

## DRAFT

## Sheffield Local Public Sector Delivery Plan for Achieving the Smoking Quitters Target 2006 – 2008

### TARGET

The DOH target is to achieve 4,865 smoking quitters in 2006/7 and 5,078 in 2007/8. In addition, as part of the 2006 to 2008 Sheffield LPSA, a 'stretch' target of achieving a further 150 smoking quitters over and above the DOH target for the two-year period has been agreed.

### Delivering targets

Delivery was below target in 2006 (cumulative for 2003/4 + 2004/5 + 2005/6) and our position remains very challenging relative to future target levels as shown in figure 1. Sheffield achieved smoking quitter targets for the financial year 2004/5, as measured by cumulative delivery over the period 2003/5.

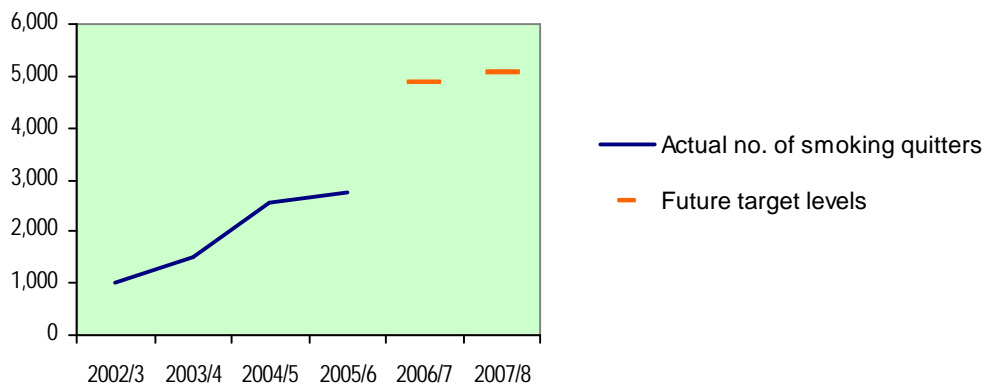


Figure 1. Trend in the number of smoking quitters and target levels for the next two years

Our two major challenges are to:

- double referrals to the Stop Smoking Service
- ensure capacity and cost effectiveness of the Stop Smoking Service.

Assuming 62% of those referred go on to set a quit date, and 50% of those successfully quit, we need:

- About 16,000 referrals (equivalent to about 16% of the smoking population) to produce:
  - 10,000 smokers setting quit dates to deliver
  - 5,000 smoking quitters

There is an immediate need to identify new ways for public services to engage effectively with smokers and improve access to stop smoking programmes to reach smokers who wish to quit (surveys consistently show that around 70% of smokers do wish to stop).

The plan delivers this through coordinated and concerted action across the range of local public sector services, including links to delivery of the Local Area Agreement. Specific contributions to the key delivery areas are needed from the public sector partner agencies:

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- § the NHS stop smoking service as the principal provider service,
- § the primary care trust as provider and commissioner of local NHS services, and
- § the city council as provider and commissioner of local authority services.

### Recruiting smokers

Investment and actions by the four PCTs has focused on improving the way primary care engages with their smokers. Primary care now provides 77% of all referrals, with GP practices accounting for 49% of those (64% of primary care referrals). Community nursing referrals most often come through GP practices. Referrals from community pharmacies have increased from virtually zero two years ago, to comprise 20% of total referrals to the service (or 26% of primary care referrals) now.

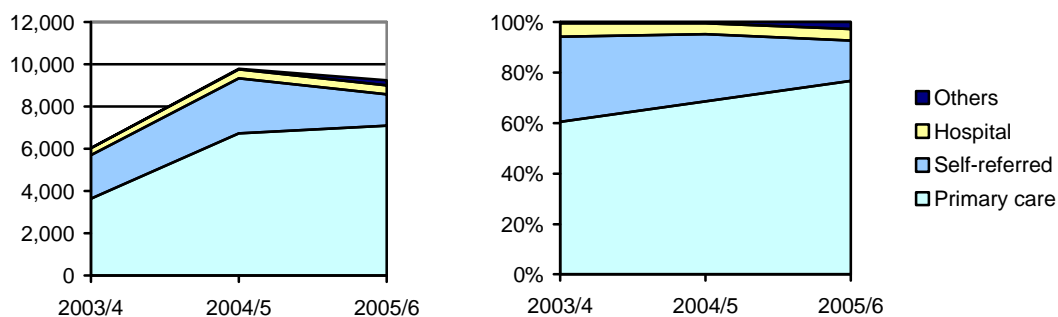


Figure 2. Sources of smokers 'referred' to the NHS stop smoking service in Sheffield

