Stop Smoking Service

DETAILED BUSINESS CASE

Project Sponsored By:

HEALTHIER COMMUNITIES

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Contents

List of abbreviations:

BHNFT – Barnsley Hospital NHS Foundation Trust

CCG – Clinical Commissioning Group

CVS – Community and Voluntary Sector

E-cigs – Electronic Cigarettes

ICS – Integrated Care System

LES – Local Enhanced Service

MECC – Making Every Contact Count

NCSCT – National Centre for Smoking Cessation and Training

NRT – Nicotine Replacement Therapy

OMSC – Ottawa Model for Smoking Cessation

SMI – Serious Mental Illness

SSIPC – Stop Smoking Interventions in Practise

SSS – Stop Smoking Service

STP – Sustainable Transformation Plans

SWYPFT – South West Yorkshire Partnership Foundation Trust

SYFR – South Yorkshire Fire and Rescue

TCCC – Tobacco Control Collaboration Centre

TTM – Trans Theoretical Model of Change

1. Introduction

The Health and Social Care Act 2012 transferred the responsibility for Public Health from the NHS to the local authority from 1 April 2013. The current provider of the Barnsley Stop Smoking Service (SSS) is South West Yorkshire Partnership Foundation Trust (SWPFT) and this is funded as part of the Public Health Grant. The contract is due to expire on the 31st October 2019.

Smoking was once seen as a behavioural habit of the affluent but now is recognised as the single biggest preventable cause of death in England (ASH, 2016). Despite the decline in smoking rates in previous years Barnsley still has one of the highest levels of adult smoking prevalence within the country at around 1 in 6 people who smoke (18.2%), although this has dropped significantly since the previous year (20.6%) (PHE Fingertips 2017). The NHS long term plan (2019) has also highlighted the importance of prevention and health inequalities, with a national and local focus on four priority cohorts;

- Routine and manual as a result of low income.
- Secondary care – as a result of presenting illnesses.
- Pregnant women.
- Mental health.

The data included in the section below supports the importance of targeting these groups in Barnsley.

1.1. Key highlights for Barnsley

- Smoking prevalence in Barnsley is reducing but we still have one of the highest smoking rates in the country.
- The latest data illustrates that 18.2% of the adult population In Barnsley are smokers - **significantly higher** than the England average (14.9%) (PHE 2017).
- The prevalence amongst routine and manual workers (27.5%) within Barnsley **is similar** compared to the England average (25.7%) (PHE 2017).
- The smoking status at time of delivery (14.2%) is **significantly worse** than the England average (10.8%) (PHE 2017/18).
- Smoking prevalence in adults with serious mental illness (SMI) (43.7%) and is **significantly worse** than the England average (40.5%) (PHE 2017).
- Smoking prevalence in adults with long term mental health condition **is significantly worse** in Barnsley (34.5%) compared to the England average 27.8%) (PHE 2017).
- Smoking attributable mortality of over 35s (299.7 per 100,000 people) is **significantly worse** than the England average (262.6 per 100,000 people) (PHE 2017).
- Roughly £63.5 million per year to society is estimated to be spent on smoking in Barnsley. This is on average around £1,323 per smoker per year. When net income and smoking expenditure is taken into account, 8,326 (32%) households with a smoker fall below the poverty line. If these smokers were to quit, 2,140 households would be elevated out of poverty, these households include around 1,707 dependent children (ASH 2015).

1.2 Tobacco Control in UK

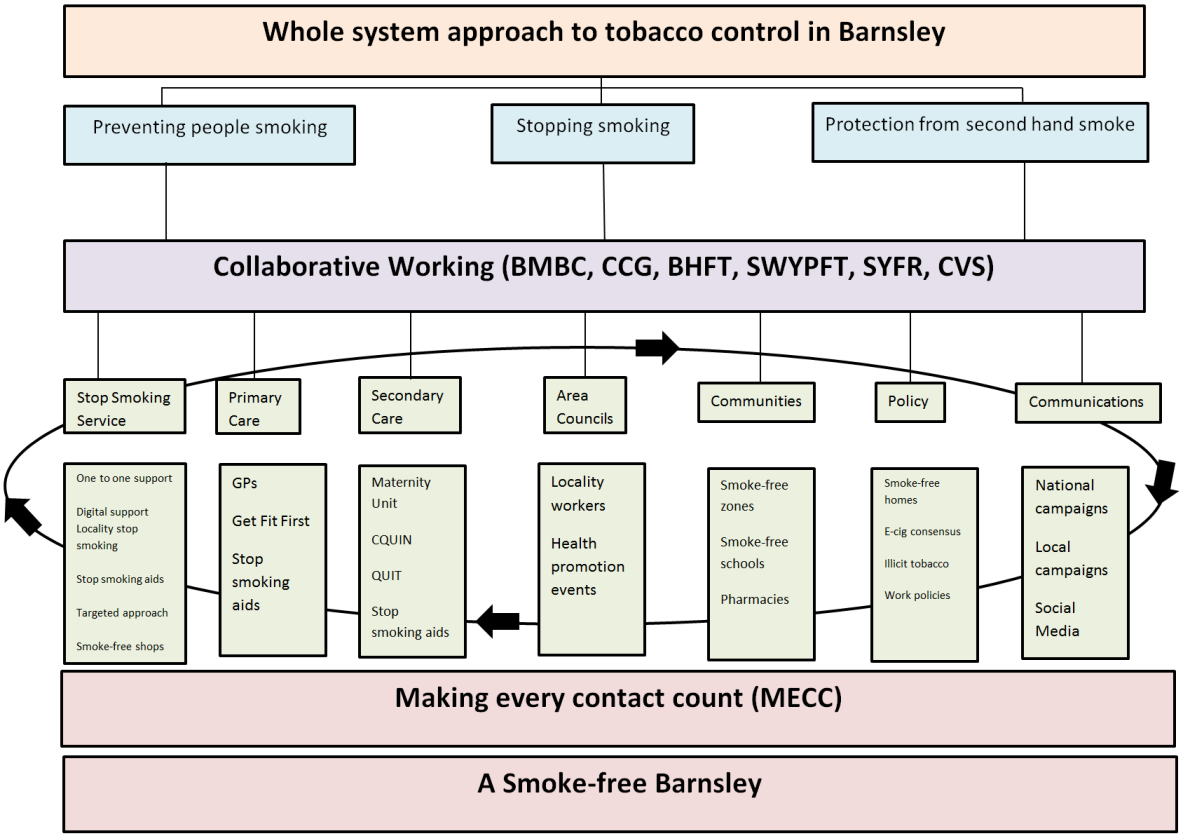
The Department of Health and Social Care has developed The Tobacco Control Plan for England 2017-2022. In addition, the regional Breathe 2025 campaign, developed by Public Health England sets out to achieve a tobacco free generation using a multifactorial approach.

The plan and the campaign work provided Barnsley with a steer on taking a whole system approach to tobacco control working towards a 'Smoke-free Barnsley,' and this is being addressed through robust governance arrangements. The Tobacco Control Alliance has an action plan drawn together in partnership with the Clinical Commissioning Group (CCG), Barnsley Hospital NHS Foundation Trust (BHNFT), South West Yorkshire Partnership Foundation Trust (SWYPFT), Area Councils, South Yorkshire Fire and Rescue (SYFR) and the Community and Voluntary Sector (CVS). Each organisation contributes to the three pillars of a whole system tobacco control approach which are:

- **Preventing people from smoking**.
- **Stopping people from smoking**.
- **Protecting people from second hand smoke**.

The progress made in reducing the prevalence and making smoking invisible is a result of the collective work from all organisations with the current stop smoking service playing a key part. This works alongside e.g. Smoke-free public places across Barnsley and enforcement around illegal/illicit tobacco. There are also ongoing national and local developments including harm reduction techniques using E-cigarettes, and the Q.U.I.T and CQUIN initiatives in secondary care which help identify smokers and offer very brief advice.

