NICE National Institute for Health and Care Excellence

NICE support for commissioning for smoking cessation: supporting people to stop smoking

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1 Introduction

Implementing the recommendations from NICE guidance and other NICE-accredited guidance is the best way to support improvements in the quality of care or services, in line with the statements and measures that comprise the NICE quality standards. This report:

- considers the cost of implementing the changes needed to achieve the quality standard at a local level
- identifies where potential cost savings can be made
- highlights the areas of care in the quality standard that have potential implications for commissioners
- directs commissioners and service providers to a package of support tools that can help them implement NICE guidance and redesign services.

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. They draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. For more information, see NICE quality standards.

Commissioning services in line with the NICE quality standard for smoking cessation contributes to improving outcomes of the Public Health Outcomes Framework 2013–2016 and NHS Outcomes Framework 2013/14. Each quality statement has accompanying quality measures, which focus on

improving the processes of care that are considered to be linked to health, public health and social care outcomes.

Commissioners can use the quality standards to improve services by including quality statements and measures in the service specification of the standard contract and establishing key performance indicators as part of tendering. They 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.

Commissioners can use the quality standard measures to make a baseline assessment of local practice against the statement and its measures. They should discuss the results with relevant providers and use this information to prioritise areas for improvement and to measure and reward performance. These priorities should be addressed in future service improvement or commissioning plans.

Health and wellbeing boards or local strategic partnerships may wish to ask clinical commissioning groups and local authorities to report on their performance against the quality standards.

This report on the smoking cessation quality standard should be read alongside:

Published

- NICE quality standard for smoking cessation. NICE quality standard 43 (2013).
- NICE quality standard for antenatal care, which includes statement 5 on risk assessment – smoking cessation.
- Tobacco harm reduction. NICE public health guidance 45 (2013).

- Quitting smoking in pregnancy and following childbirth. NICE public health guidance 26 (2010).
- School-based interventions to prevent smoking. NICE public health guidance 23 (2010).
- Identifying and supporting people most at risk of dying prematurely. NICE public health guidance 15 (2008).
- Preventing the uptake of smoking by children and young people. NICE public health guidance 14 (2008).
- Smoking cessation services. NICE public health guidance 10 (2008).
- Brief interventions and referral for smoking cessation. NICE public health guidance 1 (2006).
- Varenicline for smoking cessation. NICE technology appraisal guidance 123 (2007).
- Quitting smoking in pregnancy and following childbirth. NICE support for commissioning (2012).

In development

- Smoking cessation: acute, maternity and mental health services. NICE public health guidance. Publication expected November 2013.
- Behaviour change (partial update of PH6). NICE public health guidance. Publication expected December 2013.

2 Overview of smoking cessation

NICE has published a range of guidance to support smoking cessation which can be seen in the NICE pathway on smoking. NICE has also published a tobacco Return On Investment Tool.

Smoking is the main cause of preventable illness and premature death in England. It is the primary reason for the gap in healthy life expectancy between rich and poor.

A wide range of diseases and conditions are caused by smoking, including cancers, respiratory diseases, coronary heart and other circulatory diseases,

stomach and duodenal ulcers, erectile dysfunction and infertility, osteoporosis, cataracts, age-related macular degeneration and periodontitis.

Smoking cessation services are well-established in most localities. Stopping in one step is the standard approach to smoking cessation currently adopted by the majority of NHS- or local authority-commissioned stop smoking services. The person makes a commitment to stop smoking on or before a particular date (the quit date)[1]. Smoking cessation services normally provide a combination of behavioural support and pharmacotherapy to help the person stop smoking. The behavioural support is free but pharmacotherapy may incur a standard prescription charge. The evidence-based treatment is based on the National Centre for Smoking Cessation and Training (NCSCT) standard programme, and involves practitioners trained to its standards or the equivalent[2].

2.1 Epidemiology of smoking

Tobacco smoking remains the single greatest cause of preventable illness and early death in England, accounting for 79,100 deaths among adults aged 35 and over in 2011[3].

Treating smoking-related illnesses costs the NHS in England an estimated £2.7 billion in 2006/07[4]. The overall financial burden to society has been estimated at £13.74 billion a year. This includes NHS costs (based on the figure above) and loss of productivity because of illness and early death[5].

