCT Standard Treatment Programme - http://www.ncsct.co.uk/publication_ncsct-standard-treatment-programme.php

xv West, R. (2017). Stop-Smoking+: a possible approach to commissioning. Expert testimony to inform NICE guideline development.

[xvi] NCSCT Integrated health behaviour (lifestyle) services: a review of the evidence http://www.ncsct.co.uk/usr/pub/Integrated%20health%20behaviour%20services%20review.pdf

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[xviii] NCSCT Service and Delivery Guidance – Section 3 *Monitoring* and *Checklist for Commissioners* - http://www.ncsct.co.uk/usr/pub/LSSS_service_delivery_guidance.pdf

[xix] NCSCT Training Standard http://www.ncsct.co.uk/usr/pub/NCSCT_training_standard.pdf