Many of the elements that contribute to this success are featured in the diagram below.



This whole approach needs to be strengthened and communicated further which will ensure effective outcomes for the residents of Barnsley.

1.3 Purpose of the document

This business case provides the evidence, current position and options for a future stop smoking service.

Two-thirds of smokers say that they want to quit and smokers who get the right support are up to four times as likely to quit successfully. The most effective approach to supporting people to stop smoking remains the provision of specialist behavioural support combined with pharmacotherapy as provided by evidence based local stop smoking services.

The business case for this Specialist Stop Smoking Service recommends supporting a number of targeted groups of people to maximise resources and impact, and includes a more universal offer to other people who want to quit that is available through e.g. online services, national campaigns & recommended quitting aids as well as community and family support.

The recommissioning of any service provides an opportunity to review the current provision (which is performing well) and explore options to strengthen the service where possible as part of future commissioning.

This will be achieved by:

- Understanding the need, value and benefits of the service, understanding the overarching Tobacco Control Agenda for Barnsley, national and local evidence base around Smoking & Smoking prevalence data.
- Analysis of current service & resources including structure, finance and performance against key performance indicators.
- Identifying and evaluating options for the new Stop Smoking Service.

2. Evidence base

2.1 Reducing Health Inequalities – national overview

People in England experience avoidable differences in health, well-being and length of life (Marmot Review 2010). This is also reflected within the circumstances in which people are born, grow, live, work and age. Marmot also highlights the need for tobacco control to be central to any strategy to tackle health inequalities, as smoking is the single most important driver for health inequalities. Smoking prevalence varies across the population which translates into major differences in death and illness rates between difference socio-economic groups. It is suggested that to reduce inequalities in England, sustainability and assets within the community also need to be improved to reduce the gap between the most affluent and deprived.

Measuring life expectancy is a measurement used to assess health inequalities. In addition we can measure healthy life expectancy which helps identify the years lived in disability free health and the determinants of health will influence life expectancy e.g. tobacco usage. The highlights from BMBC data for life expectancy and healthy life expectancy at birth are as follows:

At Birth Males:

- Life Expectancy at birth in Barnsley in 2015-2017 is 78.1 years; lower than the Yorkshire and The Humber and England rates of 78.7 years and 79.6 years respectively.
- Healthy Life Expectancy at birth in Barnsley could expect to live 59.7 years in “good” health (3.7 years less than men in England overall).

At Birth Females:

- Life Expectancy at birth in Barnsley in 2015-2017 is 81.9 years; lower than the Yorkshire and The Humber and England rates of 82.4 years and 83.1 years respectively.
- Healthy Life Expectancy at birth in Barnsley could expect to live 61.0 years in “good” health (2.8 years less than women in England overall).

Individuals who smoke on average will lose around 10 years of their life attributed by their habit. It is clear that smoking is a key contribution towards life expectancy and health inequalities.

2.2 Smoking Prevalence – National and local

There has been significant progress in tobacco control in the UK. There are a number of influences that underpin tobacco usage such as social norms, addiction, religion, ethnicity, self-perceived health, education level and social economic status (ONS 2018).

Nationally, the prevalence for people over the age of 18 smoking is 14.9% (PHE fingertips 2017) and research suggests males are statistically more likely (17%) to smoke than women (13.3%) except amongst 11-15 year olds where the opposite seems to be true. A similar trend can also be seen across other comparators for example, The British Thoracic Society; Smoking Cessation Audit (2016) reported that inpatients in secondary (25%) are more likely to smoke than the general population due to the causal link between tobacco and disease. There is also evidence to suggest that routine

and manual workers are statistically more likely to smoke compare to managerial and professional positions.

National data on tobacco usage suggests we are still seeing:

- A decline in Smoking prevalence overall, but it is slower among disadvantaged groups
- Smoking-related deaths are two to three times higher in low income groups than in wealthier social groups.
- Approximately half of the difference in life expectancy between the lowest and highest income groups.
- Smoking has a consistent and strong relationship with both years of life lost and years of healthy life with as much as 14 years for smokers compared to non-smokers. This demonstrates both the morbidity and mortality effects of smoking.
- People with no qualifications, who are around twice as likely to smoke as those with qualifications
- Smoking amongst people with mental health disorders is substantially higher than among the general population.

This evidence further supports the requirement to target these four specific cohorts and the local highlights detailed in section 1.

2.3 The harmful effect of smoking - Smoking related diseases

There is widespread misconception amongst smokers and health professionals that most of the harm of smoking comes from the nicotine. While nicotine is the addictive substance in cigarettes, it is relatively harmless. In fact, almost all of the harm from smoking comes from the thousands of other chemicals in tobacco smoke, many of which are toxic (PHE 2018).

The impact of smoking https://www.gov.uk/government/publications/health-matters-stopping-smoking-what-works/health-matters-stopping-smoking-what-works

Smoking can increases the risk of developing more than 50 serious health conditions and others causing irreversible long-term damage to health. This includes at least 14 different types of cancer,

damage to the heart and blood circulation and harmful effects from passive smoking. Smoking causes around 90% of lung cases and can cause cancer and complications in various other body parts. (See infographic above);

2.3.1 Second Hand Smoke

Second hand smoke comes from the tip of a lit cigarette and the smoke that the smoker breathes out. Breathing in second hand smoke increases the risk of getting the same health conditions as smokers. For example, non-smokers exposed to second hand smoke increase their risk of lung cancer by a quarter (NHS 2016). To help reduce the risk of second hand smoke at a local level, BMBC are aiming to shift the social norms by make smoking invisible in their Smoke-Free Barnsley Tobacco Alliance Action Plan 2018-2020 by encouraging smoke-free places including:

- Smoke-free schools
- Smoke-free zones e.g. town centre, markets, parks, high streets
- Smoke-free homes
- Smoke-free hospitals

2.3.2 The Cost of Smoking to Society

Smoking attributable mortality in England is 262.6 per 100,000 people in the UK (PHOF, 2017) and is estimated to cost the UK economy in excess of £11 billion per year. Of this, it is estimated to cost £2.5 billion to the NHS, where smokers see their GP 35% more than non-smokers. Another £5.3 billion fell to employers as smokers, on average, are absent from work 2.7 days more per year than ex and non-smokers (PHE 2017).

In Barnsley, smoking related deaths is 333.9 per 100,000 and smoking attributable hospital admissions is 2,799 per 100,000. These are significantly worse than the national averages. However every year it is estimated that the smoking costs to society is **around £63.5 million:** This includes factors such as lost productivity, the cost of social care, smoking-related house fires, tobacco litter, illicit tobacco and organised crime.

The average gross income per person in Barnsley is £495.70 a week which is lower than the England average and it is well evidenced that those individuals who live in poverty experience poorer health outcomes. Given that the poorest fifth of the working-age population in the UK will need to spend approximately 70-80% of their income for rent, fuel, food etc., a smoking habit of 20 per day (£72.80 per week) is likely to impact significantly on their disposable income. It is clear to see the cost of smoking to individuals and society, and the contribution towards increasing health inequalities is significant.

3. National Strategic Priorities

3.1 Tobacco Control

'Towards a Smoke-free generation; Tobacco Control Plan for England 2017-2022' was published to support the continued leading national effort on tobacco control. The vision is to have smoking prevalence 5% or below. To deliver this the government has set out the following national ambitions using a whole system approach for tobacco control:

National Ambitions
The first smoke-free generation
A smoke-free pregnancy for all
Parity of esteem for those with mental health conditions
Backing evidence based innovations to support quitting

The delivery plan aims to look at prevention first, supporting smokers to quit, eliminate variation in smoking rates and explore effective enforcement of taxation and illicit tobacco. An element of this includes eliminating health inequalities through targeting those populations where smoking rates remain high, within the borough this equates to routine and manual workers and smoking at time of delivery in Secondary Care. After 2022, the ambition is to reduce smoking prevalence further to achieve a smoke-free generation.