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[1] NICE (2013). Tobacco: harm reduction approaches to smoking NICE public health guidance PH45.

[2] NICE (2013). Tobacco: harm reduction approaches to smoking NICE public health guidance PH45.

[3] Health & Social Care Information Centre (2012) Statistics on smoking: England 2012. Leeds: Health & Social Care Information Centre.

[4] Callum C, Boyle S, Sandford A (2010) Estimating the cost of smoking to the NHS in England and the impact of declining prevalence in health economics, policy and law

[5] Nash R, Featherstone H (2010) Cough up: balancing tobacco income and costs in society. London: Policy Exchange

Total expenditure on NHS Stop Smoking Services was £88.2 million in 2011–2012[6].

Although smoking prevalence has fallen sharply in the past 30 years, there is some evidence that this decline is levelling off. In 2010, 1 in 5 (20%) adults in England smoked cigarettes, with prevalence highest among those aged 20–24 and 25–34 (28% and 26% respectively)[7].

People from routine and manual occupational backgrounds are much more likely to smoke compared with those from managerial or professional backgrounds (26% versus 15%)[8]. Smoking is responsible for at least half of the excess risk of premature deaths faced by middle-aged men in manual occupations, compared with those in professional groups[9].

Smoking prevalence is particularly high among some groups, including lesbian, gay and bisexual people, transgender people, those with mental health problems, people in prison and those who are homeless. For example, a survey of smoking prevalence among gay and bisexual men found that just over 35% smoked cigarettes, including 48% of those who were HIV-positive[10].

There are less UK data available on lesbian women, but small surveys in the West Midlands indicate that 42–55% smoke – twice as many as the West Midlands' average for women[11].

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[6] Health & Social Care Information Centre (2012) Statistics on NHS Stop Smoking Services – England, April 2011 to March 2012. Leeds: Health & Social Care Information Centre.

[7] Health & Social Care Information Centre (2012) Statistics on smoking: England 2012. Leeds: Health & Social Care Information Centre

[8] Health & Social Care Information Centre (2012) Statistics on smoking: England 2012. Leeds: Health & Social Care Information Centre

[9] Jha P, Peto R, Zatonski W et al. (2006) Social inequalities in male mortality, and in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland and North America. Lancet 368: 367–70

[10] Hickson F, Weatherburn P, Reid D et al. (2007) Consuming passions: findings from the United Kingdom gay men's health survey 2005 [online]

[11] Meads C, Buckley E, Sanderson P (2007) Ten years of lesbian health survey research in the UK West Midlands. BMC Public Health 7: 251

A third (33%) of people with mental health problems[12], and more than two-thirds (70%) of patients in psychiatric units, smoke cigarettes[13]. 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. However, support is not always available[14,15].

3 Commissioning and resource implications

Local authorities have the responsibility for the commissioning of tobacco control and smoking cessation services guided by the Public Health Outcomes Framework, local joint strategic needs assessment, and joint health and wellbeing strategy.

The quality standard for smoking cessation applies to a wide range of services, settings and practitioners. Commissioners from public health and clinical commissioning groups therefore need to work collaboratively to ensure a coordinated approach to using the quality standard to improve outcomes for people stopping smoking.

When reviewing local strategies and services for smoking cessation, commissioners should refer to:

- Local stop smoking services: key updates to the 2011/12 service delivery and monitoring guidance for 2012/13
- Local stop smoking services: service delivery and monitoring guidance 2011/12

[12] McManus S, Meltzer H, Campion J (2010) Cigarette smoking and mental health in England

[13] Jochelson K, Majrowski B (2006) Clearing the air: debating smoke-free policies in psychiatric units [online]

[14] Jochelson K, Majrowski B (2006) Clearing the air: debating smoke-free policies in psychiatric units [online]

[15] Siru R, Hulse GK, Tait RJ (2009) Assessing motivation to quit smoking in people with mental illness: a review. Addiction 104: 719–33

- Public Health England's Local tobacco control profiles.