We need to maintain and redouble the focus on primary care services. Identifying smokers and giving advice to stop smoking in a health context is very effective, especially when the advice comes from a GP. The 2003 Health Development Agency guidance identifies GPs as being central to increasing the numbers of smokers accessing local stop smoking services. We are extending this to other healthcare services, particularly the hospital sector.

### Delivering programmes

We have also changed the routes through which intervention programmes are delivered. There has been a move away from PCT-provided community groups towards direct provision by GP practices and community pharmacies as one-to-one advice (figure 3), which smokers prefer.

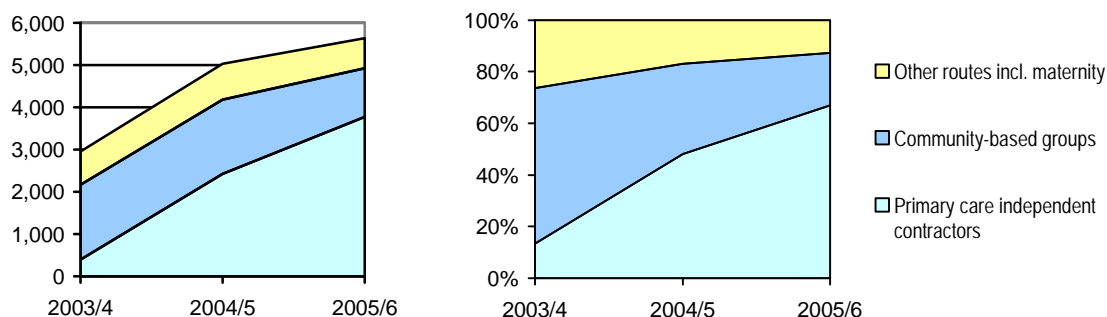


Figure 3. Providers of NHS stop smoking programmes in Sheffield (numbers of service users)

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The importance of direct delivery through primary care services – and GP practices in particular – as the principal delivery route has been reinforced by our review of successful services in Manchester, Bradford and Newcastle. We need to continue our present approaches, and do more.

### Other priorities

#### Efficiency & cost effectiveness

The necessary increase in smoking quitters and the capacity to deliver this has to be achieved within a static resource base, and this introduces a significant cost pressure. Efficiency improvement measures have been identified to address this, however modelled outcomes indicate there would still be a residual underlying cost pressure. Improved efficiency would also contribute to increasing quitter outcomes. A sensitivity analysis of modelled financial outcome scenarios are set out in the appendix.

#### Smoking in pregnancy

The DOH targets to achieve a “one percentage point per year” reduction in the proportion of women who continue to smoke throughout their pregnancy (measured as the proportion who were current smokers at the time of delivery) is also challenging. To date Sheffield has achieved a greater than target reduction. The target was re-baselined for 2004/5, which now makes the trajectory very challenging indeed. New measures in this plan are aimed at increasing quitters and providing on-going support.

#### Communities of interest

Increased delivery has to be achieved whilst maintaining a focus on tackling smoking in our more deprived, and higher risk communities. Effective links with the Enhanced Public Health Programme must ensure close working between the stop smoking service and community development programmes. The 36 target neighbourhoods identified in the EPHP are estimated to contain 50% of the smokers in the city from just 36% of the adult population. The city council can make a significant contribution to this element of the plan.

### NEW FOCUS

There are three key new building blocks for achieving increased delivery over and above the continuation of improvements already underway. These are:

1. New actions in NHS primary care services – principally GP practices and pharmacies.
2. Working with pre-surgery assessment teams to assess the smoking status of all patients and refer smokers to the stop smoking service, as the first phase in engaging hospital services.
3. Local authority services to use their wide ‘population reach’ to good effect in promoting stopping smoking and signposting the local stop smoking service.