3.2 NICE Guidance

3.2.1. Stop Smoking Services

NICE [NG92] published on March 2018 provides guidance which covers stop smoking interventions and services delivered in primary care and community settings for everyone over the age of 12. It aims to ensure that everyone who smokes is advised and encouraged to stop smoking and given the support they need to quit. It emphasises the importance of targeting vulnerable groups who find giving up smoking difficult or for those who smoke a lot (NICE 2018).

NICE [NG92] recommendations for stop smoking services
Commissioning and providing stop smoking interventions and services
Monitoring stop smoking services
Evidence-based stop smoking interventions
Engaging with people who smoke
Advice on e-cigarettes
People who want to quit
People who are not ready to quit
Telephone quit lines
Education and training
Campaigns to promote awareness of local stop smoking services
Closed institutions
Employers
Aim to treat 5% of their smoking population each year with a success rate of at least 35%

2.2.2 Smoking in Pregnancy

NICE guidance [PH26] published in June 2010 called "Smoking: stopping in pregnancy and after childbirth" covers support to help women stop smoking during pregnancy and in the first year after childbirth. Further NICE guidance [PH48} published in November 2013 called "Smoking: acute, maternity and mental health services. General recommendations from these guidelines include:

Recommendations from NICE [PH26] & (PH48)
Identifying patients/pregnant women and other patients who smoke and referring them to NHS Stop Smoking services – this may include intensive support if required
Contacting and supporting pregnant women who have been referred
Use of nicotine replacement therapy (NRT) and other pharmacological support
Meeting the needs of disadvantaged pregnant women who smoke
Partners and others in the household who smoke
Putting referral systems in place for people who smoke
Developing smoke-free policies and commissioning smoke-free secondary care services
Supporting staff to stop smoking and providing stop smoking training for frontline staff

3.3. Stop Smoking Services (SSS) Guidance

SSS were first established in England in 1999-2000 and were piloted in areas of higher deprivation (NCSCT 2013). The aim was to prioritise supporting less affluent smokers to quit in recognition of smoking's contribution to causing health inequalities and today this is still the main emphasis for the services. 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.

Evidence suggests that in contrast to other health interventions, SSS were effective at both reaching and treating disadvantage groups and around 60% of smokers want to quit and individuals who access SSS, are four times more likely to quit than if they were to attempt to quit by themselves.

Recommendations for commissioning effective Stop Smoking Services include the following;

- Ensure those in priority populations (also detailed in section 1) are offered, and can easily access effective support (e.g. behavioural support and medication) to maximise reductions in smoking prevalence and health inequalities; Routine & Manual, Smoking in Pregnancy, People with Mental Health Problems and those with long term conditions i.e. secondary care
- 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 e.g. telephone/online support & information.

(PHE 2017 Models of delivery for stop smoking services: Options and evidence)

Individuals who attend a SSS make a commitment to stopping smoking on or before a particular date and the smoking cessation service provide a combination of behavioural support and pharmacotherapy to help with the quit attempt (NICE 2013). This is formed around the National Centre for Smoking Cessation and Training (NCSCT) standard programme, and involves practitioners trained to its standards or the equivalent (NICE 2013).

3.3.1 Stop smoking aids

There is good evidence to show that using stop smoking aids increases the chances of quitting successfully, particularly when combined with expert face-to-face support from a local stop smoking service. There are 3 types of aids:

- Prescription tablets (Varenicline and Bupropion)
- Nicotine replacement therapy products such as patches, inhalers and gum
- E-cigarettes or vapes (advice only due to not being licensed products)

Prescription tablets

There are 2 prescription-only stop smoking medicines - Varenicline (Champix) and Bupropion (Zyban). Neither medicine is licensed for use during pregnancy or by people with certain pre-existing conditions or by under-18s.

Prescription tablet	
Verenicline	Reduces cravings for nicotine by blocking the rewarding and reinforcing effects of smoking which take place in the brain. It increases the chances of long-term quitting success between 2 and 3 times compared to a quit attempt without the use of a stop smoking aid.
Bupropion	Reduces urges to smoke and helps with withdrawal symptoms. The likelihood of staying smoke-free using this medication is similar to that for nicotine replacement therapy.

Nicotine replacement therapy (NRT)

NRT is a medicine that provides users with nicotine without the tar, carbon monoxide and other poisonous chemicals present in tobacco smoke. It can help to reduce tobacco withdrawal symptoms, such as irritability and cravings.

NRT is an effective stop smoking method, increasing chances of stopping smoking for 6 months or more by more than half. There is also strong evidence to show that combination of NRT is more effective than single product use.

Nicotine is addictive but the level of addictiveness depends on the delivery system. The addictiveness of tobacco cigarettes is enhanced by compounds in the smoke other than nicotine.

NRT products are available in different strengths so that nicotine intake can be gradually reduced when the person feels ready. Premature cessation of NRT is associated with relapse to smoking.

A nicotine patch releases nicotine slowly into the body's system to help keep it on a constant level, while a fast-acting product such as an inhaler, lozenge or gum helps with immediate cravings. NICE recommends that combination NRT should be considered as a viable option for all smokers wanting to quit. There are many types of NRT available on prescription which includes: Skin Patches, Chewing Gum, Inhalers, Oral Strips, Lozenges, Microtabs and nasal/mouth sprays

Since October 1st 2018 residents of Barnsley are able to get a free prescription of NRT.

Electronic Cigarettes (E-cigs)

E-cigs are devices which convert liquid nicotine into a vapor or mist which the user inhales. As with tobacco products there is a minimum age of sale of 18 for e-cigs and they cannot be purchased on behalf of someone under the age of 18.

The modern E-cigs have been around since 2003 which were originally designed for stopping smoking and have been successful. In the first half of 2017 quit rates were at their highest rates observed for the first time and it is plausible that e-cigs were a contributing factor. Is it currently estimated that E-cig usage in the UK is around 6%.

Public Health England published a review on the 'evidence of e-cigarettes and heated tobacco products in 2018' to help clear up the confusion of the effectiveness and safety of their use. Some of the highlights relevant for the business case include:

E-cigarettes and heated tobacco products highlights
E-cigs are 95% less harmful compared to smoking cigarettes and nearly half the population was unaware of e-cigs being much less harmful.
They do not contribute significantly to non-smokers taking up e-cigarette smoking with less than 1% of E-cig users never smoked.
Despite some experimentation with these devices among never smokers, e-cigs are attracting very few young people who have never smoked in regular use.
Poisoning from accidental ingestion of e-cigs liquids are usually short in duration and of minimal severity.
Cancer potencies of e-cigs were largely under 0.5% of the risk of smoking.
To date there is no evidence to health risk of second hand vapour from e-cigs

There are three main types of e-cigs:

- Disposable products (non-rechargeable and single use only) - These present potential environmental problems through unregulated or improper disposal, storage and recycling of reusable and non-reusable components (Science for Environment Policy 2015).
- An electronic cigarette kit that is recharged and replaced with pre-filled cartridges.

- An electronic cigarette that is rechargeable and has a tank or reservoir which has to be filled with liquid nicotine.

E-cigarette use, alone or in combination with licensed medication and behavioural support from a SSS, appear to be helpful in the short term. However, e-cigarettes are not licensed products and cannot be prescribed by the SSS.

4. Local Strategic Priorities

4.1 Corporate Vision and Priorities

As part of the 'Future' Council's corporate vision for 'working together for a brighter future, a better Barnsley,' there is a clear strategy to continue developing capacity and capabilities within our communities and shift the balance from a 'paternalistic' approach to one that 'empowers' individuals, families and communities to do more for themselves; key areas include; Early Help, behaviour change and making better use of technology. We need to take opportunities around the smoking agenda to build on this further.