Commissioners may also wish to refer to NICE's tobacco Return On Investment Tool. The tool evaluates a portfolio of tobacco control interventions and models the economic returns that can be expected in different payback timescales.

The quality standard relates to smoking cessation; however, commissioners should be aware that NICE has recently produced guidance on Tobacco harm reduction (NICE public health guidance 45). Stop smoking (smoking cessation) services provide highly cost-effective interventions to help people stop smoking[16] and any investment in the harm-reduction approaches covered by this guidance should not detract from their provision. Rather, the recommendations in Tobacco harm reduction are intended to support and extend the reach and impact of existing services[17].

The cost of meeting the quality standard for smoking cessation depends on the local service provision and the progress organisations have made in implementing guidance including NICE and NICE-accredited guidance.

Table 1 summarises the commissioning and resource implications for commissioners working towards achieving this quality standard. See section 4 for more detail on commissioning and resource implications.

[16] See NICE guidance on smoking cessation services

[17] NICE (2013). Tobacco: harm reduction approaches to smoking NICE public health guidance PH45

Table 1 Potential commissioning and resource implications of achieving the quality standard for smoking cessation

Area of care	Commissioning implications	Estimated resource impact
Identification and referral	Identifying relevant services at a local level Skills and competencies in advice and behaviour change Consider using range of levers to incentivise performance Raise awareness of services and referral pathways	There may be training costs, which should be assessed locally. Use of CQUINS by commissioners may incur extra costs offset by savings from efficiencies and improved outcomes. Resource impacts to be determined locally.
Behavioural support and pharmacotherapy	Skills and competencies behaviour change Specify local arrangements to ensure that people are offered the full course of pharmacotherapy. Specify arrangements for special groups, for example, children and young people, and pregnant women	There may be training costs to enable behavioural support to be provided. Costs may be around £2500 per 100,000 population. Potential increase in prescribing costs of around £2600 per 100,000 population. Potential savings from smoking-related illness avoided in people who successfully stop smoking. Savings may be around £6100 recurrently per 100,000 population. Resource impacts to be determined locally.
Outcomes	Specify the use of carbon monoxide testing at 4 weeks within contracts.	Potential savings from health interventions avoided for people who successfully stop smoking. Use of CQUINS by commissioners may incur extra costs offset by savings from efficiencies and improved outcomes. Resource impacts to be determined locally.
Achieving the quality statements may help general practices collect data for QOF indicators for recording smoking status. The extent of this will be variable. There may be a cost impact for NHS England, who would make higher practice achievement payments to general practices.		

4 Commissioning implications and cost impact

This section considers the commissioning implications and potential resource impact of implementing the recommendations to achieve the NICE quality standard for smoking cessation.

4.1 Identification and referral

Quality statement 1: Identifying people who smoke

People are asked if they smoke by their healthcare practitioner, and those who smoke are offered advice on how to stop.

Quality statement 2: Referral to smoking cessation services

People who smoke are offered a referral to an evidence-based smoking cessation service.

There is evidence that people who smoke are receptive to smoking cessation advice in all healthcare settings. It is therefore important that healthcare practitioners proactively ask people if they smoke, and offer advice on how to stop. Smoking cessation services provide the most effective route to stopping smoking, but many people who smoke do not use these services when they try to stop. It is therefore important that practitioners are aware of and make use of the opportunities to refer people who smoke.

Healthcare practitioners include a range of professionals working across a number of hospital and community settings. Therefore commissioners from public health and clinical commissioning groups may wish to include the provision of stop smoking advice and referral to smoking cessation services in all provider contracts. Commissioners will also need to work collaboratively to raise awareness of evidence based services within their local area.

Commissioners should refer to Local stop smoking services: service delivery and monitoring guidance 2011/12 and Local stop smoking services: key updates to the 2011/12 service delivery and monitoring guidance for 2012/13 for detailed guidance on the commissioning of services.

Commissioners should consider ways to encourage referral to smoking cessation services, such as those detailed in Local stop smoking services: key updates to the 2011/12 service delivery and monitoring guidance for 2012/13 to improve performance in secondary care settings. For an example, see a smoking brief advice CQUIN for the Heart of England NHS Trust.