## Workstream 1: Efficiency improvements

Delivery area	Stop Smoking Service actions
<p>Improve the cost efficiency and delivery effectiveness of stop smoking programmes to deliver to target within allocated resources</p> <p>Rationale The SSS has made significant progress with introducing systems to give accurate and up to date information about the cost of delivering quit programmes through different routes and providers. This has allowed key cost components to be identified, targeted and reduced. The challenge now is that we have to increase the delivery of smoking quitters within a context of static resources. We therefore need to continue to achieve cost effectiveness improvements through reductions in direct delivery costs, and by integrating some smoking quitter delivery into mainstream services.</p>	<ol style="list-style-type: none"> <li>1. Increase the effectiveness of quit programme with the aim of achieving an aggregate conversion rate of at least 55% (of quit dates set to programme outcomes at four weeks).</li> <li>2. A target cost-per-quit of £55 (direct cost), or better if already achieving this, will be applied to each of the independent contractor delivery pathways.</li> <li>3. Telephone-based support programmes and the national 'together' programme will be promoted wherever applicable to improve advisor utility.</li> </ol>
	<p>PCT actions</p>
	<ol style="list-style-type: none"> <li>4. PCT provider services to consider opportunities for the provision of smoking cessation support from within mainstream primary care provider services.</li> </ol>
	<p>City Council actions</p>
	<ol style="list-style-type: none"> <li>5. Council to consider opportunities for integrating the delivery of quit programmes into mainstream services.</li> </ol>

## Workstream 2: Independent contractors

Delivery area	Stop Smoking Service actions
<p>Increase the delivery of smoking quitters through independent contractor activity</p> <p>Rationale The 2003 HDA guidance to on achieving the smoking quitters target (to support the 2003-6 LDP) states that “an increase in GP referrals / recommendations will be the primary means of increasing numbers”. In Sheffield this has been the primary source of growth over the last two years; however the rate of referral is not yet sufficient. GP referrals (4,547) accounted for 49% of all contacts with the SSS in 2005/6. The HDA recommends that GPs and staff should be referring 10% of their smoking population each year to the local SSS in order to achieve target. In 2005/6 Sheffield GPs referred circa 4% of their smoking population.</p> <p>There is also considerable further scope to increase the engagement and referral of smokers through pharmacies, and dental practices (once the new contract is in place). There is also scope for the City Council to engage with its contractors to extend its engagement with smokers in the city.</p>	<ol style="list-style-type: none"> <li>1. Monitor the rate of GP practice referral and prescribing of cessation aids relative to the number of smokers in the registered population. Target level = at least 8% of the smoking population referred per year. Support will be targeted to achieve this where needed, and especially in areas of high need / deprivation.</li> <li>2. Increase the number and proportion of smoking quitters delivered through independent contractor programmes to more than 70% of total delivery by March 2008.</li> <li>3. Provide targeted support to GP practices and pharmacies accredited as programme providers to increase activity and improve average quit success rate, to be at least 50% for every provider.</li> <li>4. Appraise options for making the reporting of practices and pharmacies quit activity easier, quicker and less paper-reliant.</li> <li>5. Monitoring data will be provided to PCT primary care services and contract review leads (refer to point 6).</li> </ol> <p style="text-align: center;"><b>PCT actions</b></p> <ol style="list-style-type: none"> <li>6. Use the primary care contract review process to promote effective engagement and referral of smokers by independent contractors. These to include: <ul style="list-style-type: none"> <li>§ GP core contract reviews and practice plans</li> <li>§ GP QOF reviews</li> <li>§ Pharmacy contract monitoring and development.</li> <li>§ Dental contract monitoring and development when in place.</li> </ul> </li> <li>7. Explore converting GP practice smoking cessation provider SLAs to local enhanced service contracts to improve their contractual basis.</li> </ol> <p style="text-align: center;"><b>City Council actions</b></p> <ol style="list-style-type: none"> <li>8. Council to identify a named lead to take forward this workstream.</li> <li>9. Council to consider ways to use its contractor portfolio to promote stopping smoking and signposting to services, for example through Sheffield Homes, Sheffield International Venues or care providers.</li> </ol>