Alongside this will be the achievement of a number of 2020 Corporate Outcomes. The proposed service will contribute to the following corporate priorities:

People achieving their potential
Reducing demand through access to early help
Children and adults are safe from harm
People are healthier, happier , independent and active
Strong & resilient communities
Customers can contact us easily and use more services online

4.2 Barnsley Health and Wellbeing Strategy

'Feel Good Barnsley 2016-2020' sets out how the Health and Wellbeing Board will drive to improve services to join up care and support people in Barnsley to better help themselves by improving health and wellbeing and reducing health inequalities across the borough with the vision of:

> "…..the people of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives in safer and stronger communities, whoever they are and wherever they live."

Reducing smoking is an identified area of improvement within the strategy as part of a wider transformation agenda to help people to get the right support at the right time. This will be achieved through four principles; focus on "efficiencies and outcomes", "inspire and empower, connect", "collaborate and co-produce" and "go further faster" supporting the outcomes set out in the Future Council 2020 plan.

4.3 Public Health Annual Report, Strategy & Priorities

Smoking has been a priority for the Public Health Strategy over the last few years and continues to have an important focus, particularly in relation to the wider determinants of health. The Public Health Strategy for Barnsley also supports the principles detailed in future council.

Work continues to focus on the fact that health is shaped about 'where and how we live' and that there is still a need to '….reduce the stark inequalities which mean the most vulnerable and most deprived bear the heaviest burden of disease' – and smoking is a key feature of this. It is important to create and sustain good health and wellbeing across the life course in Barnsley (DPH 2017)

4.4. Smoke-Free Barnsley Tobacco Alliance Action Plan 2016-2018

The "Smoke-Free Barnsley Tobacco Alliance Action Plan Refresh 2018-2020" aims "to see the next generation of children in Barnsley born and raised in a place free from tobacco, where smoking is unusual". This is in line with the Breathe 2025 campaign and will be achieved by;

- Setting a clear example
- Making it harder for children and young people to access and use tobacco
- Making tobacco less affordable, especially for children and young people
- Limit tobacco marketing and exposure to smoking seen by children and young people
- Educate young people to make healthier choices around smoking and tobacco
- Reduce exposure to second hand smoke

The Smoke-free Barnsley Tobacco Alliance also has a consensus statement (see Appendix 1) on electronic-cigarettes informed by the best current evidence from Public Health England, Royal College Physicians, Action on Smoking and Health, National Centre Smoking Cessation Training and NICE guidance on Smoking Harm Reduction. The aim of this policy statement is to develop an agreed consensus in Barnsley on e-cigarettes that all partners in the borough are signed up to. This is to ensure that the public receive clear, evidenced based consistent advice on e-cigarettes.

4.5 BMBC Smoking and Vaping at work policy

The Smoking and Vaping at Work policy indicates that smoking and vaping is not permitted in any designated council workplace; in the immediate vicinity of the entrance or exit of any council workplace where you would be in the view of the public; in council vehicles or in enclosed public places (including public buildings) owned by the council. Smoking/vaping is to be taken on your own time, and any smoking breaks are fully recorded when taken during the working day.

The Public Health campaign "Breathe 2025" aims to remove the normality of people smoking and making smoke invisible to inspire a smoke-free generation by 2025. The leadership culture within the council is supportive of this and it forms a key part of the BMBC Corporate Council Plan 2015-2018: where people are encouraged to achieve their potential and to be healthier happier, independent and active". Smokers in the council are entitled to 4.5 hours of special leave over a maximum 12 week period to attend smoking/vaping cessation support.

The existing commissioned service provides advice via Yorkshire Smoke-free Freephone 0800 612 0011 (landline) or 0330 660 1166 (mobile) or by visiting http://yorkshiresmokefree.nhs.uk/

4.6 Barnsley Integrated Care System (ICS)

In 2016, NHS organisations and local councils came together to develop 44 Sustainability and Transformation Plans (STPs) covering the whole of England. Some areas were identified as 'trail - blazers' to develop partnerships to form an integrated care system which proposes to improve health and care for patients built around collaborative working. The STP or Integrated Care System (ICS) as it is now known, covers South Yorkshire and Bassetlaw, of which Barnsley is one of five 'places'.

A 'Place' based Plan has been developed for each place within the ICS, and in Barnsley, this has led to the development of a local network to include; BMBC, CCG, SWYFT, BHNFT and the Community & Voluntary Sector called 'Barnsley Health and Care Together'.

The delivery of this agenda forms a significant part of the newly published 10 year plan for the NHS (2019) where local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere. ICSs will have a key role in working with Local Authorities at 'place' level and through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health.

Integrated Care System Outcomes Framework

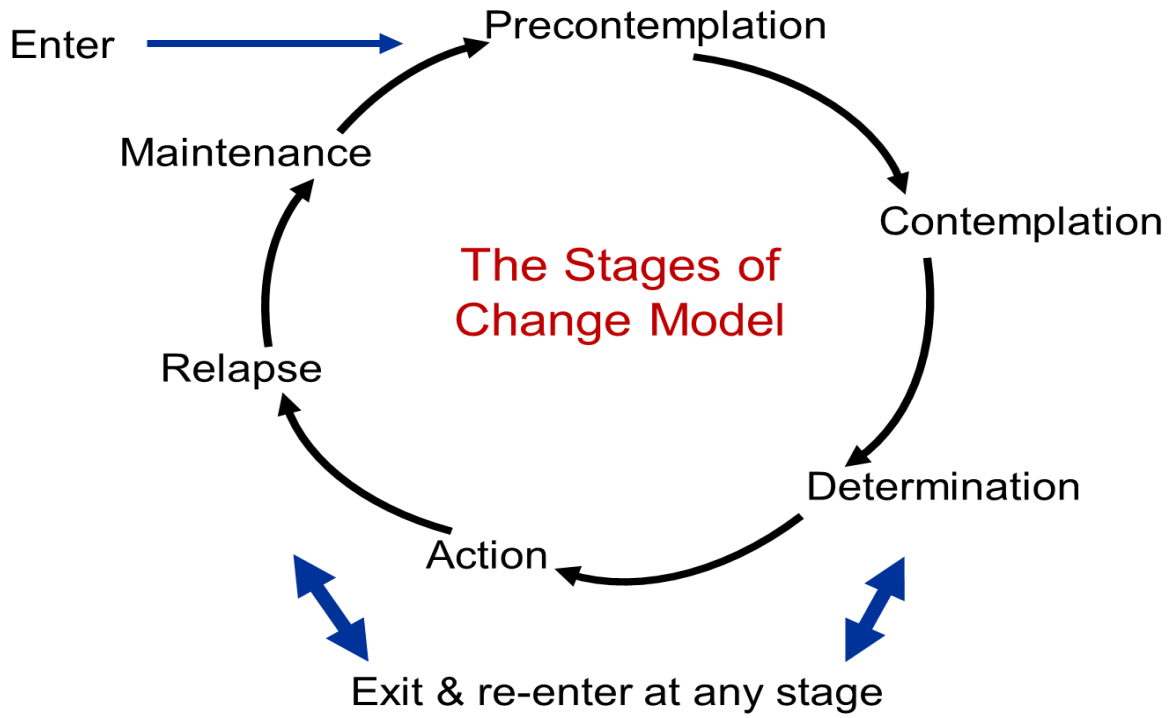
5. Models/Theories for Behaviour Change

There are number of behaviour change theories that can be considered when developing a Specialist Stop Smoking Service. Both the models detailed below are widely recognised in relation effective stop smoking services and will allow us to consider the requirements for the new service in Barnsley.