Commissioners may also need to specify 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 chronic obstructive pulmonary disease.

The cost impact of meeting quality statement 1 will vary, depending on a number of factors, including the number of staff who require training, the level of training required and how the training is provided. Use of accredited online training may help keep costs to a minimum. A local assessment of workforce training needs should therefore be carried out.

It is anticipated that where commissioners take steps to meet quality statements 1 and 2 there may be an increase in referrals to evidence-based smoking cessation services. Commissioners should review their local capacity in order to identify the level of stop smoking cessation support that is available locally, not only from specialist services, but also from pharmacy, GP practices and other sources.

Commissioners may wish to refer to the NICE tobacco Return On Investment Tool.

Commissioners and others may wish to refer to the Online learning module on smoking cessation from the BMJ in association with NICE and also the implementation advice and slide set for NICE public health guidance PH10 on smoking cessation services.

Commissioners may also wish to refer to the following Shared learning examples: Implementing an inpatient stop smoking treatment service in the secondary care setting (2013); Open wide project: raising awareness of the risks of smokeless tobacco and shisha pipe smoking and the signs and

symptoms of mouth cancer (2013); Trafford Tobacco Control Strategy (2011); The HEALTH Passport: Helping Everyone Achieve Long Term Health (2011).

4.2 Behavioural support and pharmacotherapy

Quality statement 3: Behavioural support with pharmacotherapy

People who smoke are offered behavioural support with pharmacotherapy by an evidence-based smoking cessation service.

Quality statement 4: Pharmacotherapy

People who seek support to stop smoking and who agree to take pharmacotherapy are offered a full course.

People who smoke are more likely to stop smoking if they are offered a combination of interventions, with combined behavioural support and pharmacotherapy the most likely to be successful. Pharmacotherapy interventions act as an aid to help people to stop smoking, increasing the chances of success. It is therefore important that people receive behavioural support and the full course of their chosen pharmacotherapy in line with recommendation 4 in NICE public health guidance 10 and NICE technology appraisal guidance 123 and in accordance with the Department of Health's Local delivery guidance 2011/12 for stop smoking services and Local stop smoking services: key updates to the 2011/12 service delivery and monitoring guidance for 2012/13.

Pharmacotherapy for smoking cessation includes medication such as varenicline or bupropion, as well as nicotine replacement therapy (NRT) products[18]. Expert opinion of the NICE Quality Standards Advisory Committee indicates that there is still variation in practice across the country, and that the full range of pharmacotherapy recommended by NICE for smoking cessation

[18] NICE (2013). Tobacco: harm reduction approaches to smoking NICE public health guidance PH45.

(particularly varenicline) is not available as first-line treatment in some areas of the country.

Commissioners should therefore review local arrangements to ensure that people are offered both behavioural support and the full course of pharmacotherapy, in line with Department of Health guidance and relevant NICE guidance as set out in section 1. Commissioners need to review how pharmacotherapy for smoking cessation is currently prescribed and provided; ensuring that all steps in the pathway are followed and that there is nothing preventing people from receiving the full course of treatment. Commissioners may also wish to review local use of patient group directions for pharmacotherapy for smoking cessation.

Commissioning services in line with quality statements 3 and 4 may result in an increase in prescribing of pharmacotherapy, and because behavioural support should be provided as part of an integrated offering, there may also be a corresponding increase in support provided.

The costing template for NICE technology appraisal guidance 123 (updated with current costs) estimates that, for a population of 100,000 people, there may be an increase in prescribing costs of around £2600 if 60 people switch from NRT and bupropion to varenicline, and if they are offered a full course of treatment. Using the assumptions from the costing template for NICE public health guidance 10 (updated with current costs), it is estimated that the cost of group behaviour sessions for these 60 people is around £2500, and around £7000 for individual behaviour interventions. However, the cost impact may be lower if local services already exist and there is only an incremental increase in service provision.

The combination of behavioural support and pharmacotherapy should result in a reduction in smoking-related illness because of the increased number of people stopping smoking. The costing template for NICE technology appraisal guidance 123 estimates that 4 of the 60 people will successfully stop smoking, thereby avoiding 2 incidences of smoking-related illness. Using the costing

template updated with current payment by results tariffs, the cost saving is calculated as around £6100 recurrently for the 60 people.