**Workstream 3: Communities of interest**

Delivery area	Stop Smoking Service actions
<p>Ensure the provision of programmes tailored to the specific needs of the BME community and other communities as identified in the Healthier Communities action plan of the Sheffield Area Agreement.</p> <p>Rationale Access to stop smoking programmes by ethnic minority smokers is about proportionate to Sheffield population demographics. We would prefer access to be disproportionately higher in view of the higher disease risk profile of some groups.</p> <p>There are around 35,000 students with term-time residence in the city from the two universities, plus those studying at Sheffield college. They are another community of interest.</p>	<ol style="list-style-type: none"> <li>1. Support neighbourhood teams in engaging local communities to tackle smoking effectively.</li> <li>2. Provide approved information and promotion materials in relevant languages and media to support local programmes. This will include promoting the Asian quitline.</li> <li>3. Provide regular neighbourhood monitoring data, and by ethnic origin.</li> <li>4. We will work with the two university health services to undertake at least one stop smoking promotion campaign each year, and support the practices in effectively engaging student smokers through general medical services.</li> <li>5. Support Sheffield Care Trust in maintaining capacity to provide stop smoking programmes to patients with mental health problems.</li> </ol> <div data-bbox="674 659 2201 711" style="background-color: #003366; color: white; text-align: center; padding: 2px;">PCT actions</div> <ol style="list-style-type: none"> <li>6. Ensure an explicit focus on tackling smoking in target priority neighbourhoods.</li> <li>7. Plans targeting the BME community must include explicit actions to tackle smoking. Aim: to achieve at least population pro rata proportion of 4.6% of individuals of South Asian origin (who are at higher risk of smoking-related disease) accessing stop smoking programmes.</li> </ol> <div data-bbox="674 938 2201 991" style="background-color: #003366; color: white; text-align: center; padding: 2px;">City Council actions</div> <ol style="list-style-type: none"> <li>8. As action 5. in relation to the council's contribution to enhanced public health programmes.</li> </ol>

### Workstream 4: Smoking in pregnancy

Delivery area	Stop Smoking Service actions
<p>Achieve a further 1% per year decline in the proportion of women who continue to smoke throughout their pregnancy</p> <p>Rationale Sheffield has achieved better than target reductions in smoking in pregnancy, which has been brought down from 19.4% in 2003 to 16.8% in 2005. However, the future trajectory is challenging. As a result of re-baselining this now needs to be reduced to 15.6% by March 2007 and 14.7% by March 2008. In order to achieve this it will be necessary for mainstream maternity services to engage in tackling smoking. Currently over 80% of successful pregnancy quits are delivered through just 1.2wte specialist smoking cessation midwives. This is not going to deliver the target. Only 16 pregnant quitters were contributed during the whole of 2005/6 by maternity services and Sure Start programmes citywide.</p>	<ol style="list-style-type: none"> <li>1. Continue a specialist smoking cessation midwife service, focusing on high risk individuals, cases of high level addiction and those with complex behavioural or clinical needs.</li> <li>2. Specialist midwives to support mainstream maternity services and Sure Start programmes to increase the number of pregnant women they help to successfully stop smoking.</li> <li>3. Specialist midwives to provide intervention training to community midwives and support staff as input to formal midwifery training programmes.</li> <li>4. Provide maternity services and Sure Start programmes with relevant monitoring data.</li> </ol>
	<p>PCT actions</p>
	<ol style="list-style-type: none"> <li>5. The PCT to incorporate agreed community maternity services contribution to tackling smoking in pregnancy into the STHFT contract.</li> </ol>
	<p>City Council actions</p>
	<p>§ Relevant services to identify pregnant smokers and signpost / refer to stop smoking services.</p>