5.1 Trans-theoretical model of change (TTM)

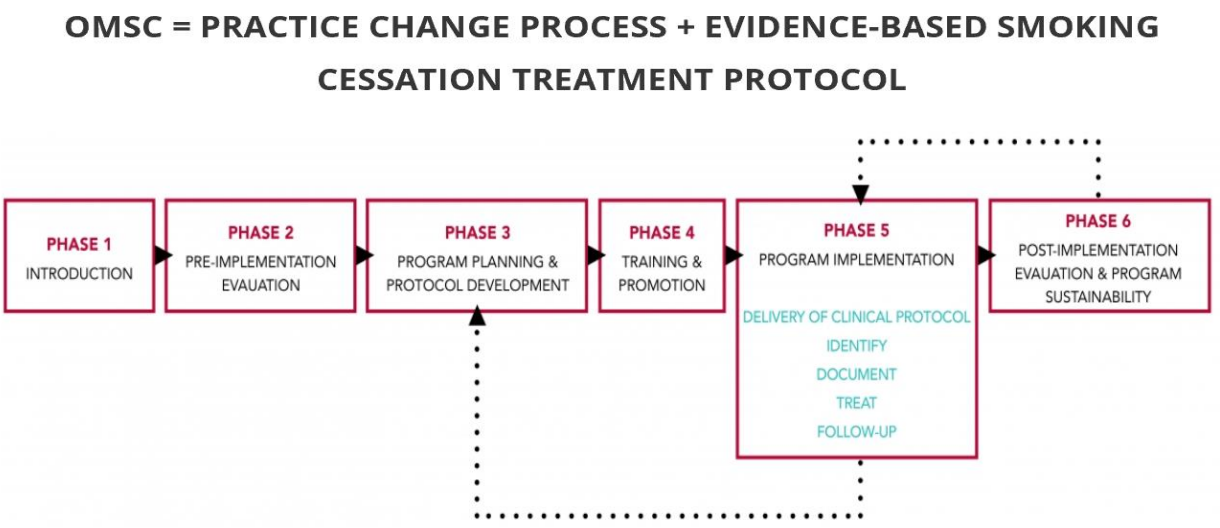
The Trans-theoretical Model (also called the Stages of Change Model) (TTM), developed by Prochaska and DiClemente examined the experiences of smokers who quit on their own with those requiring further treatment to understand why some people were capable of quitting on their own. It was determined that people quit smoking if they were ready to do so.

The TTM focuses on the decision-making of the individual and is a model of intention and readiness to change. The TTM operates on the assumption that people do not change behaviors quickly and decisively. The breakdown of the stages of change is detailed below



5.2 Ottawa Model for Smoking Cessation

The Ottawa Model for Smoking Cessation (OMSC) is a systematic, comprehensive approach to clinical tobacco dependence for secondary care. This approach assists healthcare organisations and health professionals to transform clinical practices appropriate to the treatment of smokers through knowledge translation, implementation support, and quality evaluation (see model below).



The programme's success rate is unparalleled, with 44% of participants remaining smoke free for 6 months or longer. The Ottawa Model now offers options for outpatient and primary care clinics since 2009. This adaption of the programme included the revision of protocol and tools to meet the needs of the primary care professionals. Pilots of 8 primary care practices in the Champlain Local Health Integration Network were involved. Evaluation of the data from the pilot showed significant increase in the number of patients who received advice to quit and assistance with quitting (Ottawa Model for Smoking Cessation Primary Care Program Summary 2018).

This model has been adapted by Greater Manchester under their CURE project in secondary care for treatment of tobacco addiction in October 2018 and awaits evaluation. This model has also been adopted by South Yorkshire and Bassetlaw Integrated Care System as part of the QUIT program.

5.3 BabyClear – Stopping Smoking in Pregnancy

BabyClear © is a whole system approach to help pregnant woman remain smoke-free during their pregnancy and post-partum period.

The BabyClear approach to smoking cessation in pregnancy
CO screening for all pregnant women
An opt out referral system
Briefing sessions for midwifery staff and other relevant health professionals
Protocols and care pathways reflecting the evidence base and NICE guidance
Advanced skills training to support Stop Smoking Advisors to work effectively with pregnant women
Ways to reach out to those pregnant smokers who currently do not engage with the Stop Smoking Services, including a Risk Perception Intervention.
Administrative / call centre staff training to increase the number of women accepting appointments
Awareness raising and engagement with all health professionals involved with pregnant smokers
Supporting materials developed with the support of young pregnant smokers.
A performance management system
Monitoring and evaluation of effectiveness

The programme follows NICE guidance (detailed above) and the Tobacco Control Collaborating Centre (TCCC) has worked with local areas to identify how to apply the guidance and evidence to ensure a significant impact on local prevalence is sustainable.

6. Current Provision in Barnsley

The current service provider for Stop Smoking Services in Barnsley is South West Yorkshire Partnership Foundation NHS Trust (SWYPFT). This contract is due to expire on 31st October 2019.

As mentioned in the introduction, this specialist service forms one part of the of the whole system approach to tobacco control across the Borough, incorporating work with various different partners. The service is a single point of contact and accepts self-referrals in multiple delivery points in GP practices and community venues across the borough. However more recently work has been done locally to target groups with significant high prevalence rates which include routine and manual, mental health (diagnosed) pregnancy and secondary care.

The SSS team has adopted the use of the SSIPC (Stop Smoking Interventions in Practice) Framework. SSIPC is an evidenced systems based tiered approach to help health care practitioners deliver stop smoking interventions and forms the basis of their stakeholder engagement work across Barnsley. SSIPC includes the agreement of a treatment pathway with individual stakeholders and the delivery of training, provision of resources and activity feedback. The aim of SSIPC is to encourage stakeholders to provide 2 elements;

- Very Brief Advice (VBA) and offer of referral to the specialist service
- Behavioural support - which is provided "in-house" via a subcontracting arrangement with the specialist service

The service aims to provide universal information in a variety of languages (including access to interpretation services and BSL, large print and braille), advice, and guidance through personalised face to face support, or the use of technology to build resilience. The team works holistically to support other services across the borough and signpost people to a range of universal and specialist services to address wider lifestyle issues including debt, welfare and housing. This also includes supporting other organisations in health promotion, developing and maintaining information sharing protocols and delivering a range of training to professionals and partners including harm reduction.

<u>Stop Smoking Services in Barnsley Hospital Foundation Trust (BHNFT)</u>

The SSS has a presence in BHNFT supporting Maternity Stop Smoking Services (see below) and wider secondary care services; this includes both inpatients and outpatients. The Stop Smoking Service core opening hours are 9am-5pm, with at least one late night clinic per week.

<u>Stop Smoking in Pregnancy (BHNFT)</u>

The Maternity Stop Smoking Service consists of two whole time equivalent staff working on a 1:1 basis providing support and treatment to women and their families who smoke. This service is commissioned through a sub-contract arrangement with SWYFT.

In addition to this, a Public Health Specialist Midwife (PHSM) provides the management and leadership to the team, monitoring progress and meeting on a regular basis with the team and the commissioners to ensure the team is performing to the required standard. The team is also represented at the Tobacco Control Alliance, and is the Chair and host of the Regional Stop Smoking

meeting, as well as a member of the Hospital trust led QUIT programme. This PHSM is funded by the maternity unit at BHNFT.

As a Maternity Unit, there are plans to develop a new way of working to promote 'Continuity of care.' The plan for 2019 is to achieve 20% of women in Barnsley who choose to have their baby within the local maternity service, to be placed on a Maternity Continuity pathway. This will mean that these women will be cared for in the antenatal, intrapartum and postnatal period by a small team of six midwives. In addition to the Maternity Stop Smoking service these six 'continuity' midwives will be receiving level 2 stop smoking practitioner training to deliver not only very brief advice but the whole quit programme. This is an innovative approach being developed in Barnsley. These midwives are employed by the Maternity Service, hence adding added value to the commissioned Stop Smoking Service arrangements.