A local assessment should be made of the cost impact of any specific service to be provided to specific groups. Where commissioning budgets and responsibilities are across multiple organisations, they should work together to agree a suitable funding and commissioning plan of services as part of the overall approach in the locality.

Commissioners may wish to refer to:

- NICE good practice guidance GPG1 on developing and updating local formularies and GPG2 on patient group directives
- Audit support, slide set, costing report and costing template for NICE public health guidance PH10 on smoking cessation.
- The audit criteria and costing template for NICE technology appraisal guidance 123 on Varenicline for smoking cessation.
- The NICE tobacco Return On Investment Tool.
- NICE local government public health briefing: tobacco.
- Shared learning example: Varenicline – designing a pathway for a multidisciplinary team (2013).

4.3 Outcomes

Quality statement 5: Outcome measurement

People who smoke who have set a quit date with an evidence-based smoking cessation service are assessed for carbon monoxide levels 4 weeks after the quit date.

Recording smoking status after 4 weeks provides an incentive for people who are attempting to stop smoking, and is an objective way to measure individual and service-level outcomes. Between April 2011 and March 2012, 288,612

people (72%) of the 400,955 successful quitters at 4 weeks were validated by carbon monoxide testing[19].

Testing of carbon monoxide levels is covered in detail in the Department of Health's Local delivery guidance 2011/12 for stop smoking services and Local stop smoking services: key updates to the 2011/12 service delivery and monitoring guidance for 2012/13 and is therefore not repeated here.

Using carbon monoxide testing as an incentive for people who are attempting to stop smoking may increase the number of people who successfully stop smoking. It is anticipated that carbon monoxide testing equipment is already in place. However, where it is not, there may be a local cost impact for service providers and a local assessment should be made.

The costing report for NICE public health guidance 45 explains that the economic analysis for the guidance showed that a smoking intervention that achieves 1 additional 'reducer' aged 50 will save the NHS approximately £767 over the person's lifetime. An intervention that leads to 1 person stopping smoking will save the NHS £1412 over the same period.

5 Other useful resources

5.1 Policy documents

- Department of Health (2011) Local delivery guidance 2011/12 for stop smoking services
- Department of Health (2012) Local stop smoking services: key updates to the 2011/12 service delivery and monitoring guidance for 2012/13
- Her Majesty's Government (2011) The Tobacco Control Plan for England

5.2 Useful resources

- Action on smoking and health (ASH). CLeaR – Excellence in local tobacco control

[19] Health & Social Care Information Centre (2012). Statistics on NHS Stop Smoking Services – England, April 2011 to March 2012. Leeds: Health & Social Care Information Centre.

- Action on smoking and health (ASH). Smoking cessation in pregnancy: a call to action
- National Centre for Smoking Cessation Training (NCSCT). Very brief advice training module
- Smoking cessation: online learning module. BMJ in association with NICE (2010)

5.3 NICE implementation support

- Tobacco. NICE local government public health briefing (2012).
- NICE tobacco return on investment tool.
- Smoking cessation: online learning module. BMJ in association with NICE (2010).
- Shared learning example: Implementing an inpatient stop smoking treatment service in the secondary care setting (2013).
- Shared learning example: Open wide project: raising awareness of the risks of smokeless tobacco and shisha pipe smoking and the signs and symptoms of mouth cancer (2013).
- Shared learning example: Varenicline: designing a pathway for a multidisciplinary team (2013).
- Shared learning example: Trafford Tobacco Control Strategy (2011).
- Shared learning example: The HEALTH passport: helping everyone achieve long-term health (2011).
- Shared learning example: Smoking cessation in routine antenatal care (2011).
- Shared learning example: (Update of) Hospital-based smoking cessation practice including preoperative assessment (2011).
- Quitting smoking in pregnancy and following childbirth (NICE public health guidance 26): costing template, slide set and self-assessment tool.
- Varenicline for smoking cessation (NICE technology appraisal guidance 123): audit criteria and costing template.

5.4 NICE pathways

- Smoking

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