**Workstream 5: Public sector provider services**

Delivery area	Stop Smoking Service actions
<p>Engage public sector provider services in the recruitment of smokers to quit programmes</p> <p>Rationale Next to GP referrals, NHS provider services have the greatest potential for engaging and referring smokers; principally hospital services. However, during 2005/6 only 5% of SSS referrals (440 vs. 4,547 GP-referred) came from Sheffield hospitals, which was around the same as the previous year.</p> <p>It is difficult to identify the number or proportion of referrals coming specifically from PCT community services since many, such as community nurses, physiotherapists etc, operate and refer through GP practices. However PCT clinical provider services are not universally active in engaging with and referring smokers. There is some potential for Council services to engage with the public directly in relation to smoking</p>	<ol style="list-style-type: none"> <li>1. Work closely with Sheffield Teaching Hospitals to support the Trust in:               <ol style="list-style-type: none"> <li>a. Establishing pre-operative smoking status assessments, recording and cessation advice-giving for all surgical patients (DOH provider trust target for 2006/7). Components:                   <ol style="list-style-type: none"> <li>i. Provision of brief intervention training to all relevant pre-operative assessment staff.</li> <li>ii. Establish a recording system and referral pathway to the SSS.</li> <li>iii. Consider offer of NRT to patients who are prepared to commence a quit attempt immediately.</li> </ol> </li> <li>b. Expansion of the provision of brief intervention advice in outpatient and rehabilitation clinics, with a particular emphasis on the cardiac, vascular and respiratory pathways. To include the offer of NRT and referral to the SSS.</li> </ol> </li> <li>2. Provide regular activity monitoring data by referring specialty to STHFT, as a component of contract monitoring.</li> <li>3. Smoking intervention training will be offered to PCT community healthcare staff citywide.</li> </ol>
	PCT actions
	<ol style="list-style-type: none"> <li>4. The requirement for smoking assessments in surgical pathways and other agreed Trust actions to be incorporated into the STHFT contract, and formal monitoring / review processes.</li> </ol>
	City Council actions
	<ol style="list-style-type: none"> <li>5. Council to consider opportunities for the provision of brief intervention advice to clients of Council services where client assessments are a feature of the service.</li> </ol>

## Workstream 6: Self-referring smokers

Delivery area	Stop Smoking Service actions
<p>Increase the number of self-referred smokers</p> <p>Rationale The number of self-referred smokers has declined significantly during 2005/6 to about half of the level seen in the preceding two years (1,209 versus 2,445 &amp; 2,272). At least in part this has been by design due to markedly improved access to quit programmes in GP practices and pharmacies. However self referral is still an important route into the service, since we need to be effective at getting the message across to the public who do not frequent surgeries and pharmacies. The promotion of access to NHS stop smoking services also needs to be integrated with actions aimed at promoting stopping smoking and encouraging smoke-free environments. The aim is to exceed earlier self-referral rates.</p> <p>Engaging the media is key to achieving this. Through a managed approach to PR we have been successful in maintaining at least 50 hits in the local media per year, i.e. average of one per week. During 2005/6 we achieved around 70 hits.</p>	<ol style="list-style-type: none"> <li>1. Continue engagement with local media, an agreed PR plan, and respond to opportunistic media issues, to maintain at least 50 media hits per year.</li> <li>2. Media / public interest is expected to increase pre- and post-introduction of the 2006 Health Act (smoking ban). Continue to promote the Smoke Free Sheffield brand as a high visibility vehicle for the smoke-free / stop smoking message.</li> <li>3. Ensure availability and distribution of effective promotion materials.</li> <li>4. Monitor access to programmes to ensure effective targeting of community-based provision in areas of high need / deprivation.</li> </ol> <p style="text-align: center;"><b>PCT actions</b></p> <ol style="list-style-type: none"> <li>5. Posters and information materials available to all GP practices and pharmacies.</li> <li>6. Require at least one citywide community pharmacy based stop smoking promotion campaign each year to fulfil of the new pharmacy contract.</li> <li>7. Local health awareness events include promotion of the stop smoking service wherever relevant.</li> <li>8. Also see the communities of interest workstream (component 3).</li> </ol> <p style="text-align: center;"><b>City Council actions</b></p> <ol style="list-style-type: none"> <li>9. All practical opportunities exploited for advertising &amp; promoting the stop smoking service through Council information and service outlets -             <ul style="list-style-type: none"> <li>§ Council staff are able to provide contact detail for the SSS to customers on request</li> <li>§ Posters and information materials are available at all Council public reception areas, e.g. Firstpoint, Town Hall, Libraries, community care offices, licensing offices</li> <li>§ Displaying information at Council public meetings/events, e.g. area panels</li> <li>§ Including references in all relevant Council newsletters, mailings, leaflets and publications</li> <li>§ Providing high profile links to the SSS on the Council website</li> </ul> </li> <li>10. Council neighbourhoods programmes tackle smoking as a priority element of delivering the Local Area Agreement.</li> </ol>