The Maternity Unit is also part of an NHS Improvement plan called 'The Maternal and Neonatal Health Safety Collaborative' which is a three-year programme, launched in February 2017. The aims of the plan are to improve the safety and outcomes of maternal and neonatal care by reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020. There are five drivers all underpinned by a strong focus on safety culture, systems and processes, engaging with staff, women and families, and learning from both error and excellence. One of these drivers is 'Improving the proportion of smoke-free pregnancy' as part of this work there has been a real appetite for change and further training and consultation with staff, women and families.

Local Enhanced Service (LES) – Primary Care

The team works with both GP Practices and pharmacies to provide locally enhanced services where staff within practices and pharmacies can be trained to deliver stop smoking support. For those that do not have a LES, direct referrals are made to the Stop Smoking Service.

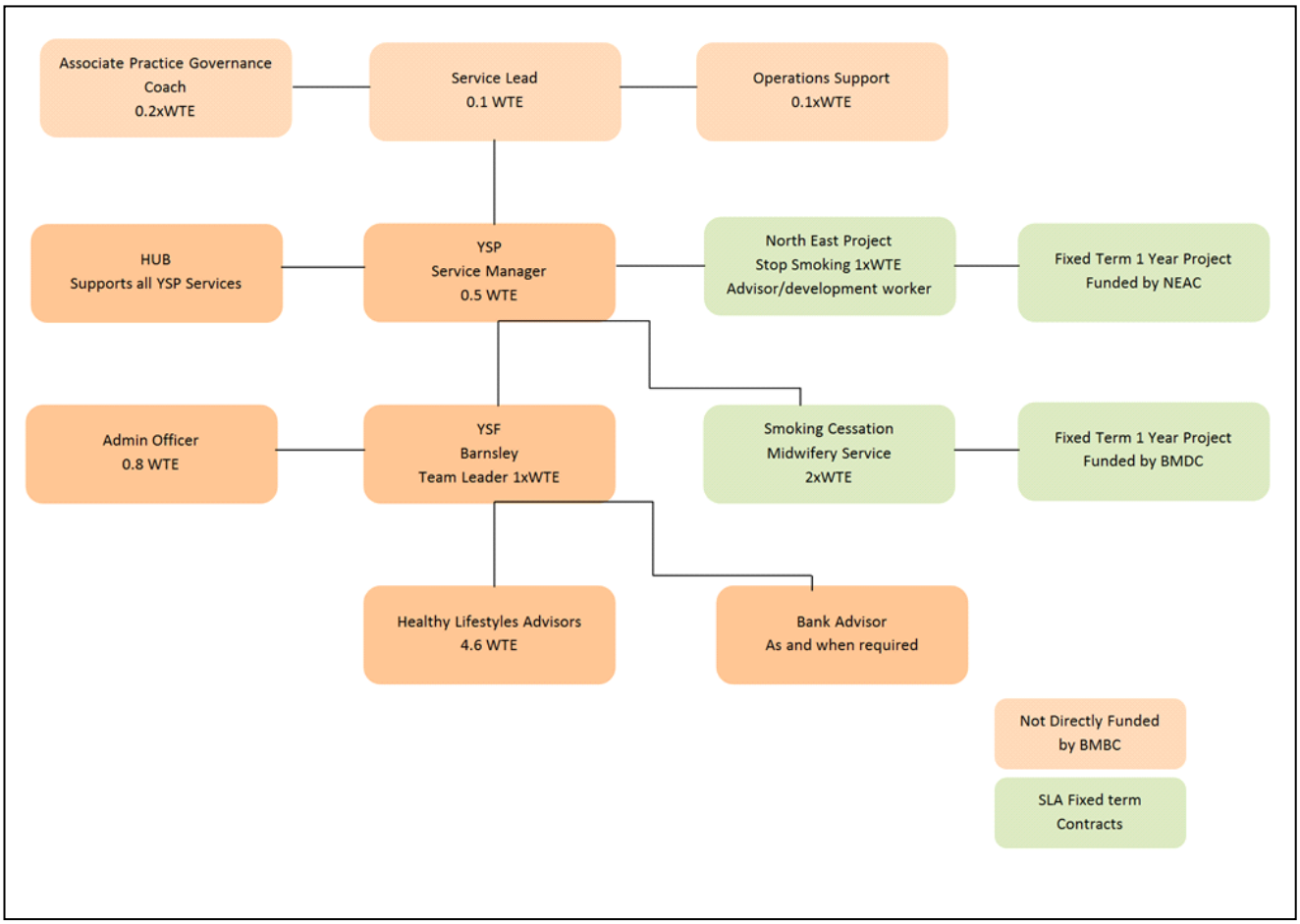
Locality based working

The Service has a number of advisors working across different localities within Barnsley, roughly aligned to the Area Council Footprint. Each of these advisors has a role in engaging in local communities and linking with key stakeholders to promote the stop smoking agenda. Each advisor leads on a specific cohort e.g. Routine & Manual, Young People, People with Long Term Conditions, and have developed expertise and good practice that is shared across the team. The team recognise the opportunities for working holistically and linking with other services in each locality.

It is also worth noting that the North East Area Council has commissioned an additional Stop Smoking Adviser (not part of this service commission) to help reduce smoking prevalence within their area and to support primary care colleagues. Local evidence suggests that a locality based co-ordinator engaging and encouraging local communities to quit smoking has had some positive impacts. A year-end evaluation of this work is planned to compare and contrast the impact and to use the Social Return on Investment (SROI) toolkit.

Stop smoking service structure

The SSS works across a system wide approach with having staff situated in Primary and Secondary Care. The service structure is detailed below;



6.1 Assessment of performance

The current service reports on 13 indicators (A full breakdown is provided in appendix 3) with two main BMBC corporate indicators that record that we are "aiming to treat 4% of the smoking population based on a prevalence of 21%" and "aiming to get 55% of those in treatment (Setting a quit date) to have quit by 4 weeks**". Both of these indicators have exceeded the target and are performing consistently.**

NICE [NG92] recommends "Aim to treat 5% of their smoking population each year with a success rate of at least 35%" however since the healthy lifestyles contract was separated in 2016/7 and the previous provider missing targets it was negotiated between BMBC and the service provider to aim to treat 4% of the smoking population (with a stretch to 5%).

There have been new indicators to report on, for which baseline data is not yet available, but the service is performing consistently well across a number of other indicators. The service is

underperforming on two indicators; "Aiming to get 50% of those which have quit at 4 weeks to quit at 12 weeks" and "Referral's from midwives at BDHT processed by SWYPFT within two working days". On further investigation, there seems to be a reporting error with the data from the midwives and since the error has been reported the new 12 week data was not available at the time of the end of year report. However, this issue has been resolved now and the midwifery service is meeting the 48 hour targets.

A breakdown of the key performance indicators the SSS end of year report is as follows;

Stop Smoking Service End of Year Report KPIs				
Key Performance Indicators	**Target**	**Actual (end of year)**	**Rag Rating**	**Notes**
Aiming to treat 4% of the smoking population based on a prevalence of 21% (52,253) with a stretch target of 5%.	2090	3057		
Aiming to get 55% of those in treatment (Setting a quit date) to have a quit date by 4 weeks	1,155 (55%)	2,448 (66%)		
Aiming to get 50% of those which have quit at 4 weeks to quit at 12 weeks	488 (50%)	390 (40%)		This is a new indicator so no RAG rating available.
Measuring the number of users who are CO validated – Target is 70% - against face to face quits (90% of total quits)	614 (70%)	643 (72%)		
Number still quit 8 weeks after birth		6		This is a new indicator and no baseline is available.
Referrals from Midwives at BDHT processed by SWFT within 2 working days	707 (100%)	489 (69%)		
Targeted Cohorts				
Routine and Manual		264 (27%)		New Measure
Mental Health (Diagnosed)		61 (6%)		New Measure
Pregnant		124 (13%)		New Measure
Secondary Care		124 (13%)		New Measure

Stop Smoking Service: Key performance indicators baseline and end of year figures

6.2 Other Initiatives linked to Services in Barnsley

6.2.1 QUIT Programme – developing options in Barnsley Hospital

QUIT has been developed by the Integrated Care System across South Yorkshire and Bassetlaw and builds on the principles of the Ottawa Model. The aims of the programme include:

- Every health care professional is aware of the smoking status of every patient they care for
- Every health care professional has the competence and confidence to offer help to stop smoking through direct action and referral
- Every patient has access to the best available treatments and expert support to treat this disease
- There is recognition that tobacco addiction is a chronic and relapsing disease, not a lifestyle choice
- Staff policies support all hospital staff to quit or remain tobacco-free during working hours, including the offer of smoking cessation support and appropriate short term medication.
- All the hospitals in SY&B become institutions of health promotion and truly smoke-free zones

Four comprehensive steps for the programme;

Principles of Q.U.I.T	
Q – ask the question	All hospital patients should be asked if they are a current smoker.
U – understand their addiction	All hospital patients should be asked to exhale into a CO monitor and their result noted in patient records. This provides not only evidence of the conversation taking place, but provides a strong indicator of level of addiction which will support and indicate further treatment, but also contributes to triggering quit attempts.
I – inform patients about smoke-free sites	All patients should be informed that the hospital site is smoke-free and that patients and visitors are not permitted to smoke anywhere on site, but that they can access support for nicotine replacement.
T – initiate treatment	Refer patients to smoking cessation support including advice and treatment (NRT, varenicline and other options) as soon as possible, enabling them to quit during their inpatient stay where possible and ensuring appropriate ongoing support after discharge. The gold standard is that patients should be offered nicotine replacement support within 30 minutes of arrival on the ward.

Barnsley Hospital has fully signed up to implement QUIT with the Chief Executive being the executive sponsor and the Consultant in Public Health leading the work in partnership with Barnsley Council and the South Yorkshire and Bassetlaw Integrated Care System.

The provider of the stop smoking service is expected to work with hospital colleagues in order to provide a service that meets the needs of QUIT.

6.2.2 Preventing Ill Health by risky Behaviours CQUIN -Alcohol and Tobacco - Barnsley Hospital

The CQUIN indicator applies to Mental Health Trusts and Community Trusts 17/18 and 18/19 (SWYPFT). The indicator applies to Acute Trusts in 18/19 (BHNFT).

There are five parts to the CQUIN, three of which relate to tobacco, specifically;

9a) Tobacco screening
9b) Tobacco brief advice
9c) Tobacco referrals and medication offer

A comprehensive review shows that stopping smoking interventions are effective for hospitalised patients regardless of the admitting diagnosis. Inpatients stopping smoking leads to a reduced rate of wound infections improved wound healing and increased rate of bone healing.

During 18/19 BHNFT recruited two 'Healthy Behaviour Nursing Auxiliary' posts to support implementation of the CQUIN requirements. Brief advice training for these staff has been provided by the SSS. An e-form has been developed to meet the reporting requirements of the CQUIN.

6.2.3 Get Fit First (GFF)

The Get Fit First is an initiative set up by Barnsley Clinical Commissioning Group to encourage individuals to lose weight/give up smoking or both prior to undergoing surgery. It is estimated that approximately 4000 patients per annum may be asked to undergo a health improvement period due to Get Fit First. A third of these patients (1,330 will be smokers) therefore supporting identification from primary care. GPs are able to refer patients into the SSS. Of the total population:

- 36% of the population have a BMI of 30+
- 18% are smokers only
- 6% are combined smokers and BMI of 30+

7. Equality Impact and Risk Assessments

These will be completed as part of the service specification.

7. Options going forward

Overview	Pros	Cons	Evidence
Option 1: Do not commission a service	Allocate money into other services	Barnsley smoking prevalence is too high to not commission a service.	PHE fingertips database SSS data
Option 2: Recommission with the same service specification Self-support for those who want to stop but do not want professional support. 4x targeted cohorts (R&M, Pregnancy, MH and Secondary Care) Evidence-based specialist support for smokers who need it and are willing to make the necessary commitment to quit (including combination of behaviour and pharmacotherapy)	Service is performing well The KPI's show the SSS has greatly improved over the last couple of years. Sound theory based on PHE recommendations The model includes universal approach, targeted and specialist support.	Considerations given to under/over performing indicators Secondary care underperforming Treating more than 4% of the smoking population should be more aspirational.	SSS data Models of delivery for stop smoking services: Options and evidence (2017)
Option 3: Revise specification with a strong focus on secondary care including midwifery and integration. To include Self-support for those who want to stop but do not want professional support. 4x targeted cohorts (R&M, Pregnancy, MH and Secondary Care) Evidence-based specialist support for smokers who need it and are willing to make the necessary commitment to quit (including combination of behaviour and pharmacotherapy) Integrated and neighbourhood working. Brief advice/support and a stop-smoking medicine for those who want help but are not willing to commit to a specialist course Ottawa model adapted in secondary care to build on QUIT and MECC Extend targets for smoking population	Links to national and local priorities Targeted interventions Opportunities for developments in integrated care Increase capacity in secondary care Smokers in hospital more likely to be ill (causal response from smoking)	Smokers in hospital might not be ready to quit e.g. other health concerns.	Manchester CURE project Models of delivery for stop smoking services: Options and evidence (2017) Ottawa Model

Finance:

The available annual budget for the commission of the new service is between -

£415,000 - £450,000.

8. Conclusion

Smoking is the leading cause of preventable death, as well as presenting a significant economic and social impact for the people living and working in Barnsley.

The service should offer universal support, work holistically with partners and also focus our intensions on cohorts of interests that have the highest prevalence: Routine and Manual, Secondary Care, Pregnancy and Mental Health.

The evidence provided clearly demonstrates the need for a stop smoking service in Barnsley to continue to support a reduction in smoking prevalence, and to continue the good work towards the national and local ambitions of a healthier and smoke free generation.

Appendices

Appendix 1: The Smoke-free Barnsley Tobacco Alliance Consensus Statement on Electronic Cigarettes

The Smoke free Barnsley Tobacco Alliance consensus statement on electronic-cigarettes

This policy statement is informed by the best current evidence from Public Health England, Royal College Physicians, Action on Smoking and Health, National Centre Smoking Cessation Training and NICE guidance on Smoking Harm Reduction. The aim of this policy statement is to develop an agreed consensus in Barnsley on e-cigarettes that all partners in the borough are signed up to. This is to ensure that the public receive clear, evidenced based consistent advice on e-cigarettes.

Evidenced statements:

1. Smoking remains the leading cause of illness and early death in Barnsley and is a significant cause of inequalities in health outcomes.

2. Electronic-cigarettes (e-cigarettes) present a real opportunity to contribute to a reduction in smoking prevalence in Barnsley and reduce harm from combustible tobacco.

3. The Smokefree Barnsley Tobacco Alliance, in line with current evidence from PHE, **advise all smokers to stop completely and immediately** and to access support via the Yorkshire Smokefree Barnsley Service and utilise a combination of behavioural support and stop smoking medication such as Nicotine Replacement Therapy (NRT) or Champix. Smokers are four times more likely to be successful in quitting if they access this type of support.