## Workstream 7: Workplaces

Delivery area	Stop Smoking Service actions
<p>Promotion of smoking quitters through workplace programmes</p> <p>Rationale High potential for making an impact on smoking through workplace focused activity. In practice this is difficult to make a reality because, a) it is hard to achieve employer engagement, even in existing smoke-free businesses, and b) drop-out rates are high in work-based programmes. The scope for employer &amp; employee engagement will increase as we approach the introduction of the Health Act in 2007, and we wish to respond to this.</p>	<ol style="list-style-type: none"> <li>1. Continue to promote the offer of workplace-based quit programmes to PCT staff.</li> <li>2. Support other Sheffield NHS trusts and the city council in the promoting and providing work-based quit programmes to staff.</li> <li>3. Evaluate the capacity implications of extending the offer of quit programmes to businesses going smoke free in response to the introduction of the 2006 Health Act, so that resources can be employed effectively.</li> <li>4. Work closely with the health protection unit of the City Council to engage with businesses going smoke free.</li> </ol>
	<p style="text-align: center;">PCT actions</p>
	<ol style="list-style-type: none"> <li>5. Promote and provide opportunities in work time where practicable to support staff to stop smoking.</li> <li>6. Smoke-free businesses workstream to be transferred to the City Council's health protection unit.</li> </ol>
	<p style="text-align: center;">City Council actions</p>
<ol style="list-style-type: none"> <li>7. City Council health protection unit to encourage Sheffield businesses to go smoke-free early, and encourage employers to provide opportunities / support for their staff to stop smoking.</li> <li>8. Establish comprehensive work-based quit programme for Council employees, including provision of stop smoking support in work time.</li> <li>9. Explore opportunities to promote the delivery of work-based quit programme within the Council's main contracting organisations, e.g. Kier, Sheffield Homes and Libarata.</li> </ol>	

## APPENDIX

### SENSITIVITY ANALYSIS OF FINANCIAL OUTURN

	Number of quitters	Indirect delivery costs	Direct Cost	Total Cost	Allocation	Variance +ve = overspend
Scenario 1 - assumes the unit delivery costs for 2006/7 & 2007/8 remain the same as for 2005/6		£	£	£	£	£
1a – 05/06 cost per quit, 2006/7 target delivery	4,865	330,230	287,522	617,752	591,990	25,762
1b – 05/06 cost per quit, 2007/8 target delivery	5,078	330,230	300,110	630,340	591,990	38,350
1c – break even, 05/06 cost per quit	4,429	330,230	261,754	591,990	591,990	b/e
Scenario 2 - assumes target reduction in delivery costs are achieved						
2a – target cost per quit, 2006/7 target delivery	4,865	330,230	264,656	594,886	591,990	2,896
2b – target cost per quit, 2007/8 target delivery	5,078	330,230	276,243	606,473	591,990	14,483
2c – break even, target cost per quit	4,812	330,230	261,782	591,990	591,990	b/e

#### Assumptions

- a) Total budget allocation remains as for 2005/6.
- b) Proportion of service users and quitters by intervention route remains as for 2005/6.
- c) Indirect costs are kept within budgeted amounts.

#### Current and target direct delivery costs

Delivery route	Scenario 1 2005/6 £ per quit	Scenario 2 target £ per quit
Service delivery *	82	70
GP practice	60	55
Pharmacy	50	50
Dentist	56	55

\* largely community groups and maternity interventions

These are incremental costs, i.e. the total direct costs increase / decrease proportionately with the number of smoking quitters delivered through the associated route.

#### Conclusion

1. Achieving the target number of smoking quitters at the 2005/6 level of unit (direct) costs would incur a cost pressure for the PCT of circa £26k in 2006/7 and £38k in 2007/8.
2. A target reduction in delivery costs has been set which, whilst difficult, we feel is achievable (scenario 2). The planned cost reduction is to be achieved by efficiency improvements focused on increasing the ratio of service users who become successful quitters (usually referred to as the 'quit rate'). There is a sizeable risk associated with achieving this because there are key dependencies on external factors, such as being limited in the extent to which we can influence the actions of the staff of independent contractors. However, even if planned efficiencies are delivered, achieving a breakeven position would still be challenging.