4. Smokers who cannot or do not want to stop using nicotine are encouraged to **switch to using an e-cigarette as a harm reduction measure.**

5. The aim of the Smokefree Barnsley Tobacco Alliance is to achieve a smoke free generation in Barnsley by 2025 (in line with *Breathe 2025: Inspiring a Smoke Free Generation*, a bold Yorkshire and Humber vision to see the next generation of children born and raised in a place free from tobacco, where smoking is unusual).

6. The latest evidence published by Public Health England (PHE, 2018) estimate that **vaping is around 95% safer for users than smoking**.

7. Evidence does not support the concern that e-cigarettes are acting a route into smoking for young people.

8. To date there have been no identified health risks of passive vaping to bystanders.

9. The review found that chemicals in tobacco smoke that harm health – including cancer causing chemicals – are either absent in e-cigarette vapour or, if present, they are mostly at levels much below 5% of smoking doses.

10. Most people continue to smoke due to addiction to nicotine and not lifestyle choice. Nicotine itself is not carcinogenic and does not cause serious adverse health effects such as acute cardiac events, coronary heart disease or cerebrovascular disease.

11. Public perceptions of harm from e-cigarettes remain inaccurate; only half of smokers believe that e-cigarettes are less harmful than smoking and these decreases to one third among smokers who have never tried e-cigarette.

12. Pregnant women who find it difficult to stop smoking are recommended to use licensed nicotine replacement therapy (NRT) products. However if a pregnant woman makes an informed choice to use an e-cigarette and if that helps them to stay smokefree, they should not be discouraged from doing so.

Commitment statements:

1. We want to combine the most popular with the most effective. The stop smoking service in Barnsley is 'e-cigarette friendly' and will provide behavioural support for those who want to stop smoking and use e-cigarettes as a quit aid.

2. We recommend that smokers who wish to use e-cigarettes to quit or switch should purchase their products from a retailer that is committed to selling products that are registered with Medicines and Healthcare Products Regulatory Agency (MHRA) under the TPD and are compliant with the requirements of the TPD. A number of standards must now be met in order to be compliant with the TPD including;
   - Child resistant tamper evident packaging is required for liquids and devices
   - The device must be protected against breakage and leakage and capable of being refilled without leakage.

- Devices must deliver a consistent dose of nicotine under normal conditions
- Tank and cartridge sizes must be no more than 2ml in volume and nicotine strengths of liquids must be no more than 20mg (this must appear on the label)
- The packaging must have a 30% health warning 'this product contains nicotine which is a highly addictive substance' on front and backs of packs. Cover 30% of packs.
- Packs must contain information leaflet on use of the product and ingredients within the e-liquid
- e-cigarettes must not be sold to anyone under 18 years of age

3. In the event that licensed e-cigarette products become available and potentially eligible for NHS prescription, they will be assessed in order to establish best practice. The assessment will consider clinical effectiveness, clinical safety, cost-effectiveness and affordability.

4. We will continue to be vigilant and ensure we protect tobacco control activities in relation to e-cigarettes from the vested interests of the Tobacco Industry in line with our commitment to the WHO FCTC Article 5.3.

5. We will review and update our position on electronic cigarettes as evidence continues to emerge.

The following partners of the Smokefree Barnsley Tobacco Alliance endorse and support this Barnsley consensus statement on e-cigarettes.

BARNSLEY Metropolitan Borough Council

NHS Barnsley Hospital NHS Foundation Trust

NHS Barnsley Clinical Commissioning Group

NHS South West Yorkshire Partnership NHS Foundation Trust

Barnsley College Together We Achieve

BERNESLAI HOMES

pss person shaped support

South Yorkshire Fire & Rescue

Appendix 2: Models of delivery for stop smoking services: Options and evidence (2017)

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.

Appendix 3: Barnsley Stop Smoking Performance Monitoring October 2017 – September 2018

Barnsley Stop Smoking Performance Monitoring October 2017 - September 2018																
Key Performance Indicators																
Barnsley Population as of 2011 Census is 239,300. The smoking prevalence is 21% (2016 JSNA) in adults or 52,253. Of this 32% are routine & manual or 16,060.																
THOSE IN TREATMENT - target 4%																
Ref No.			Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Annual target	Annual performance	Difference
C2	Mental Health (diagnosed) - M	Number counted	7	5	3	9	5	8	3	2	2	6	6	5		61	
		Performance as a %	7%	7%	5%	8%	7%	11%	3%	2%	3%	8%	7%	6%		6%	
C3	Pregnant - P	Number counted	1	1	2		1		1	1		2	1	1		11	
		Performance as a %	1%	1%	3%	0%	1%	0%	1%	1%	0%	3%	1%	1%		1%	
C4	Secondary Care - S	Number counted	13	15	8	18	7	8	8	6	9	9	12	11		124	
		Performance as a %	13%	22%	14%	15%	10%	11%	9%	7%	12%	12%	14%	14%		13%	
C5	RM	Number counted	4	2	1	5		1	3	1	4	2	1	4		28	
		Performance as a %	4%	3%	2%	4%	0%	1%	3%	1%	5%	3%	1%	5%		3%	
C6	RP	Number counted	1	1	1	2	3	8	12	8	13	8	10	6		73	
		Performance as a %	1%	1%	2%	2%	4%	11%	13%	10%	17%	11%	12%	8%		7%	
C7	RS	Number counted	9	4	6	5	4	5	5	8	3	4	5	2		60	
		Performance as a %	9%	6%	10%	4%	6%	7%	5%	10%	4%	5%	6%	3%		6%	
C8	MP	Number counted	2					1								3	
		Performance as a %	2%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%	0%		0%	
C9	MS	Number counted	9	2	6	9	2	4	5	1	3	3	3	10		57	
		Performance as a %	9%	3%	10%	8%	3%	6%	5%	1%	4%	4%	4%	13%		6%	
C10	PS	Number counted														0	
		Performance as a %	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%	
C11	RMPS	Number counted														0	
		Performance as a %	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%	
C12	RMP	Number counted							1							1	
		Performance as a %	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%		0%	
C13	RMS	Number counted	1	2		1	1	1		2						8	
		Performance as a %	1%	3%	0%	1%	1%	1%	0%	2%	0%	0%	0%	0%		1%	
C14	MPS	Number counted														0	
		Performance as a %	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%	
C15	RPS	Number counted														0	
		Performance as a %	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%	

Appendix 1

			WARD PROFILES													
	Central	Number counted	25	13	16	32	24	15	25	26	20	18	23	20		257
		% of total quitters	26%	19%	27%	27%	33%	21%	27%	32%	26%	24%	28%	25%		26%
	Dearne	Number counted	6	9	5	15	7	15	12	7	8	6	8	9		107
		% of total quitters	6%	13%	8%	13%	10%	21%	13%	9%	11%	8%	10%	11%		11%
	North Area	Number counted	16	11	6	16	14	10	18	15	10	19	6	11		152
		% of total quitters	16%	16%	10%	13%	19%	14%	19%	18%	13%	25%	7%	14%		16%
	North East	Number counted	19	18	9	22	9	10	23	13	18	12	18	19		190
		% of total quitters	20%	27%	15%	18%	13%	14%	24%	16%	24%	16%	22%	24%		19%
	Penistone	Number counted	2	1	6	6	3	5	5	1	2	1	7	5		44
		% of total quitters	2%	1%	10%	5%	4%	7%	5%	1%	3%	1%	8%	6%		5%
	Out of Area	Number counted	4	3	4	2	1	2	1	5	1	4	3			30
		% of total quitters	4%	4%	7%	2%	1%	3%	1%	6%	1%	5%	4%	0%		3%
	South	Number counted	25	12	12	27	14	13	10	15	17	16	18	15		194
		% of total quitters	26%	18%	20%	23%	19%	19%	11%	18%	22%	21%	22%	19%		20%
	Homeless	Number counted			1											1
		% of total quitters	0%	0%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%

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